MISSISSIPPI LEGISLATURE REGULAR SESSION 2025

By: Senator(s) Blackwell To: Medicaid

SENATE BILL NO. 2386

AN ACT TO BRING FORWARD SECTIONS 27-15-103, 27-15-109, 27-15-115 AND 27-15-129, MISSISSIPPI CODE OF 1972, WHICH PROVIDE FOR CERTAIN PREMIUM TAXES APPLIED TO CERTAIN INSURANCE ENTITIES; TO BRING FORWARD SECTIONS 43-13-5, 43-13-11, 43-13-105, 43-13-107, 43-13-111, 43-13-113, 43-13-115, 43-13-116, 43-13-117, 43-13-117.1, 43-13-121, 43-13-122, 43-13-123, 43-13-126, 43-13-133, 43-13-143, 43-13-145 AND 43-13-147, MISSISSIPPI CODE OF 1972, WHICH PROVIDE FOR VARIOUS PROVISIONS RELATED TO THE DIVISION OF MEDICAID, REIMBURSEMENT, BENEFICIARIES, HOSPITAL ASSESSMENT AND THE CHILDREN'S HEALTH INSURANCE PROGRAM, FOR THE PURPOSE OF POSSIBLE AMENDMENT; AND FOR RELATED PURPOSES.

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

SECTION 1. Section 27-15-103, Mississippi Code of 1972, is brought forward as follows:

27-15-103. (1) Except as otherwise provided in Section 83-61-11, in addition to the license tax now or hereafter provided by law, which tax shall be paid when the company enters or is admitted to do business in this state, there is hereby levied and imposed upon all foreign insurance companies and associations, including life insurance companies and associations, health, accident and industrial insurance companies and associations, fire and casualty insurance companies and associations, and all other

foreign insurance companies and associations of every kind and description, an additional annual license or privilege tax of three percent (3%) of the gross amount of premium receipts received from, and on insurance policies and contracts written in, or covering risks located in this state, except for premiums received on policies issued to fund a deferred compensation plan qualified under Section 457 of the Federal Tax Code for federal tax exemption. In determining said amount of premiums, there shall be deducted therefrom premiums received for reinsurance from companies authorized to do business in this state, cash dividends paid under policy contracts in this state, and premiums returned to policyholders and cancellations on accounts of policies not taken, and, in the case of mutual insurance companies (including interinsurance and reciprocal exchanges, but not including mutual life, accident, health or industrial insurance companies) any refund made or credited to the policyholder other than for losses. The term "premium" as used herein shall also include policy fees, membership fees, and all other fees collected by the companies. No credit or deduction from gross premium receipts shall be allowed for any commission, fee or compensation paid to any agent, solicitor or representative. Provided, however, that any foreign insurance carrier selected to furnish service to the State of Mississippi under the State Employees Life and Health Insurance Plan shall not be required to pay the annual license or privilege tax on the premiums collected for coverage under the said plan.

(2) In the event that the Mississippi Supreme Court or another court finally adjudicates that any tax levied prior to July 1, 1985, under the provisions of this section was collected unconstitutionally and that a liability for a credit or refund for such collection has accrued, then the rate of tax set forth above shall be increased to four percent (4%) for a period of six (6) years beginning July 1 following such adjudication.

(3) The taxes herein levied and imposed for the calendar year 1982 and all calendar years thereafter shall be reduced by the net amount of income tax paid to this state for the preceding calendar year, provided, in no event may the credit be taken more than once. The credit herein authorized shall, in no event, be greater than the premium tax due under this section; it being the purpose and intent of this paragraph that whichever of the annual insurance premium tax or the income tax is greater in amount shall be paid.

SECTION 2. Section 27-15-109, Mississippi Code of 1972, is brought forward as follows:

27-15-109. (1) Except as otherwise provided in Section 83-61-11, there is hereby levied and imposed upon each domestic company doing business in this state an annual tax of three percent (3%) of the gross amount of premiums collected by such domestic company on insurance policies and contracts written in, or covering risks located in this state, except for premiums received on policies issued to fund a retirement, thrift or

deferred compensation plan qualified under Section 401, Section 403 or Section 457 of the Federal Tax Code for federal tax exemption. Provided, however, that a domestic insurance company against which is levied additional premium tax under retaliatory laws of other states in which it does business, as a result of the tax increase provided by Sections 27-15-103 through 27-15-117, may deduct the total of such additional retaliatory tax from the state income tax due by it to the State of Mississippi. The insurance carriers selected to furnish service to the State of Mississippi, under the State Employees Life and Health Insurance Plan, shall not be required to pay the premium tax levied against insurance companies under this section on the premiums collected for coverage under the state employees plan.

(2) Except as expressly provided by subsection (1) of this section, all of the provisions of Sections 27-15-103 through 27-15-117 shall be applicable to such domestic insurance companies. However, the statement filed with the State Tax Commission by domestic insurance companies as provided in Section 27-15-107 shall include therein a sworn statement of all additional retaliatory premium taxes paid by them to other states as a result of the increase in premium taxes imposed by Sections 27-15-103 through 27-15-117, itemized by states to which paid.

(3) In the event that the Mississippi Supreme Court or another court finally adjudicates that any tax levied prior to July 1, 1985, under the provisions of this section was collected

unconstitutionally and that a liability for a credit or refund for such collection has accrued, then the rate of tax set forth above shall be increased to four percent (4%) for a period of six (6) years beginning July 1 following such adjudication.

SECTION 3. Section 27-15-115, Mississippi Code of 1972, is brought forward as follows:

27-15-115. In addition to all other taxes authorized by law, insurance companies shall pay the license and privilege taxes imposed by Sections 27-15-81 and 27-15-83, the taxes imposed by Sections 27-15-103 through 27-15-117, ad valorem taxes on real estate and tangible personal property, state income tax, sales tax levied on a vendor with a requirement of adding it to the sales price and use tax levied on the cost of tangible personal property purchased outside this state for use within this state.

SECTION 4. Section 27-15-129, Mississippi Code of 1972, is brought forward as follows:

27-15-129. (1) The amount of premium tax payable pursuant to Sections 27-15-103, 27-15-109, 27-15-119 and 83-31-45, Mississippi Code of 1972, shall be reduced from the amount otherwise fixed in such sections if the payer files a sworn statement with the required annual report showing as of the beginning of the reporting period that at least the following amounts of the total admitted assets of the payer were invested and maintained in qualifying Mississippi investments as

hereinafter defined in subsection (2) of this section over the period covered by such report:

Percentage of Total Admitted Assets in Qualifying Mississippi Investments	Percentage of Premium Tax Payable
1%	99%
2%	98%
3%	97%
4%	96%
5%	95%
6%	94%
7%	93%
8%	92%
9%	91%
10%	80%
15%	70%
20%	60%
25%	50%

(2) For the purpose of this section, "a qualifying Mississippi investment" is hereby defined as follows:

(a) Certificates of deposit issued by any bank or savings and loan association domiciled in this state;

(b) Bonds of this state or bonds of municipal, school, road or levee districts, or other political subdivisions of this state;

(c) Loans evidenced by notes and secured by deeds of trust on property located in this state;

(d) Real property located in this state;

(e) Policy loans to residents of Mississippi, or other loans to residents of this state, or to corporations domiciled in this state;

(f) Common or preferred stock, bonds and other evidences of indebtedness of corporations domiciled in this state; and

(g) Cash on deposit in any bank or savings and loan association domiciled in this state.

"A qualifying Mississippi investment" shall not include any investment for which a credit is allocated under Section 57-105-1 and/or Section 57-115-1 et seq.

(3) If the credits, or any part thereof, authorized by the preceding provisions of this section shall be held by a court of final jurisdiction to be unconstitutional and void for any reason or to make the annual premium taxes levied by Sections 27-15-103, 27-15-109, 27-15-119 and 83-31-45, Mississippi Code of 1972, unlawfully discriminatory or otherwise invalid under the Fourteenth Amendment or the Commerce Clause of the Constitution of the United States or under any state or other federal constitutional provisions, it is hereby expressly declared that such fact shall in no way affect the validity of the annual premium taxes levied thereby, and that such provisions would have

been enacted even though the Legislature had known this credit section would be held invalid.

(4) This section shall apply to taxes accruing and investments existing from and after July 1, 1985.

SECTION 5. Section 43-13-5, Mississippi Code of 1972, is brought forward as follows:

43-13-5. The State Department of Public Welfare, after having made a determination with respect to eligibility with due regard to the resources and income of the applicant, may make vendor payments on behalf of eligible individuals for such care as may be authorized within the limits of available funds, provided that such medical or remedial care is rendered by or under the supervision of a licensed practitioner, and provided further that no regulation shall be promulgated which limits or abridges the recipient’s free choice of the provider of medical and remedial care or service. Such recipients of medical assistance for the aged shall only be persons:

(1) Who shall have attained the age of sixty-five (65) years;

(2) Who are not receiving old age assistance;

(3) Who have net income and resources not exceeding amounts as may be set forth from time to time by the administering agency of the state; and

(4) Who have not made a voluntary assignment or transfer of property for the purpose of qualifying for such

assistance at any time within two (2) years immediately prior to the filing of an application for medical assistance for the aged.

Medical assistance for the aged shall be payable under this article on behalf of any person who is a patient of an institution, public or private, where such payments are matchable under the provisions of the federal Social Security Act as amended and where such institution conforms to the requirements of the federal Social Security Act as amended and the applicable statutes of Mississippi.

SECTION 6. Section 43-13-11, Mississippi Code of 1972, is brought forward as follows:

43-13-11. The administering agency is authorized to contract with other state government and nongovernment agencies and organizations in the State of Mississippi for purposes of performing all or part of the administrative aspects of medical or remedial care programs herein authorized, paying a reasonable fee for such service.

SECTION 7. Section 43-13-105, Mississippi Code of 1972, is brought forward as follows:

43-13-105. When used in this article, the following definitions shall apply, unless the context requires otherwise:

(a) "Administering agency" means the Division of Medicaid in the Office of the Governor as created by this article.

(b) "Division" or "Division of Medicaid" means the Division of Medicaid in the Office of the Governor.

(c) "Medical assistance" means payment of part or all of the costs of medical and remedial care provided under the terms of this article and in accordance with provisions of Titles XIX and XXI of the Social Security Act, as amended.

(d) "Applicant" means a person who applies for assistance under Titles IV, XVI, XIX or XXI of the Social Security Act, as amended, and under the terms of this article.

(e) "Recipient" means a person who is eligible for assistance under Title XIX or XXI of the Social Security Act, as amended and under the terms of this article.

(f) "State health agency" means any agency, department, institution, board or commission of the State of Mississippi, except the University of Mississippi Medical School, which is supported in whole or in part by any public funds, including funds directly appropriated from the State Treasury, funds derived by taxes, fees levied or collected by statutory authority, or any other funds used by "state health agencies" derived from federal sources, when any funds available to such agency are expended either directly or indirectly in connection with, or in support of, any public health, hospital, hospitalization or other public programs for the preventive treatment or actual medical treatment of persons with a physical disability, mental illness or an intellectual disability.

(g) "Mississippi Medicaid Commission" or "Medicaid Commission," wherever they appear in the laws of the State of

Mississippi, means the Division of Medicaid in the Office of the Governor.

SECTION 8. Section 43-13-107, Mississippi Code of 1972, is brought forward as follows:

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

(2) (a) The Governor shall appoint a full-time executive director, with the advice and consent of the Senate, who shall be either (i) a physician with administrative experience in a medical care or health program, or (ii) a person holding a graduate degree in medical care administration, public health, hospital administration, or the equivalent, or (iii) a person holding a bachelor's degree with at least three (3) years' experience in management-level administration of, or policy development for, Medicaid programs. Provided, however, no one who has been a member of the Mississippi Legislature during the previous three (3) years may be executive director. The executive director shall be the official secretary and legal custodian of the records of the division; shall be the agent of the division for the purpose of receiving all service of process, summons and notices directed to the division; shall perform such other duties as the Governor may prescribe from time to time; and shall perform all other duties that are now or may be imposed upon him or her by law.

(b) The executive director shall serve at the will and pleasure of the Governor.

(c) The executive director shall, before entering upon the discharge of the duties of the office, take and subscribe to the oath of office prescribed by the Mississippi Constitution and shall file the same in the Office of the Secretary of State, and shall execute a bond in some surety company authorized to do business in the state in the penal sum of One Hundred Thousand Dollars ($100,000.00), conditioned for the faithful and impartial discharge of the duties of the office. The premium on the bond shall be paid as provided by law out of funds appropriated to the Division of Medicaid for contractual services.

(d) The executive director, with the approval of the Governor and subject to the rules and regulations of the State Personnel Board, shall employ such professional, administrative, stenographic, secretarial, clerical and technical assistance as may be necessary to perform the duties required in administering this article and fix the compensation for those persons, all in accordance with a state merit system meeting federal requirements. When the salary of the executive director is not set by law, that salary shall be set by the State Personnel Board. No employees of the Division of Medicaid shall be considered to be staff members of the immediate Office of the Governor; however, Section 25-9-107(c)(xv) shall apply to the executive director and other administrative heads of the division.

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

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

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

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

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

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

(c) The respective Chairmen of the House Medicaid Committee, the House Public Health and Human Services Committee, the House Appropriations Committee, the Senate Medicaid Committee, the Senate Public Health and Welfare Committee and the Senate Appropriations Committee, or their designees, one (1) member of the State Senate appointed by the Lieutenant Governor and one (1) member of the House of Representatives appointed by the Speaker of

the House, shall serve as ex officio nonvoting members of the advisory committee.

(d) In addition to the committee members required by paragraph (b), the advisory committee shall consist of such other members as are necessary to meet the requirements of the federal regulation applicable to the advisory committee, who shall be appointed as provided in the federal regulation.

(e) The chairmanship of the advisory committee shall be elected by the voting members of the committee annually and shall not serve more than two (2) consecutive years as chairman.

(f) The members of the advisory committee specified in paragraph (b) shall serve for terms that are concurrent with the terms of members of the Legislature, and any member appointed under paragraph (b) may be reappointed to the advisory committee. The members of the advisory committee specified in paragraph (b) shall serve without compensation, but shall receive reimbursement to defray actual expenses incurred in the performance of committee business as authorized by law. Legislators shall receive per diem and expenses, which may be paid from the contingent expense funds of their respective houses in the same amounts as provided for committee meetings when the Legislature is not in session.

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

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

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

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

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

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

(iv) Communicate the views of the medical care professions to the division and communicate the views of the division to the medical care professions;

(v) Gather information on reasons that medical care providers do not participate in the Medicaid program and changes that could be made in the program to encourage more providers to participate in the Medicaid program, and advise the division with respect to encouraging physicians and other medical care providers to participate in the Medicaid program;

(vi) Provide a written report on or before November 30 of each year to the Governor, Lieutenant Governor and Speaker of the House of Representatives.

(4) (a) There is established a Drug Use Review Board, which shall be the board that is required by federal law to:

(i) Review and initiate retrospective drug use, review including ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists and individuals receiving Medicaid benefits or associated with specific drugs or groups of drugs.

(ii) Review and initiate ongoing interventions for physicians and pharmacists, targeted toward therapy problems or individuals identified in the course of retrospective drug use reviews.

(iii) On an ongoing basis, assess data on drug use against explicit predetermined standards using the compendia and literature set forth in federal law and regulations.

(b) The board shall consist of not less than twelve (12) members appointed by the Governor, or his designee.

(c) The board shall meet at least quarterly, and board members shall be furnished written notice of the meetings at least ten (10) days before the date of the meeting.

(d) The board meetings shall be open to the public, members of the press, legislators and consumers. Additionally,

all documents provided to board members shall be available to members of the Legislature in the same manner, and shall be made available to others for a reasonable fee for copying. However, patient confidentiality and provider confidentiality shall be protected by blinding patient names and provider names with numerical or other anonymous identifiers. The board meetings shall be subject to the Open Meetings Act (Sections 25-41-1 through 25-41-17). Board meetings conducted in violation of this section shall be deemed unlawful.

(5) (a) There is established a Pharmacy and Therapeutics Committee, which shall be appointed by the Governor, or his designee.

(b) The committee shall meet as often as needed to fulfill its responsibilities and obligations as set forth in this section, and committee members shall be furnished written notice of the meetings at least ten (10) days before the date of the meeting.

(c) The committee meetings shall be open to the public, members of the press, legislators and consumers. Additionally, all documents provided to committee members shall be available to members of the Legislature in the same manner, and shall be made available to others for a reasonable fee for copying. However, patient confidentiality and provider confidentiality shall be protected by blinding patient names and provider names with numerical or other anonymous identifiers. The committee meetings

shall be subject to the Open Meetings Act (Sections 25-41-1 through 25-41-17). Committee meetings conducted in violation of this section shall be deemed unlawful.

(d) After a thirty-day public notice, the executive director, or his or her designee, shall present the division's recommendation regarding prior approval for a therapeutic class of drugs to the committee. However, in circumstances where the division deems it necessary for the health and safety of Medicaid beneficiaries, the division may present to the committee its recommendations regarding a particular drug without a thirty-day public notice. In making that presentation, the division shall state to the committee the circumstances that precipitate the need for the committee to review the status of a particular drug without a thirty-day public notice. The committee may determine whether or not to review the particular drug under the circumstances stated by the division without a thirty-day public notice. If the committee determines to review the status of the particular drug, it shall make its recommendations to the division, after which the division shall file those recommendations for a thirty-day public comment under Section 25-43-7(1).

(e) Upon reviewing the information and recommendations, the committee shall forward a written recommendation approved by a majority of the committee to the executive director, or his or her designee. The decisions of the committee regarding any

limitations to be imposed on any drug or its use for a specified indication shall be based on sound clinical evidence found in labeling, drug compendia, and peer-reviewed clinical literature pertaining to use of the drug in the relevant population.

(f) Upon reviewing and considering all recommendations including recommendations of the committee, comments, and data, the executive director shall make a final determination whether to require prior approval of a therapeutic class of drugs, or modify existing prior approval requirements for a therapeutic class of drugs.

(g) At least thirty (30) days before the executive director implements new or amended prior authorization decisions, written notice of the executive director's decision shall be provided to all prescribing Medicaid providers, all Medicaid enrolled pharmacies, and any other party who has requested the notification. However, notice given under Section 25-43-7(1) will substitute for and meet the requirement for notice under this subsection.

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

SECTION 9. Section 43-13-111, Mississippi Code of 1972, is brought forward as follows:

43-13-111. Every state health agency, as defined in Section 43-13-105, shall obtain an appropriation of state funds from the State Legislature for all medical assistance programs rendered by the agency and shall organize its programs and budgets in such a manner as to secure maximum federal funding through the Division of Medicaid under Title XIX or Title XXI of the federal Social Security Act, as amended.

SECTION 10. Section 43-13-113, Mississippi Code of 1972, is brought forward as follows:

43-13-113. (1) The State Treasurer shall receive on behalf of the state, and execute all instruments incidental thereto, federal and other funds to be used for financing the medical assistance plan or program adopted pursuant to this article, and place all such funds in a special account to the credit of the Governor's Office-Division of Medicaid, which funds shall be expended by the division for the purposes and under the provisions of this article, and shall be paid out by the State Treasurer as funds appropriated to carry out the provisions of this article are paid out by him.

The division shall issue all checks or electronic transfers for administrative expenses, and for medical assistance under the provisions of this article. All such checks or electronic transfers shall be drawn upon funds made available to the division

by the State Auditor, upon requisition of the director. It is the purpose of this section to provide that the State Auditor shall transfer, in lump sums, amounts to the division for disbursement under the regulations which shall be made by the director with the approval of the Governor; however, the division, or its fiscal agent in behalf of the division, shall be authorized in maintaining separate accounts with a Mississippi bank to handle claim payments, refund recoveries and related Medicaid program financial transactions, to aggressively manage the float in these accounts while awaiting clearance of checks or electronic transfers and/or other disposition so as to accrue maximum interest advantage of the funds in the account, and to retain all earned interest on these funds to be applied to match federal funds for Medicaid program operations.

(2) The division is authorized to obtain a line of credit through the State Treasurer from the Working Cash-Stabilization Fund or any other special source funds maintained in the State Treasury in an amount not exceeding One Hundred Fifty Million Dollars ($150,000,000.00) to fund shortfalls which, from time to time, may occur due to decreases in state matching fund cash flow. The length of indebtedness under this provision shall not carry past the end of the quarter following the loan origination. Loan proceeds shall be received by the State Treasurer and shall be placed in a Medicaid designated special fund account. Loan proceeds shall be expended only for health care services provided

under the Medicaid program. The division may pledge as security for such interim financing future funds that will be received by the division. Any such loans shall be repaid from the first available funds received by the division in the manner of and subject to the same terms provided in this section.

In the event the State Treasurer makes a determination that special source funds are not sufficient to cover a line of credit for the Division of Medicaid, the division is authorized to obtain a line of credit, in an amount not exceeding One Hundred Fifty Million Dollars ($150,000,000.00), from a commercial lender or a consortium of lenders. The length of indebtedness under this provision shall not carry past the end of the quarter following the loan origination. The division shall obtain a minimum of two (2) written quotes that shall be presented to the State Fiscal Officer and State Treasurer, who shall jointly select a lender. Loan proceeds shall be received by the State Treasurer and shall be placed in a Medicaid designated special fund account. Loan proceeds shall be expended only for health care services provided under the Medicaid program. The division may pledge as security for such interim financing future funds that will be received by the division. Any such loans shall be repaid from the first available funds received by the division in the manner of and subject to the same terms provided in this section.

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

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

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

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

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

(e) If a claim is neither paid nor denied for valid and proper reasons by the end of the time periods as specified above, the Division of Medicaid's fiscal agent must pay the provider interest on the claim at the rate of one and one-half percent (1-1/2%) per month on the amount of such claim until it is finally settled or adjudicated.

(4) The date of receipt is the date the fiscal agent receives the claim as indicated by its date stamp on the claim or, for those claims filed electronically, the date of receipt is the date of transmission.

(5) The date of payment is the date of the check or, for those claims paid by electronic funds transfer, the date of the transfer.

(6) The above specified time limitations do not apply in the following circumstances:

(a) Retroactive adjustments paid to providers reimbursed under a retrospective payment system;

(b) If a claim for payment under Medicare has been filed in a timely manner, the fiscal agent may pay a Medicaid claim relating to the same services within six (6) months after it, or the provider, receives notice of the disposition of the Medicare claim;

(c) Claims from providers under investigation for fraud or abuse; and

(d) The Division of Medicaid and/or its fiscal agent may make payments at any time in accordance with a court order, to carry out hearing decisions or corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.

(7) [Repealed.]

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

SECTION 11. Section 43-13-115, Mississippi Code of 1972, is brought forward as follows:

43-13-115. Recipients of Medicaid shall be the following persons only:

(1) Those who are qualified for public assistance grants under provisions of Title IV-A and E of the federal Social Security Act, as amended, including those statutorily deemed to be IV-A and low income families and children under Section 1931 of the federal Social Security Act. For the purposes of this paragraph (1) and paragraphs (8), (17) and (18) of this section, any reference to Title IV-A or to Part A of Title IV of the federal Social Security Act, as amended, or the state plan under Title IV-A or Part A of Title IV, shall be considered as a reference to Title IV-A of the federal Social Security Act, as amended, and the state plan under Title IV-A, including the income and resource standards and methodologies under Title IV-A and the state plan, as they existed on July 16, 1996. The Department of Human Services shall determine Medicaid eligibility for children receiving public assistance grants under Title IV-E. The division shall determine eligibility for low income families under Section 1931 of the federal Social Security Act and shall redetermine eligibility for those continuing under Title IV-A grants.

(2) Those qualified for Supplemental Security Income (SSI) benefits under Title XVI of the federal Social Security Act, as amended, and those who are deemed SSI eligible as contained in

federal statute. The eligibility of individuals covered in this paragraph shall be determined by the Social Security Administration and certified to the Division of Medicaid.

(3) Qualified pregnant women who would be eligible for Medicaid as a low income family member under Section 1931 of the federal Social Security Act if her child were born. The eligibility of the individuals covered under this paragraph shall be determined by the division.

(4) [Deleted]

(5) A child born on or after October 1, 1984, to a woman eligible for and receiving Medicaid under the state plan on the date of the child's birth shall be deemed to have applied for Medicaid and to have been found eligible for Medicaid under the plan on the date of that birth, and will remain eligible for Medicaid for a period of one (1) year so long as the child is a member of the woman's household and the woman remains eligible for Medicaid or would be eligible for Medicaid if pregnant. The eligibility of individuals covered in this paragraph shall be determined by the Division of Medicaid.

(6) Children certified by the State Department of Human Services to the Division of Medicaid of whom the state and county departments of human services have custody and financial responsibility, and children who are in adoptions subsidized in full or part by the Department of Human Services, including special needs children in non-Title IV-E adoption assistance, who

are approvable under Title XIX of the Medicaid program. The eligibility of the children covered under this paragraph shall be determined by the State Department of Human Services.

(7) Persons certified by the Division of Medicaid who are patients in a medical facility (nursing home, hospital, tuberculosis sanatorium or institution for treatment of mental diseases), and who, except for the fact that they are patients in that medical facility, would qualify for grants under Title IV, Supplementary Security Income (SSI) benefits under Title XVI or state supplements, and those aged, blind and disabled persons who would not be eligible for Supplemental Security Income (SSI) benefits under Title XVI or state supplements if they were not institutionalized in a medical facility but whose income is below the maximum standard set by the Division of Medicaid, which standard shall not exceed that prescribed by federal regulation.

(8) Children under eighteen (18) years of age and pregnant women (including those in intact families) who meet the financial standards of the state plan approved under Title IV-A of the federal Social Security Act, as amended. The eligibility of children covered under this paragraph shall be determined by the Division of Medicaid.

(9) Individuals who are:

(a) Children born after September 30, 1983, who have not attained the age of nineteen (19), with family income

that does not exceed one hundred percent (100%) of the nonfarm official poverty level;

(b) Pregnant women, infants and children who have not attained the age of six (6), with family income that does not exceed one hundred thirty-three percent (133%) of the federal poverty level; and

(c) Pregnant women and infants who have not attained the age of one (1), with family income that does not exceed one hundred eighty-five percent (185%) of the federal poverty level.

The eligibility of individuals covered in (a), (b) and (c) of this paragraph shall be determined by the division.

(10) Certain disabled children age eighteen (18) or under who are living at home, who would be eligible, if in a medical institution, for SSI or a state supplemental payment under Title XVI of the federal Social Security Act, as amended, and therefore for Medicaid under the plan, and for whom the state has made a determination as required under Section 1902(e)(3)(b) of the federal Social Security Act, as amended. The eligibility of individuals under this paragraph shall be determined by the Division of Medicaid.

(11) Until the end of the day on December 31, 2005, individuals who are sixty-five (65) years of age or older or are disabled as determined under Section 1614(a)(3) of the federal Social Security Act, as amended, and whose income does not exceed

one hundred thirty-five percent (135%) of the nonfarm official poverty level as defined by the Office of Management and Budget and revised annually, and whose resources do not exceed those established by the Division of Medicaid. The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid. After December 31, 2005, only those individuals covered under the 1115(c) Healthier Mississippi waiver will be covered under this category.

Any individual who applied for Medicaid during the period from July 1, 2004, through March 31, 2005, who otherwise would have been eligible for coverage under this paragraph (11) if it had been in effect at the time the individual submitted his or her application and is still eligible for coverage under this paragraph (11) on March 31, 2005, shall be eligible for Medicaid coverage under this paragraph (11) from March 31, 2005, through December 31, 2005. The division shall give priority in processing the applications for those individuals to determine their eligibility under this paragraph (11).

(12) Individuals who are qualified Medicare beneficiaries (QMB) entitled to Part A Medicare as defined under Section 301, Public Law 100-360, known as the Medicare Catastrophic Coverage Act of 1988, and whose income does not exceed one hundred percent (100%) of the nonfarm official poverty level as defined by the Office of Management and Budget and revised annually.

The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid, and those individuals determined eligible shall receive Medicare cost-sharing expenses only as more fully defined by the Medicare Catastrophic Coverage Act of 1988 and the Balanced Budget Act of 1997.

(13) (a) Individuals who are entitled to Medicare Part A as defined in Section 4501 of the Omnibus Budget Reconciliation Act of 1990, and whose income does not exceed one hundred twenty percent (120%) of the nonfarm official poverty level as defined by the Office of Management and Budget and revised annually. Eligibility for Medicaid benefits is limited to full payment of Medicare Part B premiums.

(b) Individuals entitled to Part A of Medicare, with income above one hundred twenty percent (120%), but less than one hundred thirty-five percent (135%) of the federal poverty level, and not otherwise eligible for Medicaid. Eligibility for Medicaid benefits is limited to full payment of Medicare Part B premiums. The number of eligible individuals is limited by the availability of the federal capped allocation at one hundred percent (100%) of federal matching funds, as more fully defined in the Balanced Budget Act of 1997.

The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid.

(14) [Deleted]

(15) Disabled workers who are eligible to enroll in Part A Medicare as required by Public Law 101-239, known as the Omnibus Budget Reconciliation Act of 1989, and whose income does not exceed two hundred percent (200%) of the federal poverty level as determined in accordance with the Supplemental Security Income (SSI) program. The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid and those individuals shall be entitled to buy-in coverage of Medicare Part A premiums only under the provisions of this paragraph (15).

(16) In accordance with the terms and conditions of approved Title XIX waiver from the United States Department of Health and Human Services, persons provided home- and community-based services who are physically disabled and certified by the Division of Medicaid as eligible due to applying the income and deeming requirements as if they were institutionalized.

(17) In accordance with the terms of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193), persons who become ineligible for assistance under Title IV-A of the federal Social Security Act, as amended, because of increased income from or hours of employment of the caretaker relative or because of the expiration of the applicable earned income disregards, who were eligible for Medicaid for at least three (3) of the six (6) months preceding the month in which the ineligibility begins, shall be eligible for Medicaid for up to twelve (12) months. The eligibility of the

individuals covered under this paragraph shall be determined by the division.

(18) Persons who become ineligible for assistance under Title IV-A of the federal Social Security Act, as amended, as a result, in whole or in part, of the collection or increased collection of child or spousal support under Title IV-D of the federal Social Security Act, as amended, who were eligible for Medicaid for at least three (3) of the six (6) months immediately preceding the month in which the ineligibility begins, shall be eligible for Medicaid for an additional four (4) months beginning with the month in which the ineligibility begins. The eligibility of the individuals covered under this paragraph shall be determined by the division.

(19) Disabled workers, whose incomes are above the Medicaid eligibility limits, but below two hundred fifty percent (250%) of the federal poverty level, shall be allowed to purchase Medicaid coverage on a sliding fee scale developed by the Division of Medicaid.

(20) Medicaid eligible children under age eighteen (18) shall remain eligible for Medicaid benefits until the end of a period of twelve (12) months following an eligibility determination, or until such time that the individual exceeds age eighteen (18).

(21) Women of childbearing age whose family income does not exceed one hundred eighty-five percent (185%) of the federal

poverty level. The eligibility of individuals covered under this paragraph (21) shall be determined by the Division of Medicaid, and those individuals determined eligible shall only receive family planning services covered under Section 43-13-117(13) and not any other services covered under Medicaid. However, any individual eligible under this paragraph (21) who is also eligible under any other provision of this section shall receive the benefits to which he or she is entitled under that other provision, in addition to family planning services covered under Section 43-13-117(13).

The Division of Medicaid shall apply to the United States Secretary of Health and Human Services for a federal waiver of the applicable provisions of Title XIX of the federal Social Security Act, as amended, and any other applicable provisions of federal law as necessary to allow for the implementation of this paragraph (21). The provisions of this paragraph (21) shall be implemented from and after the date that the Division of Medicaid receives the federal waiver.

(22) Persons who are workers with a potentially severe disability, as determined by the division, shall be allowed to purchase Medicaid coverage. The term "worker with a potentially severe disability" means a person who is at least sixteen (16) years of age but under sixty-five (65) years of age, who has a physical or mental impairment that is reasonably expected to cause the person to become blind or disabled as defined under Section

1614(a) of the federal Social Security Act, as amended, if the person does not receive items and services provided under Medicaid.

The eligibility of persons under this paragraph (22) shall be conducted as a demonstration project that is consistent with Section 204 of the Ticket to Work and Work Incentives Improvement Act of 1999, Public Law 106-170, for a certain number of persons as specified by the division. The eligibility of individuals covered under this paragraph (22) shall be determined by the Division of Medicaid.

(23) Children certified by the Mississippi Department of Human Services for whom the state and county departments of human services have custody and financial responsibility who are in foster care on their eighteenth birthday as reported by the Mississippi Department of Human Services shall be certified Medicaid eligible by the Division of Medicaid until their twenty-first birthday.

(24) Individuals who have not attained age sixty-five (65), are not otherwise covered by creditable coverage as defined in the Public Health Services Act, and have been screened for breast and cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act in accordance with the requirements of that act and who need treatment for breast or cervical cancer. Eligibility of

individuals under this paragraph (24) shall be determined by the Division of Medicaid.

(25) The division shall apply to the Centers for Medicare and Medicaid Services (CMS) for any necessary waivers to provide services to individuals who are sixty-five (65) years of age or older or are disabled as determined under Section 1614(a)(3) of the federal Social Security Act, as amended, and whose income does not exceed one hundred thirty-five percent (135%) of the nonfarm official poverty level as defined by the Office of Management and Budget and revised annually, and whose resources do not exceed those established by the Division of Medicaid, and who are not otherwise covered by Medicare. Nothing contained in this paragraph (25) shall entitle an individual to benefits. The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid.

(26) The division shall apply to the Centers for Medicare and Medicaid Services (CMS) for any necessary waivers to provide services to individuals who are sixty-five (65) years of age or older or are disabled as determined under Section 1614(a)(3) of the federal Social Security Act, as amended, who are end stage renal disease patients on dialysis, cancer patients on chemotherapy or organ transplant recipients on antirejection drugs, whose income does not exceed one hundred thirty-five percent (135%) of the nonfarm official poverty level as defined by the Office of Management and Budget and revised annually, and

whose resources do not exceed those established by the division. Nothing contained in this paragraph (26) shall entitle an individual to benefits. The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid.

(27) Individuals who are entitled to Medicare Part D and whose income does not exceed one hundred fifty percent (150%) of the nonfarm official poverty level as defined by the Office of Management and Budget and revised annually. Eligibility for payment of the Medicare Part D subsidy under this paragraph shall be determined by the division.

(28) The division is authorized and directed to provide up to twelve (12) months of continuous coverage postpartum for any individual who qualifies for Medicaid coverage under this section as a pregnant woman, to the extent allowable under federal law and as determined by the division.

The division shall redetermine eligibility for all categories of recipients described in each paragraph of this section not less frequently than required by federal law.

SECTION 12. Section 43-13-116, Mississippi Code of 1972, is brought forward as follows:

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

(2) In determining Medicaid eligibility, the Division of Medicaid is authorized to enter into an agreement with the Secretary of the Department of Health and Human Services for the purpose of securing the transfer of eligibility information from the Social Security Administration on those individuals receiving supplemental security income benefits under the federal Social Security Act and any other information necessary in determining Medicaid eligibility. The Division of Medicaid is further empowered to enter into contractual arrangements with its fiscal agent or with the State Department of Human Services in securing electronic data processing support as may be necessary.

(3) Administrative hearings shall be available to any applicant who requests it because his or her claim of eligibility for services is denied or is not acted upon with reasonable promptness or by any recipient who requests it because he or she believes the agency has erroneously taken action to deny, reduce, or terminate benefits. The agency need not grant a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients. Eligibility determinations that are made by other agencies and certified to the Division of Medicaid pursuant to Section 43-13-115 are not subject to the administrative hearing procedures of the Division of Medicaid but are subject to the administrative hearing procedures of the agency that determined eligibility.

(a) A request may be made either for a local regional office hearing or a state office hearing when the local regional office has made the initial decision that the claimant seeks to appeal or when the regional office has not acted with reasonable promptness in making a decision on a claim for eligibility or services. The only exception to requesting a local hearing is when the issue under appeal involves either (i) a disability or blindness denial, or termination, or (ii) a level of care denial or termination for a disabled child living at home. An appeal involving disability, blindness or level of care must be handled as a state level hearing. The decision from the local hearing may be appealed to the state office for a state hearing. A decision to deny, reduce or terminate benefits that is initially made at the state office may be appealed by requesting a state hearing.

(b) A request for a hearing, either state or local, must be made in writing by the claimant or claimant's legal representative. "Legal representative" includes the claimant's authorized representative, an attorney retained by the claimant or claimant's family to represent the claimant, a paralegal representative with a legal aid services, a parent of a minor child if the claimant is a child, a legal guardian or conservator or an individual with power of attorney for the claimant. The claimant may also be represented by anyone that he or she so designates but must give the designation to the Medicaid regional

office or state office in writing, if the person is not the legal representative, legal guardian, or authorized representative.

(c) The claimant may make a request for a hearing in person at the regional office but an oral request must be put into written form. Regional office staff will determine from the claimant if a local or state hearing is requested and assist the claimant in completing and signing the appropriate form. Regional office staff may forward a state hearing request to the appropriate division in the state office or the claimant may mail the form to the address listed on the form. The claimant may make a written request for a hearing by letter. A simple statement requesting a hearing that is signed by the claimant or legal representative is sufficient; however, if possible, the claimant should state the reason for the request. The letter may be mailed to the regional office or it may be mailed to the state office. If the letter does not specify the type of hearing desired, local or state, Medicaid staff will attempt to contact the claimant to determine the level of hearing desired. If contact cannot be made within three (3) days of receipt of the request, the request will be assumed to be for a local hearing and scheduled accordingly. A hearing will not be scheduled until either a letter or the appropriate form is received by the regional or state office.

(d) When both members of a couple wish to appeal an action or inaction by the agency that affects both applications or cases similarly and arose from the same issue, one or both may

file the request for hearing, both may present evidence at the hearing, and the agency's decision will be applicable to both. If both file a request for hearing, two (2) hearings will be registered but they will be conducted on the same day and in the same place, either consecutively or jointly, as the couple wishes. If they so desire, only one of the couple need attend the hearing.

(e) The procedure for administrative hearings shall be as follows:

(i) The claimant has thirty (30) days from the date the agency mails the appropriate notice to the claimant of its decision regarding eligibility, services, or benefits to request either a state or local hearing. This time period may be extended if the claimant can show good cause for not filing within thirty (30) days. Good cause includes, but may not be limited to, illness, failure to receive the notice, being out of state, or some other reasonable explanation. If good cause can be shown, a late request may be accepted provided the facts in the case remain the same. If a claimant's circumstances have changed or if good cause for filing a request beyond thirty (30) days is not shown, a hearing request will not be accepted. If the claimant wishes to have eligibility reconsidered, he or she may reapply.

(ii) If a claimant or representative requests a hearing in writing during the advance notice period before benefits are reduced or terminated, benefits must be continued or reinstated to the benefit level in effect before the effective

date of the adverse action. Benefits will continue at the original level until the final hearing decision is rendered. Any hearing requested after the advance notice period will not be accepted as a timely request in order for continuation of benefits to apply.

(iii) Upon receipt of a written request for a hearing, the request will be acknowledged in writing within twenty (20) days and a hearing scheduled. The claimant or representative will be given at least five (5) days' advance notice of the hearing date. The local and/or state level hearings will be held by telephone unless, at the hearing officer's discretion, it is determined that an in-person hearing is necessary. If a local hearing is requested, the regional office will notify the claimant or representative in writing of the time of the local hearing. If a state hearing is requested, the state office will notify the claimant or representative in writing of the time of the state hearing. If an in-person hearing is necessary, local hearings will be held at the regional office and state hearings will be held at the state office unless other arrangements are necessitated by the claimant's inability to travel.

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

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

(vi) The claimant or his representative has the following rights in connection with a local or state hearing:

(A) The right to examine at a reasonable time before the date of the hearing and during the hearing the content of the claimant's case record;

(B) The right to have legal representation at the hearing and to bring witnesses;

(C) The right to produce documentary evidence and establish all facts and circumstances concerning eligibility, services, or benefits;

(D) The right to present an argument without undue interference;

(E) The right to question or refute any testimony or evidence including an opportunity to confront and cross-examine adverse witnesses.

(vii) When a request for a local hearing is received by the regional office or if the regional office is notified by the state office that a local hearing has been requested, the Medicaid specialist supervisor in the regional office will review the case record, reexamine the action taken on the case, and determine if policy and procedures have been followed. If any adjustments or corrections should be made, the Medicaid specialist supervisor will ensure that corrective action is taken. If the request for hearing was timely made such that continuation of benefits applies, the Medicaid specialist supervisor will ensure that benefits continue at the level before the proposed adverse action that is the subject of the appeal. The Medicaid specialist supervisor will also ensure that all needed information, verification, and evidence is in the case record for the hearing.

(viii) When a state hearing is requested that appeals the action or inaction of a regional office, the regional office will prepare copies of the case record and forward it to the appropriate division in the state office no later than five (5) days after receipt of the request for a state hearing. The original case record will remain in the regional office. Either the original case record in the regional office or the copy

forwarded to the state office will be available for inspection by the claimant or claimant's representative a reasonable time before the date of the hearing.

(ix) The Medicaid specialist supervisor will serve as the hearing officer for a local hearing unless the Medicaid specialist supervisor actually participated in the eligibility, benefits, or services decision under appeal, in which case the Medicaid specialist supervisor must appoint a Medicaid specialist in the regional office who did not actually participate in the decision under appeal to serve as hearing officer. The local hearing will be an informal proceeding in which the claimant or representative may present new or additional information, may question the action taken on the client's case, and will hear an explanation from agency staff as to the regulations and requirements that were applied to claimant's case in making the decision.

(x) After the hearing, the hearing officer will prepare a written summary of the hearing procedure and file it with the case record. The hearing officer will consider the facts presented at the local hearing in reaching a decision. The claimant will be notified of the local hearing decision on the appropriate form that will state clearly the reason for the decision, the policy that governs the decision, the claimant's right to appeal the decision to the state office, and, if the original adverse action is upheld, the new effective date of the

reduction or termination of benefits or services if continuation of benefits applied during the hearing process. The new effective date of the reduction or termination of benefits or services must be at the end of the fifteen-day advance notice period from the mailing date of the notice of hearing decision. The notice to claimant will be made part of the case record.

(xi) The claimant has the right to appeal a local hearing decision by requesting a state hearing in writing within fifteen (15) days of the mailing date of the notice of local hearing decision. The state hearing request should be made to the regional office. If benefits have been continued pending the local hearing process, then benefits will continue throughout the fifteen-day advance notice period for an adverse local hearing decision. If a state hearing is timely requested within the fifteen-day period, then benefits will continue pending the state hearing process. State hearings requested after the fifteen-day local hearing advance notice period will not be accepted unless the initial thirty-day period for filing a hearing request has not expired because the local hearing was held early, in which case a state hearing request will be accepted as timely within the number of days remaining of the unexpired initial thirty-day period in addition to the fifteen-day time period. Continuation of benefits during the state hearing process, however, will only apply if the state hearing request is received within the fifteen-day advance notice period.

(xii) When a request for a state hearing is received in the regional office, the request will be made part of the case record and the regional office will prepare the case record and forward it to the appropriate division in the state office within five (5) days of receipt of the state hearing request. A request for a state hearing received in the state office will be forwarded to the regional office for inclusion in the case record and the regional office will prepare the case record and forward it to the appropriate division in the state office within five (5) days of receipt of the state hearing request.

(xiii) Upon receipt of the hearing record, an impartial hearing officer will be assigned to hear the case either by the Executive Director of the Division of Medicaid or his or her designee. Hearing officers will be individuals with appropriate expertise employed by the division and who have not been involved in any way with the action or decision on appeal in the case. The hearing officer will review the case record and if the review shows that an error was made in the action of the agency or in the interpretation of policy, or that a change of policy has been made, the hearing officer will discuss these matters with the appropriate agency personnel and request that an appropriate adjustment be made. Appropriate agency personnel will discuss the matter with the claimant and if the claimant is agreeable to the adjustment of the claim, then agency personnel

will request in writing dismissal of the hearing and the reason therefor, to be placed in the case record. If the hearing is to go forward, it shall be scheduled by the hearing officer in the manner set forth in subparagraph (iii) of this paragraph (e).

(xiv) In conducting the hearing, the state hearing officer will inform those present of the following:

(A) That the hearing will be recorded on tape and that a transcript of the proceedings will be typed for the record;

(B) The action taken by the agency which prompted the appeal;

(C) An explanation of the claimant's rights during the hearing as outlined in subparagraph (vi) of this paragraph (e);

(D) That the purpose of the hearing is for the claimant to express dissatisfaction and present additional information or evidence;

(E) That the case record is available for review by the claimant or representative during the hearing;

(F) That the final hearing decision will be rendered by the Executive Director of the Division of Medicaid on the basis of facts presented at the hearing and the case record and that the claimant will be notified by letter of the final decision.

(xv) During the hearing, the claimant and/or representative will be allowed an opportunity to make a full statement concerning the appeal and will be assisted, if necessary, in disclosing all information on which the claim is based. All persons representing the claimant and those representing the Division of Medicaid will have the opportunity to state all facts pertinent to the appeal. The hearing officer may recess or continue the hearing for a reasonable time should additional information or facts be required or if some change in the claimant's circumstances occurs during the hearing process which impacts the appeal. When all information has been presented, the hearing officer will close the hearing and stop the recorder.

(xvi) Immediately following the hearing the hearing tape will be transcribed and a copy of the transcription forwarded to the regional office for filing in the case record. As soon as possible, the hearing officer shall review the evidence and record of the proceedings, testimony, exhibits, and other supporting documents, prepare a written summary of the facts as the hearing officer finds them, and prepare a written recommendation of action to be taken by the agency, citing appropriate policy and regulations that govern the recommendation. The decision cannot be based on any material, oral or written, not available to the claimant before or during the hearing. The hearing officer's recommendation will become part of the case

record which will be submitted to the Executive Director of the Division of Medicaid for further review and decision.

(xvii) The Executive Director of the Division of Medicaid, upon review of the recommendation, proceedings and the record, may sustain the recommendation of the hearing officer, reject the same, or remand the matter to the hearing officer to take additional testimony and evidence, in which case, the hearing officer thereafter shall submit to the executive director a new recommendation. The executive director shall prepare a written decision summarizing the facts and identifying policies and regulations that support the decision, which shall be mailed to the claimant and the representative, with a copy to the regional office if appropriate, as soon as possible after submission of a recommendation by the hearing officer. The decision notice will specify any action to be taken by the agency, specify any revised eligibility dates or, if continuation of benefits applies, will notify the claimant of the new effective date of reduction or termination of benefits or services, which will be fifteen (15) days from the mailing date of the notice of decision. The decision rendered by the Executive Director of the Division of Medicaid is final and binding. The claimant is entitled to seek judicial review in a court of proper jurisdiction.

(xviii) The Division of Medicaid must take final administrative action on a hearing, whether state or local, within

ninety (90) days from the date of the initial request for a hearing.

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

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

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

In all group hearings, whether initiated by the Division of Medicaid or by the claimants, the policies governing fair hearings must be followed. Each claimant in a group hearing must be permitted to present his or her own case and be represented by his or her own representative, or to withdraw from the group hearing and have his or her appeal heard individually. As in individual hearings, the hearing will be conducted only on the issue being appealed, and each claimant will be expected to keep individual testimony within a reasonable time frame as a matter of consideration to the other claimants involved.

(xx) Any specific matter necessitating an administrative hearing not otherwise provided under this article or agency policy shall be afforded under the hearing procedures as outlined above. If the specific time frames of such a unique matter relating to requesting, granting, and concluding of the

hearing is contrary to the time frames as set out in the hearing procedures above, the specific time frames will govern over the time frames as set out within these procedures.

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

SECTION 13. Section 43-13-117, Mississippi Code of 1972, is brought forward as follows:

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

(1) Inpatient hospital services.

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

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

(2) Outpatient hospital services.

(a) Emergency services.

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

methodology of outpatient reimbursement to maintain consistency, efficiency, economy and quality of care.

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

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

(3) Laboratory and x-ray services.

(4) Nursing facility services.

(a) The division shall make full payment to nursing facilities for each day, not exceeding forty-two (42) days per year, that a patient is absent from the facility on home leave. Payment may be made for the following home leave days in addition to the forty-two-day limitation: Christmas, the day

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

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

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

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

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

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

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

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

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

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

(6) Physician services. Fees for physician's services that are covered only by Medicaid shall be reimbursed at ninety percent (90%) of the rate established on January 1, 2018, and as may be adjusted each July thereafter, under Medicare. The division may provide for a reimbursement rate for physician's

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

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

(b) [Repealed]

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

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

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

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

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

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

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

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

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

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

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

The division shall develop a pharmacy policy in which drugs in tamper-resistant packaging that are prescribed for a resident of a nursing facility but are not dispensed to the resident shall be returned to the pharmacy and not billed to Medicaid, in accordance with guidelines of the State Board of Pharmacy.

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

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

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

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

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

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

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

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

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

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

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

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

(12) Intermediate care facility services.

(a) The division shall make full payment to all intermediate care facilities for individuals with intellectual disabilities for each day, not exceeding sixty-three (63) days per

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

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

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

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

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

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

(b) Dialysis center services.

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

availability of funds specifically appropriated for that purpose by the Legislature.

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

(17) Durable medical equipment services and medical supplies. Precertification of durable medical equipment and medical supplies must be obtained as required by the division. The Division of Medicaid may require durable medical equipment providers to obtain a surety bond in the amount and to the

specifications as established by the Balanced Budget Act of 1997. A maximum dollar amount of reimbursement for noninvasive ventilators or ventilation treatments properly ordered and being used in an appropriate care setting shall not be set by any health maintenance organization, coordinated care organization, provider-sponsored health plan, or other organization paid for services on a capitated basis by the division under any managed care program or coordinated care program implemented by the division under this section. Reimbursement by these organizations to durable medical equipment suppliers for home use of noninvasive and invasive ventilators shall be on a continuous monthly payment basis for the duration of medical need throughout a patient's valid prescription period.

(18) (a) Notwithstanding any other provision of this section to the contrary, as provided in the Medicaid state plan amendment or amendments as defined in Section 43-13-145(10), the division shall make additional reimbursement to hospitals that serve a disproportionate share of low-income patients and that meet the federal requirements for those payments as provided in Section 1923 of the federal Social Security Act and any applicable regulations. It is the intent of the Legislature that the division shall draw down all available federal funds allotted to the state for disproportionate share hospitals. However, from and after January 1, 1999, public hospitals participating in the Medicaid disproportionate share program may be required to

participate in an intergovernmental transfer program as provided in Section 1903 of the federal Social Security Act and any applicable regulations.

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

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

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

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

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

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

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

to the extent possible, but in no event shall the effective date of such payment models be later than July 1, 2020. The Chairmen of the Senate and House Medicaid Committees shall be provided a copy of the proposed payment model(s) prior to submission. Effective July 1, 2018, and until such time as any payment model(s) as described above become effective, the division, in consultation with the hospital industry, is authorized to implement a transitional program for inpatient and outpatient payments and/or supplemental payments (including, but not limited to, MHAP and directed payments), to redistribute available supplemental funds among hospital providers, provided that when compared to a hospital's prior year supplemental payments, supplemental payments made pursuant to any such transitional program shall not result in a decrease of more than five percent (5%) and shall not increase by more than the amount needed to maximize the distribution of the available funds.

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

2. The division shall calculate the ambulance service access payment amount as the balance of the

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

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

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

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

would have received from commercial insurers for those services reimbursed by Medicaid.

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

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

(ii) Subject to approval by the Centers for Medicare and Medicaid Services (CMS), the MHAP shall provide increased inpatient capitation (PMPM) payments to managed care entities contracting with the division pursuant to subsection (H) of this section to support availability of hospital services or

such other payments permissible under federal law necessary to accomplish the intent of this subsection.

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

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

(19) (a) Perinatal risk management services. The division shall promulgate regulations to be effective from and after October 1, 1988, to establish a comprehensive perinatal system for risk assessment of all pregnant and infant Medicaid recipients and for management, education and follow-up for those who are determined to be at risk. Services to be performed include case management, nutrition assessment/counseling,

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

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

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

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

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

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

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

(23) Inpatient psychiatric services.

(a) Inpatient psychiatric services to be determined by the division for recipients under age twenty-one (21) that are provided under the direction of a physician in an inpatient program in a licensed acute care psychiatric facility or in a licensed psychiatric residential treatment facility, before the recipient reaches age twenty-one (21) or, if the recipient was receiving the services immediately before he or she reached age twenty-one (21), before the earlier of the date he or she no longer requires the services or the date he or she reaches age twenty-two (22), as provided by federal regulations. From and after January 1, 2015, the division shall update the fair rental reimbursement system for psychiatric residential treatment

facilities. Precertification of inpatient days and residential treatment days must be obtained as required by the division. From and after July 1, 2009, all state-owned and state-operated facilities that provide inpatient psychiatric services to persons under age twenty-one (21) who are eligible for Medicaid reimbursement shall be reimbursed for those services on a full reasonable cost basis.

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

(24) [Deleted]

(25) [Deleted]

(26) Hospice care. As used in this paragraph, the term "hospice care" means a coordinated program of active professional medical attention within the home and outpatient and inpatient care that treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses that are experienced during the final stages of illness and during dying and bereavement and meets the Medicare requirements for participation as a hospice as provided in federal regulations.

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

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

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

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

(31) Targeted case management services for children with special needs, under waivers from the United States Department of Health and Human Services, using state funds that are provided from the appropriation to the Mississippi Department

of Human Services and used to match federal funds under a cooperative agreement between the division and the department.

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

(33) Podiatrist services.

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

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

(36) Nonemergency transportation services for Medicaid-eligible persons as determined by the division. The PEER Committee shall conduct a performance evaluation of the nonemergency transportation program to evaluate the administration of the program and the providers of transportation services to determine the most cost-effective ways of providing nonemergency

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

(37) [Deleted]

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

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

(40) [Deleted]

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

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

(42) [Deleted]

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

(44) Nursing facility services for the severely disabled.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(52) Notwithstanding any provisions of this article, the division may pay enhanced reimbursement fees related to trauma care, as determined by the division in conjunction with the State Department of Health, using funds appropriated to the State Department of Health for trauma care and services and used to match federal funds under a cooperative agreement between the division and the State Department of Health. The division, in conjunction with the State Department of Health, may use grants, waivers, demonstrations, enhanced reimbursements, Upper Payment Limits Programs, supplemental payments, or other projects as necessary in the development and implementation of this reimbursement program.

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

(54) [Deleted]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) If the chairman of either committee or both chairmen jointly object to the proposed rate change or any part thereof, the chairman or chairmen shall notify the division and provide the reasons for their objection in writing not later than seven (7) calendar days after receipt of the notice from the division. The chairman or chairmen may make written

recommendations to the division for changes to be made to a proposed rate change.

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

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

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

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

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

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

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

(E) Notwithstanding any provision of this article, no new groups or categories of recipients and new types of care and services may be added without enabling legislation from the Mississippi Legislature, except that the division may authorize

those changes without enabling legislation when the addition of recipients or services is ordered by a court of proper authority.

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

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

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

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

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

To the extent allowed under federal law, any reduction to services or reimbursement rates under this subsection (F) shall be accompanied by a reduction, to the fullest allowable amount, to the profit margin and administrative fee portions of capitated

payments to organizations described in paragraph (1) of subsection (H).

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

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

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

health maintenance organization program, or provider-sponsored health plan may:

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

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

(c) Pay providers at a rate that is less than the normal Medicaid reimbursement rate. It is the intent of the Legislature that all managed care entities described in this subsection (H), in collaboration with the division, develop and implement innovative payment models that incentivize improvements in health care quality, outcomes, or value, as determined by the division. Participation in the provider network of any managed care, coordinated care, provider-sponsored health plan, or similar contractor shall not be conditioned on the provider's agreement to accept such alternative payment models;

(d) Implement a prior authorization and utilization review program for medical services, transportation

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

(e) [Deleted]

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

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

Each health maintenance organization, coordinated care organization, provider-sponsored health plan, or other organization paid for services on a capitated basis by the division under any managed care program or coordinated care program implemented by the division under this section shall use a clear set of level of care guidelines in the determination of medical necessity and in all utilization management practices,

including the prior authorization process, concurrent reviews, retrospective reviews and payments, that are consistent with widely accepted professional standards of care. Organizations participating in a managed care program or coordinated care program implemented by the division may not use any additional criteria that would result in denial of care that would be determined appropriate and, therefore, medically necessary under those levels of care guidelines.

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

(3) (a) Any contractors receiving capitated payments under a managed care delivery system established in this section shall provide to the Legislature and the division statistical data to be shared with provider groups in order to improve patient access, appropriate utilization, cost savings and health outcomes not later than October 1 of each year. Additionally, each contractor shall disclose to the Chairmen of the Senate and House

Medicaid Committees the administrative expenses costs for the prior calendar year, and the number of full-equivalent employees located in the State of Mississippi dedicated to the Medicaid and CHIP lines of business as of June 30 of the current year.

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

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

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

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

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

(iv) Administrative expense allocation methodologies,

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

(vi) Capitated arrangements with related party subcontractors,

(vii) Reasonableness of corporate allocations,

(viii) Value-added benefits and the extent to which they are used,

(ix) The effectiveness of subcontractor oversight, including subcontractor review,

(x) Whether health care outcomes have been improved, and

(xi) The most common claim denial codes to determine the reasons for the denials.

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

(4) All health maintenance organizations, coordinated care organizations, provider-sponsored health plans, or other organizations paid for services on a capitated basis by the division under any managed care program or coordinated care program implemented by the division under this section shall reimburse all providers in those organizations at rates no lower than those provided under this section for beneficiaries who are not participating in those programs.

(5) No health maintenance organization, coordinated care organization, provider-sponsored health plan, or other organization paid for services on a capitated basis by the division under any managed care program or coordinated care program implemented by the division under this section shall

require its providers or beneficiaries to use any pharmacy that ships, mails or delivers prescription drugs or legend drugs or devices.

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

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

credentialing of the providers by the division's credentialing process.

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

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

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

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

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

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

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

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

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

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

delivery system established in this section shall implement innovative programs to improve the health and well-being of members diagnosed with prediabetes and diabetes.

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

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

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

(I) [Deleted]

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

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

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

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

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

SECTION 14. Section 43-13-117.1, Mississippi Code of 1972, is brought forward as follows:

43-13-117.1. It is the intent of the Legislature to expand access to Medicaid-funded home- and community-based services for eligible nursing facility residents who choose those services. The Executive Director of the Division of Medicaid is authorized to transfer funds allocated for nursing facility services for eligible residents to cover the cost of services available through the Independent Living Waiver, the Traumatic Brain Injury/Spinal Cord Injury Waiver, the Elderly and Disabled Waiver, and the Assisted Living Waiver programs when eligible residents choose those community services. The amount of funding transferred by the division shall be sufficient to cover the cost of home- and community-based waiver services for each eligible nursing facility * * * resident who * * * chooses those services. The number of nursing facility residents who return to the community and home- and community-based waiver services shall not count against the total number of waiver slots for which the Legislature appropriates funding each year. Any funds remaining in the

program when a former nursing facility resident ceases to participate in a home- and community-based waiver program under this provision shall be returned to nursing facility funding.

SECTION 15. Section 43-13-121, Mississippi Code of 1972, is brought forward as follows:

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

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

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

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

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

(iv) Providing for fair and impartial hearings;

(v) Providing safeguards for preserving the confidentiality of records; and

(vi) For detecting and processing fraudulent practices and abuses of the program;

(b) Receive and expend state, federal and other funds in accordance with court judgments or settlements and agreements between the State of Mississippi and the federal government, the rules and regulations promulgated by the division, with the approval of the Governor, and within the limitations and restrictions of this article and within the limits of funds available for that purpose;

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

No agreements, specifically including the general plan for the operation of the Medicaid program in this state, shall be made by and between the division and the United States Department of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

competent jurisdiction of the conviction shall constitute prima facie evidence of the conviction for disqualification purposes;

(m) Establish and provide such methods of administration as may be necessary for the proper and efficient operation of the Medicaid program, fully utilizing computer equipment as may be necessary to oversee and control all current expenditures for purposes of this article, and to closely monitor and supervise all recipient payments and vendors rendering services under this article. Notwithstanding any other provision of state law, the division is authorized to enter into a ten-year contract(s) with a vendor(s) to provide services described in this paragraph (m). Notwithstanding any provision of law to the contrary, the division is authorized to extend its Medicaid Management Information System, including all related components and services, and Decision Support System, including all related components and services, contracts in effect on June 30, 2020, for a period not to exceed two (2) years without complying with state procurement regulations;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(j) Revocation of license or certification.

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

(l) Failure to meet any condition of enrollment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 16. Section 43-13-122, Mississippi Code of 1972, is brought forward as follows:

43-13-122. (1) The division is authorized to apply to the Center for Medicare and Medicaid Services of the United States Department of Health and Human Services for waivers and research and demonstration grants.

(2) The division is further authorized to accept and expend any grants, donations or contributions from any public or private organization together with any additional federal matching funds that may accrue and, including, but not limited to, one hundred percent (100%) federal grant funds or funds from any governmental entity or instrumentality thereof in furthering the purposes and objectives of the Mississippi Medicaid program, provided that such receipts and expenditures are reported and otherwise handled in accordance with the General Fund Stabilization Act. The Department of Finance and Administration is authorized to transfer monies to the division from special funds in the State Treasury in amounts not exceeding the amounts authorized in the appropriation to the division.

SECTION 17. Section 43-13-123, Mississippi Code of 1972, is brought forward as follows:

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

(a) By contract with insurance companies licensed to do business in the State of Mississippi or with nonprofit hospital service corporations, medical or dental service corporations, authorized to do business in Mississippi to underwrite on an insured premium approach, such medical assistance benefits as may be available, and any carrier selected under the provisions of

this article is expressly authorized and empowered to undertake the performance of the requirements of that contract.

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

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

The authorization of the foregoing methods shall not preclude other methods of providing payment of claims through direct operation of the program by the state or its agencies.

SECTION 18. Section 43-13-126, Mississippi Code of 1972, is brought forward as follows:

43-13-126. As a condition of doing business in the state, health insurers, including self-insured plans, group health plans (as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, are required to:

(a) Provide, with respect to individuals who are eligible for, or are provided, medical assistance under the state

plan, upon the request of the Division of Medicaid, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address and identifying number of the plan) in a manner prescribed by the Secretary of the Department of Health and Human Services;

(b) Accept the Division of Medicaid's right of recovery and the assignment to the division of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the state plan;

(c) Respond to any inquiry by the Division of Medicaid regarding a claim for payment for any health care item or service that is submitted not later than three (3) years after the date of the provision of that health care item or service; and

(d) Agree not to deny a claim submitted by the Division of Medicaid solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point of sale that is the basis of the claim, if:

(i) The claim is submitted by the division within the three-year period beginning on the date on which the item or service was furnished; and

(ii) Any action by the division to enforce its rights with respect to the claim is begun within six (6) years of the division's submission of the claim.

SECTION 19. Section 43-13-133, Mississippi Code of 1972, is brought forward as follows:

43-13-133. It is the intent of the Legislature that all federal matching funds for medical assistance under Titles V, XVIII and XIX of the federal Social Security Act paid into any state health agency after the passage of this article shall be used exclusively to defray the cost of medical assistance expended under the terms of this article.

SECTION 20. Section 43-13-143, Mississippi Code of 1972, is brought forward as follows:

43-13-143. There is created in the State Treasury a special fund to be known as the "Medical Care Fund," which shall be comprised of monies transferred by public or private health care providers, governing bodies of counties, municipalities, public or community hospitals and other political subdivisions of the state, individuals, corporations, associations and any other entities for the purpose of providing health care services. Any transfer made to the fund shall be paid to the State Treasurer for deposit into the fund, and all such transfers shall be considered as unconditional transfers to the fund. The monies in the Medical Care Fund shall be expended only for health care services, and may be expended only upon appropriation of the Legislature. All

transfers of monies to the Division of Medicaid by health care providers and by governing bodies of counties, municipalities, public or community hospitals and other political subdivisions of the state shall be deposited into the fund. Unexpended monies remaining in the fund at the end of a fiscal year shall not lapse into the State General Fund, and any interest earned on monies in the fund shall be deposited to the credit of the fund.

SECTION 21. Section 43-13-145, Mississippi Code of 1972, is brought forward as follows:

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

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

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

(ii) The State Veterans Affairs Board.

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

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

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

(ii) The State Veterans Affairs Board; or

(iii) The University of Mississippi Medical Center.

(3) (a) Upon each psychiatric residential treatment facility licensed by the State of Mississippi, there is levied an assessment in an amount set by the division, equal to the maximum rate allowed by federal law or regulation, for each licensed and occupied bed of the facility.

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

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

(ii) The University of Mississippi Medical Center; or

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

(4) Hospital assessment.

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

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

(ii) In addition to the assessment provided under subparagraph (i), an additional annual assessment on each hospital

licensed in the state is imposed on each non-Medicare hospital inpatient day as defined below at a rate that is determined by dividing twenty-five percent (25%) of any provider reductions in the Medicaid program as authorized in Section 43-13-117(F) for that fiscal year up to the following maximum amount, plus the nonfederal share necessary to maximize the Disproportionate Share Hospital (DSH) and inpatient Medicare Upper Payment Limits (UPL) Program payments and inpatient hospital access payments, by the total number of non-Medicare hospital inpatient days as defined below for all licensed Mississippi hospitals: in fiscal year 2010, the maximum amount shall be Twenty-four Million Dollars ($24,000,000.00); in fiscal year 2011, the maximum amount shall be Thirty-two Million Dollars ($32,000,000.00); and in fiscal year 2012 and thereafter, the maximum amount shall be Forty Million Dollars ($40,000,000.00). Any such deficit in the Medicaid program shall be reviewed by the PEER Committee as provided in Section 43-13-117(F).

(iii) In addition to the assessments provided in subparagraphs (i) and (ii), an additional annual assessment on each hospital licensed in the state is imposed pursuant to the provisions of Section 43-13-117(F) if the cost-containment measures described therein have been implemented and there are insufficient funds in the Health Care Trust Fund to reconcile any remaining deficit in any fiscal year. If the Governor institutes any other additional cost-containment measures on any program or

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

(b) Definitions.

(i) [Deleted]

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

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

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

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

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

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

(c) The assessment provided in this subsection is intended to satisfy and not be in addition to the assessment and intergovernmental transfers provided in Section 43-13-117(A)(18). Nothing in this section shall be construed to authorize any state agency, division or department, or county, municipality or other local governmental unit to license for revenue, levy or impose any other tax, fee or assessment upon hospitals in this state not authorized by a specific statute.

(d) Hospitals operated by the United States Department of Veterans Affairs and state-operated facilities that provide

only inpatient and outpatient psychiatric services shall not be subject to the hospital assessment provided in this subsection.

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

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

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

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

(f) Applicability.

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

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

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

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

(6) [Deleted]

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

(8) The assessment levied under this section shall be in addition to any other assessments, taxes or fees levied by law, and the assessment shall constitute a debt due the State of Mississippi from the time the assessment is due until it is paid.

(9) (a) If a health care facility that is liable for payment of an assessment levied by the division does not pay the assessment when it is due, the division shall give written notice to the health care facility demanding payment of the assessment

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

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

shall forward the notice to the circuit clerk who shall enter the notice of the tax lien as a judgment upon the judgment roll and show in the appropriate columns the name of the health care facility as judgment debtor, the name of the division as judgment creditor, the amount of the unpaid assessment, and the date and time of enrollment. The judgment shall be valid as against mortgagees, pledgees, entrusters, purchasers, judgment creditors and other persons from the time of filing with the clerk. The amount of the judgment shall be a debt due the State of Mississippi and remain a lien upon the tangible property of the health care facility until the judgment is satisfied. The judgment shall be the equivalent of any enrolled judgment of a court of record and shall serve as authority for the issuance of writs of execution, writs of attachment or other remedial writs.

(10) (a) To further the provisions of Section 43-13-117(A)(18), the Division of Medicaid shall submit to the Centers for Medicare and Medicaid Services (CMS) any documents regarding the hospital assessment established under subsection (4) of this section. In addition to defining the assessment established in subsection (4) of this section if necessary, the documents shall describe any supplement payment programs and/or payment methodologies as authorized in Section 43-13-117(A)(18) if necessary.

(b) All hospitals satisfying the minimum federal DSH eligibility requirements (Section 1923(d) of the Social Security

Act) may, subject to OBRA 1993 payment limitations, receive a DSH payment. This DSH payment shall expend the balance of the federal DSH allotment and associated state share not utilized in DSH payments to state-owned institutions for treatment of mental diseases. The payment to each hospital shall be calculated by applying a uniform percentage to the uninsured costs of each eligible hospital, excluding state-owned institutions for treatment of mental diseases; however, that percentage for a state-owned teaching hospital located in Hinds County shall be multiplied by a factor of two (2).

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

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

(13) Payment.

(a) The hospital assessment as described in subsection (4) for the nonfederal share necessary to maximize the Medicare Upper Payments Limits (UPL) Program payments and hospital access payments and such other supplemental payments as may be developed pursuant to Section 43-3-117(A)(18) shall be assessed and

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

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

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

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

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

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

SECTION 22. Section 43-13-147, Mississippi Code of 1972, is brought forward as follows:

43-13-147. (1) The Mississippi Medicaid Program and the Children's Health Insurance Program, in consultation with statewide organizations focused on premature infant health care, shall:

(a) Examine and improve hospital discharge and follow-up care procedures for premature infants born earlier than thirty-seven (37) weeks gestational age to ensure standardized and coordinated processes are followed as premature infants leave the hospital from either a Level 1 (well baby nursery), Level 2 (step down or transitional nursery) or Level 3 (neonatal intensive care unit) unit and transition to follow-up care by a health care provider in the community; and

(b) Use guidance from the Centers for Medicare and Medicaid Services' Neonatal Outcomes Improvement Project to implement programs to improve newborn outcomes, reduce newborn health costs and establish ongoing quality improvement for newborns.

(2) Data regarding the incidence and cause of rehospitalization in the first six (6) months of life for infants born premature at earlier than thirty-seven (37) weeks gestational age shall be reported to the Chairman of the House Public Health and Human Services Committee and the Chairman of the Senate Public Health and Welfare Committee by the Mississippi State Department of Health utilizing the mandated hospital discharge data system authorized in Section 41-63-4.

SECTION 23. This act shall take effect and be in force from and after July 1, 2025.