MISSISSIPPI LEGISLATURE REGULAR SESSION 2023

By: Representative Hood To: Medicaid

HOUSE BILL NO. 990

1 AN ACT TO AMEND SECTIONS 43-13-107, 43-13-113, 43-13-117.1
2 AND 43-13-122, MISSISSIPPI CODE OF 1972, WHICH RELATE TO THE
3 MEDICAID PROGRAM, TO MAKE SOME MINOR, NONSUBSTANTIVE CHANGES; TO
4 BRING FORWARD SECTIONS 43-13-103, 43-13-105, 43-13-109, 43-13-116,
5 43-13-120, 43-13-121, 43-13-123, 43-13-125, 43-13-139 AND
6 43-13-145, MISSISSIPPI CODE OF 1972, WHICH RELATE TO THE MEDICAID
7 PROGRAM, FOR THE PURPOSE OF POSSIBLE AMENDMENT; AND FOR RELATED
8 PURPOSES.

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

10 **SECTION 1.** Section 43-13-103, Mississippi Code of 1972, is
11 brought forward as follows:

12 43-13-103. For the purpose of affording health care and
13 remedial and institutional services in accordance with the
14 requirements for federal grants and other assistance under Titles
15 XVIII, XIX and XXI of the Social Security Act, as amended, a
16 statewide system of medical assistance is established and shall be
17 in effect in all political subdivisions of the state, to be
18 financed by state appropriations and federal matching funds
19 therefor, and to be administered by the Office of the Governor as
20 hereinafter provided.

21 **SECTION 2.** Section 43-13-105, Mississippi Code of 1972, is
22 brought forward as follows:
23 43-13-105. When used in this article, the following
24 definitions shall apply, unless the context requires otherwise:
25 (a) "Administering agency" means the Division of
26 Medicaid in the Office of the Governor as created by this article.
27 (b) "Division" or "Division of Medicaid" means the
28 Division of Medicaid in the Office of the Governor.
29 (c) "Medical assistance" means payment of part or all
30 of the costs of medical and remedial care provided under the terms
31 of this article and in accordance with provisions of Titles XIX
32 and XXI of the Social Security Act, as amended.
33 (d) "Applicant" means a person who applies for
34 assistance under Titles IV, XVI, XIX or XXI of the Social Security
35 Act, as amended, and under the terms of this article.
36 (e) "Recipient" means a person who is eligible for
37 assistance under Title XIX or XXI of the Social Security Act, as
38 amended and under the terms of this article.
39 (f) "State health agency" means any agency, department,
40 institution, board or commission of the State of Mississippi,
41 except the University of Mississippi Medical School, which is
42 supported in whole or in part by any public funds, including funds
43 directly appropriated from the State Treasury, funds derived by
44 taxes, fees levied or collected by statutory authority, or any
45 other funds used by "state health agencies" derived from federal

46 sources, when any funds available to such agency are expended
47 either directly or indirectly in connection with, or in support
48 of, any public health, hospital, hospitalization or other public
49 programs for the preventive treatment or actual medical treatment
50 of persons with a physical disability, mental illness or an
51 intellectual disability.

52 (g) "Mississippi Medicaid Commission" or "Medicaid
53 Commission," wherever they appear in the laws of the State of
54 Mississippi, means the Division of Medicaid in the Office of the
55 Governor.

56 **SECTION 3.** Section 43-13-107, Mississippi Code of 1972, is
57 amended as follows:

58 43-13-107. (1) The Division of Medicaid is created in the
59 Office of the Governor and established to administer this article
60 and perform such other duties as are prescribed by law.

61 (2) (a) The Governor shall appoint a full-time executive
62 director, with the advice and consent of the Senate, who shall be
63 either (i) a physician with administrative experience in a medical
64 care or health program, or (ii) a person holding a graduate degree
65 in medical care administration, public health, hospital
66 administration, or the equivalent, or (iii) a person holding a
67 bachelor's degree with at least three (3) years' experience in
68 management-level administration of, or policy development for,
69 Medicaid programs. Provided, however, no one who has been a
70 member of the Mississippi Legislature during the previous three

71 (3) years may be executive director. The executive director shall
72 be the official secretary and legal custodian of the records of
73 the division; shall be the agent of the division for the purpose
74 of receiving all service of process, summons and notices directed
75 to the division; shall perform such other duties as the Governor
76 may prescribe from time to time; and shall perform all other
77 duties that are now or may be imposed upon him or her by law.
78 (b) The executive director shall serve at the will and
79 pleasure of the Governor.
80 (c) The executive director shall, before entering upon
81 the discharge of the duties of the office, take and subscribe to
82 the oath of office prescribed by the Mississippi Constitution and
83 shall file the same in the Office of the Secretary of State, and
84 shall execute a bond in some surety company authorized to do
85 business in the state in the penal sum of One Hundred Thousand
86 Dollars ($100,000.00), conditioned for the faithful and impartial
87 discharge of the duties of the office. The premium on the bond
88 shall be paid as provided by law out of funds appropriated to the
89 Division of Medicaid for contractual services.
90 (d) The executive director, with the approval of the
91 Governor and subject to the rules and regulations of the State
92 Personnel Board, shall employ such professional, administrative,
93 stenographic, secretarial, clerical and technical assistance as
94 may be necessary to perform the duties required in administering
95 this article and fix the compensation for those persons, all in

96 accordance with a state merit system meeting federal requirements.
97 When the salary of the executive director is not set by law, that
98 salary shall be set by the State Personnel Board. No employees of
99 the Division of Medicaid shall be considered to be staff members
100 of the immediate Office of the Governor; however, Section
101 25-9-107(c)(xv) shall apply to the executive director and other
102 administrative heads of the division.

103 (3) (a) There is established a Medical Care Advisory
104 Committee, which shall be the committee that is required by
105 federal regulation to advise the Division of Medicaid about health
106 and medical care services.

107 (b) The advisory committee shall consist of not less
108 than eleven (11) members, as follows:

109 (i) The Governor shall appoint five (5) members,
110 one (1) from each congressional district and one (1) from the
111 state at large;

112 (ii) The Lieutenant Governor shall appoint three
113 (3) members, one (1) from each Supreme Court district;

114 (iii) The Speaker of the House of Representatives
115 shall appoint three (3) members, one (1) from each Supreme Court
116 district.

117 All members appointed under this paragraph shall either be
118 health care providers or consumers of health care services. One
119 (1) member appointed by each of the appointing authorities shall
120 be a board-certified physician.

121 (c) The respective Chairmen of the House Medicaid
122 Committee, the House Public Health and Human Services Committee,
123 the House Appropriations Committee, the Senate Medicaid Committee,
124 the Senate Public Health and Welfare Committee and the Senate
125 Appropriations Committee, or their designees, one (1) member of
126 the State Senate appointed by the Lieutenant Governor and one (1)
127 member of the House of Representatives appointed by the Speaker of
128 the House, shall serve as ex officio nonvoting members of the
129 advisory committee.
130 (d) In addition to the committee members required by
131 paragraph (b), the advisory committee shall consist of such other
132 members as are necessary to meet the requirements of the federal
133 regulation applicable to the advisory committee, who shall be
134 appointed as provided in the federal regulation.
135 (e) The chairmanship of the advisory committee shall be
136 elected by the voting members of the committee annually and shall
137 not serve more than two (2) consecutive years as chairman.
138 (f) The members of the advisory committee specified in
139 paragraph (b) shall serve for terms that are concurrent with the
140 terms of members of the Legislature, and any member appointed
141 under paragraph (b) may be reappointed to the advisory committee.
142 The members of the advisory committee specified in paragraph (b)
143 shall serve without compensation, but shall receive reimbursement
144 to defray actual expenses incurred in the performance of committee
145 business as authorized by law. Legislators shall receive per diem

146 and expenses, which may be paid from the contingent expense funds
147 of their respective houses in the same amounts as provided for
148 committee meetings when the Legislature is not in session.

149 (g) The advisory committee shall meet not less than
150 quarterly, and advisory committee members shall be furnished
151 written notice of the meetings at least ten (10) days before the
152 date of the meeting.

153 (h) The executive director shall submit to the advisory
154 committee all amendments, modifications and changes to the state
155 plan for the operation of the Medicaid program, for review by the
156 advisory committee before the amendments, modifications or changes
157 may be implemented by the division.

158 (i) The advisory committee, among its duties and
159 responsibilities, shall:

160 (i) Advise the division with respect to
161 amendments, modifications and changes to the state plan for the
162 operation of the Medicaid program;

163 (ii) Advise the division with respect to issues
164 concerning receipt and disbursement of funds and eligibility for
165 Medicaid;

166 (iii) Advise the division with respect to
167 determining the quantity, quality and extent of medical care
168 provided under this article;

169 (iv) Communicate the views of the medical care
170 professions to the division and communicate the views of the
171 division to the medical care professions;
172 (v) Gather information on reasons that medical
173 care providers do not participate in the Medicaid program and
174 changes that could be made in the program to encourage more
175 providers to participate in the Medicaid program, and advise the
176 division with respect to encouraging physicians and other medical
177 care providers to participate in the Medicaid program;
178 (vi) Provide a written report on or before
179 November 30 of each year to the Governor, Lieutenant Governor and
180 Speaker of the House of Representatives.
181 (4) (a) There is established a Drug Use Review Board, which
182 shall be the board that is required by federal law to:
183 (i) Review and initiate retrospective drug use,
184 review including ongoing periodic examination of claims data and
185 other records in order to identify patterns of fraud, abuse, gross
186 overuse, or inappropriate or medically unnecessary care, among
187 physicians, pharmacists and individuals receiving Medicaid
188 benefits or associated with specific drugs or groups of drugs.
189 (ii) Review and initiate ongoing interventions for
190 physicians and pharmacists, targeted toward therapy problems or
191 individuals identified in the course of retrospective drug use
192 reviews.

193 (iii) On an ongoing basis, assess data on drug use
194 against explicit predetermined standards using the compendia and
195 literature set forth in federal law and regulations.
196 (b) The board shall consist of not less than twelve
197 (12) members appointed by the Governor, or his designee.
198 (c) The board shall meet at least quarterly, and board
199 members shall be furnished written notice of the meetings at least
200 ten (10) days before the date of the meeting.
201 (d) The board meetings shall be open to the public,
202 members of the press, legislators and consumers. Additionally,
203 all documents provided to board members shall be available to
204 members of the Legislature in the same manner, and shall be made
205 available to others for a reasonable fee for copying. However,
206 patient confidentiality and provider confidentiality shall be
207 protected by blinding patient names and provider names with
208 numerical or other anonymous identifiers. The board meetings
209 shall be subject to the Open Meetings Act (Sections 25-41-1
210 through 25-41-17). Board meetings conducted in violation of this
211 section shall be deemed unlawful.
212 (5) (a) There is established a Pharmacy and Therapeutics
213 Committee, which shall be appointed by the Governor, or his
214 designee.
215 (b) The committee shall meet as often as needed to
216 fulfill its responsibilities and obligations as set forth in this
217 section, and committee members shall be furnished written notice

218 of the meetings at least ten (10) days before the date of the
219 meeting.
220 (c) The committee meetings shall be open to the public,
221 members of the press, legislators and consumers. Additionally,
222 all documents provided to committee members shall be available to
223 members of the Legislature in the same manner, and shall be made
224 available to others for a reasonable fee for copying. However,
225 patient confidentiality and provider confidentiality shall be
226 protected by blinding patient names and provider names with
227 numerical or other anonymous identifiers. The committee meetings
228 shall be subject to the Open Meetings Act (Sections 25-41-1
229 through 25-41-17). Committee meetings conducted in violation of
230 this section shall be deemed unlawful.
231 (d) After a thirty-day public notice, the executive
232 director, or his or her designee, shall present the division's
233 recommendation regarding prior approval for a therapeutic class of
234 drugs to the committee. However, in circumstances where the
235 division deems it necessary for the health and safety of Medicaid
236 beneficiaries, the division may present to the committee its
237 recommendations regarding a particular drug without a thirty-day
238 public notice. In making that presentation, the division shall
239 state to the committee the circumstances that precipitate the need
240 for the committee to review the status of a particular drug
241 without a thirty-day public notice. The committee may determine
242 whether or not to review the particular drug under the

243 circumstances stated by the division without a thirty-day public
244 notice. If the committee determines to review the status of the
245 particular drug, it shall make its recommendations to the
246 division, after which the division shall file those
247 recommendations for a thirty-day public comment under Section
248 25-43-7(1).
249 (e) Upon reviewing the information and recommendations,
250 the committee shall forward a written recommendation approved by a
251 majority of the committee to the executive director, or his or her
252 designee. The decisions of the committee regarding any
253 limitations to be imposed on any drug or its use for a specified
254 indication shall be based on sound clinical evidence found in
255 labeling, drug compendia, and peer-reviewed clinical literature
256 pertaining to use of the drug in the relevant population.
257 (f) Upon reviewing and considering all recommendations
258 including recommendations of the committee, comments, and data,
259 the executive director shall make a final determination whether to
260 require prior approval of a therapeutic class of drugs, or modify
261 existing prior approval requirements for a therapeutic class of
262 drugs.
263 (g) At least thirty (30) days before the executive
264 director implements new or amended prior authorization decisions,
265 written notice of the executive director's decision shall be
266 provided to all prescribing Medicaid providers, all Medicaid
267 enrolled pharmacies, and any other party who has requested the

268 notification. However, notice given under Section 25-43-7(1) will
269 substitute for and meet the requirement for notice under this
270 subsection.

271 (h) Members of the committee shall dispose of matters
272 before the committee in an unbiased and professional manner. If a
273 matter being considered by the committee presents a real or
274 apparent conflict of interest for any member of the committee,
275 that member shall disclose the conflict in writing to the
276 committee chair and recuse himself or herself from any discussions
277 and/or actions on the matter.

278 **SECTION 4.** Section 43-13-109, Mississippi Code of 1972, is
279 brought forward as follows:

280 43-13-109. The director, with the approval of the Governor
281 and pursuant to the rules and regulations of the State Personnel
282 Board, may adopt reasonable rules and regulations to provide for
283 an open, competitive or qualifying examination for all employees
284 of the division other than the director, part-time consultants and
285 professional staff members.

286 **SECTION 5.** Section 43-13-113, Mississippi Code of 1972, is
287 amended as follows:

288 43-13-113. (1) The State Treasurer shall receive on behalf
289 of the state, and execute all instruments incidental thereto,
290 federal and other funds to be used for financing the medical
291 assistance plan or program adopted pursuant to this article, and
292 place all such funds in a special account to the credit of the

293 Governor's Office-Division of Medicaid, which funds shall be
294 expended by the division for the purposes and under the provisions
295 of this article, and shall be paid out by the State Treasurer as
296 funds appropriated to carry out the provisions of this article are
297 paid out by him.

298 The division shall issue all checks or electronic transfers
299 for administrative expenses, and for medical assistance under the
300 provisions of this article. All such checks or electronic
301 transfers shall be drawn upon funds made available to the division
302 by the State Auditor, upon requisition of the director. It is the
303 purpose of this section to provide that the State Auditor shall
304 transfer, in lump sums, amounts to the division for disbursement
305 under the regulations which shall be made by the director with the
306 approval of the Governor; however, the division, or its fiscal
307 agent in behalf of the division, shall be authorized in
308 maintaining separate accounts with a Mississippi bank to handle
309 claim payments, refund recoveries and related Medicaid program
310 financial transactions, to aggressively manage the float in these
311 accounts while awaiting clearance of checks or electronic
312 transfers and/or other disposition so as to accrue maximum
313 interest advantage of the funds in the account, and to retain all
314 earned interest on these funds to be applied to match federal
315 funds for Medicaid program operations.

316 (2) The division is authorized to obtain a line of credit
317 through the State Treasurer from the Working Cash-Stabilization

318 Fund or any other special source funds maintained in the State
319 Treasury in an amount not exceeding One Hundred Fifty Million
320 Dollars ($150,000,000.00) to fund shortfalls which, from time to
321 time, may occur due to decreases in state matching fund cash flow.
322 The length of indebtedness under this provision shall not carry
323 past the end of the quarter following the loan origination. Loan
324 proceeds shall be received by the State Treasurer and shall be
325 placed in a Medicaid designated special fund account. Loan
326 proceeds shall be expended only for health care services provided
327 under the Medicaid program. The division may pledge as security
328 for such interim financing future funds that will be received by
329 the division. Any such loans shall be repaid from the first
330 available funds received by the division in the manner of and
331 subject to the same terms provided in this section.

332 In the event the State Treasurer makes a determination that
333 special source funds are not sufficient to cover a line of credit
334 for the Division of Medicaid, the division is authorized to obtain
335 a line of credit, in an amount not exceeding One Hundred Fifty
336 Million Dollars ($150,000,000.00), from a commercial lender or a
337 consortium of lenders. The length of indebtedness under this
338 provision shall not carry past the end of the quarter following
339 the loan origination. The division shall obtain a minimum of two
340 (2) written quotes that shall be presented to the State Fiscal
341 Officer and State Treasurer, who shall jointly select a lender.
342 Loan proceeds shall be received by the State Treasurer and shall

343 be placed in a Medicaid designated special fund account. Loan
344 proceeds shall be expended only for health care services provided
345 under the Medicaid program. The division may pledge as security
346 for such interim financing future funds that will be received by
347 the division. Any such loans shall be repaid from the first
348 available funds received by the division in the manner of and
349 subject to the same terms provided in this section.

350 (3) Disbursement of funds to providers shall be made as
351 follows:

352 (a) All providers must submit all claims to the
353 Division of Medicaid's fiscal agent no later than twelve (12)
354 months from the date of service.

355 (b) The Division of Medicaid's fiscal agent must pay
356 ninety percent (90%) of all clean claims within thirty (30) days
357 of the date of receipt.

358 (c) The Division of Medicaid's fiscal agent must pay
359 ninety-nine percent (99%) of all clean claims within ninety (90)
360 days of the date of receipt.

361 (d) The Division of Medicaid's fiscal agent must pay
362 all other claims within twelve (12) months of the date of receipt.

363 (e) If a claim is neither paid nor denied for valid and
364 proper reasons by the end of the time periods as specified above,
365 the Division of Medicaid's fiscal agent must pay the provider
366 interest on the claim at the rate of one and one-half percent

367 (1-1/2%) per month on the amount of such claim until it is finally
368 settled or adjudicated.
369 (4) The date of receipt is the date the fiscal agent
370 receives the claim as indicated by its date stamp on the claim or,
371 for those claims filed electronically, the date of receipt is the
372 date of transmission.
373 (5) The date of payment is the date of the check or, for
374 those claims paid by electronic funds transfer, the date of the
375 transfer.
376 (6) The above specified time limitations do not apply in the
377 following circumstances:
378 (a) Retroactive adjustments paid to providers
379 reimbursed under a retrospective payment system;
380 (b) If a claim for payment under Medicare has been
381 filed in a timely manner, the fiscal agent may pay a Medicaid
382 claim relating to the same services within six (6) months after
383 it, or the provider, receives notice of the disposition of the
384 Medicare claim;
385 (c) Claims from providers under investigation for fraud
386 or abuse; and
387 (d) The Division of Medicaid and/or its fiscal agent
388 may make payments at any time in accordance with a court order, to
389 carry out hearing decisions or corrective actions taken to resolve
390 a dispute, or to extend the benefits of a hearing decision,

391 corrective action, or court order to others in the same situation
392 as those directly affected by it.

393 (7) [Repealed.]

394 (8) If sufficient funds are appropriated therefor by the
395 Legislature, the Division of Medicaid may contract with the
396 Mississippi Dental Association, or an approved designee, to
397 develop and operate a Donated Dental Services (DDS) program
398 through which volunteer dentists will treat needy disabled, aged
399 and medically-compromised individuals who are non-Medicaid
400 eligible recipients.

401 **SECTION 6.** Section 43-13-116, Mississippi Code of 1972, is
402 brought forward as follows:

403 43-13-116. (1) It shall be the duty of the Division of
404 Medicaid to fully implement and carry out the administrative
405 functions of determining the eligibility of those persons who
406 qualify for medical assistance under Section 43-13-115.

407 (2) In determining Medicaid eligibility, the Division of
408 Medicaid is authorized to enter into an agreement with the
409 Secretary of the Department of Health and Human Services for the
410 purpose of securing the transfer of eligibility information from
411 the Social Security Administration on those individuals receiving
412 supplemental security income benefits under the federal Social
413 Security Act and any other information necessary in determining
414 Medicaid eligibility. The Division of Medicaid is further
415 empowered to enter into contractual arrangements with its fiscal

416 agent or with the State Department of Human Services in securing
417 electronic data processing support as may be necessary.
418 (3) Administrative hearings shall be available to any
419 applicant who requests it because his or her claim of eligibility
420 for services is denied or is not acted upon with reasonable
421 promptness or by any recipient who requests it because he or she
422 believes the agency has erroneously taken action to deny, reduce,
423 or terminate benefits. The agency need not grant a hearing if the
424 sole issue is a federal or state law requiring an automatic change
425 adversely affecting some or all recipients. Eligibility
426 determinations that are made by other agencies and certified to
427 the Division of Medicaid pursuant to Section 43-13-115 are not
428 subject to the administrative hearing procedures of the Division
429 of Medicaid but are subject to the administrative hearing
430 procedures of the agency that determined eligibility.
431 (a) A request may be made either for a local regional
432 office hearing or a state office hearing when the local regional
433 office has made the initial decision that the claimant seeks to
434 appeal or when the regional office has not acted with reasonable
435 promptness in making a decision on a claim for eligibility or
436 services. The only exception to requesting a local hearing is
437 when the issue under appeal involves either (i) a disability or
438 blindness denial, or termination, or (ii) a level of care denial
439 or termination for a disabled child living at home. An appeal
440 involving disability, blindness or level of care must be handled

441 as a state level hearing. The decision from the local hearing may
442 be appealed to the state office for a state hearing. A decision
443 to deny, reduce or terminate benefits that is initially made at
444 the state office may be appealed by requesting a state hearing.
445 (b) A request for a hearing, either state or local,
446 must be made in writing by the claimant or claimant's legal
447 representative. "Legal representative" includes the claimant's
448 authorized representative, an attorney retained by the claimant or
449 claimant's family to represent the claimant, a paralegal
450 representative with a legal aid services, a parent of a minor
451 child if the claimant is a child, a legal guardian or conservator
452 or an individual with power of attorney for the claimant. The
453 claimant may also be represented by anyone that he or she so
454 designates but must give the designation to the Medicaid regional
455 office or state office in writing, if the person is not the legal
456 representative, legal guardian, or authorized representative.
457 (c) The claimant may make a request for a hearing in
458 person at the regional office but an oral request must be put into
459 written form. Regional office staff will determine from the
460 claimant if a local or state hearing is requested and assist the
461 claimant in completing and signing the appropriate form. Regional
462 office staff may forward a state hearing request to the
463 appropriate division in the state office or the claimant may mail
464 the form to the address listed on the form. The claimant may make
465 a written request for a hearing by letter. A simple statement

466 requesting a hearing that is signed by the claimant or legal
467 representative is sufficient; however, if possible, the claimant
468 should state the reason for the request. The letter may be mailed
469 to the regional office or it may be mailed to the state office. If
470 the letter does not specify the type of hearing desired, local or
471 state, Medicaid staff will attempt to contact the claimant to
472 determine the level of hearing desired. If contact cannot be made
473 within three (3) days of receipt of the request, the request will
474 be assumed to be for a local hearing and scheduled accordingly. A
475 hearing will not be scheduled until either a letter or the
476 appropriate form is received by the regional or state office.
477 (d) When both members of a couple wish to appeal an
478 action or inaction by the agency that affects both applications or
479 cases similarly and arose from the same issue, one or both may
480 file the request for hearing, both may present evidence at the
481 hearing, and the agency's decision will be applicable to both. If
482 both file a request for hearing, two (2) hearings will be
483 registered but they will be conducted on the same day and in the
484 same place, either consecutively or jointly, as the couple wishes.
485 If they so desire, only one of the couple need attend the hearing.
486 (e) The procedure for administrative hearings shall be
487 as follows:
488 (i) The claimant has thirty (30) days from the
489 date the agency mails the appropriate notice to the claimant of
490 its decision regarding eligibility, services, or benefits to

491 request either a state or local hearing. This time period may be
492 extended if the claimant can show good cause for not filing within
493 thirty (30) days. Good cause includes, but may not be limited to,
494 illness, failure to receive the notice, being out of state, or
495 some other reasonable explanation. If good cause can be shown, a
496 late request may be accepted provided the facts in the case remain
497 the same. If a claimant's circumstances have changed or if good
498 cause for filing a request beyond thirty (30) days is not shown, a
499 hearing request will not be accepted. If the claimant wishes to
500 have eligibility reconsidered, he or she may reapply.

501 (ii) If a claimant or representative requests a
502 hearing in writing during the advance notice period before
503 benefits are reduced or terminated, benefits must be continued or
504 reinstated to the benefit level in effect before the effective
505 date of the adverse action. Benefits will continue at the
506 original level until the final hearing decision is rendered. Any
507 hearing requested after the advance notice period will not be
508 accepted as a timely request in order for continuation of benefits
509 to apply.

510 (iii) Upon receipt of a written request for a
511 hearing, the request will be acknowledged in writing within twenty
512 (20) days and a hearing scheduled. The claimant or representative
513 will be given at least five (5) days' advance notice of the
514 hearing date. The local and/or state level hearings will be held
515 by telephone unless, at the hearing officer's discretion, it is

516 determined that an in-person hearing is necessary. If a local
517 hearing is requested, the regional office will notify the claimant
518 or representative in writing of the time of the local hearing. If
519 a state hearing is requested, the state office will notify the
520 claimant or representative in writing of the time of the state
521 hearing. If an in-person hearing is necessary, local hearings
522 will be held at the regional office and state hearings will be
523 held at the state office unless other arrangements are
524 necessitated by the claimant's inability to travel.

525 (iv) All persons attending a hearing will attend
526 for the purpose of giving information on behalf of the claimant or
527 rendering the claimant assistance in some other way, or for the
528 purpose of representing the Division of Medicaid.

529 (v) A state or local hearing request may be
530 withdrawn at any time before the scheduled hearing, or after the
531 hearing is held but before a decision is rendered. The withdrawal
532 must be in writing and signed by the claimant or representative.
533 A hearing request will be considered abandoned if the claimant or
534 representative fails to appear at a scheduled hearing without good
535 cause. If no one appears for a hearing, the appropriate office
536 will notify the claimant in writing that the hearing is dismissed
537 unless good cause is shown for not attending. The proposed agency
538 action will be taken on the case following failure to appear for a
539 hearing if the action has not already been effected.

540 (vi) The claimant or his representative has the
541 following rights in connection with a local or state hearing:
542 (A) The right to examine at a reasonable time
543 before the date of the hearing and during the hearing the content
544 of the claimant's case record;
545 (B) The right to have legal representation at
546 the hearing and to bring witnesses;
547 (C) The right to produce documentary evidence
548 and establish all facts and circumstances concerning eligibility,
549 services, or benefits;
550 (D) The right to present an argument without
551 undue interference;
552 (E) The right to question or refute any
553 testimony or evidence including an opportunity to confront and
554 cross-examine adverse witnesses.
555 (vii) When a request for a local hearing is
556 received by the regional office or if the regional office is
557 notified by the state office that a local hearing has been
558 requested, the Medicaid specialist supervisor in the regional
559 office will review the case record, reexamine the action taken on
560 the case, and determine if policy and procedures have been
561 followed. If any adjustments or corrections should be made, the
562 Medicaid specialist supervisor will ensure that corrective action
563 is taken. If the request for hearing was timely made such that
564 continuation of benefits applies, the Medicaid specialist

565 supervisor will ensure that benefits continue at the level before
566 the proposed adverse action that is the subject of the appeal.
567 The Medicaid specialist supervisor will also ensure that all
568 needed information, verification, and evidence is in the case
569 record for the hearing.

570 (viii) When a state hearing is requested that
571 appeals the action or inaction of a regional office, the regional
572 office will prepare copies of the case record and forward it to
573 the appropriate division in the state office no later than five
574 (5) days after receipt of the request for a state hearing. The
575 original case record will remain in the regional office. Either
576 the original case record in the regional office or the copy
577 forwarded to the state office will be available for inspection by
578 the claimant or claimant's representative a reasonable time before
579 the date of the hearing.

580 (ix) The Medicaid specialist supervisor will serve
581 as the hearing officer for a local hearing unless the Medicaid
582 specialist supervisor actually participated in the eligibility,
583 benefits, or services decision under appeal, in which case the
584 Medicaid specialist supervisor must appoint a Medicaid specialist
585 in the regional office who did not actually participate in the
586 decision under appeal to serve as hearing officer. The local
587 hearing will be an informal proceeding in which the claimant or
588 representative may present new or additional information, may
589 question the action taken on the client's case, and will hear an

590 explanation from agency staff as to the regulations and
591 requirements that were applied to claimant's case in making the
592 decision.

593 (x) After the hearing, the hearing officer will
594 prepare a written summary of the hearing procedure and file it
595 with the case record. The hearing officer will consider the facts
596 presented at the local hearing in reaching a decision. The
597 claimant will be notified of the local hearing decision on the
598 appropriate form that will state clearly the reason for the
599 decision, the policy that governs the decision, the claimant's
600 right to appeal the decision to the state office, and, if the
601 original adverse action is upheld, the new effective date of the
602 reduction or termination of benefits or services if continuation
603 of benefits applied during the hearing process. The new effective
604 date of the reduction or termination of benefits or services must
605 be at the end of the fifteen-day advance notice period from the
606 mailing date of the notice of hearing decision. The notice to
607 claimant will be made part of the case record.

608 (xi) The claimant has the right to appeal a local
609 hearing decision by requesting a state hearing in writing within
610 fifteen (15) days of the mailing date of the notice of local
611 hearing decision. The state hearing request should be made to the
612 regional office. If benefits have been continued pending the
613 local hearing process, then benefits will continue throughout the
614 fifteen-day advance notice period for an adverse local hearing

615 decision. If a state hearing is timely requested within the
616 fifteen-day period, then benefits will continue pending the state
617 hearing process. State hearings requested after the fifteen-day
618 local hearing advance notice period will not be accepted unless
619 the initial thirty-day period for filing a hearing request has not
620 expired because the local hearing was held early, in which case a
621 state hearing request will be accepted as timely within the number
622 of days remaining of the unexpired initial thirty-day period in
623 addition to the fifteen-day time period. Continuation of benefits
624 during the state hearing process, however, will only apply if the
625 state hearing request is received within the fifteen-day advance
626 notice period.

627 (xii) When a request for a state hearing is
628 received in the regional office, the request will be made part of
629 the case record and the regional office will prepare the case
630 record and forward it to the appropriate division in the state
631 office within five (5) days of receipt of the state hearing
632 request. A request for a state hearing received in the state
633 office will be forwarded to the regional office for inclusion in
634 the case record and the regional office will prepare the case
635 record and forward it to the appropriate division in the state
636 office within five (5) days of receipt of the state hearing
637 request.

638 (xiii) Upon receipt of the hearing record, an
639 impartial hearing officer will be assigned to hear the case either

640 by the Executive Director of the Division of Medicaid or his or
641 her designee. Hearing officers will be individuals with
642 appropriate expertise employed by the division and who have not
643 been involved in any way with the action or decision on appeal in
644 the case. The hearing officer will review the case record and if
645 the review shows that an error was made in the action of the
646 agency or in the interpretation of policy, or that a change of
647 policy has been made, the hearing officer will discuss these
648 matters with the appropriate agency personnel and request that an
649 appropriate adjustment be made. Appropriate agency personnel will
650 discuss the matter with the claimant and if the claimant is
651 agreeable to the adjustment of the claim, then agency personnel
652 will request in writing dismissal of the hearing and the reason
653 therefor, to be placed in the case record. If the hearing is to
654 go forward, it shall be scheduled by the hearing officer in the
655 manner set forth in subparagraph (iii) of this paragraph (e).
656 (xiv) In conducting the hearing, the state hearing
657 officer will inform those present of the following:
658 (A) That the hearing will be recorded on tape
659 and that a transcript of the proceedings will be typed for the
660 record;
661 (B) The action taken by the agency which
662 prompted the appeal;

663 (C) An explanation of the claimant's rights
664 during the hearing as outlined in subparagraph (vi) of this
665 paragraph (e);
666 (D) That the purpose of the hearing is for
667 the claimant to express dissatisfaction and present additional
668 information or evidence;
669 (E) That the case record is available for
670 review by the claimant or representative during the hearing;
671 (F) That the final hearing decision will be
672 rendered by the Executive Director of the Division of Medicaid on
673 the basis of facts presented at the hearing and the case record
674 and that the claimant will be notified by letter of the final
675 decision.
676 (xv) During the hearing, the claimant and/or
677 representative will be allowed an opportunity to make a full
678 statement concerning the appeal and will be assisted, if
679 necessary, in disclosing all information on which the claim is
680 based. All persons representing the claimant and those
681 representing the Division of Medicaid will have the opportunity to
682 state all facts pertinent to the appeal. The hearing officer may
683 recess or continue the hearing for a reasonable time should
684 additional information or facts be required or if some change in
685 the claimant's circumstances occurs during the hearing process
686 which impacts the appeal. When all information has been

687 presented, the hearing officer will close the hearing and stop the
688 recorder.

689 (xvi) Immediately following the hearing the
690 hearing tape will be transcribed and a copy of the transcription
691 forwarded to the regional office for filing in the case record.
692 As soon as possible, the hearing officer shall review the evidence
693 and record of the proceedings, testimony, exhibits, and other
694 supporting documents, prepare a written summary of the facts as
695 the hearing officer finds them, and prepare a written
696 recommendation of action to be taken by the agency, citing
697 appropriate policy and regulations that govern the recommendation.
698 The decision cannot be based on any material, oral or written, not
699 available to the claimant before or during the hearing. The
700 hearing officer's recommendation will become part of the case
701 record which will be submitted to the Executive Director of the
702 Division of Medicaid for further review and decision.

703 (xvii) The Executive Director of the Division of
704 Medicaid, upon review of the recommendation, proceedings and the
705 record, may sustain the recommendation of the hearing officer,
706 reject the same, or remand the matter to the hearing officer to
707 take additional testimony and evidence, in which case, the hearing
708 officer thereafter shall submit to the executive director a new
709 recommendation. The executive director shall prepare a written
710 decision summarizing the facts and identifying policies and
711 regulations that support the decision, which shall be mailed to

712 the claimant and the representative, with a copy to the regional
713 office if appropriate, as soon as possible after submission of a
714 recommendation by the hearing officer. The decision notice will
715 specify any action to be taken by the agency, specify any revised
716 eligibility dates or, if continuation of benefits applies, will
717 notify the claimant of the new effective date of reduction or
718 termination of benefits or services, which will be fifteen (15)
719 days from the mailing date of the notice of decision. The
720 decision rendered by the Executive Director of the Division of
721 Medicaid is final and binding. The claimant is entitled to seek
722 judicial review in a court of proper jurisdiction.

723 (xviii) The Division of Medicaid must take final
724 administrative action on a hearing, whether state or local, within
725 ninety (90) days from the date of the initial request for a
726 hearing.

727 (xix) A group hearing may be held for a number of
728 claimants under the following circumstances:

729 (A) The Division of Medicaid may consolidate
730 the cases and conduct a single group hearing when the only issue
731 involved is one (1) of a single law or agency policy;

732 (B) The claimants may request a group hearing
733 when there is one (1) issue of agency policy common to all of
734 them.

735 In all group hearings, whether initiated by the Division of
736 Medicaid or by the claimants, the policies governing fair hearings

737 must be followed. Each claimant in a group hearing must be
738 permitted to present his or her own case and be represented by his
739 or her own representative, or to withdraw from the group hearing
740 and have his or her appeal heard individually. As in individual
741 hearings, the hearing will be conducted only on the issue being
742 appealed, and each claimant will be expected to keep individual
743 testimony within a reasonable time frame as a matter of
744 consideration to the other claimants involved.

745 (xx) Any specific matter necessitating an
746 administrative hearing not otherwise provided under this article
747 or agency policy shall be afforded under the hearing procedures as
748 outlined above. If the specific time frames of such a unique
749 matter relating to requesting, granting, and concluding of the
750 hearing is contrary to the time frames as set out in the hearing
751 procedures above, the specific time frames will govern over the
752 time frames as set out within these procedures.

753 (4) The Executive Director of the Division of Medicaid, with
754 the approval of the Governor, shall be authorized to employ
755 eligibility, technical, clerical and supportive staff as may be
756 required in carrying out and fully implementing the determination
757 of Medicaid eligibility, including conducting quality control
758 reviews and the investigation of the improper receipt of medical
759 assistance. Staffing needs will be set forth in the annual
760 appropriation act for the division. Additional office space as

761 needed in performing eligibility, quality control and
762 investigative functions shall be obtained by the division.
763 **SECTION 7.** Section 43-13-117.1, Mississippi Code of 1972, is
764 amended as follows:
765 43-13-117.1. It is the intent of the Legislature to expand
766 access to Medicaid-funded home- and community-based services for
767 eligible nursing facility residents who choose those services.
768 The Executive Director of the Division of Medicaid is authorized
769 to transfer funds allocated for nursing facility services for
770 eligible residents to cover the cost of services available through
771 the Independent Living Waiver, the Traumatic Brain Injury/Spinal
772 Cord Injury Waiver, the Elderly and Disabled Waiver, and the
773 Assisted Living Waiver programs when eligible residents choose
774 those community services. The amount of funding transferred by
775 the division shall be sufficient to cover the cost of home- and
776 community-based waiver services for each eligible nursing
777 facility *** * *** resident who *** * *** chooses those services. The
778 number of nursing facility residents who return to the community
779 and home- and community-based waiver services shall not count
780 against the total number of waiver slots for which the Legislature
781 appropriates funding each year. Any funds remaining in the
782 program when a former nursing facility resident ceases to
783 participate in a home- and community-based waiver program under
784 this provision shall be returned to nursing facility funding.

785 **SECTION 8.** Section 43-13-120, Mississippi Code of 1972, is
786 brought forward as follows:
787 43-13-120. (1) Any person who is a Medicaid recipient and
788 is receiving medical assistance for services provided in a
789 long-term care facility under the provisions of Section 43-13-117
790 from the Division of Medicaid in the Office of the Governor, who
791 dies intestate and leaves no known heirs, shall have deemed,
792 through his acceptance of such medical assistance, the Division of
793 Medicaid as his beneficiary to all such funds in an amount not to
794 exceed Two Hundred Fifty Dollars ($250.00) which are in his
795 possession at the time of his death. Such funds, together with
796 any accrued interest thereon, shall be reported by the long-term
797 care facility to the State Treasurer in the manner provided in
798 subsection (2).
799 (2) The report of such funds shall be verified, shall be on
800 a form prescribed or approved by the Treasurer, and shall include
801 (a) the name of the deceased person and his last known address
802 prior to entering the long-term care facility; (b) the name and
803 last known address of each person who may possess an interest in
804 such funds; and (c) any other information which the Treasurer
805 prescribes by regulation as necessary for the administration of
806 this section. The report shall be filed with the Treasurer prior
807 to November 1 of each year in which the long-term care facility
808 has provided services to a person or persons having funds to which
809 this section applies.

810 (3) Within one hundred twenty (120) days from November 1 of
811 each year in which a report is made pursuant to subsection (2),
812 the Treasurer shall cause notice to be published in a newspaper
813 having general circulation in the county of this state in which is
814 located the last known address of the person or persons named in
815 the report who may possess an interest in such funds, or if no
816 such person is named in the report, in the county in which is
817 located the last known address of the deceased person prior to
818 entering the long-term care facility. If no address is given in
819 the report or if the address is outside of this state, the notice
820 shall be published in a newspaper having general circulation in
821 the county in which the facility is located. The notice shall
822 contain (a) the name of the deceased person; (b) his last known
823 address prior to entering the facility; (c) the name and last
824 known address of each person named in the report who may possess
825 an interest in such funds; and (d) a statement that any person
826 possessing an interest in such funds must make a claim therefor to
827 the Treasurer within ninety (90) days after such publication date
828 or the funds will become the property of the State of Mississippi.
829 In any year in which the Treasurer publishes a notice of abandoned
830 property under Section 89-12-27, the Treasurer may combine the
831 notice required by this section with the notice of abandoned
832 property. The cost to the Treasurer of publishing the notice
833 required by this section shall be paid by the Division of
834 Medicaid.

835 (4) Each long-term care facility that makes a report of
836 funds of a deceased person under this section shall pay over and
837 deliver such funds, together with any accrued interest thereon, to
838 the Treasurer not later than ten (10) days after notice of such
839 funds has been published by the Treasurer as provided in
840 subsection (3). If a claim to such funds is not made by any
841 person having an interest therein within ninety (90) days of the
842 published notice, the Treasurer shall place such funds in the
843 special account in the State Treasury to the credit of the
844 "Governor's Office - Division of Medicaid" to be expended by the
845 Division of Medicaid for the purposes provided under Mississippi
846 Medicaid Law.
847 (5) This section shall not be applicable to any Medicaid
848 patient in a long-term care facility of a state institution listed
849 in Section 41-7-73, who has a personal deposit fund as provided
850 for in Section 41-7-90.
851 **SECTION 9.** Section 43-13-121, Mississippi Code of 1972, is
852 brought forward as follows:
853 43-13-121. (1) The division shall administer the Medicaid
854 program under the provisions of this article, and may do the
855 following:
856 (a) Adopt and promulgate reasonable rules, regulations
857 and standards, with approval of the Governor, and in accordance
858 with the Administrative Procedures Law, Section 25-43-1.101 et
859 seq.:

860 (i) Establishing methods and procedures as may be
861 necessary for the proper and efficient administration of this
862 article;
863 (ii) Providing Medicaid to all qualified
864 recipients under the provisions of this article as the division
865 may determine and within the limits of appropriated funds;
866 (iii) Establishing reasonable fees, charges and
867 rates for medical services and drugs; in doing so, the division
868 shall fix all of those fees, charges and rates at the minimum
869 levels absolutely necessary to provide the medical assistance
870 authorized by this article, and shall not change any of those
871 fees, charges or rates except as may be authorized in Section
872 43-13-117;
873 (iv) Providing for fair and impartial hearings;
874 (v) Providing safeguards for preserving the
875 confidentiality of records; and
876 (vi) For detecting and processing fraudulent
877 practices and abuses of the program;
878 (b) Receive and expend state, federal and other funds
879 in accordance with court judgments or settlements and agreements
880 between the State of Mississippi and the federal government, the
881 rules and regulations promulgated by the division, with the
882 approval of the Governor, and within the limitations and
883 restrictions of this article and within the limits of funds
884 available for that purpose;

885 (c) Subject to the limits imposed by this article and
886 subject to the provisions of subsection (8) of this section, to
887 submit a Medicaid plan to the United States Department of Health
888 and Human Services for approval under the provisions of the
889 federal Social Security Act, to act for the state in making
890 negotiations relative to the submission and approval of that plan,
891 to make such arrangements, not inconsistent with the law, as may
892 be required by or under federal law to obtain and retain that
893 approval and to secure for the state the benefits of the
894 provisions of that law.

895 No agreements, specifically including the general plan for
896 the operation of the Medicaid program in this state, shall be made
897 by and between the division and the United States Department of
898 Health and Human Services unless the Attorney General of the State
899 of Mississippi has reviewed the agreements, specifically including
900 the operational plan, and has certified in writing to the Governor
901 and to the executive director of the division that the agreements,
902 including the plan of operation, have been drawn strictly in
903 accordance with the terms and requirements of this article;

904 (d) In accordance with the purposes and intent of this
905 article and in compliance with its provisions, provide for aged
906 persons otherwise eligible for the benefits provided under Title
907 XVIII of the federal Social Security Act by expenditure of funds
908 available for those purposes;

909 (e) To make reports to the United States Department of
910 Health and Human Services as from time to time may be required by
911 that federal department and to the Mississippi Legislature as
912 provided in this section;
913 (f) Define and determine the scope, duration and amount
914 of Medicaid that may be provided in accordance with this article
915 and establish priorities therefor in conformity with this article;
916 (g) Cooperate and contract with other state agencies
917 for the purpose of coordinating Medicaid provided under this
918 article and eliminating duplication and inefficiency in the
919 Medicaid program;
920 (h) Adopt and use an official seal of the division;
921 (i) Sue in its own name on behalf of the State of
922 Mississippi and employ legal counsel on a contingency basis with
923 the approval of the Attorney General;
924 (j) To recover any and all payments incorrectly made by
925 the division to a recipient or provider from the recipient or
926 provider receiving the payments. The division shall be authorized
927 to collect any overpayments to providers sixty (60) days after the
928 conclusion of any administrative appeal unless the matter is
929 appealed to a court of proper jurisdiction and bond is posted.
930 Any appeal filed after July 1, 2015, shall be to the Chancery
931 Court of the First Judicial District of Hinds County, Mississippi,
932 within sixty (60) days after the date that the division has
933 notified the provider by certified mail sent to the proper address

934 of the provider on file with the division and the provider has
935 signed for the certified mail notice, or sixty (60) days after the
936 date of the final decision if the provider does not sign for the
937 certified mail notice. To recover those payments, the division
938 may use the following methods, in addition to any other methods
939 available to the division:

940 (i) The division shall report to the Department of
941 Revenue the name of any current or former Medicaid recipient who
942 has received medical services rendered during a period of
943 established Medicaid ineligibility and who has not reimbursed the
944 division for the related medical service payment(s). The
945 Department of Revenue shall withhold from the state tax refund of
946 the individual, and pay to the division, the amount of the
947 payment(s) for medical services rendered to the ineligible
948 individual that have not been reimbursed to the division for the
949 related medical service payment(s).

950 (ii) The division shall report to the Department
951 of Revenue the name of any Medicaid provider to whom payments were
952 incorrectly made that the division has not been able to recover by
953 other methods available to the division. The Department of
954 Revenue shall withhold from the state tax refund of the provider,
955 and pay to the division, the amount of the payments that were
956 incorrectly made to the provider that have not been recovered by
957 other available methods;

958 (k) To recover any and all payments by the division
959 fraudulently obtained by a recipient or provider. Additionally,
960 if recovery of any payments fraudulently obtained by a recipient
961 or provider is made in any court, then, upon motion of the
962 Governor, the judge of the court may award twice the payments
963 recovered as damages;
964 (l) Have full, complete and plenary power and authority
965 to conduct such investigations as it may deem necessary and
966 requisite of alleged or suspected violations or abuses of the
967 provisions of this article or of the regulations adopted under
968 this article, including, but not limited to, fraudulent or
969 unlawful act or deed by applicants for Medicaid or other benefits,
970 or payments made to any person, firm or corporation under the
971 terms, conditions and authority of this article, to suspend or
972 disqualify any provider of services, applicant or recipient for
973 gross abuse, fraudulent or unlawful acts for such periods,
974 including permanently, and under such conditions as the division
975 deems proper and just, including the imposition of a legal rate of
976 interest on the amount improperly or incorrectly paid. Recipients
977 who are found to have misused or abused Medicaid benefits may be
978 locked into one (1) physician and/or one (1) pharmacy of the
979 recipient's choice for a reasonable amount of time in order to
980 educate and promote appropriate use of medical services, in
981 accordance with federal regulations. If an administrative hearing
982 becomes necessary, the division may, if the provider does not

983 succeed in his or her defense, tax the costs of the administrative
984 hearing, including the costs of the court reporter or stenographer
985 and transcript, to the provider. The convictions of a recipient
986 or a provider in a state or federal court for abuse, fraudulent or
987 unlawful acts under this chapter shall constitute an automatic
988 disqualification of the recipient or automatic disqualification of
989 the provider from participation under the Medicaid program.

990 A conviction, for the purposes of this chapter, shall include
991 a judgment entered on a plea of nolo contendere or a
992 nonadjudicated guilty plea and shall have the same force as a
993 judgment entered pursuant to a guilty plea or a conviction
994 following trial. A certified copy of the judgment of the court of
995 competent jurisdiction of the conviction shall constitute prima
996 facie evidence of the conviction for disqualification purposes;

997 (m) Establish and provide such methods of
998 administration as may be necessary for the proper and efficient
999 operation of the Medicaid program, fully utilizing computer
1000 equipment as may be necessary to oversee and control all current
1001 expenditures for purposes of this article, and to closely monitor
1002 and supervise all recipient payments and vendors rendering
1003 services under this article. Notwithstanding any other provision
1004 of state law, the division is authorized to enter into a ten-year
1005 contract(s) with a vendor(s) to provide services described in this
1006 paragraph (m). Notwithstanding any provision of law to the
1007 contrary, the division is authorized to extend its Medicaid

1008 Management Information System, including all related components
1009 and services, and Decision Support System, including all related
1010 components and services, contracts in effect on June 30, 2020, for
1011 a period not to exceed two (2) years without complying with state
1012 procurement regulations;

1013 (n) To cooperate and contract with the federal
1014 government for the purpose of providing Medicaid to Vietnamese and
1015 Cambodian refugees, under the provisions of Public Law 94-23 and
1016 Public Law 94-24, including any amendments to those laws, only to
1017 the extent that the Medicaid assistance and the administrative
1018 cost related thereto are one hundred percent (100%) reimbursable
1019 by the federal government. For the purposes of Section 43-13-117,
1020 persons receiving Medicaid under Public Law 94-23 and Public Law
1021 94-24, including any amendments to those laws, shall not be
1022 considered a new group or category of recipient; and

1023 (o) The division shall impose penalties upon Medicaid
1024 only, Title XIX participating long-term care facilities found to
1025 be in noncompliance with division and certification standards in
1026 accordance with federal and state regulations, including interest
1027 at the same rate calculated by the United States Department of
1028 Health and Human Services and/or the Centers for Medicare and
1029 Medicaid Services (CMS) under federal regulations.

1030 (2) The division also shall exercise such additional powers
1031 and perform such other duties as may be conferred upon the
1032 division by act of the Legislature.

1033 (3) The division, and the State Department of Health as the
1034 agency for licensure of health care facilities and certification
1035 and inspection for the Medicaid and/or Medicare programs, shall
1036 contract for or otherwise provide for the consolidation of on-site
1037 inspections of health care facilities that are necessitated by the
1038 respective programs and functions of the division and the
1039 department.
1040 (4) The division and its hearing officers shall have power
1041 to preserve and enforce order during hearings; to issue subpoenas
1042 for, to administer oaths to and to compel the attendance and
1043 testimony of witnesses, or the production of books, papers,
1044 documents and other evidence, or the taking of depositions before
1045 any designated individual competent to administer oaths; to
1046 examine witnesses; and to do all things conformable to law that
1047 may be necessary to enable them effectively to discharge the
1048 duties of their office. In compelling the attendance and
1049 testimony of witnesses, or the production of books, papers,
1050 documents and other evidence, or the taking of depositions, as
1051 authorized by this section, the division or its hearing officers
1052 may designate an individual employed by the division or some other
1053 suitable person to execute and return that process, whose action
1054 in executing and returning that process shall be as lawful as if
1055 done by the sheriff or some other proper officer authorized to
1056 execute and return process in the county where the witness may
1057 reside. In carrying out the investigatory powers under the

1058 provisions of this article, the executive director or other
1059 designated person or persons may examine, obtain, copy or
1060 reproduce the books, papers, documents, medical charts,
1061 prescriptions and other records relating to medical care and
1062 services furnished by the provider to a recipient or designated
1063 recipients of Medicaid services under investigation. In the
1064 absence of the voluntary submission of the books, papers,
1065 documents, medical charts, prescriptions and other records, the
1066 Governor, the executive director, or other designated person may
1067 issue and serve subpoenas instantly upon the provider, his or her
1068 agent, servant or employee for the production of the books,
1069 papers, documents, medical charts, prescriptions or other records
1070 during an audit or investigation of the provider. If any provider
1071 or his or her agent, servant or employee refuses to produce the
1072 records after being duly subpoenaed, the executive director may
1073 certify those facts and institute contempt proceedings in the
1074 manner, time and place as authorized by law for administrative
1075 proceedings. As an additional remedy, the division may recover
1076 all amounts paid to the provider covering the period of the audit
1077 or investigation, inclusive of a legal rate of interest and a
1078 reasonable attorney's fee and costs of court if suit becomes
1079 necessary. Division staff shall have immediate access to the
1080 provider's physical location, facilities, records, documents,
1081 books, and any other records relating to medical care and services
1082 rendered to recipients during regular business hours.

1083 (5) If any person in proceedings before the division
1084 disobeys or resists any lawful order or process, or misbehaves
1085 during a hearing or so near the place thereof as to obstruct the
1086 hearing, or neglects to produce, after having been ordered to do
1087 so, any pertinent book, paper or document, or refuses to appear
1088 after having been subpoenaed, or upon appearing refuses to take
1089 the oath as a witness, or after having taken the oath refuses to
1090 be examined according to law, the executive director shall certify
1091 the facts to any court having jurisdiction in the place in which
1092 it is sitting, and the court shall thereupon, in a summary manner,
1093 hear the evidence as to the acts complained of, and if the
1094 evidence so warrants, punish that person in the same manner and to
1095 the same extent as for a contempt committed before the court, or
1096 commit that person upon the same condition as if the doing of the
1097 forbidden act had occurred with reference to the process of, or in
1098 the presence of, the court.
1099 (6) In suspending or terminating any provider from
1100 participation in the Medicaid program, the division shall preclude
1101 the provider from submitting claims for payment, either personally
1102 or through any clinic, group, corporation or other association to
1103 the division or its fiscal agents for any services or supplies
1104 provided under the Medicaid program except for those services or
1105 supplies provided before the suspension or termination. No
1106 clinic, group, corporation or other association that is a provider
1107 of services shall submit claims for payment to the division or its

1108 fiscal agents for any services or supplies provided by a person
1109 within that organization who has been suspended or terminated from
1110 participation in the Medicaid program except for those services or
1111 supplies provided before the suspension or termination. When this
1112 provision is violated by a provider of services that is a clinic,
1113 group, corporation or other association, the division may suspend
1114 or terminate that organization from participation. Suspension may
1115 be applied by the division to all known affiliates of a provider,
1116 provided that each decision to include an affiliate is made on a
1117 case-by-case basis after giving due regard to all relevant facts
1118 and circumstances. The violation, failure or inadequacy of
1119 performance may be imputed to a person with whom the provider is
1120 affiliated where that conduct was accomplished within the course
1121 of his or her official duty or was effectuated by him or her with
1122 the knowledge or approval of that person.

1123 (7) The division may deny or revoke enrollment in the
1124 Medicaid program to a provider if any of the following are found
1125 to be applicable to the provider, his or her agent, a managing
1126 employee or any person having an ownership interest equal to five
1127 percent (5%) or greater in the provider:

1128 (a) Failure to truthfully or fully disclose any and all
1129 information required, or the concealment of any and all
1130 information required, on a claim, a provider application or a
1131 provider agreement, or the making of a false or misleading
1132 statement to the division relative to the Medicaid program.

1133 (b) Previous or current exclusion, suspension,
1134 termination from or the involuntary withdrawing from participation
1135 in the Medicaid program, any other state's Medicaid program,
1136 Medicare or any other public or private health or health insurance
1137 program. If the division ascertains that a provider has been
1138 convicted of a felony under federal or state law for an offense
1139 that the division determines is detrimental to the best interest
1140 of the program or of Medicaid beneficiaries, the division may
1141 refuse to enter into an agreement with that provider, or may
1142 terminate or refuse to renew an existing agreement.
1143 (c) Conviction under federal or state law of a criminal
1144 offense relating to the delivery of any goods, services or
1145 supplies, including the performance of management or
1146 administrative services relating to the delivery of the goods,
1147 services or supplies, under the Medicaid program, any other
1148 state's Medicaid program, Medicare or any other public or private
1149 health or health insurance program.
1150 (d) Conviction under federal or state law of a criminal
1151 offense relating to the neglect or abuse of a patient in
1152 connection with the delivery of any goods, services or supplies.
1153 (e) Conviction under federal or state law of a criminal
1154 offense relating to the unlawful manufacture, distribution,
1155 prescription or dispensing of a controlled substance.

1156 (f) Conviction under federal or state law of a criminal
1157 offense relating to fraud, theft, embezzlement, breach of
1158 fiduciary responsibility or other financial misconduct.
1159 (g) Conviction under federal or state law of a criminal
1160 offense punishable by imprisonment of a year or more that involves
1161 moral turpitude, or acts against the elderly, children or infirm.
1162 (h) Conviction under federal or state law of a criminal
1163 offense in connection with the interference or obstruction of any
1164 investigation into any criminal offense listed in paragraphs (c)
1165 through (i) of this subsection.
1166 (i) Sanction for a violation of federal or state laws
1167 or rules relative to the Medicaid program, any other state's
1168 Medicaid program, Medicare or any other public health care or
1169 health insurance program.
1170 (j) Revocation of license or certification.
1171 (k) Failure to pay recovery properly assessed or
1172 pursuant to an approved repayment schedule under the Medicaid
1173 program.
1174 (l) Failure to meet any condition of enrollment.
1175 (8) (a) As used in this subsection (8), the following terms
1176 shall be defined as provided in this paragraph, except as
1177 otherwise provided in this subsection:
1178 (i) "Committees" means the Medicaid Committees of
1179 the House of Representatives and the Senate, and "committee" means
1180 either one of those committees.

1181 (ii) "State Plan" means the agreement between the
1182 State of Mississippi and the federal government regarding the
1183 nature and scope of Mississippi's Medicaid Program.
1184 (iii) "State Plan Amendment" means a change to the
1185 State Plan, which must be approved by the Centers for Medicare and
1186 Medicaid Services (CMS) before its implementation.
1187 (b) Whenever the Division of Medicaid proposes a State
1188 Plan Amendment, the division shall give notice to the chairmen of
1189 the committees at least thirty (30) calendar days before the
1190 proposed State Plan Amendment is filed with CMS. The division
1191 shall furnish the chairmen with a concise summary of each proposed
1192 State Plan Amendment along with the notice, and shall furnish the
1193 chairmen with a copy of any proposed State Plan Amendment upon
1194 request. The division also shall provide a summary and copy of
1195 any proposed State Plan Amendment to any other member of the
1196 Legislature upon request.
1197 (c) If the chairman of either committee or both
1198 chairmen jointly object to the proposed State Plan Amendment or
1199 any part thereof, the chairman or chairmen shall notify the
1200 division and provide the reasons for their objection in writing
1201 not later than seven (7) calendar days after receipt of the notice
1202 from the division. The chairman or chairmen may make written
1203 recommendations to the division for changes to be made to a
1204 proposed State Plan Amendment.

1205 (d) (i) The chairman of either committee or both
1206 chairmen jointly may hold a committee meeting to review a proposed
1207 State Plan Amendment. If either chairman or both chairmen decide
1208 to hold a meeting, they shall notify the division of their
1209 intention in writing within seven (7) calendar days after receipt
1210 of the notice from the division, and shall set the date and time
1211 for the meeting in their notice to the division, which shall not
1212 be later than fourteen (14) calendar days after receipt of the
1213 notice from the division.

1214 (ii) After the committee meeting, the committee or
1215 committees may object to the proposed State Plan Amendment or any
1216 part thereof. The committee or committees shall notify the
1217 division and the reasons for their objection in writing not later
1218 than seven (7) calendar days after the meeting. The committee or
1219 committees may make written recommendations to the division for
1220 changes to be made to a proposed State Plan Amendment.

1221 (e) If both chairmen notify the division in writing
1222 within seven (7) calendar days after receipt of the notice from
1223 the division that they do not object to the proposed State Plan
1224 Amendment and will not be holding a meeting to review the proposed
1225 State Plan Amendment, the division may proceed to file the
1226 proposed State Plan Amendment with CMS.

1227 (f) (i) If there are any objections to a proposed rate
1228 change or any part thereof from either or both of the chairmen or
1229 the committees, the division may withdraw the proposed State Plan

1230 Amendment, make any of the recommended changes to the proposed
1231 State Plan Amendment, or not make any changes to the proposed
1232 State Plan Amendment.
1233 (ii) If the division does not make any changes to
1234 the proposed State Plan Amendment, it shall notify the chairmen of
1235 that fact in writing, and may proceed to file the State Plan
1236 Amendment with CMS.
1237 (iii) If the division makes any changes to the
1238 proposed State Plan Amendment, the division shall notify the
1239 chairmen of its actions in writing, and may proceed to file the
1240 State Plan Amendment with CMS.
1241 (g) Nothing in this subsection (8) shall be construed
1242 as giving the chairmen or the committees any authority to veto,
1243 nullify or revise any State Plan Amendment proposed by the
1244 division. The authority of the chairmen or the committees under
1245 this subsection shall be limited to reviewing, making objections
1246 to and making recommendations for changes to State Plan Amendments
1247 proposed by the division.
1248 (i) If the division does not make any changes to
1249 the proposed State Plan Amendment, it shall notify the chairmen of
1250 that fact in writing, and may proceed to file the proposed State
1251 Plan Amendment with CMS.
1252 (ii) If the division makes any changes to the
1253 proposed State Plan Amendment, the division shall notify the

1254 chairmen of the changes in writing, and may proceed to file the
1255 proposed State Plan Amendment with CMS.
1256 (h) Nothing in this subsection (8) shall be construed
1257 as giving the chairmen of the committees any authority to veto,
1258 nullify or revise any State Plan Amendment proposed by the
1259 division. The authority of the chairmen of the committees under
1260 this subsection shall be limited to reviewing, making objections
1261 to and making recommendations for suggested changes to State Plan
1262 Amendments proposed by the division.
1263 **SECTION 10.** Section 43-13-122, Mississippi Code of 1972, is
1264 amended as follows:
1265 43-13-122. (1) The division is authorized to apply to the
1266 Center for Medicare and Medicaid Services of the United States
1267 Department of Health and Human Services for waivers and research
1268 and demonstration grants.
1269 (2) The division is further authorized to accept and expend
1270 any grants, donations or contributions from any public or private
1271 organization together with any additional federal matching funds
1272 that may accrue and, including, but not limited to, one hundred
1273 percent (100%) federal grant funds or funds from any governmental
1274 entity or instrumentality thereof in furthering the purposes and
1275 objectives of the Mississippi Medicaid program, provided that such
1276 receipts and expenditures are reported and otherwise handled in
1277 accordance with the General Fund Stabilization Act. The
1278 Department of Finance and Administration is authorized to transfer

1279 monies to the division from special funds in the State Treasury in
1280 amounts not exceeding the amounts authorized in the appropriation
1281 to the division.

1282 **SECTION 11.** Section 43-13-123, Mississippi Code of 1972, is
1283 brought forward as follows:

1284 43-13-123. The determination of the method of providing
1285 payment of claims under this article shall be made by the
1286 division, with approval of the Governor, which methods may be:

1287 (a) By contract with insurance companies licensed to do
1288 business in the State of Mississippi or with nonprofit hospital
1289 service corporations, medical or dental service corporations,
1290 authorized to do business in Mississippi to underwrite on an
1291 insured premium approach, such medical assistance benefits as may
1292 be available, and any carrier selected under the provisions of
1293 this article is expressly authorized and empowered to undertake
1294 the performance of the requirements of that contract.

1295 (b) By contract with an insurance company licensed to
1296 do business in the State of Mississippi or with nonprofit hospital
1297 service, medical or dental service organizations, or other
1298 organizations including data processing companies, authorized to
1299 do business in Mississippi to act as fiscal agent.

1300 The division shall obtain services to be provided under
1301 either of the above-described provisions in accordance with the
1302 Personal Service Contract Review Board Procurement Regulations.

1303 The authorization of the foregoing methods shall not preclude
1304 other methods of providing payment of claims through direct
1305 operation of the program by the state or its agencies.
1306 **SECTION 12.** Section 43-13-125, Mississippi Code of 1972, is
1307 brought forward as follows:
1308 43-13-125. (1) If Medicaid is provided to a recipient under
1309 this article for injuries, disease or sickness caused under
1310 circumstances creating a cause of action in favor of the recipient
1311 against any person, firm, corporation, political subdivision or
1312 other state agency, then the division shall be entitled to recover
1313 the proceeds that may result from the exercise of any rights of
1314 recovery that the recipient may have against any such person,
1315 firm, corporation, political subdivision or other state agency, to
1316 the extent of the Division of Medicaid's interest on behalf of the
1317 recipient. The recipient shall execute and deliver instruments
1318 and papers to do whatever is necessary to secure those rights and
1319 shall do nothing after Medicaid is provided to prejudice the
1320 subrogation rights of the division. Court orders or agreements
1321 for reimbursement of Medicaid's interest shall direct those
1322 payments to the Division of Medicaid, which shall be authorized to
1323 endorse any and all, including, but not limited to, multipayee
1324 checks, drafts, money orders, or other negotiable instruments
1325 representing Medicaid payment recoveries that are received. In
1326 accordance with Section 43-13-305, endorsement of multipayee
1327 checks, drafts, money orders or other negotiable instruments by

1328 the Division of Medicaid shall be deemed endorsed by the
1329 recipient. All payments must be remitted to the division within
1330 sixty (60) days from the date of a settlement or the entry of a
1331 final judgment; failure to do so hereby authorizes the division to
1332 assert its rights under Sections 43-13-307 and 43-13-315, plus
1333 interest.

1334 The division, with the approval of the Governor, may
1335 compromise or settle any such claim and execute a release of any
1336 claim it has by virtue of this section at the division's sole
1337 discretion. Nothing in this section shall be construed to require
1338 the Division of Medicaid to compromise any such claim.

1339 (2) The acceptance of Medicaid under this article or the
1340 making of a claim under this article shall not affect the right of
1341 a recipient or his or her legal representative to recover
1342 Medicaid's interest as an element of damages in any action at law;
1343 however, a copy of the pleadings shall be certified to the
1344 division at the time of the institution of suit, and proof of
1345 that notice shall be filed of record in that action. The division
1346 may, at any time before the trial on the facts, join in that
1347 action or may intervene in that action. Any amount recovered by a
1348 recipient or his or her legal representative shall be applied as
1349 follows:

1350 (a) The reasonable costs of the collection, including
1351 attorney's fees, as approved and allowed by the court in which

1352 that action is pending, or in case of settlement without suit, by
1353 the legal representative of the division;

1354 (b) The amount of Medicaid's interest on behalf of the
1355 recipient; or such amount as may be arrived at by the legal
1356 representative of the division and the recipient's attorney; and

1357 (c) Any excess shall be awarded to the recipient.

1358 (3) No compromise of any claim by the recipient or his or
1359 her legal representative shall be binding upon or affect the
1360 rights of the division against the third party unless the
1361 division, with the approval of the Governor, has entered into the
1362 compromise in writing. The recipient or his or her legal
1363 representative maintain the absolute duty to notify the division
1364 of the institution of legal proceedings, and the third party and
1365 his or her insurer maintain the absolute duty to notify the
1366 division of a proposed compromise for which the division has an
1367 interest. The aforementioned absolute duties may not be delegated
1368 or assigned by contract or otherwise. Any compromise effected by
1369 the recipient or his or her legal representative with the third
1370 party in the absence of advance notification to and approved by
1371 the division shall constitute conclusive evidence of the liability
1372 of the third party, and the division, in litigating its claim
1373 against the third party, shall be required only to prove the
1374 amount and correctness of its claim relating to the injury,
1375 disease or sickness. If the recipient or his or her legal
1376 representative fails to notify the division of the institution of

1377 legal proceedings against a third party for which the division has
1378 a cause of action, the facts relating to negligence and the
1379 liability of the third party, if judgment is rendered for the
1380 recipient, shall constitute conclusive evidence of liability in a
1381 subsequent action maintained by the division and only the amount
1382 and correctness of the division's claim relating to injuries,
1383 disease or sickness shall be tried before the court. The division
1384 shall be authorized in bringing that action against the third
1385 party and his or her insurer jointly or against the insurer alone.
1386 (4) Nothing in this section shall be construed to diminish
1387 or otherwise restrict the subrogation rights of the Division of
1388 Medicaid against a third party for Medicaid provided by the
1389 Division of Medicaid to the recipient as a result of injuries,
1390 disease or sickness caused under circumstances creating a cause of
1391 action in favor of the recipient against such a third party.
1392 (5) Any amounts recovered by the division under this section
1393 shall, by the division, be placed to the credit of the funds
1394 appropriated for benefits under this article proportionate to the
1395 amounts provided by the state and federal governments
1396 respectively.
1397 **SECTION 13.** Section 43-13-139, Mississippi Code of 1972, is
1398 brought forward as follows:
1399 43-13-139. Nothing contained in this article shall be
1400 construed to prevent the Governor, in his discretion, from
1401 discontinuing or limiting medical assistance to any individuals

1402 who are classified or deemed to be within any optional group or
1403 optional category of recipients as prescribed under Title XIX of
1404 the federal Social Security Act or the implementing federal
1405 regulations. If the Congress or the United States Department of
1406 Health and Human Services ceases to provide federal matching funds
1407 for any group or category of recipients or any type of care and
1408 services, the division shall cease state funding for such group or
1409 category or such type of care and services, notwithstanding any
1410 provision of this article. If any state plan amendment submitted
1411 to comply with the provisions of Section 43-13-117 is disapproved
1412 by the United States Department of Health and Human Services, the
1413 division may operate under the state plan as previously approved
1414 by the United States Department of Health and Human Services in
1415 order to preserve federal matching funds. The division shall
1416 provide notice of the disapproval to the Chairmen of the House and
1417 Senate Medicaid Committees.

1418 **SECTION 14.** Section 43-13-145, Mississippi Code of 1972, is
1419 brought forward as follows:

1420 43-13-145. (1) (a) Upon each nursing facility licensed by
1421 the State of Mississippi, there is levied an assessment in an
1422 amount set by the division, equal to the maximum rate allowed by
1423 federal law or regulation, for each licensed and occupied bed of
1424 the facility.

1425 (b) A nursing facility is exempt from the assessment
1426 levied under this subsection if the facility is operated under the
1427 direction and control of:
1428 (i) The United States Veterans Administration or
1429 other agency or department of the United States government; or
1430 (ii) The State Veterans Affairs Board.
1431 (2) (a) Upon each intermediate care facility for
1432 individuals with intellectual disabilities licensed by the State
1433 of Mississippi, there is levied an assessment in an amount set by
1434 the division, equal to the maximum rate allowed by federal law or
1435 regulation, for each licensed and occupied bed of the facility.
1436 (b) An intermediate care facility for individuals with
1437 intellectual disabilities is exempt from the assessment levied
1438 under this subsection if the facility is operated under the
1439 direction and control of:
1440 (i) The United States Veterans Administration or
1441 other agency or department of the United States government;
1442 (ii) The State Veterans Affairs Board; or
1443 (iii) The University of Mississippi Medical
1444 Center.
1445 (3) (a) Upon each psychiatric residential treatment
1446 facility licensed by the State of Mississippi, there is levied an
1447 assessment in an amount set by the division, equal to the maximum
1448 rate allowed by federal law or regulation, for each licensed and
1449 occupied bed of the facility.

1450 (b) A psychiatric residential treatment facility is
1451 exempt from the assessment levied under this subsection if the
1452 facility is operated under the direction and control of:
1453 (i) The United States Veterans Administration or
1454 other agency or department of the United States government;
1455 (ii) The University of Mississippi Medical Center;
1456 or
1457 (iii) A state agency or a state facility that
1458 either provides its own state match through intergovernmental
1459 transfer or certification of funds to the division.
1460 (4) Hospital assessment.
1461 (a) (i) Subject to and upon fulfillment of the
1462 requirements and conditions of paragraph (f) below, and
1463 notwithstanding any other provisions of this section, an annual
1464 assessment on each hospital licensed in the state is imposed on
1465 each non-Medicare hospital inpatient day as defined below at a
1466 rate that is determined by dividing the sum prescribed in this
1467 subparagraph (i), plus the nonfederal share necessary to maximize
1468 the Disproportionate Share Hospital (DSH) and Medicare Upper
1469 Payment Limits (UPL) Program payments and hospital access payments
1470 and such other supplemental payments as may be developed pursuant
1471 to Section 43-13-117(A)(18), by the total number of non-Medicare
1472 hospital inpatient days as defined below for all licensed
1473 Mississippi hospitals, except as provided in paragraph (d) below.
1474 If the state-matching funds percentage for the Mississippi

1475 Medicaid program is sixteen percent (16%) or less, the sum used in
1476 the formula under this subparagraph (i) shall be Seventy-four
1477 Million Dollars ($74,000,000.00). If the state-matching funds
1478 percentage for the Mississippi Medicaid program is twenty-four
1479 percent (24%) or higher, the sum used in the formula under this
1480 subparagraph (i) shall be One Hundred Four Million Dollars
1481 ($104,000,000.00). If the state-matching funds percentage for the
1482 Mississippi Medicaid program is between sixteen percent (16%) and
1483 twenty-four percent (24%), the sum used in the formula under this
1484 subparagraph (i) shall be a pro rata amount determined as follows:
1485 the current state-matching funds percentage rate minus sixteen
1486 percent (16%) divided by eight percent (8%) multiplied by Thirty
1487 Million Dollars ($30,000,000.00) and add that amount to
1488 Seventy-four Million Dollars ($74,000,000.00). However, no
1489 assessment in a quarter under this subparagraph (i) may exceed the
1490 assessment in the previous quarter by more than Three Million
1491 Seven Hundred Fifty Thousand Dollars ($3,750,000.00) (which would
1492 be Fifteen Million Dollars ($15,000,000.00) on an annualized
1493 basis). The division shall publish the state-matching funds
1494 percentage rate applicable to the Mississippi Medicaid program on
1495 the tenth day of the first month of each quarter and the
1496 assessment determined under the formula prescribed above shall be
1497 applicable in the quarter following any adjustment in that
1498 state-matching funds percentage rate. The division shall notify
1499 each hospital licensed in the state as to any projected increases

1500 or decreases in the assessment determined under this subparagraph
1501 (i). However, if the Centers for Medicare and Medicaid Services
1502 (CMS) does not approve the provision in Section 43-13-117(39)
1503 requiring the division to reimburse crossover claims for inpatient
1504 hospital services and crossover claims covered under Medicare Part
1505 B for dually eligible beneficiaries in the same manner that was in
1506 effect on January 1, 2008, the sum that otherwise would have been
1507 used in the formula under this subparagraph (i) shall be reduced
1508 by Seven Million Dollars ($7,000,000.00).
1509 (ii) In addition to the assessment provided under
1510 subparagraph (i), an additional annual assessment on each hospital
1511 licensed in the state is imposed on each non-Medicare hospital
1512 inpatient day as defined below at a rate that is determined by
1513 dividing twenty-five percent (25%) of any provider reductions in
1514 the Medicaid program as authorized in Section 43-13-117(F) for
1515 that fiscal year up to the following maximum amount, plus the
1516 nonfederal share necessary to maximize the Disproportionate Share
1517 Hospital (DSH) and inpatient Medicare Upper Payment Limits (UPL)
1518 Program payments and inpatient hospital access payments, by the
1519 total number of non-Medicare hospital inpatient days as defined
1520 below for all licensed Mississippi hospitals: in fiscal year
1521 2010, the maximum amount shall be Twenty-four Million Dollars
1522 ($24,000,000.00); in fiscal year 2011, the maximum amount shall be
1523 Thirty-two Million Dollars ($32,000,000.00); and in fiscal year
1524 2012 and thereafter, the maximum amount shall be Forty Million

1525 Dollars ($40,000,000.00). Any such deficit in the Medicaid
1526 program shall be reviewed by the PEER Committee as provided in
1527 Section 43-13-117(F).
1528 (iii) In addition to the assessments provided in
1529 subparagraphs (i) and (ii), an additional annual assessment on
1530 each hospital licensed in the state is imposed pursuant to the
1531 provisions of Section 43-13-117(F) if the cost-containment
1532 measures described therein have been implemented and there are
1533 insufficient funds in the Health Care Trust Fund to reconcile any
1534 remaining deficit in any fiscal year. If the Governor institutes
1535 any other additional cost-containment measures on any program or
1536 programs authorized under the Medicaid program pursuant to Section
1537 43-13-117(F), hospitals shall be responsible for twenty-five
1538 percent (25%) of any such additional imposed provider cuts, which
1539 shall be in the form of an additional assessment not to exceed the
1540 twenty-five percent (25%) of provider expenditure reductions.
1541 Such additional assessment shall be imposed on each non-Medicare
1542 hospital inpatient day in the same manner as assessments are
1543 imposed under subparagraphs (i) and (ii).
1544 (b) Definitions.
1545 (i) [Deleted]
1546 (ii) For purposes of this subsection (4):
1547 1. "Non-Medicare hospital inpatient day"
1548 means total hospital inpatient days including subcomponent days
1549 less Medicare inpatient days including subcomponent days from the

1550 hospital's most recent Medicare cost report for the second
1551 calendar year preceding the beginning of the state fiscal year, on
1552 file with CMS per the CMS HCRIS database, or cost report submitted
1553 to the Division if the HCRIS database is not available to the
1554 division, as of June 1 of each year.

1555 a. Total hospital inpatient days shall
1556 be the sum of Worksheet S-3, Part 1, column 8 row 14, column 8 row
1557 16, and column 8 row 17, excluding column 8 rows 5 and 6.

1558 b. Hospital Medicare inpatient days
1559 shall be the sum of Worksheet S-3, Part 1, column 6 row 14, column
1560 6 row 16.00, and column 6 row 17, excluding column 6 rows 5 and 6.

1561 c. Inpatient days shall not include
1562 residential treatment or long-term care days.

1563 2. "Subcomponent inpatient day" means the
1564 number of days of care charged to a beneficiary for inpatient
1565 hospital rehabilitation and psychiatric care services in units of
1566 full days. A day begins at midnight and ends twenty-four (24)
1567 hours later. A part of a day, including the day of admission and
1568 day on which a patient returns from leave of absence, counts as a
1569 full day. However, the day of discharge, death, or a day on which
1570 a patient begins a leave of absence is not counted as a day unless
1571 discharge or death occur on the day of admission. If admission
1572 and discharge or death occur on the same day, the day is
1573 considered a day of admission and counts as one (1) subcomponent
1574 inpatient day.

1575 (c) The assessment provided in this subsection is
1576 intended to satisfy and not be in addition to the assessment and
1577 intergovernmental transfers provided in Section 43-13-117(A)(18).
1578 Nothing in this section shall be construed to authorize any state
1579 agency, division or department, or county, municipality or other
1580 local governmental unit to license for revenue, levy or impose any
1581 other tax, fee or assessment upon hospitals in this state not
1582 authorized by a specific statute.
1583 (d) Hospitals operated by the United States Department
1584 of Veterans Affairs and state-operated facilities that provide
1585 only inpatient and outpatient psychiatric services shall not be
1586 subject to the hospital assessment provided in this subsection.
1587 (e) Multihospital systems, closure, merger, change of
1588 ownership and new hospitals.
1589 (i) If a hospital conducts, operates or maintains
1590 more than one (1) hospital licensed by the State Department of
1591 Health, the provider shall pay the hospital assessment for each
1592 hospital separately.
1593 (ii) Notwithstanding any other provision in this
1594 section, if a hospital subject to this assessment operates or
1595 conducts business only for a portion of a fiscal year, the
1596 assessment for the state fiscal year shall be adjusted by
1597 multiplying the assessment by a fraction, the numerator of which
1598 is the number of days in the year during which the hospital
1599 operates, and the denominator of which is three hundred sixty-five

1600 (365). Immediately upon ceasing to operate, the hospital shall
1601 pay the assessment for the year as so adjusted (to the extent not
1602 previously paid).

1603 (iii) The division shall determine the tax for new
1604 hospitals and hospitals that undergo a change of ownership in
1605 accordance with this section, using the best available
1606 information, as determined by the division.

1607 (f) Applicability.

1608 The hospital assessment imposed by this subsection shall not
1609 take effect and/or shall cease to be imposed if:

1610 (i) The assessment is determined to be an
1611 impermissible tax under Title XIX of the Social Security Act; or

1612 (ii) CMS revokes its approval of the division's
1613 2009 Medicaid State Plan Amendment for the methodology for DSH
1614 payments to hospitals under Section 43-13-117(A)(18).

1615 (5) Each health care facility that is subject to the
1616 provisions of this section shall keep and preserve such suitable
1617 books and records as may be necessary to determine the amount of
1618 assessment for which it is liable under this section. The books
1619 and records shall be kept and preserved for a period of not less
1620 than five (5) years, during which time those books and records
1621 shall be open for examination during business hours by the
1622 division, the Department of Revenue, the Office of the Attorney
1623 General and the State Department of Health.

1624 (6) [Deleted]

1625 (7) All assessments collected under this section shall be
1626 deposited in the Medical Care Fund created by Section 43-13-143.
1627 (8) The assessment levied under this section shall be in
1628 addition to any other assessments, taxes or fees levied by law,
1629 and the assessment shall constitute a debt due the State of
1630 Mississippi from the time the assessment is due until it is paid.
1631 (9) (a) If a health care facility that is liable for
1632 payment of an assessment levied by the division does not pay the
1633 assessment when it is due, the division shall give written notice
1634 to the health care facility demanding payment of the assessment
1635 within ten (10) days from the date of delivery of the notice. If
1636 the health care facility fails or refuses to pay the assessment
1637 after receiving the notice and demand from the division, the
1638 division shall withhold from any Medicaid reimbursement payments
1639 that are due to the health care facility the amount of the unpaid
1640 assessment and a penalty of ten percent (10%) of the amount of the
1641 assessment, plus the legal rate of interest until the assessment
1642 is paid in full. If the health care facility does not participate
1643 in the Medicaid program, the division shall turn over to the
1644 Office of the Attorney General the collection of the unpaid
1645 assessment by civil action. In any such civil action, the Office
1646 of the Attorney General shall collect the amount of the unpaid
1647 assessment and a penalty of ten percent (10%) of the amount of the
1648 assessment, plus the legal rate of interest until the assessment
1649 is paid in full.

1650 (b) As an additional or alternative method for
1651 collecting unpaid assessments levied by the division, if a health
1652 care facility fails or refuses to pay the assessment after
1653 receiving notice and demand from the division, the division may
1654 file a notice of a tax lien with the chancery clerk of the county
1655 in which the health care facility is located, for the amount of
1656 the unpaid assessment and a penalty of ten percent (10%) of the
1657 amount of the assessment, plus the legal rate of interest until
1658 the assessment is paid in full. Immediately upon receipt of
1659 notice of the tax lien for the assessment, the chancery clerk
1660 shall forward the notice to the circuit clerk who shall enter the
1661 notice of the tax lien as a judgment upon the judgment roll and
1662 show in the appropriate columns the name of the health care
1663 facility as judgment debtor, the name of the division as judgment
1664 creditor, the amount of the unpaid assessment, and the date and
1665 time of enrollment. The judgment shall be valid as against
1666 mortgagees, pledgees, entrusters, purchasers, judgment creditors
1667 and other persons from the time of filing with the clerk. The
1668 amount of the judgment shall be a debt due the State of
1669 Mississippi and remain a lien upon the tangible property of the
1670 health care facility until the judgment is satisfied. The
1671 judgment shall be the equivalent of any enrolled judgment of a
1672 court of record and shall serve as authority for the issuance of
1673 writs of execution, writs of attachment or other remedial writs.

1674 (10) (a) To further the provisions of Section
1675 43-13-117(A)(18), the Division of Medicaid shall submit to the
1676 Centers for Medicare and Medicaid Services (CMS) any documents
1677 regarding the hospital assessment established under subsection (4)
1678 of this section. In addition to defining the assessment
1679 established in subsection (4) of this section if necessary, the
1680 documents shall describe any supplement payment programs and/or
1681 payment methodologies as authorized in Section 43-13-117(A)(18) if
1682 necessary.
1683 (b) All hospitals satisfying the minimum federal DSH
1684 eligibility requirements (Section 1923(d) of the Social Security
1685 Act) may, subject to OBRA 1993 payment limitations, receive a DSH
1686 payment. This DSH payment shall expend the balance of the federal
1687 DSH allotment and associated state share not utilized in DSH
1688 payments to state-owned institutions for treatment of mental
1689 diseases. The payment to each hospital shall be calculated by
1690 applying a uniform percentage to the uninsured costs of each
1691 eligible hospital, excluding state-owned institutions for
1692 treatment of mental diseases; however, that percentage for a
1693 state-owned teaching hospital located in Hinds County shall be
1694 multiplied by a factor of two (2).
1695 (11) The division shall implement DSH and supplemental
1696 payment calculation methodologies that result in the maximization
1697 of available federal funds.

1698 (12) The DSH payments shall be paid on or before December
1699 31, March 31, and June 30 of each fiscal year, in increments of
1700 one-third (1/3) of the total calculated DSH amounts. Supplemental
1701 payments developed pursuant to Section 43-13-117(A)(18) shall be
1702 paid monthly.

1703 (13) Payment.

1704 (a) The hospital assessment as described in subsection
1705 (4) for the nonfederal share necessary to maximize the Medicare
1706 Upper Payments Limits (UPL) Program payments and hospital access
1707 payments and such other supplemental payments as may be developed
1708 pursuant to Section 43-3-117(A)(18) shall be assessed and
1709 collected monthly no later than the fifteenth calendar day of each
1710 month.

1711 (b) The hospital assessment as described in subsection
1712 (4) for the nonfederal share necessary to maximize the
1713 Disproportionate Share Hospital (DSH) payments shall be assessed
1714 and collected on December 15, March 15 and June 15.

1715 (c) The annual hospital assessment and any additional
1716 hospital assessment as described in subsection (4) shall be
1717 assessed and collected on September 15 and on the 15th of each
1718 month from December through June.

1719 (14) If for any reason any part of the plan for annual DSH
1720 and supplemental payment programs to hospitals provided under
1721 subsection (10) of this section and/or developed pursuant to

1722 Section 43-13-117(A)(18) is not approved by CMS, the remainder of
1723 the plan shall remain in full force and effect.

1724 (15) Nothing in this section shall prevent the Division of
1725 Medicaid from facilitating participation in Medicaid supplemental
1726 hospital payment programs by a hospital located in a county
1727 contiguous to the State of Mississippi that is also authorized by
1728 federal law to submit intergovernmental transfers (IGTs) to the
1729 State of Mississippi to fund the state share of the hospital's
1730 supplemental and/or MHAP payments.

1731 (16) This section shall stand repealed on July 1, 2024.

1732 **SECTION 15.** This act shall take effect and be in force from
1733 and after July 1, 2023.