

By: Representative Roberson

To: Medicaid

HOUSE BILL NO. 250

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO AUTHORIZE THE DIRECT ON-SITE SUPERVISOR OF A PROVIDER IN A
3 MANAGED CARE ORGANIZATION UNDER ANY MANAGED CARE PROGRAM
4 IMPLEMENTED BY THE DIVISION OF MEDICAID WHO HAS BEGUN THE PROCESS
5 FOR CREDENTIALING AND PREVIOUSLY HAS NOT BEEN DENIED CREDENTIALING
6 TO SIGN OFF ON THE WORK OF THE PROVIDER DURING THE TIME THAT THE
7 PROVIDER IS AWAITING A DECISION ON HIS OR HER CREDENTIALING, AND
8 TO ALLOW THE PROVIDER TO RECEIVE REIMBURSEMENT FROM THE
9 ORGANIZATION FOR THE WORK THAT HAS BEEN SIGNED OFF ON BY THE
10 SUPERVISOR; TO AMEND SECTION 43-13-121, MISSISSIPPI CODE OF 1972,
11 TO PROVIDE THAT WHENEVER THE DIVISION DETERMINES AFTER A HEARING
12 THAT A PROVIDER HAS VIOLATED ANY PROVISION OF THE MEDICAID LAW,
13 THE DIVISION MAY NOT SUSPEND REIMBURSEMENT PAYMENTS TO THE
14 PROVIDER DURING THE TIME THAT THE DECISION OF THE DIVISION IS ON
15 APPEAL BY THE PROVIDER, UNLESS THE PROVIDER PREVIOUSLY HAS BEEN
16 CONVICTED OF FRAUD IN CONNECTION WITH THE MEDICAID PROGRAM; AND
17 FOR RELATED PURPOSES.

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

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

21 43-13-117. (A) Medicaid as authorized by this article shall
22 include payment of part or all of the costs, at the discretion of
23 the division, with approval of the Governor and the Centers for
24 Medicare and Medicaid Services, of the following types of care and
25 services rendered to eligible applicants who have been determined



to be eligible for that care and services, within the limits of state appropriations and federal matching funds:

(1) Inpatient hospital services.

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

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

(2) Outpatient hospital services.

(a) Emergency services.

(b) Other outpatient hospital services. The division shall allow benefits for other medically necessary outpatient hospital services (such as chemotherapy, radiation, surgery and therapy), including outpatient services in a clinic or other facility that is not located inside the hospital, but that has been designated as an outpatient facility by the hospital, and that was in operation or under construction on July 1, 2009, provided that the costs and charges associated with the operation of the hospital clinic are included in the hospital's cost report. In addition, the Medicare thirty-five-mile rule will apply to those hospital clinics not located inside the hospital that are



constructed after July 1, 2009. Where the same services are reimbursed as clinic services, the division may revise the rate or methodology of outpatient reimbursement to maintain consistency, efficiency, economy and quality of care.

(c) The division is authorized to implement an Ambulatory Payment Classification (APC) methodology for outpatient hospital services. The division shall give rural hospitals that have fifty (50) or fewer licensed beds the option to not be reimbursed for outpatient hospital services using the APC methodology, but reimbursement for outpatient hospital services provided by those hospitals shall be based on one hundred one percent (101%) of the rate established under Medicare for outpatient hospital services. Those hospitals choosing to not be reimbursed under the APC methodology shall remain under cost-based reimbursement for a two-year period.

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

(3) Laboratory and x-ray services.

(4) Nursing facility services.

(a) The division shall make full payment to nursing facilities for each day, not exceeding forty-two (42) days per year, that a patient is absent from the facility on home



76 leave. Payment may be made for the following home leave days in
77 addition to the forty-two-day limitation: Christmas, the day
78 before Christmas, the day after Christmas, Thanksgiving, the day
79 before Thanksgiving and the day after Thanksgiving.

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

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

95 (d) On or after January 1, 2015, the division
96 shall update the case-mix payment system resource utilization
97 grouper and classifications and fair rental reimbursement system.
98 The division shall develop and implement a payment add-on to
99 reimburse nursing facilities for ventilator-dependent resident
100 services.



101 (e) The division shall develop and implement, not
102 later than January 1, 2001, a case-mix payment add-on determined
103 by time studies and other valid statistical data that will
104 reimburse a nursing facility for the additional cost of caring for
105 a resident who has a diagnosis of Alzheimer's or other related
106 dementia and exhibits symptoms that require special care. Any
107 such case-mix add-on payment shall be supported by a determination
108 of additional cost. The division shall also develop and implement
109 as part of the fair rental reimbursement system for nursing
110 facility beds, an Alzheimer's resident bed depreciation enhanced
111 reimbursement system that will provide an incentive to encourage
112 nursing facilities to convert or construct beds for residents with
113 Alzheimer's or other related dementia.

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

118 The division shall apply for necessary federal waivers to
119 assure that additional services providing alternatives to nursing
120 facility care are made available to applicants for nursing
121 facility care.

122 (5) Periodic screening and diagnostic services for
123 individuals under age twenty-one (21) years as are needed to
124 identify physical and mental defects and to provide health care
125 treatment and other measures designed to correct or ameliorate



defects and physical and mental illness and conditions discovered by the screening services, regardless of whether these services are included in the state plan. The division may include in its periodic screening and diagnostic program those discretionary services authorized under the federal regulations adopted to implement Title XIX of the federal Social Security Act, as amended. The division, in obtaining physical therapy services, occupational therapy services, and services for individuals with speech, hearing and language disorders, may enter into a cooperative agreement with the State Department of Education for the provision of those services to handicapped students by public school districts using state funds that are provided from the appropriation to the Department of Education to obtain federal matching funds through the division. The division, in obtaining medical and mental health assessments, treatment, care and services for children who are in, or at risk of being put in, the custody of the Mississippi Department of Human Services may enter into a cooperative agreement with the Mississippi Department of Human Services for the provision of those services using state funds that are provided from the appropriation to the Department of Human Services to obtain federal matching funds through the division.

(6) Physician services. Fees for physician's services that are covered only by Medicaid shall be reimbursed at ninety percent (90%) of the rate established on January 1, 2018, and as



may be adjusted each July thereafter, under Medicare. The division may provide for a reimbursement rate for physician's services of up to one hundred percent (100%) of the rate established under Medicare for physician's services that are provided after the normal working hours of the physician, as determined in accordance with regulations of the division. The division may reimburse eligible providers, as determined by the division, for certain primary care services at one hundred percent (100%) of the rate established under Medicare. The division shall reimburse obstetricians and gynecologists for certain primary care services as defined by the division at one hundred percent (100%) of the rate established under Medicare.

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

(b) [Repealed]

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



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

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

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

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

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

Drugs prescribed for a resident of a psychiatric residential treatment facility must be provided in true unit doses when available. The division may require that drugs not covered by Medicare Part D for a resident of a long-term care facility be



provided in true unit doses when available. Those drugs that were originally billed to the division but are not used by a resident in any of those facilities shall be returned to the billing pharmacy for credit to the division, in accordance with the guidelines of the State Board of Pharmacy and any requirements of federal law and regulation. Drugs shall be dispensed to a recipient and only one (1) dispensing fee per month may be charged. The division shall develop a methodology for reimbursing for restocked drugs, which shall include a restock fee as determined by the division not exceeding Seven Dollars and Eighty-two Cents (\$7.82).

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

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

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

The division shall develop a pharmacy policy in which drugs in tamper-resistant packaging that are prescribed for a resident of a nursing facility but are not dispensed to the resident shall



be returned to the pharmacy and not billed to Medicaid, in accordance with guidelines of the State Board of Pharmacy.

The division shall develop and implement a method or methods by which the division will provide on a regular basis to Medicaid providers who are authorized to prescribe drugs, information about the costs to the Medicaid program of single-source drugs and innovator multiple-source drugs, and information about other drugs that may be prescribed as alternatives to those single-source drugs and innovator multiple-source drugs and the costs to the Medicaid program of those alternative drugs.

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

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

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



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

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

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

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

The division shall increase the amount of the reimbursement rate for diagnostic and preventative dental services for each of the fiscal years 2022, 2023 and 2024 by five percent (5%) above the amount of the reimbursement rate for the previous fiscal year. The division shall increase the amount of the reimbursement rate for restorative dental services for each of the fiscal years 2023, 2024 and 2025 by five percent (5%) above the amount of the reimbursement rate for the previous fiscal year. It is the intent of the Legislature that the reimbursement rate revision for preventative dental services will be an incentive to increase the



number of dentists who actively provide Medicaid services. This dental services reimbursement rate revision shall be known as the "James Russell Dumas Medicaid Dental Services Incentive Program."

The Medical Care Advisory Committee, assisted by the Division of Medicaid, shall annually determine the effect of this incentive by evaluating the number of dentists who are Medicaid providers, the number who and the degree to which they are actively billing Medicaid, the geographic trends of where dentists are offering what types of Medicaid services and other statistics pertinent to the goals of this legislative intent. This data shall annually be presented to the Chair of the Senate Medicaid Committee and the Chair of the House Medicaid Committee.

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

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

(12) Intermediate care facility services.



299 (a) The division shall make full payment to all
300 intermediate care facilities for individuals with intellectual
301 disabilities for each day, not exceeding sixty-three (63) days per
302 year, that a patient is absent from the facility on home leave.
303 Payment may be made for the following home leave days in addition
304 to the sixty-three-day limitation: Christmas, the day before
305 Christmas, the day after Christmas, Thanksgiving, the day before
306 Thanksgiving and the day after Thanksgiving.

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

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

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

316 (14) Clinic services. Preventive, diagnostic,
317 therapeutic, rehabilitative or palliative services that are
318 furnished by a facility that is not part of a hospital but is
319 organized and operated to provide medical care to outpatients.
320 Clinic services include, but are not limited to:

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

323 (b) Dialysis center services.



324 (15) Home- and community-based services for the elderly
325 and disabled, as provided under Title XIX of the federal Social
326 Security Act, as amended, under waivers, subject to the
327 availability of funds specifically appropriated for that purpose
328 by the Legislature.

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

347 (17) Durable medical equipment services and medical
348 supplies. Precertification of durable medical equipment and



349 medical supplies must be obtained as required by the division.
350 The Division of Medicaid may require durable medical equipment
351 providers to obtain a surety bond in the amount and to the
352 specifications as established by the Balanced Budget Act of 1997.
353 A maximum dollar amount of reimbursement for noninvasive
354 ventilators or ventilation treatments properly ordered and being
355 used in an appropriate care setting shall not be set by any health
356 maintenance organization, coordinated care organization,
357 provider-sponsored health plan, or other organization paid for
358 services on a capitated basis by the division under any managed
359 care program or coordinated care program implemented by the
360 division under this section. Reimbursement by these organizations
361 to durable medical equipment suppliers for home use of noninvasive
362 and invasive ventilators shall be on a continuous monthly payment
363 basis for the duration of medical need throughout a patient's
364 valid prescription period.

365 (18) (a) Notwithstanding any other provision of this
366 section to the contrary, as provided in the Medicaid state plan
367 amendment or amendments as defined in Section 43-13-145(10), the
368 division shall make additional reimbursement to hospitals that
369 serve a disproportionate share of low-income patients and that
370 meet the federal requirements for those payments as provided in
371 Section 1923 of the federal Social Security Act and any applicable
372 regulations. It is the intent of the Legislature that the
373 division shall draw down all available federal funds allotted to



the state for disproportionate share hospitals. However, from and after January 1, 1999, public hospitals participating in the Medicaid disproportionate share program may be required to participate in an intergovernmental transfer program as provided in Section 1903 of the federal Social Security Act and any applicable regulations.

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

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

(ii) The division shall assess each hospital, nursing facility, and emergency ambulance transportation provider for the sole purpose of financing the state portion of the Medicare Upper Payment Limits Program or other program(s) authorized under this subsection (A)(18)(b). The hospital assessment shall be as provided in Section 43-13-145(4)(a), and



the nursing facility and the emergency ambulance transportation assessments, if established, shall be based on Medicaid utilization or other appropriate method, as determined by the division, consistent with federal regulations. The assessments will remain in effect as long as the state participates in the Medicare Upper Payment Limits Program or other program(s) authorized under this subsection (A)(18)(b). In addition to the hospital assessment provided in Section 43-13-145(4)(a), hospitals with physicians participating in the Medicare Upper Payment Limits Program or other program(s) authorized under this subsection (A)(18)(b) shall be required to participate in an intergovernmental transfer or assessment, as determined by the division, for the purpose of financing the state portion of the physician UPL payments or other payment(s) authorized under this subsection (A)(18)(b).

(iii) Subject to approval by the Centers for Medicare and Medicaid Services (CMS) and the provisions of this subsection (A)(18)(b), the division shall make additional reimbursement to hospitals, nursing facilities, and emergency ambulance transportation providers for the Medicare Upper Payment Limits Program or other program(s) authorized under this subsection (A)(18)(b), and, if the program is established for physicians, shall make additional reimbursement for physicians, as defined in Section 1902(a)(30) of the federal Social Security Act



and any applicable federal regulations, provided the assessment in this subsection (A) (18) (b) is in effect.

(iv) Notwithstanding any other provision of this article to the contrary, effective upon implementation of the Mississippi Hospital Access Program (MHAP) provided in subparagraph (c) (i) below, the hospital portion of the inpatient Upper Payment Limits Program shall transition into and be replaced by the MHAP program. However, the division is authorized to develop and implement an alternative fee-for-service Upper Payment Limits model in accordance with federal laws and regulations if necessary to preserve supplemental funding. Further, the division, in consultation with the hospital industry shall develop alternative models for distribution of medical claims and supplemental payments for inpatient and outpatient hospital services, and such models may include, but shall not be limited to the following: increasing rates for inpatient and outpatient services; creating a low-income utilization pool of funds to reimburse hospitals for the costs of uncompensated care, charity care and bad debts as permitted and approved pursuant to federal regulations and the Centers for Medicare and Medicaid Services; supplemental payments based upon Medicaid utilization, quality, service lines and/or costs of providing such services to Medicaid beneficiaries and to uninsured patients. The goals of such payment models shall be to ensure access to inpatient and outpatient care and to maximize any federal funds that are



448 available to reimburse hospitals for services provided. Any such
449 documents required to achieve the goals described in this
450 paragraph shall be submitted to the Centers for Medicare and
451 Medicaid Services, with a proposed effective date of July 1, 2019,
452 to the extent possible, but in no event shall the effective date
453 of such payment models be later than July 1, 2020. The Chairmen
454 of the Senate and House Medicaid Committees shall be provided a
455 copy of the proposed payment model(s) prior to submission.
456 Effective July 1, 2018, and until such time as any payment
457 model(s) as described above become effective, the division, in
458 consultation with the hospital industry, is authorized to
459 implement a transitional program for inpatient and outpatient
460 payments and/or supplemental payments (including, but not limited
461 to, MHAP and directed payments), to redistribute available
462 supplemental funds among hospital providers, provided that when
463 compared to a hospital's prior year supplemental payments,
464 supplemental payments made pursuant to any such transitional
465 program shall not result in a decrease of more than five percent
466 (5%) and shall not increase by more than the amount needed to
467 maximize the distribution of the available funds.

468 (v) 1. To preserve and improve access to
469 ambulance transportation provider services, the division shall
470 seek CMS approval to make ambulance service access payments as set
471 forth in this subsection (A)(18)(b) for all covered emergency
472 ambulance services rendered on or after July 1, 2022, and shall



make such ambulance service access payments for all covered services rendered on or after the effective date of CMS approval.

2. The division shall calculate the ambulance service access payment amount as the balance of the portion of the Medical Care Fund related to ambulance transportation service provider assessments plus any federal matching funds earned on the balance, up to, but not to exceed, the upper payment limit gap for all emergency ambulance service providers.

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

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

c. As used in this paragraph (18)(b)(v), the term "upper payment limit gap" means the



498 difference between the total amount that the ambulance
499 transportation service provider received from Medicaid and the
500 average amount that the ambulance transportation service provider
501 would have received from commercial insurers for those services
502 reimbursed by Medicaid.

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

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

521 (ii) Subject to approval by the Centers for
522 Medicare and Medicaid Services (CMS), the MHAP shall provide



523 increased inpatient capitation (PMPM) payments to managed care
524 entities contracting with the division pursuant to subsection (H)
525 of this section to support availability of hospital services or
526 such other payments permissible under federal law necessary to
527 accomplish the intent of this subsection.

528 (iii) The intent of this subparagraph (c) is
529 that effective for all inpatient hospital Medicaid services during
530 state fiscal year 2016, and so long as this provision shall remain
531 in effect hereafter, the division shall to the fullest extent
532 feasible replace the additional reimbursement for hospital
533 inpatient services under the inpatient Medicare Upper Payment
534 Limits (UPL) Program with additional reimbursement under the MHAP
535 and other payment programs for inpatient and/or outpatient
536 payments which may be developed under the authority of this
537 paragraph.

538 (iv) The division shall assess each hospital
539 as provided in Section 43-13-145(4) (a) for the purpose of
540 financing the state portion of the MHAP, supplemental payments and
541 such other purposes as specified in Section 43-13-145. The
542 assessment will remain in effect as long as the MHAP and
543 supplemental payments are in effect.

544 (19) (a) Perinatal risk management services. The
545 division shall promulgate regulations to be effective from and
546 after October 1, 1988, to establish a comprehensive perinatal
547 system for risk assessment of all pregnant and infant Medicaid



548 recipients and for management, education and follow-up for those
549 who are determined to be at risk. Services to be performed
550 include case management, nutrition assessment/counseling,
551 psychosocial assessment/counseling and health education. The
552 division shall contract with the State Department of Health to
553 provide services within this paragraph (Perinatal High Risk
554 Management/Infant Services System (PHRM/ISS)). The State
555 Department of Health shall be reimbursed on a full reasonable cost
556 basis for services provided under this subparagraph (a).

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



572 (20) Home- and community-based services for physically
573 disabled approved services as allowed by a waiver from the United
574 States Department of Health and Human Services for home- and
575 community-based services for physically disabled people using
576 state funds that are provided from the appropriation to the State
577 Department of Rehabilitation Services and used to match federal
578 funds under a cooperative agreement between the division and the
579 department, provided that funds for these services are
580 specifically appropriated to the Department of Rehabilitation
581 Services.

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



nurse practitioner, as determined in accordance with regulations of the division.

(22) Ambulatory services delivered in federally qualified health centers, rural health centers and clinics of the local health departments of the State Department of Health for individuals eligible for Medicaid under this article based on reasonable costs as determined by the division. Federally qualified health centers shall be reimbursed by the Medicaid prospective payment system as approved by the Centers for Medicare and Medicaid Services. The division shall recognize federally qualified health centers (FQHCs), rural health clinics (RHCs) and community mental health centers (CMHCs) as both an originating and distant site provider for the purposes of telehealth reimbursement. The division is further authorized and directed to reimburse FQHCs, RHCs and CMHCs for both distant site and originating site services when such services are appropriately provided by the same organization.

(23) Inpatient psychiatric services.

(a) Inpatient psychiatric services to be determined by the division for recipients under age twenty-one (21) that are provided under the direction of a physician in an inpatient program in a licensed acute care psychiatric facility or in a licensed psychiatric residential treatment facility, before the recipient reaches age twenty-one (21) or, if the recipient was receiving the services immediately before he or she reached age



621 twenty-one (21), before the earlier of the date he or she no
622 longer requires the services or the date he or she reaches age
623 twenty-two (22), as provided by federal regulations. From and
624 after January 1, 2015, the division shall update the fair rental
625 reimbursement system for psychiatric residential treatment
626 facilities. Precertification of inpatient days and residential
627 treatment days must be obtained as required by the division. From
628 and after July 1, 2009, all state-owned and state-operated
629 facilities that provide inpatient psychiatric services to persons
630 under age twenty-one (21) who are eligible for Medicaid
631 reimbursement shall be reimbursed for those services on a full
632 reasonable cost basis.

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

637 (24) [Deleted]

638 (25) [Deleted]

639 (26) Hospice care. As used in this paragraph, the term
640 "hospice care" means a coordinated program of active professional
641 medical attention within the home and outpatient and inpatient
642 care that treats the terminally ill patient and family as a unit,
643 employing a medically directed interdisciplinary team. The
644 program provides relief of severe pain or other physical symptoms
645 and supportive care to meet the special needs arising out of



646 physical, psychological, spiritual, social and economic stresses
647 that are experienced during the final stages of illness and during
648 dying and bereavement and meets the Medicare requirements for
649 participation as a hospice as provided in federal regulations.

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

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

657 (29) The Division of Medicaid may apply for a waiver
658 from the United States Department of Health and Human Services for
659 home- and community-based services for developmentally disabled
660 people using state funds that are provided from the appropriation
661 to the State Department of Mental Health and/or funds transferred
662 to the department by a political subdivision or instrumentality of
663 the state and used to match federal funds under a cooperative
664 agreement between the division and the department, provided that
665 funds for these services are specifically appropriated to the
666 Department of Mental Health and/or transferred to the department
667 by a political subdivision or instrumentality of the state.

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



671 (31) Targeted case management services for children
672 with special needs, under waivers from the United States
673 Department of Health and Human Services, using state funds that
674 are provided from the appropriation to the Mississippi Department
675 of Human Services and used to match federal funds under a
676 cooperative agreement between the division and the department.

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

683 (33) Podiatrist services.

684 (34) Assisted living services as provided through
685 home- and community-based services under Title XIX of the federal
686 Social Security Act, as amended, subject to the availability of
687 funds specifically appropriated for that purpose by the
688 Legislature.

689 (35) Services and activities authorized in Sections
690 43-27-101 and 43-27-103, using state funds that are provided from
691 the appropriation to the Mississippi Department of Human Services
692 and used to match federal funds under a cooperative agreement
693 between the division and the department.

694 (36) Nonemergency transportation services for
695 Medicaid-eligible persons as determined by the division. The PEER



696 Committee shall conduct a performance evaluation of the
697 nonemergency transportation program to evaluate the administration
698 of the program and the providers of transportation services to
699 determine the most cost-effective ways of providing nonemergency
700 transportation services to the patients served under the program.
701 The performance evaluation shall be completed and provided to the
702 members of the Senate Medicaid Committee and the House Medicaid
703 Committee not later than January 1, 2019, and every two (2) years
704 thereafter.

705 (37) [Deleted]

706 (38) Chiropractic services. A chiropractor's manual
707 manipulation of the spine to correct a subluxation, if x-ray
708 demonstrates that a subluxation exists and if the subluxation has
709 resulted in a neuromusculoskeletal condition for which
710 manipulation is appropriate treatment, and related spinal x-rays
711 performed to document these conditions. Reimbursement for
712 chiropractic services shall not exceed Seven Hundred Dollars
713 (\$700.00) per year per beneficiary.

714 (39) Dually eligible Medicare/Medicaid beneficiaries.
715 The division shall pay the Medicare deductible and coinsurance
716 amounts for services available under Medicare, as determined by
717 the division. From and after July 1, 2009, the division shall
718 reimburse crossover claims for inpatient hospital services and
719 crossover claims covered under Medicare Part B in the same manner



that was in effect on January 1, 2008, unless specifically authorized by the Legislature to change this method.

(40) [Deleted]

(41) Services provided by the State Department of Rehabilitation Services for the care and rehabilitation of persons with spinal cord injuries or traumatic brain injuries, as allowed under waivers from the United States Department of Health and Human Services, using up to seventy-five percent (75%) of the funds that are appropriated to the Department of Rehabilitation Services from the Spinal Cord and Head Injury Trust Fund established under Section 37-33-261 and used to match federal funds under a cooperative agreement between the division and the department.

(42) [Deleted]

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

(44) Nursing facility services for the severely disabled.

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



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

747 (45) Physician assistant services. Services furnished
748 by a physician assistant who is licensed by the State Board of
749 Medical Licensure and is practicing with physician supervision
750 under regulations adopted by the board, under regulations adopted
751 by the division. Reimbursement for those services shall not
752 exceed ninety percent (90%) of the reimbursement rate for
753 comparable services rendered by a physician. The division may
754 provide for a reimbursement rate for physician assistant services
755 of up to one hundred percent (100%) or the reimbursement rate for
756 comparable services rendered by a physician for physician
757 assistant services that are provided after the normal working
758 hours of the physician assistant, as determined in accordance with
759 regulations of the division.

760 (46) The division shall make application to the federal
761 Centers for Medicare and Medicaid Services (CMS) for a waiver to
762 develop and provide services for children with serious emotional
763 disturbances as defined in Section 43-14-1(1), which may include
764 home- and community-based services, case management services or
765 managed care services through mental health providers certified by
766 the Department of Mental Health. The division may implement and
767 provide services under this waived program only if funds for
768 these services are specifically appropriated for this purpose by



the Legislature, or if funds are voluntarily provided by affected agencies.

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

(b) Participation in any disease management program implemented under this paragraph (47) is optional with the individual. An individual must affirmatively elect to participate in the disease management program in order to participate, and may elect to discontinue participation in the program at any time.

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

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

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

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



793 (50) Services provided by the State Department of
794 Rehabilitation Services for the care and rehabilitation of persons
795 who are deaf and blind, as allowed under waivers from the United
796 States Department of Health and Human Services to provide home-
797 and community-based services using state funds that are provided
798 from the appropriation to the State Department of Rehabilitation
799 Services or if funds are voluntarily provided by another agency.

800 (51) Upon determination of Medicaid eligibility and in
801 association with annual redetermination of Medicaid eligibility,
802 beneficiaries shall be encouraged to undertake a physical
803 examination that will establish a base-line level of health and
804 identification of a usual and customary source of care (a medical
805 home) to aid utilization of disease management tools. This
806 physical examination and utilization of these disease management
807 tools shall be consistent with current United States Preventive
808 Services Task Force or other recognized authority recommendations.

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

812 (52) Notwithstanding any provisions of this article,
813 the division may pay enhanced reimbursement fees related to trauma
814 care, as determined by the division in conjunction with the State
815 Department of Health, using funds appropriated to the State
816 Department of Health for trauma care and services and used to
817 match federal funds under a cooperative agreement between the



division and the State Department of Health. The division, in conjunction with the State Department of Health, may use grants, waivers, demonstrations, enhanced reimbursements, Upper Payment Limits Programs, supplemental payments, or other projects as necessary in the development and implementation of this reimbursement program.

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

(54) [Deleted]

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

(56) Prescribed pediatric extended care centers services for medically dependent or technologically dependent children with complex medical conditions that require continual



843 care as prescribed by the child's attending physician, as
844 determined by the division.

845 (57) No Medicaid benefit shall restrict coverage for
846 medically appropriate treatment prescribed by a physician and
847 agreed to by a fully informed individual, or if the individual
848 lacks legal capacity to consent by a person who has legal
849 authority to consent on his or her behalf, based on an
850 individual's diagnosis with a terminal condition. As used in this
851 paragraph (57), "terminal condition" means any aggressive
852 malignancy, chronic end-stage cardiovascular or cerebral vascular
853 disease, or any other disease, illness or condition which a
854 physician diagnoses as terminal.

855 (58) Treatment services for persons with opioid
856 dependency or other highly addictive substance use disorders. The
857 division is authorized to reimburse eligible providers for
858 treatment of opioid dependency and other highly addictive
859 substance use disorders, as determined by the division. Treatment
860 related to these conditions shall not count against any physician
861 visit limit imposed under this section.

862 (59) The division shall allow beneficiaries between the
863 ages of ten (10) and eighteen (18) years to receive vaccines
864 through a pharmacy venue. The division and the State Department
865 of Health shall coordinate and notify OB-GYN providers that the
866 Vaccines for Children program is available to providers free of
867 charge.



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

(a) Payments may only be made to a border city university-affiliated pediatric teaching hospital if the Centers for Medicare and Medicaid Services (CMS) approve an increase in the annual request for the provider payment initiative authorized under 42 CFR Section 438.6(c) in an amount equal to or greater than the estimated annual payment to be made to the border city university-affiliated pediatric teaching hospital. The estimate shall be based on the hospital's prior year Mississippi managed care utilization.

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



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

897 (d) It is the intent of the Legislature that
898 payments shall not result in any in-state hospital receiving
899 payments lower than they would otherwise receive if not for the
900 payments made to any border city university-affiliated pediatric
901 teaching hospital.

902 (e) This paragraph (60) shall stand repealed on
903 July 1, 2024.

904 (B) Planning and development districts participating in the
905 home- and community-based services program for the elderly and
906 disabled as case management providers shall be reimbursed for case
907 management services at the maximum rate approved by the Centers
908 for Medicare and Medicaid Services (CMS).

909 (C) The division may pay to those providers who participate
910 in and accept patient referrals from the division's emergency room
911 redirection program a percentage, as determined by the division,
912 of savings achieved according to the performance measures and
913 reduction of costs required of that program. Federally qualified
914 health centers may participate in the emergency room redirection
915 program, and the division may pay those centers a percentage of
916 any savings to the Medicaid program achieved by the centers'



917 accepting patient referrals through the program, as provided in
918 this subsection (C).

919 (D) (1) As used in this subsection (D), the following terms
920 shall be defined as provided in this paragraph, except as
921 otherwise provided in this subsection:

922 (a) "Committees" means the Medicaid Committees of
923 the House of Representatives and the Senate, and "committee" means
924 either one of those committees.

925 (b) "Rate change" means an increase, decrease or
926 other change in the payments or rates of reimbursement, or a
927 change in any payment methodology that results in an increase,
928 decrease or other change in the payments or rates of
929 reimbursement, to any Medicaid provider that renders any services
930 authorized to be provided to Medicaid recipients under this
931 article.

932 (2) Whenever the Division of Medicaid proposes a rate
933 change, the division shall give notice to the chairmen of the
934 committees at least thirty (30) calendar days before the proposed
935 rate change is scheduled to take effect. The division shall
936 furnish the chairmen with a concise summary of each proposed rate
937 change along with the notice, and shall furnish the chairmen with
938 a copy of any proposed rate change upon request. The division
939 also shall provide a summary and copy of any proposed rate change
940 to any other member of the Legislature upon request.



941 (3) If the chairman of either committee or both
942 chairmen jointly object to the proposed rate change or any part
943 thereof, the chairman or chairmen shall notify the division and
944 provide the reasons for their objection in writing not later than
945 seven (7) calendar days after receipt of the notice from the
946 division. The chairman or chairmen may make written
947 recommendations to the division for changes to be made to a
948 proposed rate change.

949 (4) (a) The chairman of either committee or both
950 chairmen jointly may hold a committee meeting to review a proposed
951 rate change. If either chairman or both chairmen decide to hold a
952 meeting, they shall notify the division of their intention in
953 writing within seven (7) calendar days after receipt of the notice
954 from the division, and shall set the date and time for the meeting
955 in their notice to the division, which shall not be later than
956 fourteen (14) calendar days after receipt of the notice from the
957 division.

958 (b) After the committee meeting, the committee or
959 committees may object to the proposed rate change or any part
960 thereof. The committee or committees shall notify the division
961 and the reasons for their objection in writing not later than
962 seven (7) calendar days after the meeting. The committee or
963 committees may make written recommendations to the division for
964 changes to be made to a proposed rate change.



965 (5) If both chairmen notify the division in writing
966 within seven (7) calendar days after receipt of the notice from
967 the division that they do not object to the proposed rate change
968 and will not be holding a meeting to review the proposed rate
969 change, the proposed rate change will take effect on the original
970 date as scheduled by the division or on such other date as
971 specified by the division.

972 (6) (a) If there are any objections to a proposed rate
973 change or any part thereof from either or both of the chairmen or
974 the committees, the division may withdraw the proposed rate
975 change, make any of the recommended changes to the proposed rate
976 change, or not make any changes to the proposed rate change.

977 (b) If the division does not make any changes to
978 the proposed rate change, it shall notify the chairmen of that
979 fact in writing, and the proposed rate change shall take effect on
980 the original date as scheduled by the division or on such other
981 date as specified by the division.

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

986 (7) Nothing in this subsection (D) shall be construed
987 as giving the chairmen or the committees any authority to veto,
988 nullify or revise any rate change proposed by the division. The
989 authority of the chairmen or the committees under this subsection



shall be limited to reviewing, making objections to and making recommendations for changes to rate changes proposed by the division.

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

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

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

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

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



1015 (4) Any additional cost-containment measures deemed
1016 appropriate by the Governor.

1017 To the extent allowed under federal law, any reduction to
1018 services or reimbursement rates under this subsection (F) shall be
1019 accompanied by a reduction, to the fullest allowable amount, to
1020 the profit margin and administrative fee portions of capitated
1021 payments to organizations described in paragraph (1) of subsection
1022 (H).

1023 Beginning in fiscal year 2010 and in fiscal years thereafter,
1024 when Medicaid expenditures are projected to exceed funds available
1025 for the fiscal year, the division shall submit the expected
1026 shortfall information to the PEER Committee not later than
1027 December 1 of the year in which the shortfall is projected to
1028 occur. PEER shall review the computations of the division and
1029 report its findings to the Legislative Budget Office not later
1030 than January 7 in any year.

1031 (G) Notwithstanding any other provision of this article, it
1032 shall be the duty of each provider participating in the Medicaid
1033 program to keep and maintain books, documents and other records as
1034 prescribed by the Division of Medicaid in accordance with federal
1035 laws and regulations.

1036 (H) (1) Notwithstanding any other provision of this
1037 article, the division is authorized to implement (a) a managed
1038 care program, (b) a coordinated care program, (c) a coordinated
1039 care organization program, (d) a health maintenance organization



1040 program, (e) a patient-centered medical home program, (f) an
1041 accountable care organization program, (g) provider-sponsored
1042 health plan, or (h) any combination of the above programs. As a
1043 condition for the approval of any program under this subsection
1044 (H)(1), the division shall require that no managed care program,
1045 coordinated care program, coordinated care organization program,
1046 health maintenance organization program, or provider-sponsored
1047 health plan may:

1048 (a) Pay providers at a rate that is less than the
1049 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
1050 reimbursement rate;

1051 (b) Override the medical decisions of hospital
1052 physicians or staff regarding patients admitted to a hospital for
1053 an emergency medical condition as defined by 42 US Code Section
1054 1395dd. This restriction (b) does not prohibit the retrospective
1055 review of the appropriateness of the determination that an
1056 emergency medical condition exists by chart review or coding
1057 algorithm, nor does it prohibit prior authorization for
1058 nonemergency hospital admissions;

1059 (c) Pay providers at a rate that is less than the
1060 normal Medicaid reimbursement rate. It is the intent of the
1061 Legislature that all managed care entities described in this
1062 subsection (H), in collaboration with the division, develop and
1063 implement innovative payment models that incentivize improvements
1064 in health care quality, outcomes, or value, as determined by the



1065 division. Participation in the provider network of any managed
1066 care, coordinated care, provider-sponsored health plan, or similar
1067 contractor shall not be conditioned on the provider's agreement to
1068 accept such alternative payment models;

1069 (d) Implement a prior authorization and
1070 utilization review program for medical services, transportation
1071 services and prescription drugs that is more stringent than the
1072 prior authorization processes used by the division in its
1073 administration of the Medicaid program. Not later than December
1074 2, 2021, the contractors that are receiving capitated payments
1075 under a managed care delivery system established under this
1076 subsection (H) shall submit a report to the Chairmen of the House
1077 and Senate Medicaid Committees on the status of the prior
1078 authorization and utilization review program for medical services,
1079 transportation services and prescription drugs that is required to
1080 be implemented under this subparagraph (d);

1081 (e) [Deleted]

1082 (f) Implement a preferred drug list that is more
1083 stringent than the mandatory preferred drug list established by
1084 the division under subsection (A)(9) of this section;

1085 (g) Implement a policy which denies beneficiaries
1086 with hemophilia access to the federally funded hemophilia
1087 treatment centers as part of the Medicaid Managed Care network of
1088 providers.



1089 Each health maintenance organization, coordinated care
1090 organization, provider-sponsored health plan, or other
1091 organization paid for services on a capitated basis by the
1092 division under any managed care program or coordinated care
1093 program implemented by the division under this section shall use a
1094 clear set of level of care guidelines in the determination of
1095 medical necessity and in all utilization management practices,
1096 including the prior authorization process, concurrent reviews,
1097 retrospective reviews and payments, that are consistent with
1098 widely accepted professional standards of care. Organizations
1099 participating in a managed care program or coordinated care
1100 program implemented by the division may not use any additional
1101 criteria that would result in denial of care that would be
1102 determined appropriate and, therefore, medically necessary under
1103 those levels of care guidelines.

1104 (2) Notwithstanding any provision of this section, the
1105 recipients eligible for enrollment into a Medicaid Managed Care
1106 Program authorized under this subsection (H) may include only
1107 those categories of recipients eligible for participation in the
1108 Medicaid Managed Care Program as of January 1, 2021, the
1109 Children's Health Insurance Program (CHIP), and the CMS-approved
1110 Section 1115 demonstration waivers in operation as of January 1,
1111 2021. No expansion of Medicaid Managed Care Program contracts may
1112 be implemented by the division without enabling legislation from
1113 the Mississippi Legislature.



1114 (3) (a) Any contractors receiving capitated payments
1115 under a managed care delivery system established in this section
1116 shall provide to the Legislature and the division statistical data
1117 to be shared with provider groups in order to improve patient
1118 access, appropriate utilization, cost savings and health outcomes
1119 not later than October 1 of each year. Additionally, each
1120 contractor shall disclose to the Chairmen of the Senate and House
1121 Medicaid Committees the administrative expenses costs for the
1122 prior calendar year, and the number of full-equivalent employees
1123 located in the State of Mississippi dedicated to the Medicaid and
1124 CHIP lines of business as of June 30 of the current year.

1125 (b) The division and the contractors participating
1126 in the managed care program, a coordinated care program or a
1127 provider-sponsored health plan shall be subject to annual program
1128 reviews or audits performed by the Office of the State Auditor,
1129 the PEER Committee, the Department of Insurance and/or independent
1130 third parties.

1131 (c) Those reviews shall include, but not be
1132 limited to, at least two (2) of the following items:

1133 (i) The financial benefit to the State of
1134 Mississippi of the managed care program,

1135 (ii) The difference between the premiums paid
1136 to the managed care contractors and the payments made by those
1137 contractors to health care providers,



1138 (iii) Compliance with performance measures
1139 required under the contracts,
1140 (iv) Administrative expense allocation
1141 methodologies,
1142 (v) Whether nonprovider payments assigned as
1143 medical expenses are appropriate,
1144 (vi) Capitated arrangements with related
1145 party subcontractors,
1146 (vii) Reasonableness of corporate
1147 allocations,
1148 (viii) Value-added benefits and the extent to
1149 which they are used,
1150 (ix) The effectiveness of subcontractor
1151 oversight, including subcontractor review,
1152 (x) Whether health care outcomes have been
1153 improved, and
1154 (xi) The most common claim denial codes to
1155 determine the reasons for the denials.

1156 The audit reports shall be considered public documents and
1157 shall be posted in their entirety on the division's website.

1158 (4) All health maintenance organizations, coordinated
1159 care organizations, provider-sponsored health plans, or other
1160 organizations paid for services on a capitated basis by the
1161 division under any managed care program or coordinated care
1162 program implemented by the division under this section shall



1163 reimburse all providers in those organizations at rates no lower
1164 than those provided under this section for beneficiaries who are
1165 not participating in those programs.

1166 (5) No health maintenance organization, coordinated
1167 care organization, provider-sponsored health plan, or other
1168 organization paid for services on a capitated basis by the
1169 division under any managed care program or coordinated care
1170 program implemented by the division under this section shall
1171 require its providers or beneficiaries to use any pharmacy that
1172 ships, mails or delivers prescription drugs or legend drugs or
1173 devices.

1174 (6) (a) Not later than December 1, 2021, the
1175 contractors who are receiving capitated payments under a managed
1176 care delivery system established under this subsection (H) shall
1177 develop and implement a uniform credentialing process for
1178 providers. Under that uniform credentialing process, a provider
1179 who meets the criteria for credentialing will be credentialed with
1180 all of those contractors and no such provider will have to be
1181 separately credentialed by any individual contractor in order to
1182 receive reimbursement from the contractor. Not later than
1183 December 2, 2021, those contractors shall submit a report to the
1184 Chairmen of the House and Senate Medicaid Committees on the status
1185 of the uniform credentialing process for providers that is
1186 required under this subparagraph (a).



1187 (b) If those contractors have not implemented a
1188 uniform credentialing process as described in subparagraph (a) by
1189 December 1, 2021, the division shall develop and implement, not
1190 later than July 1, 2022, a single, consolidated credentialing
1191 process by which all providers will be credentialed. Under the
1192 division's single, consolidated credentialing process, no such
1193 contractor shall require its providers to be separately
1194 credentialed by the contractor in order to receive reimbursement
1195 from the contractor, but those contractors shall recognize the
1196 credentialing of the providers by the division's credentialing
1197 process.

1198 (c) The division shall require a uniform provider
1199 credentialing application that shall be used in the credentialing
1200 process that is established under subparagraph (a) or (b). If the
1201 contractor or division, as applicable, has not approved or denied
1202 the provider credentialing application within sixty (60) days of
1203 receipt of the completed application that includes all required
1204 information necessary for credentialing, then the contractor or
1205 division, upon receipt of a written request from the applicant and
1206 within five (5) business days of its receipt, shall issue a
1207 temporary provider credential/enrollment to the applicant if the
1208 applicant has a valid Mississippi professional or occupational
1209 license to provide the health care services to which the
1210 credential/enrollment would apply. The contractor or the division
1211 shall not issue a temporary credential/enrollment if the applicant



1212 has reported on the application a history of medical or other
1213 professional or occupational malpractice claims, a history of
1214 substance abuse or mental health issues, a criminal record, or a
1215 history of medical or other licensing board, state or federal
1216 disciplinary action, including any suspension from participation
1217 in a federal or state program. The temporary
1218 credential/enrollment shall be effective upon issuance and shall
1219 remain in effect until the provider's credentialing/enrollment
1220 application is approved or denied by the contractor or division.
1221 The contractor or division shall render a final decision regarding
1222 credentialing/enrollment of the provider within sixty (60) days
1223 from the date that the temporary provider credential/enrollment is
1224 issued to the applicant.

1225 (d) If the contractor or division does not render
1226 a final decision regarding credentialing/enrollment of the
1227 provider within the time required in subparagraph (c), the
1228 provider shall be deemed to be credentialed by and enrolled with
1229 all of the contractors and eligible to receive reimbursement from
1230 the contractors.

1231 (e) The direct on-site supervisor of a provider in
1232 a health maintenance organization, coordinated care organization,
1233 provider-sponsored health plan, or other organization paid for
1234 services on a capitated basis by the division under any managed
1235 care program or coordinated care program implemented by the
1236 division under this section, who has begun the process for



1237 credentialing and who previously has not been denied
1238 credentialing, may sign off on the work of the provider during the
1239 time that the provider is awaiting a decision on his or her
1240 credentialing, and the provider may receive reimbursement from the
1241 organization for the work that has been signed off on by the
1242 supervisor.

1243 (7) (a) Each contractor that is receiving capitated
1244 payments under a managed care delivery system established under
1245 this subsection (H) shall provide to each provider for whom the
1246 contractor has denied the coverage of a procedure that was ordered
1247 or requested by the provider for or on behalf of a patient, a
1248 letter that provides a detailed explanation of the reasons for the
1249 denial of coverage of the procedure and the name and the
1250 credentials of the person who denied the coverage. The letter
1251 shall be sent to the provider in electronic format.

1252 (b) After a contractor that is receiving capitated
1253 payments under a managed care delivery system established under
1254 this subsection (H) has denied coverage for a claim submitted by a
1255 provider, the contractor shall issue to the provider within sixty
1256 (60) days a final ruling of denial of the claim that allows the
1257 provider to have a state fair hearing and/or agency appeal with
1258 the division. If a contractor does not issue a final ruling of
1259 denial within sixty (60) days as required by this subparagraph
1260 (b), the provider's claim shall be deemed to be automatically



1261 approved and the contractor shall pay the amount of the claim to
1262 the provider.

1263 (c) After a contractor has issued a final ruling
1264 of denial of a claim submitted by a provider, the division shall
1265 conduct a state fair hearing and/or agency appeal on the matter of
1266 the disputed claim between the contractor and the provider within
1267 sixty (60) days, and shall render a decision on the matter within
1268 thirty (30) days after the date of the hearing and/or appeal.

1269 (8) It is the intention of the Legislature that the
1270 division evaluate the feasibility of using a single vendor to
1271 administer pharmacy benefits provided under a managed care
1272 delivery system established under this subsection (H). Providers
1273 of pharmacy benefits shall cooperate with the division in any
1274 transition to a carve-out of pharmacy benefits under managed care.

1275 (9) The division shall evaluate the feasibility of
1276 using a single vendor to administer dental benefits provided under
1277 a managed care delivery system established in this subsection (H).
1278 Providers of dental benefits shall cooperate with the division in
1279 any transition to a carve-out of dental benefits under managed
1280 care.

1281 (10) It is the intent of the Legislature that any
1282 contractor receiving capitated payments under a managed care
1283 delivery system established in this section shall implement
1284 innovative programs to improve the health and well-being of
1285 members diagnosed with prediabetes and diabetes.



1286 (11) It is the intent of the Legislature that any
1287 contractors receiving capitated payments under a managed care
1288 delivery system established under this subsection (H) shall work
1289 with providers of Medicaid services to improve the utilization of
1290 long-acting reversible contraceptives (LARCs). Not later than
1291 December 1, 2021, any contractors receiving capitated payments
1292 under a managed care delivery system established under this
1293 subsection (H) shall provide to the Chairmen of the House and
1294 Senate Medicaid Committees and House and Senate Public Health
1295 Committees a report of LARC utilization for State Fiscal Years
1296 2018 through 2020 as well as any programs, initiatives, or efforts
1297 made by the contractors and providers to increase LARC
1298 utilization. This report shall be updated annually to include
1299 information for subsequent state fiscal years.

1300 (12) The division is authorized to make not more than
1301 one (1) emergency extension of the contracts that are in effect on
1302 July 1, 2021, with contractors who are receiving capitated
1303 payments under a managed care delivery system established under
1304 this subsection (H), as provided in this paragraph (12). The
1305 maximum period of any such extension shall be one (1) year, and
1306 under any such extensions, the contractors shall be subject to all
1307 of the provisions of this subsection (H). The extended contracts
1308 shall be revised to incorporate any provisions of this subsection
1309 (H).

1310 (I) [Deleted]



1311 (J) There shall be no cuts in inpatient and outpatient
1312 hospital payments, or allowable days or volumes, as long as the
1313 hospital assessment provided in Section 43-13-145 is in effect.
1314 This subsection (J) shall not apply to decreases in payments that
1315 are a result of: reduced hospital admissions, audits or payments
1316 under the APR-DRG or APC models, or a managed care program or
1317 similar model described in subsection (H) of this section.

1318 (K) In the negotiation and execution of such contracts
1319 involving services performed by actuarial firms, the Executive
1320 Director of the Division of Medicaid may negotiate a limitation on
1321 liability to the state of prospective contractors.

1322 (L) The Division of Medicaid shall reimburse for services
1323 provided to eligible Medicaid beneficiaries by a licensed birthing
1324 center in a method and manner to be determined by the division in
1325 accordance with federal laws and federal regulations. The
1326 division shall seek any necessary waivers, make any required
1327 amendments to its State Plan or revise any contracts authorized
1328 under subsection (H) of this section as necessary to provide the
1329 services authorized under this subsection. As used in this
1330 subsection, the term "birthing centers" shall have the meaning as
1331 defined in Section 41-77-1(a), which is a publicly or privately
1332 owned facility, place or institution constructed, renovated,
1333 leased or otherwise established where nonemergency births are
1334 planned to occur away from the mother's usual residence following
1335 a documented period of prenatal care for a normal uncomplicated



pregnancy which has been determined to be low risk through a formal risk-scoring examination.

(M) This section shall stand repealed on July 1, 2024.

SECTION 2. Section 43-13-121, Mississippi Code of 1972, is amended as follows:

43-13-121. (1) The division shall administer the Medicaid program under the provisions of this article, and may do the following:

(a) Adopt and promulgate reasonable rules, regulations and standards, with approval of the Governor, and in accordance with the Administrative Procedures Law, Section 25-43-1.101 et seq.:

(i) Establishing methods and procedures as may be necessary for the proper and efficient administration of this article;

(ii) Providing Medicaid to all qualified recipients under the provisions of this article as the division may determine and within the limits of appropriated funds;

(iii) Establishing reasonable fees, charges and rates for medical services and drugs; in doing so, the division shall fix all of those fees, charges and rates at the minimum levels absolutely necessary to provide the medical assistance authorized by this article, and shall not change any of those fees, charges or rates except as may be authorized in Section 43-13-117;



1361 (iv) Providing for fair and impartial hearings;
1362 (v) Providing safeguards for preserving the
1363 confidentiality of records; and
1364 (vi) For detecting and processing fraudulent
1365 practices and abuses of the program;
1366 (b) Receive and expend state, federal and other funds
1367 in accordance with court judgments or settlements and agreements
1368 between the State of Mississippi and the federal government, the
1369 rules and regulations promulgated by the division, with the
1370 approval of the Governor, and within the limitations and
1371 restrictions of this article and within the limits of funds
1372 available for that purpose;
1373 (c) Subject to the limits imposed by this article and
1374 subject to the provisions of subsection (8) of this section, to
1375 submit a Medicaid plan to the United States Department of Health
1376 and Human Services for approval under the provisions of the
1377 federal Social Security Act, to act for the state in making
1378 negotiations relative to the submission and approval of that plan,
1379 to make such arrangements, not inconsistent with the law, as may
1380 be required by or under federal law to obtain and retain that
1381 approval and to secure for the state the benefits of the
1382 provisions of that law.
1383 No agreements, specifically including the general plan for
1384 the operation of the Medicaid program in this state, shall be made
1385 by and between the division and the United States Department of



1386 Health and Human Services unless the Attorney General of the State
1387 of Mississippi has reviewed the agreements, specifically including
1388 the operational plan, and has certified in writing to the Governor
1389 and to the executive director of the division that the agreements,
1390 including the plan of operation, have been drawn strictly in
1391 accordance with the terms and requirements of this article;

1392 (d) In accordance with the purposes and intent of this
1393 article and in compliance with its provisions, provide for aged
1394 persons otherwise eligible for the benefits provided under Title
1395 XVIII of the federal Social Security Act by expenditure of funds
1396 available for those purposes;

1397 (e) To make reports to the United States Department of
1398 Health and Human Services as from time to time may be required by
1399 that federal department and to the Mississippi Legislature as
1400 provided in this section;

1401 (f) Define and determine the scope, duration and amount
1402 of Medicaid that may be provided in accordance with this article
1403 and establish priorities therefor in conformity with this article;

1404 (g) Cooperate and contract with other state agencies
1405 for the purpose of coordinating Medicaid provided under this
1406 article and eliminating duplication and inefficiency in the
1407 Medicaid program;

1408 (h) Adopt and use an official seal of the division;



1409 (i) Sue in its own name on behalf of the State of
1410 Mississippi and employ legal counsel on a contingency basis with
1411 the approval of the Attorney General;

1412 (j) To recover any and all payments incorrectly made by
1413 the division to a recipient or provider from the recipient or
1414 provider receiving the payments. The division shall be authorized
1415 to collect any overpayments to providers sixty (60) days after the
1416 conclusion of any administrative appeal unless the matter is
1417 appealed to a court of proper jurisdiction and bond is posted.
1418 Any appeal filed after July 1, 2015, shall be to the Chancery
1419 Court of the First Judicial District of Hinds County, Mississippi,
1420 within sixty (60) days after the date that the division has
1421 notified the provider by certified mail sent to the proper address
1422 of the provider on file with the division and the provider has
1423 signed for the certified mail notice, or sixty (60) days after the
1424 date of the final decision if the provider does not sign for the
1425 certified mail notice. To recover those payments, the division
1426 may use the following methods, in addition to any other methods
1427 available to the division:

1428 (i) The division shall report to the Department of
1429 Revenue the name of any current or former Medicaid recipient who
1430 has received medical services rendered during a period of
1431 established Medicaid ineligibility and who has not reimbursed the
1432 division for the related medical service payment(s). The
1433 Department of Revenue shall withhold from the state tax refund of



1434 the individual, and pay to the division, the amount of the
1435 payment(s) for medical services rendered to the ineligible
1436 individual that have not been reimbursed to the division for the
1437 related medical service payment(s).

1438 (ii) The division shall report to the Department
1439 of Revenue the name of any Medicaid provider to whom payments were
1440 incorrectly made that the division has not been able to recover by
1441 other methods available to the division. The Department of
1442 Revenue shall withhold from the state tax refund of the provider,
1443 and pay to the division, the amount of the payments that were
1444 incorrectly made to the provider that have not been recovered by
1445 other available methods;

1446 (k) To recover any and all payments by the division
1447 fraudulently obtained by a recipient or provider. Additionally,
1448 if recovery of any payments fraudulently obtained by a recipient
1449 or provider is made in any court, then, upon motion of the
1450 Governor, the judge of the court may award twice the payments
1451 recovered as damages;

1452 (l) Have full, complete and plenary power and authority
1453 to conduct such investigations as it may deem necessary and
1454 requisite of alleged or suspected violations or abuses of the
1455 provisions of this article or of the regulations adopted under
1456 this article, including, but not limited to, fraudulent or
1457 unlawful act or deed by applicants for Medicaid or other benefits,
1458 or payments made to any person, firm or corporation under the



1459 terms, conditions and authority of this article, to suspend or
1460 disqualify any provider of services, applicant or recipient for
1461 gross abuse, fraudulent or unlawful acts for such periods,
1462 including permanently, and under such conditions as the division
1463 deems proper and just, including the imposition of a legal rate of
1464 interest on the amount improperly or incorrectly paid. Recipients
1465 who are found to have misused or abused Medicaid benefits may be
1466 locked into one (1) physician and/or one (1) pharmacy of the
1467 recipient's choice for a reasonable amount of time in order to
1468 educate and promote appropriate use of medical services, in
1469 accordance with federal regulations. If an administrative hearing
1470 becomes necessary, the division may, if the provider does not
1471 succeed in his or her defense, tax the costs of the administrative
1472 hearing, including the costs of the court reporter or stenographer
1473 and transcript, to the provider. The convictions of a recipient
1474 or a provider in a state or federal court for abuse, fraudulent or
1475 unlawful acts under this chapter shall constitute an automatic
1476 disqualification of the recipient or automatic disqualification of
1477 the provider from participation under the Medicaid program.

1478 A conviction, for the purposes of this chapter, shall include
1479 a judgment entered on a plea of nolo contendere or a
1480 nonadjudicated guilty plea and shall have the same force as a
1481 judgment entered pursuant to a guilty plea or a conviction
1482 following trial. A certified copy of the judgment of the court of



1483 competent jurisdiction of the conviction shall constitute prima
1484 facie evidence of the conviction for disqualification purposes;
1485 (m) Establish and provide such methods of
1486 administration as may be necessary for the proper and efficient
1487 operation of the Medicaid program, fully utilizing computer
1488 equipment as may be necessary to oversee and control all current
1489 expenditures for purposes of this article, and to closely monitor
1490 and supervise all recipient payments and vendors rendering
1491 services under this article. Notwithstanding any other provision
1492 of state law, the division is authorized to enter into a ten-year
1493 contract(s) with a vendor(s) to provide services described in this
1494 paragraph (m). Notwithstanding any provision of law to the
1495 contrary, the division is authorized to extend its Medicaid
1496 Management Information System, including all related components
1497 and services, and Decision Support System, including all related
1498 components and services, contracts in effect on June 30, 2020, for
1499 a period not to exceed two (2) years without complying with state
1500 procurement regulations;

1501 (n) To cooperate and contract with the federal
1502 government for the purpose of providing Medicaid to Vietnamese and
1503 Cambodian refugees, under the provisions of Public Law 94-23 and
1504 Public Law 94-24, including any amendments to those laws, only to
1505 the extent that the Medicaid assistance and the administrative
1506 cost related thereto are one hundred percent (100%) reimbursable
1507 by the federal government. For the purposes of Section 43-13-117,



1508 persons receiving Medicaid under Public Law 94-23 and Public Law
1509 94-24, including any amendments to those laws, shall not be
1510 considered a new group or category of recipient; and

1511 (o) The division shall impose penalties upon Medicaid
1512 only, Title XIX participating long-term care facilities found to
1513 be in noncompliance with division and certification standards in
1514 accordance with federal and state regulations, including interest
1515 at the same rate calculated by the United States Department of
1516 Health and Human Services and/or the Centers for Medicare and
1517 Medicaid Services (CMS) under federal regulations.

1518 (2) The division also shall exercise such additional powers
1519 and perform such other duties as may be conferred upon the
1520 division by act of the Legislature.

1521 (3) The division, and the State Department of Health as the
1522 agency for licensure of health care facilities and certification
1523 and inspection for the Medicaid and/or Medicare programs, shall
1524 contract for or otherwise provide for the consolidation of on-site
1525 inspections of health care facilities that are necessitated by the
1526 respective programs and functions of the division and the
1527 department.

1528 (4) The division and its hearing officers shall have power
1529 to preserve and enforce order during hearings; to issue subpoenas
1530 for, to administer oaths to and to compel the attendance and
1531 testimony of witnesses, or the production of books, papers,
1532 documents and other evidence, or the taking of depositions before



1533 any designated individual competent to administer oaths; to
1534 examine witnesses; and to do all things conformable to law that
1535 may be necessary to enable them effectively to discharge the
1536 duties of their office. In compelling the attendance and
1537 testimony of witnesses, or the production of books, papers,
1538 documents and other evidence, or the taking of depositions, as
1539 authorized by this section, the division or its hearing officers
1540 may designate an individual employed by the division or some other
1541 suitable person to execute and return that process, whose action
1542 in executing and returning that process shall be as lawful as if
1543 done by the sheriff or some other proper officer authorized to
1544 execute and return process in the county where the witness may
1545 reside. In carrying out the investigatory powers under the
1546 provisions of this article, the executive director or other
1547 designated person or persons may examine, obtain, copy or
1548 reproduce the books, papers, documents, medical charts,
1549 prescriptions and other records relating to medical care and
1550 services furnished by the provider to a recipient or designated
1551 recipients of Medicaid services under investigation. In the
1552 absence of the voluntary submission of the books, papers,
1553 documents, medical charts, prescriptions and other records, the
1554 Governor, the executive director, or other designated person may
1555 issue and serve subpoenas instantly upon the provider, his or her
1556 agent, servant or employee for the production of the books,
1557 papers, documents, medical charts, prescriptions or other records



1558 during an audit or investigation of the provider. If any provider
1559 or his or her agent, servant or employee refuses to produce the
1560 records after being duly subpoenaed, the executive director may
1561 certify those facts and institute contempt proceedings in the
1562 manner, time and place as authorized by law for administrative
1563 proceedings. As an additional remedy, the division may recover
1564 all amounts paid to the provider covering the period of the audit
1565 or investigation, inclusive of a legal rate of interest and a
1566 reasonable attorney's fee and costs of court if suit becomes
1567 necessary. Division staff shall have immediate access to the
1568 provider's physical location, facilities, records, documents,
1569 books, and any other records relating to medical care and services
1570 rendered to recipients during regular business hours.

1571 (5) If any person in proceedings before the division
1572 disobeys or resists any lawful order or process, or misbehaves
1573 during a hearing or so near the place thereof as to obstruct the
1574 hearing, or neglects to produce, after having been ordered to do
1575 so, any pertinent book, paper or document, or refuses to appear
1576 after having been subpoenaed, or upon appearing refuses to take
1577 the oath as a witness, or after having taken the oath refuses to
1578 be examined according to law, the executive director shall certify
1579 the facts to any court having jurisdiction in the place in which
1580 it is sitting, and the court shall thereupon, in a summary manner,
1581 hear the evidence as to the acts complained of, and if the
1582 evidence so warrants, punish that person in the same manner and to



1583 the same extent as for a contempt committed before the court, or
1584 commit that person upon the same condition as if the doing of the
1585 forbidden act had occurred with reference to the process of, or in
1586 the presence of, the court.

1587 (6) In suspending or terminating any provider from
1588 participation in the Medicaid program, the division shall preclude
1589 the provider from submitting claims for payment, either personally
1590 or through any clinic, group, corporation or other association to
1591 the division or its fiscal agents for any services or supplies
1592 provided under the Medicaid program except for those services or
1593 supplies provided before the suspension or termination. No
1594 clinic, group, corporation or other association that is a provider
1595 of services shall submit claims for payment to the division or its
1596 fiscal agents for any services or supplies provided by a person
1597 within that organization who has been suspended or terminated from
1598 participation in the Medicaid program except for those services or
1599 supplies provided before the suspension or termination. When this
1600 provision is violated by a provider of services that is a clinic,
1601 group, corporation or other association, the division may suspend
1602 or terminate that organization from participation. Suspension may
1603 be applied by the division to all known affiliates of a provider,
1604 provided that each decision to include an affiliate is made on a
1605 case-by-case basis after giving due regard to all relevant facts
1606 and circumstances. The violation, failure or inadequacy of
1607 performance may be imputed to a person with whom the provider is



1608 affiliated where that conduct was accomplished within the course
1609 of his or her official duty or was effectuated by him or her with
1610 the knowledge or approval of that person.

1611 (7) The division may deny or revoke enrollment in the
1612 Medicaid program to a provider if any of the following are found
1613 to be applicable to the provider, his or her agent, a managing
1614 employee or any person having an ownership interest equal to five
1615 percent (5%) or greater in the provider:

1616 (a) Failure to truthfully or fully disclose any and all
1617 information required, or the concealment of any and all
1618 information required, on a claim, a provider application or a
1619 provider agreement, or the making of a false or misleading
1620 statement to the division relative to the Medicaid program.

1621 (b) Previous or current exclusion, suspension,
1622 termination from or the involuntary withdrawing from participation
1623 in the Medicaid program, any other state's Medicaid program,
1624 Medicare or any other public or private health or health insurance
1625 program. If the division ascertains that a provider has been
1626 convicted of a felony under federal or state law for an offense
1627 that the division determines is detrimental to the best interest
1628 of the program or of Medicaid beneficiaries, the division may
1629 refuse to enter into an agreement with that provider, or may
1630 terminate or refuse to renew an existing agreement.

1631 (c) Conviction under federal or state law of a criminal
1632 offense relating to the delivery of any goods, services or



1633 supplies, including the performance of management or
1634 administrative services relating to the delivery of the goods,
1635 services or supplies, under the Medicaid program, any other
1636 state's Medicaid program, Medicare or any other public or private
1637 health or health insurance program.

1638 (d) Conviction under federal or state law of a criminal
1639 offense relating to the neglect or abuse of a patient in
1640 connection with the delivery of any goods, services or supplies.

1641 (e) Conviction under federal or state law of a criminal
1642 offense relating to the unlawful manufacture, distribution,
1643 prescription or dispensing of a controlled substance.

1644 (f) Conviction under federal or state law of a criminal
1645 offense relating to fraud, theft, embezzlement, breach of
1646 fiduciary responsibility or other financial misconduct.

1647 (g) Conviction under federal or state law of a criminal
1648 offense punishable by imprisonment of a year or more that involves
1649 moral turpitude, or acts against the elderly, children or infirm.

1650 (h) Conviction under federal or state law of a criminal
1651 offense in connection with the interference or obstruction of any
1652 investigation into any criminal offense listed in paragraphs (c)
1653 through (i) of this subsection.

1654 (i) Sanction for a violation of federal or state laws
1655 or rules relative to the Medicaid program, any other state's
1656 Medicaid program, Medicare or any other public health care or
1657 health insurance program.



1658 (j) Revocation of license or certification.

1659 (k) Failure to pay recovery properly assessed or
1660 pursuant to an approved repayment schedule under the Medicaid
1661 program.

1662 (l) Failure to meet any condition of enrollment.

1663 (8) (a) As used in this subsection (8), the following terms
1664 shall be defined as provided in this paragraph, except as
1665 otherwise provided in this subsection:

1666 (i) "Committees" means the Medicaid Committees of
1667 the House of Representatives and the Senate, and "committee" means
1668 either one of those committees.

1669 (ii) "State Plan" means the agreement between the
1670 State of Mississippi and the federal government regarding the
1671 nature and scope of Mississippi's Medicaid Program.

1672 (iii) "State Plan Amendment" means a change to the
1673 State Plan, which must be approved by the Centers for Medicare and
1674 Medicaid Services (CMS) before its implementation.

1675 (b) Whenever the Division of Medicaid proposes a State
1676 Plan Amendment, the division shall give notice to the chairmen of
1677 the committees at least thirty (30) calendar days before the
1678 proposed State Plan Amendment is filed with CMS. The division
1679 shall furnish the chairmen with a concise summary of each proposed
1680 State Plan Amendment along with the notice, and shall furnish the
1681 chairmen with a copy of any proposed State Plan Amendment upon
1682 request. The division also shall provide a summary and copy of



1683 any proposed State Plan Amendment to any other member of the
1684 Legislature upon request.

1685 (c) If the chairman of either committee or both
1686 chairmen jointly object to the proposed State Plan Amendment or
1687 any part thereof, the chairman or chairmen shall notify the
1688 division and provide the reasons for their objection in writing
1689 not later than seven (7) calendar days after receipt of the notice
1690 from the division. The chairman or chairmen may make written
1691 recommendations to the division for changes to be made to a
1692 proposed State Plan Amendment.

1693 (d) (i) The chairman of either committee or both
1694 chairmen jointly may hold a committee meeting to review a proposed
1695 State Plan Amendment. If either chairman or both chairmen decide
1696 to hold a meeting, they shall notify the division of their
1697 intention in writing within seven (7) calendar days after receipt
1698 of the notice from the division, and shall set the date and time
1699 for the meeting in their notice to the division, which shall not
1700 be later than fourteen (14) calendar days after receipt of the
1701 notice from the division.

1702 (ii) After the committee meeting, the committee or
1703 committees may object to the proposed State Plan Amendment or any
1704 part thereof. The committee or committees shall notify the
1705 division and the reasons for their objection in writing not later
1706 than seven (7) calendar days after the meeting. The committee or



1707 committees may make written recommendations to the division for
1708 changes to be made to a proposed State Plan Amendment.

1709 (e) If both chairmen notify the division in writing
1710 within seven (7) calendar days after receipt of the notice from
1711 the division that they do not object to the proposed State Plan
1712 Amendment and will not be holding a meeting to review the proposed
1713 State Plan Amendment, the division may proceed to file the
1714 proposed State Plan Amendment with CMS.

1715 (f) (i) If there are any objections to a proposed rate
1716 change or any part thereof from either or both of the chairmen or
1717 the committees, the division may withdraw the proposed State Plan
1718 Amendment, make any of the recommended changes to the proposed
1719 State Plan Amendment, or not make any changes to the proposed
1720 State Plan Amendment.

1721 (ii) If the division does not make any changes to
1722 the proposed State Plan Amendment, it shall notify the chairmen of
1723 that fact in writing, and may proceed to file the State Plan
1724 Amendment with CMS.

1725 (iii) If the division makes any changes to the
1726 proposed State Plan Amendment, the division shall notify the
1727 chairmen of its actions in writing, and may proceed to file the
1728 State Plan Amendment with CMS.

1729 (g) Nothing in this subsection (8) shall be construed
1730 as giving the chairmen or the committees any authority to veto,
1731 nullify or revise any State Plan Amendment proposed by the



1732 division. The authority of the chairmen or the committees under
1733 this subsection shall be limited to reviewing, making objections
1734 to and making recommendations for changes to State Plan Amendments
1735 proposed by the division.

1736 (i) If the division does not make any changes to
1737 the proposed State Plan Amendment, it shall notify the chairmen of
1738 that fact in writing, and may proceed to file the proposed State
1739 Plan Amendment with CMS.

1740 (ii) If the division makes any changes to the
1741 proposed State Plan Amendment, the division shall notify the
1742 chairmen of the changes in writing, and may proceed to file the
1743 proposed State Plan Amendment with CMS.

1744 (h) Nothing in this subsection (8) shall be construed
1745 as giving the chairmen of the committees any authority to veto,
1746 nullify or revise any State Plan Amendment proposed by the
1747 division. The authority of the chairmen of the committees under
1748 this subsection shall be limited to reviewing, making objections
1749 to and making recommendations for suggested changes to State Plan
1750 Amendments proposed by the division.

1751 (9) Whenever the division determines after a hearing that a
1752 provider has violated any provision of this article or Article 5
1753 of this chapter, the division may not suspend reimbursement
1754 payments to the provider during the time that the decision of the
1755 division is on appeal by the provider. This subsection does not
1756 apply: (a) if the provider previously has been convicted of fraud



1757 in connection with the Medicaid program; or (b) if the provider is
1758 a company or other entity, and an agent of the provider, a
1759 managing employee of the provider or a person having an ownership
1760 interest equal to five percent (5%) or greater in the provider
1761 previously has been convicted of fraud in connection with the
1762 Medicaid program.

1763 **SECTION 3.** This act shall take effect and be in force from
1764 and after July 1, 2023.

