

**Adopted
COMMITTEE AMENDMENT NO 1 PROPOSED TO**

House Bill No. 1725

BY: Committee

**Amend by striking all after the enacting clause and inserting
in lieu thereof the following:**

49 SECTION 1. (1) The Office of the Governor, Division of
50 Medicaid, shall enter into negotiations with the Centers for
51 Medicare and Medicaid Services (CMS) to obtain a waiver for
52 applicable provisions of the Medicaid laws and regulations under
53 Section 1115 of the Social Security Act to create a plan to allow
54 Medicaid coverage in Mississippi for individuals described in this
55 act, which contains the following provisions:

56 (a) Coverage group. Individuals eligible for coverage
57 under this section shall be persons who are not less than nineteen
58 (19) years of age but less than sixty-five (65) years of age, who



59 currently reside in households that have an income of less than
60 one hundred percent (100%) of federal poverty level, who are:

61 (i) Employed for at least one hundred twenty (120)
62 hours per month in a position for which health insurance is not
63 paid for by the employer;

64 (ii) Enrolled as a full-time student in secondary
65 or post-secondary education;

66 (iii) Enrolled full-time in a workforce training
67 program;

68 (iv) Enrolled for at least six (6) credit hours,
69 or its equivalent, as a student in secondary education,
70 post-secondary education, or a workforce training program and is
71 employed for at least sixty (60) hours per month in a position for
72 which health insurance is not paid for by the employer;

73 (v) The parent or guardian and the primary
74 caregiver of a child under six (6) years of age;

75 (vi) A person who is physically, mentally or
76 intellectually unable to meet the requirements of subparagraphs
77 (i) through (iv) of this paragraph (a) as documented by a medical
78 professional; or

79 (vii) The primary caregiver for a disabled child,
80 spouse or parent, provided that such disabled person qualifies for
81 Medicaid coverage in accordance with the federal Social Security
82 Act.



83 (b) Beneficiary enrollment. Any individual otherwise
84 eligible for coverage under this section who has health insurance
85 coverage through his or her employer or through private health
86 insurance and who voluntarily disenrolls from that health
87 insurance coverage shall not be in the coverage group until twelve
88 (12) months after the ending date of that coverage. The coverage
89 group shall not include non-United States citizens who are
90 ineligible for Medicaid benefits. The division shall verify
91 eligibility of each beneficiary in this coverage group no less
92 than on a quarterly basis. The division may consider seasonal or
93 part-time employees who are cumulatively employed for an average
94 of one hundred twenty (120) hours per month over a twelve-month
95 period as satisfying the work requirements of subsection (1)(a)(i)
96 of this section.

97 The division shall provide qualified providers with such
98 forms as are necessary for an individual in the coverage group to
99 make application for Medicaid and information on how to assist
100 such individuals in completing and filing such forms. The
101 division shall make those application forms and the application
102 process itself as simple as possible. In addition to the efforts
103 of the division, the Department of Health shall administer a
104 public awareness program regarding the coverage and eligibility
105 offered in accordance with this act. Such program shall promote
106 public awareness of the coverage offered in accordance with this
107 act to ensure that all eligible citizens of the State of



108 Mississippi are aware of and have the opportunity to apply for
109 eligibility.

110 (c) Delivery systems. All individuals in the coverage
111 group shall be enrolled in and their services shall be provided by
112 the managed care organizations (MCOs), coordinated care
113 organizations (CCOs), provider-sponsored health plans (PSHPs) and
114 other such organizations paid for services to the Medicaid
115 population on a capitated basis by the division as described in
116 Section 43-13-117(H).

117 (d) Benefit packages. Individuals enrolled under this
118 act who are not less than nineteen (19) years of age but less than
119 sixty five (65) years of age shall be provided essential health
120 services as determined by the division, which shall, at a minimum,
121 include ambulatory patient services, emergency services,
122 hospitalization, prescription drugs, rehabilitative services,
123 laboratory services, primary care services, preventive and
124 wellness services and chronic disease management.

125 (e) Funding of the plan. (i) The Section 1115 waiver
126 described in this section shall describe the funding for this act,
127 which shall be a combination of state matching funds and federal
128 matching funds in the proportions specified under the federal
129 Affordable Care Act at the time of the effective date of this act.

130 (ii) The state matching funds shall include
131 contributions from MCOs, CCOs, PSHPs and other such organizations
132 paid for services to the Medicaid population on a capitated basis



133 by the division as described in Section 43-13-117(H) in the form
134 of an assessment as provided in Section 2 of this act. The state
135 matching funds shall also include contributions from hospitals
136 that are generated through an assessment on hospitals as described
137 in Section 43-13-145 and deposited into the Medical Care Fund
138 created in Section 43-13-143.

139 (iii) The division is also authorized to accept
140 any voluntary contributions donated to the division to be used as
141 state matching funds for the purpose of this act, including, but
142 not limited to, contributions from businesses and other entities.
143 Notwithstanding any provision of this paragraph (e), state
144 matching funds for the purposes of this act may be appropriated by
145 the Legislature from any other sources.

146 (f) Timing. Within one hundred twenty (120) days of
147 the effective date of this act, the division shall apply for a
148 waiver of the applicable provisions of the Medicaid laws and
149 regulations under Section 1115 of the Social Security Act to
150 create a plan to allow Medicaid coverage in Mississippi in
151 accordance with this act, which shall include a work requirement
152 that requires beneficiaries to be employed for at least one
153 hundred twenty (120) hours per month or for such beneficiary to be
154 otherwise eligible within paragraph (a) of this subsection. The
155 division shall provide a copy of such application to the Governor,
156 Lieutenant Governor, Speaker of the House of Representatives, and
157 the Chairmen of the Senate and House Medicaid Committees on the



158 same day that the division officially applies to CMS for such
159 waiver.

160 (2) The division shall begin enrolling eligible individuals
161 into the coverage group established in this section within thirty
162 (30) days of the effective date of CMS approving the division's
163 waiver under this section.

164 (3) This section shall stand repealed on January 31, 2029.

165 (4) This section shall be subject to Section 3 of this act.

166 **SECTION 2.** (1) Notwithstanding any other provision of law,
167 upon each managed care organization, coordinated care
168 organization, provider sponsored health plan or other organization
169 paid for services to the Medicaid population on a capitated basis
170 by the Division of Medicaid as described in Section 43-13-117(H),
171 there is levied an assessment of three percent (3%) on the total
172 paid capitation. All assessments under this section shall be
173 assessed and collected by the division on the 15th of each month
174 and shall be deposited into the Medical Care Fund created by
175 Section 43-13-143. Any amount generated by the assessment that is
176 in excess of the amount needed to cover the state matching funds
177 may be used to enhance provider reimbursement for those services
178 that are most utilized by the coverage group as determined by the
179 division. This section shall be effective in the first month that
180 a capitated payment is provided to a managed care organization,
181 coordinated care organization, provider sponsored health plan or
182 other organization paid for services to the Medicaid population on



183 a capitated basis by the division as described in Section
184 43-13-117(H) for coverage of individuals eligible under Section 1
185 of this act and Section 43-13-115. The Division of Medicaid is
186 directed to apply for any applicable federal waiver to accomplish
187 the purposes of this section.

188 (2) This section shall stand repealed on January 31, 2029.

189 (3) This section shall be subject to Section 3 of this act.

190 **SECTION 3.** (1) This section, section 1, section 2 and
191 subsection (29) of Section 43-13-115 shall stand repealed on the
192 date of any of the following:

193 (a) On such date that the Centers for Medicare and
194 Medicaid Services (CMS) reject the division's work requirement
195 waiver request provided for in Section 1 of this act;

196 (b) On such date that the Centers for Medicare and
197 Medicaid Services (CMS) reject the assessment provided for in
198 Section 2 of this act;

199 (c) On such date that the Centers for Medicare and
200 Medicaid Services (CMS) withdraws approval of, cancels or
201 constructively terminates any waiver that was previously issued to
202 the division as a condition of the requirements of this act;

203 (d) On such date that a court of competent jurisdiction
204 nullifies the work requirement provided for in Section 1 of this
205 act; or

206 (e) On such date that a court of competent jurisdiction
207 nullifies the assessment provided for in Section 2 of this act.



208 (2) If the division receives a waiver in accordance with
209 Section 1 and 2 of this act, but the act is later repealed through
210 any of the events or actions listed in subsection (1) of this
211 section, then the division shall have thirty (30) days to cease
212 coverage of eligible individuals under this act and to provide
213 notice to such individuals of the termination of coverage.

214 **SECTION 4.** Section 43-13-115, Mississippi Code of 1972, is
215 amended as follows:

216 43-13-115. Recipients of Medicaid shall be the following
217 persons only:

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



233 shall determine eligibility for low income families under Section
234 1931 of the federal Social Security Act and shall redetermine
235 eligibility for those continuing under Title IV-A grants.

236 (2) Those qualified for Supplemental Security Income
237 (SSI) benefits under Title XVI of the federal Social Security Act,
238 as amended, and those who are deemed SSI eligible as contained in
239 federal statute. The eligibility of individuals covered in this
240 paragraph shall be determined by the Social Security
241 Administration and certified to the Division of Medicaid.

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

247 (4) [Deleted]

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



258 (6) Children certified by the State Department of Human
259 Services to the Division of Medicaid of whom the state and county
260 departments of human services have custody and financial
261 responsibility, and children who are in adoptions subsidized in
262 full or part by the Department of Human Services, including
263 special needs children in non-Title IV-E adoption assistance, who
264 are approvable under Title XIX of the Medicaid program. The
265 eligibility of the children covered under this paragraph shall be
266 determined by the State Department of Human Services.

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

279 (8) Children under eighteen (18) years of age and
280 pregnant women (including those in intact families) who meet the
281 financial standards of the state plan approved under Title IV-A of
282 the federal Social Security Act, as amended. The eligibility of



283 children covered under this paragraph shall be determined by the
284 Division of Medicaid.

285 (9) Individuals who are:

286 (a) Children born after September 30, 1983, who
287 have not attained the age of nineteen (19), with family income
288 that does not exceed one hundred percent (100%) of the nonfarm
289 official poverty level;

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

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

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

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



307 individuals under this paragraph shall be determined by the
308 Division of Medicaid.

309 (11) Until the end of the day on December 31, 2005,
310 individuals who are sixty-five (65) years of age or older or are
311 disabled as determined under Section 1614(a)(3) of the federal
312 Social Security Act, as amended, and whose income does not exceed
313 one hundred thirty-five percent (135%) of the nonfarm official
314 poverty level as defined by the Office of Management and Budget
315 and revised annually, and whose resources do not exceed those
316 established by the Division of Medicaid. The eligibility of
317 individuals covered under this paragraph shall be determined by
318 the Division of Medicaid. After December 31, 2005, only those
319 individuals covered under the 1115(c) Healthier Mississippi waiver
320 will be covered under this category.

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



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

338 The eligibility of individuals covered under this paragraph
339 shall be determined by the Division of Medicaid, and those
340 individuals determined eligible shall receive Medicare
341 cost-sharing expenses only as more fully defined by the Medicare
342 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
343 1997.

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

351 (b) Individuals entitled to Part A of Medicare,
352 with income above one hundred twenty percent (120%), but less than
353 one hundred thirty-five percent (135%) of the federal poverty
354 level, and not otherwise eligible for Medicaid. Eligibility for
355 Medicaid benefits is limited to full payment of Medicare Part B



356 premiums. The number of eligible individuals is limited by the
357 availability of the federal capped allocation at one hundred
358 percent (100%) of federal matching funds, as more fully defined in
359 the Balanced Budget Act of 1997.

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

362 (14) [Deleted]

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

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

378 (17) In accordance with the terms of the federal
379 Personal Responsibility and Work Opportunity Reconciliation Act of
380 1996 (Public Law 104-193), persons who become ineligible for



381 assistance under Title IV-A of the federal Social Security Act, as
382 amended, because of increased income from or hours of employment
383 of the caretaker relative or because of the expiration of the
384 applicable earned income disregards, who were eligible for
385 Medicaid for at least three (3) of the six (6) months preceding
386 the month in which the ineligibility begins, shall be eligible for
387 Medicaid for up to twelve (12) months. The eligibility of the
388 individuals covered under this paragraph shall be determined by
389 the division.

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

401 (19) Disabled workers, whose incomes are above the
402 Medicaid eligibility limits, but below two hundred fifty percent
403 (250%) of the federal poverty level, shall be allowed to purchase
404 Medicaid coverage on a sliding fee scale developed by the Division
405 of Medicaid.



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

411 (21) Women of childbearing age whose family income does
412 not exceed one hundred eighty-five percent (185%) of the federal
413 poverty level. The eligibility of individuals covered under this
414 paragraph (21) shall be determined by the Division of Medicaid,
415 and those individuals determined eligible shall only receive
416 family planning services covered under Section 43-13-117(13) and
417 not any other services covered under Medicaid. However, any
418 individual eligible under this paragraph (21) who is also eligible
419 under any other provision of this section shall receive the
420 benefits to which he or she is entitled under that other
421 provision, in addition to family planning services covered under
422 Section 43-13-117(13).

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



431 (22) Persons who are workers with a potentially severe
432 disability, as determined by the division, shall be allowed to
433 purchase Medicaid coverage. The term "worker with a potentially
434 severe disability" means a person who is at least sixteen (16)
435 years of age but under sixty-five (65) years of age, who has a
436 physical or mental impairment that is reasonably expected to cause
437 the person to become blind or disabled as defined under Section
438 1614(a) of the federal Social Security Act, as amended, if the
439 person does not receive items and services provided under
440 Medicaid.

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

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



455 (24) Individuals who have not attained age sixty-five
456 (65), are not otherwise covered by creditable coverage as defined
457 in the Public Health Services Act, and have been screened for
458 breast and cervical cancer under the Centers for Disease Control
459 and Prevention Breast and Cervical Cancer Early Detection Program
460 established under Title XV of the Public Health Service Act in
461 accordance with the requirements of that act and who need
462 treatment for breast or cervical cancer. Eligibility of
463 individuals under this paragraph (24) shall be determined by the
464 Division of Medicaid.

465 (25) The division shall apply to the Centers for
466 Medicare and Medicaid Services (CMS) for any necessary waivers to
467 provide services to individuals who are sixty-five (65) years of
468 age or older or are disabled as determined under Section
469 1614(a)(3) of the federal Social Security Act, as amended, and
470 whose income does not exceed one hundred thirty-five percent
471 (135%) of the nonfarm official poverty level as defined by the
472 Office of Management and Budget and revised annually, and whose
473 resources do not exceed those established by the Division of
474 Medicaid, and who are not otherwise covered by Medicare. Nothing
475 contained in this paragraph (25) shall entitle an individual to
476 benefits. The eligibility of individuals covered under this
477 paragraph shall be determined by the Division of Medicaid.

478 (26) The division shall apply to the Centers for
479 Medicare and Medicaid Services (CMS) for any necessary waivers to



480 provide services to individuals who are sixty-five (65) years of
481 age or older or are disabled as determined under Section
482 1614(a)(3) of the federal Social Security Act, as amended, who are
483 end stage renal disease patients on dialysis, cancer patients on
484 chemotherapy or organ transplant recipients on antirejection
485 drugs, whose income does not exceed one hundred thirty-five
486 percent (135%) of the nonfarm official poverty level as defined by
487 the Office of Management and Budget and revised annually, and
488 whose resources do not exceed those established by the division.
489 Nothing contained in this paragraph (26) shall entitle an
490 individual to benefits. The eligibility of individuals covered
491 under this paragraph shall be determined by the Division of
492 Medicaid.

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

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



504 (29) Individuals described in Section (1)(a) of this
505 act. The division shall apply for a waiver of the applicable
506 provisions of the Medicaid laws and regulations under Section 1115
507 of the Social Security Act to create a plan to allow Medicaid
508 coverage in Mississippi in accordance with Sections 1 and 2 of
509 this act, including a work requirement that requires beneficiaries
510 to be employed for at least one hundred twenty (120) hours per
511 month or for such beneficiary to be otherwise eligible within
512 Section (1)(a) of this act. The division shall begin enrolling
513 eligible individuals into the coverage group established in this
514 section within thirty (30) days of the effective date of CMS
515 approving the division's waiver under this section. This
516 paragraph (29) shall stand repealed on January 31, 2029. This
517 subsection shall be subject to Section 3 of this act.

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

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

523 43-13-5. The State Department of Public Welfare, after
524 having made a determination with respect to eligibility with due
525 regard to the resources and income of the applicant, may make
526 vendor payments on behalf of eligible individuals for such care as
527 may be authorized within the limits of available funds, provided
528 that such medical or remedial care is rendered by or under the



529 supervision of a licensed practitioner, and provided further that
530 no regulation shall be promulgated which limits or abridges the
531 recipient's free choice of the provider of medical and remedial
532 care or service. Such recipients of medical assistance for the
533 aged shall only be persons:

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

536 (2) Who are not receiving old age assistance;

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

540 (4) Who have not made a voluntary assignment or
541 transfer of property for the purpose of qualifying for such
542 assistance at any time within two (2) years immediately prior to
543 the filing of an application for medical assistance for the aged.

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

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



553 43-13-11. The administering agency is authorized to contract
554 with other state government and nongovernment agencies and
555 organizations in the State of Mississippi for purposes of
556 performing all or part of the administrative aspects of medical or
557 remedial care programs herein authorized, paying a reasonable fee
558 for such service.

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

561 43-13-105. When used in this article, the following
562 definitions shall apply, unless the context requires otherwise:

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

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

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

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

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



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

590 (g) "Mississippi Medicaid Commission" or "Medicaid
591 Commission," wherever they appear in the laws of the State of
592 Mississippi, means the Division of Medicaid in the Office of the
593 Governor.

594 **SECTION 8.** Section 43-13-113, Mississippi Code of 1972, is
595 brought forward as follows:

596 43-13-113. (1) The State Treasurer shall receive on behalf
597 of the state, and execute all instruments incidental thereto,
598 federal and other funds to be used for financing the medical
599 assistance plan or program adopted pursuant to this article, and
600 place all such funds in a special account to the credit of the
601 Governor's Office-Division of Medicaid, which funds shall be



602 expended by the division for the purposes and under the provisions
603 of this article, and shall be paid out by the State Treasurer as
604 funds appropriated to carry out the provisions of this article are
605 paid out by him.

606 The division shall issue all checks or electronic transfers
607 for administrative expenses, and for medical assistance under the
608 provisions of this article. All such checks or electronic
609 transfers shall be drawn upon funds made available to the division
610 by the State Auditor, upon requisition of the director. It is the
611 purpose of this section to provide that the State Auditor shall
612 transfer, in lump sums, amounts to the division for disbursement
613 under the regulations which shall be made by the director with the
614 approval of the Governor; however, the division, or its fiscal
615 agent in behalf of the division, shall be authorized in
616 maintaining separate accounts with a Mississippi bank to handle
617 claim payments, refund recoveries and related Medicaid program
618 financial transactions, to aggressively manage the float in these
619 accounts while awaiting clearance of checks or electronic
620 transfers and/or other disposition so as to accrue maximum
621 interest advantage of the funds in the account, and to retain all
622 earned interest on these funds to be applied to match federal
623 funds for Medicaid program operations.

624 (2) The division is authorized to obtain a line of credit
625 through the State Treasurer from the Working Cash-Stabilization
626 Fund or any other special source funds maintained in the State



627 Treasury in an amount not exceeding One Hundred Fifty Million
628 Dollars (\$150,000,000.00) to fund shortfalls which, from time to
629 time, may occur due to decreases in state matching fund cash flow.
630 The length of indebtedness under this provision shall not carry
631 past the end of the quarter following the loan origination. Loan
632 proceeds shall be received by the State Treasurer and shall be
633 placed in a Medicaid designated special fund account. Loan
634 proceeds shall be expended only for health care services provided
635 under the Medicaid program. The division may pledge as security
636 for such interim financing future funds that will be received by
637 the division. Any such loans shall be repaid from the first
638 available funds received by the division in the manner of and
639 subject to the same terms provided in this section.

640 In the event the State Treasurer makes a determination that
641 special source funds are not sufficient to cover a line of credit
642 for the Division of Medicaid, the division is authorized to obtain
643 a line of credit, in an amount not exceeding One Hundred Fifty
644 Million Dollars (\$150,000,000.00), from a commercial lender or a
645 consortium of lenders. The length of indebtedness under this
646 provision shall not carry past the end of the quarter following
647 the loan origination. The division shall obtain a minimum of two
648 (2) written quotes that shall be presented to the State Fiscal
649 Officer and State Treasurer, who shall jointly select a lender.
650 Loan proceeds shall be received by the State Treasurer and shall
651 be placed in a Medicaid designated special fund account. Loan



652 proceeds shall be expended only for health care services provided
653 under the Medicaid program. The division may pledge as security
654 for such interim financing future funds that will be received by
655 the division. Any such loans shall be repaid from the first
656 available funds received by the division in the manner of and
657 subject to the same terms provided in this section.

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

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

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

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

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

671 (e) If a claim is neither paid nor denied for valid and
672 proper reasons by the end of the time periods as specified above,
673 the Division of Medicaid's fiscal agent must pay the provider
674 interest on the claim at the rate of one and one-half percent
675 (1-1/2%) per month on the amount of such claim until it is finally
676 settled or adjudicated.



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

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

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

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

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

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

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

701 (7) [Repealed.]



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

709 **SECTION 9.** Section 43-13-116, Mississippi Code of 1972, is
710 brought forward as follows:

711 43-13-116. (1) It shall be the duty of the Division of
712 Medicaid to fully implement and carry out the administrative
713 functions of determining the eligibility of those persons who
714 qualify for medical assistance under Section 43-13-115.

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



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

739 (a) A request may be made either for a local regional
740 office hearing or a state office hearing when the local regional
741 office has made the initial decision that the claimant seeks to
742 appeal or when the regional office has not acted with reasonable
743 promptness in making a decision on a claim for eligibility or
744 services. The only exception to requesting a local hearing is
745 when the issue under appeal involves either (i) a disability or
746 blindness denial, or termination, or (ii) a level of care denial
747 or termination for a disabled child living at home. An appeal
748 involving disability, blindness or level of care must be handled
749 as a state level hearing. The decision from the local hearing may
750 be appealed to the state office for a state hearing. A decision



751 to deny, reduce or terminate benefits that is initially made at
752 the state office may be appealed by requesting a state hearing.

753 (b) A request for a hearing, either state or local,
754 must be made in writing by the claimant or claimant's legal
755 representative. "Legal representative" includes the claimant's
756 authorized representative, an attorney retained by the claimant or
757 claimant's family to represent the claimant, a paralegal
758 representative with a legal aid services, a parent of a minor
759 child if the claimant is a child, a legal guardian or conservator
760 or an individual with power of attorney for the claimant. The
761 claimant may also be represented by anyone that he or she so
762 designates but must give the designation to the Medicaid regional
763 office or state office in writing, if the person is not the legal
764 representative, legal guardian, or authorized representative.

765 (c) The claimant may make a request for a hearing in
766 person at the regional office but an oral request must be put into
767 written form. Regional office staff will determine from the
768 claimant if a local or state hearing is requested and assist the
769 claimant in completing and signing the appropriate form. Regional
770 office staff may forward a state hearing request to the
771 appropriate division in the state office or the claimant may mail
772 the form to the address listed on the form. The claimant may make
773 a written request for a hearing by letter. A simple statement
774 requesting a hearing that is signed by the claimant or legal
775 representative is sufficient; however, if possible, the claimant



776 should state the reason for the request. The letter may be mailed
777 to the regional office or it may be mailed to the state office. If
778 the letter does not specify the type of hearing desired, local or
779 state, Medicaid staff will attempt to contact the claimant to
780 determine the level of hearing desired. If contact cannot be made
781 within three (3) days of receipt of the request, the request will
782 be assumed to be for a local hearing and scheduled accordingly. A
783 hearing will not be scheduled until either a letter or the
784 appropriate form is received by the regional or state office.

785 (d) When both members of a couple wish to appeal an
786 action or inaction by the agency that affects both applications or
787 cases similarly and arose from the same issue, one or both may
788 file the request for hearing, both may present evidence at the
789 hearing, and the agency's decision will be applicable to both. If
790 both file a request for hearing, two (2) hearings will be
791 registered but they will be conducted on the same day and in the
792 same place, either consecutively or jointly, as the couple wishes.
793 If they so desire, only one of the couple need attend the hearing.

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

796 (i) The claimant has thirty (30) days from the
797 date the agency mails the appropriate notice to the claimant of
798 its decision regarding eligibility, services, or benefits to
799 request either a state or local hearing. This time period may be
800 extended if the claimant can show good cause for not filing within



801 thirty (30) days. Good cause includes, but may not be limited to,
802 illness, failure to receive the notice, being out of state, or
803 some other reasonable explanation. If good cause can be shown, a
804 late request may be accepted provided the facts in the case remain
805 the same. If a claimant's circumstances have changed or if good
806 cause for filing a request beyond thirty (30) days is not shown, a
807 hearing request will not be accepted. If the claimant wishes to
808 have eligibility reconsidered, he or she may reapply.

809 (ii) If a claimant or representative requests a
810 hearing in writing during the advance notice period before
811 benefits are reduced or terminated, benefits must be continued or
812 reinstated to the benefit level in effect before the effective
813 date of the adverse action. Benefits will continue at the
814 original level until the final hearing decision is rendered. Any
815 hearing requested after the advance notice period will not be
816 accepted as a timely request in order for continuation of benefits
817 to apply.

818 (iii) Upon receipt of a written request for a
819 hearing, the request will be acknowledged in writing within twenty
820 (20) days and a hearing scheduled. The claimant or representative
821 will be given at least five (5) days' advance notice of the
822 hearing date. The local and/or state level hearings will be held
823 by telephone unless, at the hearing officer's discretion, it is
824 determined that an in-person hearing is necessary. If a local
825 hearing is requested, the regional office will notify the claimant



826 or representative in writing of the time of the local hearing. If
827 a state hearing is requested, the state office will notify the
828 claimant or representative in writing of the time of the state
829 hearing. If an in-person hearing is necessary, local hearings
830 will be held at the regional office and state hearings will be
831 held at the state office unless other arrangements are
832 necessitated by the claimant's inability to travel.

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

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

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



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

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

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

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

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

863 (vii) When a request for a local hearing is
864 received by the regional office or if the regional office is
865 notified by the state office that a local hearing has been
866 requested, the Medicaid specialist supervisor in the regional
867 office will review the case record, reexamine the action taken on
868 the case, and determine if policy and procedures have been
869 followed. If any adjustments or corrections should be made, the
870 Medicaid specialist supervisor will ensure that corrective action
871 is taken. If the request for hearing was timely made such that
872 continuation of benefits applies, the Medicaid specialist
873 supervisor will ensure that benefits continue at the level before
874 the proposed adverse action that is the subject of the appeal.



875 The Medicaid specialist supervisor will also ensure that all
876 needed information, verification, and evidence is in the case
877 record for the hearing.

878 (viii) When a state hearing is requested that
879 appeals the action or inaction of a regional office, the regional
880 office will prepare copies of the case record and forward it to
881 the appropriate division in the state office no later than five
882 (5) days after receipt of the request for a state hearing. The
883 original case record will remain in the regional office. Either
884 the original case record in the regional office or the copy
885 forwarded to the state office will be available for inspection by
886 the claimant or claimant's representative a reasonable time before
887 the date of the hearing.

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



899 requirements that were applied to claimant's case in making the
900 decision.

901 (x) After the hearing, the hearing officer will
902 prepare a written summary of the hearing procedure and file it
903 with the case record. The hearing officer will consider the facts
904 presented at the local hearing in reaching a decision. The
905 claimant will be notified of the local hearing decision on the
906 appropriate form that will state clearly the reason for the
907 decision, the policy that governs the decision, the claimant's
908 right to appeal the decision to the state office, and, if the
909 original adverse action is upheld, the new effective date of the
910 reduction or termination of benefits or services if continuation
911 of benefits applied during the hearing process. The new effective
912 date of the reduction or termination of benefits or services must
913 be at the end of the fifteen-day advance notice period from the
914 mailing date of the notice of hearing decision. The notice to
915 claimant will be made part of the case record.

916 (xi) The claimant has the right to appeal a local
917 hearing decision by requesting a state hearing in writing within
918 fifteen (15) days of the mailing date of the notice of local
919 hearing decision. The state hearing request should be made to the
920 regional office. If benefits have been continued pending the
921 local hearing process, then benefits will continue throughout the
922 fifteen-day advance notice period for an adverse local hearing
923 decision. If a state hearing is timely requested within the



924 fifteen-day period, then benefits will continue pending the state
925 hearing process. State hearings requested after the fifteen-day
926 local hearing advance notice period will not be accepted unless
927 the initial thirty-day period for filing a hearing request has not
928 expired because the local hearing was held early, in which case a
929 state hearing request will be accepted as timely within the number
930 of days remaining of the unexpired initial thirty-day period in
931 addition to the fifteen-day time period. Continuation of benefits
932 during the state hearing process, however, will only apply if the
933 state hearing request is received within the fifteen-day advance
934 notice period.

935 (xii) When a request for a state hearing is
936 received in the regional office, the request will be made part of
937 the case record and the regional office will prepare the case
938 record and forward it to the appropriate division in the state
939 office within five (5) days of receipt of the state hearing
940 request. A request for a state hearing received in the state
941 office will be forwarded to the regional office for inclusion in
942 the case record and the regional office will prepare the case
943 record and forward it to the appropriate division in the state
944 office within five (5) days of receipt of the state hearing
945 request.

946 (xiii) Upon receipt of the hearing record, an
947 impartial hearing officer will be assigned to hear the case either
948 by the Executive Director of the Division of Medicaid or his or



949 her designee. Hearing officers will be individuals with
950 appropriate expertise employed by the division and who have not
951 been involved in any way with the action or decision on appeal in
952 the case. The hearing officer will review the case record and if
953 the review shows that an error was made in the action of the
954 agency or in the interpretation of policy, or that a change of
955 policy has been made, the hearing officer will discuss these
956 matters with the appropriate agency personnel and request that an
957 appropriate adjustment be made. Appropriate agency personnel will
958 discuss the matter with the claimant and if the claimant is
959 agreeable to the adjustment of the claim, then agency personnel
960 will request in writing dismissal of the hearing and the reason
961 therefor, to be placed in the case record. If the hearing is to
962 go forward, it shall be scheduled by the hearing officer in the
963 manner set forth in subparagraph (iii) of this paragraph (e).

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

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

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

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



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

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

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

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

997 (xvi) Immediately following the hearing the
998 hearing tape will be transcribed and a copy of the transcription



999 forwarded to the regional office for filing in the case record.
1000 As soon as possible, the hearing officer shall review the evidence
1001 and record of the proceedings, testimony, exhibits, and other
1002 supporting documents, prepare a written summary of the facts as
1003 the hearing officer finds them, and prepare a written
1004 recommendation of action to be taken by the agency, citing
1005 appropriate policy and regulations that govern the recommendation.
1006 The decision cannot be based on any material, oral or written, not
1007 available to the claimant before or during the hearing. The
1008 hearing officer's recommendation will become part of the case
1009 record which will be submitted to the Executive Director of the
1010 Division of Medicaid for further review and decision.

1011 (xvii) The Executive Director of the Division of
1012 Medicaid, upon review of the recommendation, proceedings and the
1013 record, may sustain the recommendation of the hearing officer,
1014 reject the same, or remand the matter to the hearing officer to
1015 take additional testimony and evidence, in which case, the hearing
1016 officer thereafter shall submit to the executive director a new
1017 recommendation. The executive director shall prepare a written
1018 decision summarizing the facts and identifying policies and
1019 regulations that support the decision, which shall be mailed to
1020 the claimant and the representative, with a copy to the regional
1021 office if appropriate, as soon as possible after submission of a
1022 recommendation by the hearing officer. The decision notice will
1023 specify any action to be taken by the agency, specify any revised



1024 eligibility dates or, if continuation of benefits applies, will
1025 notify the claimant of the new effective date of reduction or
1026 termination of benefits or services, which will be fifteen (15)
1027 days from the mailing date of the notice of decision. The
1028 decision rendered by the Executive Director of the Division of
1029 Medicaid is final and binding. The claimant is entitled to seek
1030 judicial review in a court of proper jurisdiction.

1031 (xviii) The Division of Medicaid must take final
1032 administrative action on a hearing, whether state or local, within
1033 ninety (90) days from the date of the initial request for a
1034 hearing.

1035 (xix) A group hearing may be held for a number of
1036 claimants under the following circumstances:

1037 (A) The Division of Medicaid may consolidate
1038 the cases and conduct a single group hearing when the only issue
1039 involved is one (1) of a single law or agency policy;

1040 (B) The claimants may request a group hearing
1041 when there is one (1) issue of agency policy common to all of
1042 them.

1043 In all group hearings, whether initiated by the Division of
1044 Medicaid or by the claimants, the policies governing fair hearings
1045 must be followed. Each claimant in a group hearing must be
1046 permitted to present his or her own case and be represented by his
1047 or her own representative, or to withdraw from the group hearing
1048 and have his or her appeal heard individually. As in individual



1049 hearings, the hearing will be conducted only on the issue being
1050 appealed, and each claimant will be expected to keep individual
1051 testimony within a reasonable time frame as a matter of
1052 consideration to the other claimants involved.

1053 (xx) Any specific matter necessitating an
1054 administrative hearing not otherwise provided under this article
1055 or agency policy shall be afforded under the hearing procedures as
1056 outlined above. If the specific time frames of such a unique
1057 matter relating to requesting, granting, and concluding of the
1058 hearing is contrary to the time frames as set out in the hearing
1059 procedures above, the specific time frames will govern over the
1060 time frames as set out within these procedures.

1061 (4) The Executive Director of the Division of Medicaid, with
1062 the approval of the Governor, shall be authorized to employ
1063 eligibility, technical, clerical and supportive staff as may be
1064 required in carrying out and fully implementing the determination
1065 of Medicaid eligibility, including conducting quality control
1066 reviews and the investigation of the improper receipt of medical
1067 assistance. Staffing needs will be set forth in the annual
1068 appropriation act for the division. Additional office space as
1069 needed in performing eligibility, quality control and
1070 investigative functions shall be obtained by the division.

1071 **SECTION 10.** Section 43-13-117, Mississippi Code of 1972, is
1072 brought forward as follows:



1073 43-13-117. (A) Medicaid as authorized by this article shall
1074 include payment of part or all of the costs, at the discretion of
1075 the division, with approval of the Governor and the Centers for
1076 Medicare and Medicaid Services, of the following types of care and
1077 services rendered to eligible applicants who have been determined
1078 to be eligible for that care and services, within the limits of
1079 state appropriations and federal matching funds:

1080 (1) Inpatient hospital services.

1081 (a) The division is authorized to implement an All
1082 Patient Refined Diagnosis Related Groups (APR-DRG) reimbursement
1083 methodology for inpatient hospital services.

1084 (b) No service benefits or reimbursement
1085 limitations in this subsection (A)(1) shall apply to payments
1086 under an APR-DRG or Ambulatory Payment Classification (APC) model
1087 or a managed care program or similar model described in subsection
1088 (H) of this section unless specifically authorized by the
1089 division.

1090 (2) Outpatient hospital services.

1091 (a) Emergency services.

1092 (b) Other outpatient hospital services. The
1093 division shall allow benefits for other medically necessary
1094 outpatient hospital services (such as chemotherapy, radiation,
1095 surgery and therapy), including outpatient services in a clinic or
1096 other facility that is not located inside the hospital, but that
1097 has been designated as an outpatient facility by the hospital, and



1098 that was in operation or under construction on July 1, 2009,
1099 provided that the costs and charges associated with the operation
1100 of the hospital clinic are included in the hospital's cost report.
1101 In addition, the Medicare thirty-five-mile rule will apply to
1102 those hospital clinics not located inside the hospital that are
1103 constructed after July 1, 2009. Where the same services are
1104 reimbursed as clinic services, the division may revise the rate or
1105 methodology of outpatient reimbursement to maintain consistency,
1106 efficiency, economy and quality of care.

1107 (c) The division is authorized to implement an
1108 Ambulatory Payment Classification (APC) methodology for outpatient
1109 hospital services. The division shall give rural hospitals that
1110 have fifty (50) or fewer licensed beds the option to not be
1111 reimbursed for outpatient hospital services using the APC
1112 methodology, but reimbursement for outpatient hospital services
1113 provided by those hospitals shall be based on one hundred one
1114 percent (101%) of the rate established under Medicare for
1115 outpatient hospital services. Those hospitals choosing to not be
1116 reimbursed under the APC methodology shall remain under cost-based
1117 reimbursement for a two-year period.

1118 (d) No service benefits or reimbursement
1119 limitations in this subsection (A) (2) shall apply to payments
1120 under an APR-DRG or APC model or a managed care program or similar
1121 model described in subsection (H) of this section unless
1122 specifically authorized by the division.



1123 (3) Laboratory and x-ray services.

1124 (4) Nursing facility services.

1125 (a) The division shall make full payment to
1126 nursing facilities for each day, not exceeding forty-two (42) days
1127 per year, that a patient is absent from the facility on home
1128 leave. Payment may be made for the following home leave days in
1129 addition to the forty-two-day limitation: Christmas, the day
1130 before Christmas, the day after Christmas, Thanksgiving, the day
1131 before Thanksgiving and the day after Thanksgiving.

1132 (b) From and after July 1, 1997, the division
1133 shall implement the integrated case-mix payment and quality
1134 monitoring system, which includes the fair rental system for
1135 property costs and in which recapture of depreciation is
1136 eliminated. The division may reduce the payment for hospital
1137 leave and therapeutic home leave days to the lower of the case-mix
1138 category as computed for the resident on leave using the
1139 assessment being utilized for payment at that point in time, or a
1140 case-mix score of 1.000 for nursing facilities, and shall compute
1141 case-mix scores of residents so that only services provided at the
1142 nursing facility are considered in calculating a facility's per
1143 diem.

1144 (c) From and after July 1, 1997, all state-owned
1145 nursing facilities shall be reimbursed on a full reasonable cost
1146 basis.



1147 (d) On or after January 1, 2015, the division
1148 shall update the case-mix payment system resource utilization
1149 grouper and classifications and fair rental reimbursement system.
1150 The division shall develop and implement a payment add-on to
1151 reimburse nursing facilities for ventilator-dependent resident
1152 services.

1153 (e) The division shall develop and implement, not
1154 later than January 1, 2001, a case-mix payment add-on determined
1155 by time studies and other valid statistical data that will
1156 reimburse a nursing facility for the additional cost of caring for
1157 a resident who has a diagnosis of Alzheimer's or other related
1158 dementia and exhibits symptoms that require special care. Any
1159 such case-mix add-on payment shall be supported by a determination
1160 of additional cost. The division shall also develop and implement
1161 as part of the fair rental reimbursement system for nursing
1162 facility beds, an Alzheimer's resident bed depreciation enhanced
1163 reimbursement system that will provide an incentive to encourage
1164 nursing facilities to convert or construct beds for residents with
1165 Alzheimer's or other related dementia.

1166 (f) The division shall develop and implement an
1167 assessment process for long-term care services. The division may
1168 provide the assessment and related functions directly or through
1169 contract with the area agencies on aging.

1170 The division shall apply for necessary federal waivers to
1171 assure that additional services providing alternatives to nursing



1172 facility care are made available to applicants for nursing
1173 facility care.

1174 (5) Periodic screening and diagnostic services for
1175 individuals under age twenty-one (21) years as are needed to
1176 identify physical and mental defects and to provide health care
1177 treatment and other measures designed to correct or ameliorate
1178 defects and physical and mental illness and conditions discovered
1179 by the screening services, regardless of whether these services
1180 are included in the state plan. The division may include in its
1181 periodic screening and diagnostic program those discretionary
1182 services authorized under the federal regulations adopted to
1183 implement Title XIX of the federal Social Security Act, as
1184 amended. The division, in obtaining physical therapy services,
1185 occupational therapy services, and services for individuals with
1186 speech, hearing and language disorders, may enter into a
1187 cooperative agreement with the State Department of Education for
1188 the provision of those services to handicapped students by public
1189 school districts using state funds that are provided from the
1190 appropriation to the Department of Education to obtain federal
1191 matching funds through the division. The division, in obtaining
1192 medical and mental health assessments, treatment, care and
1193 services for children who are in, or at risk of being put in, the
1194 custody of the Mississippi Department of Human Services may enter
1195 into a cooperative agreement with the Mississippi Department of
1196 Human Services for the provision of those services using state



1197 funds that are provided from the appropriation to the Department
1198 of Human Services to obtain federal matching funds through the
1199 division.

1200 (6) Physician services. Fees for physician's services
1201 that are covered only by Medicaid shall be reimbursed at ninety
1202 percent (90%) of the rate established on January 1, 2018, and as
1203 may be adjusted each July thereafter, under Medicare. The
1204 division may provide for a reimbursement rate for physician's
1205 services of up to one hundred percent (100%) of the rate
1206 established under Medicare for physician's services that are
1207 provided after the normal working hours of the physician, as
1208 determined in accordance with regulations of the division. The
1209 division may reimburse eligible providers, as determined by the
1210 division, for certain primary care services at one hundred percent
1211 (100%) of the rate established under Medicare. The division shall
1212 reimburse obstetricians and gynecologists for certain primary care
1213 services as defined by the division at one hundred percent (100%)
1214 of the rate established under Medicare.

1215 (7) (a) Home health services for eligible persons, not
1216 to exceed in cost the prevailing cost of nursing facility
1217 services. All home health visits must be precertified as required
1218 by the division. In addition to physicians, certified registered
1219 nurse practitioners, physician assistants and clinical nurse
1220 specialists are authorized to prescribe or order home health
1221 services and plans of care, sign home health plans of care,



1222 certify and recertify eligibility for home health services and
1223 conduct the required initial face-to-face visit with the recipient
1224 of the services.

1225 (b) [Repealed]

1226 (8) Emergency medical transportation services as
1227 determined by the division.

1228 (9) Prescription drugs and other covered drugs and
1229 services as determined by the division.

1230 The division shall establish a mandatory preferred drug list.
1231 Drugs not on the mandatory preferred drug list shall be made
1232 available by utilizing prior authorization procedures established
1233 by the division.

1234 The division may seek to establish relationships with other
1235 states in order to lower acquisition costs of prescription drugs
1236 to include single-source and innovator multiple-source drugs or
1237 generic drugs. In addition, if allowed by federal law or
1238 regulation, the division may seek to establish relationships with
1239 and negotiate with other countries to facilitate the acquisition
1240 of prescription drugs to include single-source and innovator
1241 multiple-source drugs or generic drugs, if that will lower the
1242 acquisition costs of those prescription drugs.

1243 The division may allow for a combination of prescriptions for
1244 single-source and innovator multiple-source drugs and generic
1245 drugs to meet the needs of the beneficiaries.



1246 The executive director may approve specific maintenance drugs
1247 for beneficiaries with certain medical conditions, which may be
1248 prescribed and dispensed in three-month supply increments.

1249 Drugs prescribed for a resident of a psychiatric residential
1250 treatment facility must be provided in true unit doses when
1251 available. The division may require that drugs not covered by
1252 Medicare Part D for a resident of a long-term care facility be
1253 provided in true unit doses when available. Those drugs that were
1254 originally billed to the division but are not used by a resident
1255 in any of those facilities shall be returned to the billing
1256 pharmacy for credit to the division, in accordance with the
1257 guidelines of the State Board of Pharmacy and any requirements of
1258 federal law and regulation. Drugs shall be dispensed to a
1259 recipient and only one (1) dispensing fee per month may be
1260 charged. The division shall develop a methodology for reimbursing
1261 for restocked drugs, which shall include a restock fee as
1262 determined by the division not exceeding Seven Dollars and
1263 Eighty-two Cents (\$7.82).

1264 Except for those specific maintenance drugs approved by the
1265 executive director, the division shall not reimburse for any
1266 portion of a prescription that exceeds a thirty-one-day supply of
1267 the drug based on the daily dosage.

1268 The division is authorized to develop and implement a program
1269 of payment for additional pharmacist services as determined by the
1270 division.



1271 All claims for drugs for dually eligible Medicare/Medicaid
1272 beneficiaries that are paid for by Medicare must be submitted to
1273 Medicare for payment before they may be processed by the
1274 division's online payment system.

1275 The division shall develop a pharmacy policy in which drugs
1276 in tamper-resistant packaging that are prescribed for a resident
1277 of a nursing facility but are not dispensed to the resident shall
1278 be returned to the pharmacy and not billed to Medicaid, in
1279 accordance with guidelines of the State Board of Pharmacy.

1280 The division shall develop and implement a method or methods
1281 by which the division will provide on a regular basis to Medicaid
1282 providers who are authorized to prescribe drugs, information about
1283 the costs to the Medicaid program of single-source drugs and
1284 innovator multiple-source drugs, and information about other drugs
1285 that may be prescribed as alternatives to those single-source
1286 drugs and innovator multiple-source drugs and the costs to the
1287 Medicaid program of those alternative drugs.

1288 Notwithstanding any law or regulation, information obtained
1289 or maintained by the division regarding the prescription drug
1290 program, including trade secrets and manufacturer or labeler
1291 pricing, is confidential and not subject to disclosure except to
1292 other state agencies.

1293 The dispensing fee for each new or refill prescription,
1294 including nonlegend or over-the-counter drugs covered by the



1295 division, shall be not less than Three Dollars and Ninety-one
1296 Cents (\$3.91), as determined by the division.

1297 The division shall not reimburse for single-source or
1298 innovator multiple-source drugs if there are equally effective
1299 generic equivalents available and if the generic equivalents are
1300 the least expensive.

1301 It is the intent of the Legislature that the pharmacists
1302 providers be reimbursed for the reasonable costs of filling and
1303 dispensing prescriptions for Medicaid beneficiaries.

1304 The division shall allow certain drugs, including
1305 physician-administered drugs, and implantable drug system devices,
1306 and medical supplies, with limited distribution or limited access
1307 for beneficiaries and administered in an appropriate clinical
1308 setting, to be reimbursed as either a medical claim or pharmacy
1309 claim, as determined by the division.

1310 It is the intent of the Legislature that the division and any
1311 managed care entity described in subsection (H) of this section
1312 encourage the use of Alpha-Hydroxyprogesterone Caproate (17P) to
1313 prevent recurrent preterm birth.

1314 (10) Dental and orthodontic services to be determined
1315 by the division.

1316 The division shall increase the amount of the reimbursement
1317 rate for diagnostic and preventative dental services for each of
1318 the fiscal years 2022, 2023 and 2024 by five percent (5%) above
1319 the amount of the reimbursement rate for the previous fiscal year.



1320 The division shall increase the amount of the reimbursement rate
1321 for restorative dental services for each of the fiscal years 2023,
1322 2024 and 2025 by five percent (5%) above the amount of the
1323 reimbursement rate for the previous fiscal year. It is the intent
1324 of the Legislature that the reimbursement rate revision for
1325 preventative dental services will be an incentive to increase the
1326 number of dentists who actively provide Medicaid services. This
1327 dental services reimbursement rate revision shall be known as the
1328 "James Russell Dumas Medicaid Dental Services Incentive Program."

1329 The Medical Care Advisory Committee, assisted by the Division
1330 of Medicaid, shall annually determine the effect of this incentive
1331 by evaluating the number of dentists who are Medicaid providers,
1332 the number who and the degree to which they are actively billing
1333 Medicaid, the geographic trends of where dentists are offering
1334 what types of Medicaid services and other statistics pertinent to
1335 the goals of this legislative intent. This data shall annually be
1336 presented to the Chair of the Senate Medicaid Committee and the
1337 Chair of the House Medicaid Committee.

1338 The division shall include dental services as a necessary
1339 component of overall health services provided to children who are
1340 eligible for services.

1341 (11) Eyeglasses for all Medicaid beneficiaries who have
1342 (a) had surgery on the eyeball or ocular muscle that results in a
1343 vision change for which eyeglasses or a change in eyeglasses is
1344 medically indicated within six (6) months of the surgery and is in



1345 accordance with policies established by the division, or (b) one
1346 (1) pair every five (5) years and in accordance with policies
1347 established by the division. In either instance, the eyeglasses
1348 must be prescribed by a physician skilled in diseases of the eye
1349 or an optometrist, whichever the beneficiary may select.

1350 (12) Intermediate care facility services.

1351 (a) The division shall make full payment to all
1352 intermediate care facilities for individuals with intellectual
1353 disabilities for each day, not exceeding sixty-three (63) days per
1354 year, that a patient is absent from the facility on home leave.
1355 Payment may be made for the following home leave days in addition
1356 to the sixty-three-day limitation: Christmas, the day before
1357 Christmas, the day after Christmas, Thanksgiving, the day before
1358 Thanksgiving and the day after Thanksgiving.

1359 (b) All state-owned intermediate care facilities
1360 for individuals with intellectual disabilities shall be reimbursed
1361 on a full reasonable cost basis.

1362 (c) Effective January 1, 2015, the division shall
1363 update the fair rental reimbursement system for intermediate care
1364 facilities for individuals with intellectual disabilities.

1365 (13) Family planning services, including drugs,
1366 supplies and devices, when those services are under the
1367 supervision of a physician or nurse practitioner.

1368 (14) Clinic services. Preventive, diagnostic,
1369 therapeutic, rehabilitative or palliative services that are



1370 furnished by a facility that is not part of a hospital but is
1371 organized and operated to provide medical care to outpatients.
1372 Clinic services include, but are not limited to:

1373 (a) Services provided by ambulatory surgical
1374 centers (ACSS) as defined in Section 41-75-1(a); and

1375 (b) Dialysis center services.

1376 (15) Home- and community-based services for the elderly
1377 and disabled, as provided under Title XIX of the federal Social
1378 Security Act, as amended, under waivers, subject to the
1379 availability of funds specifically appropriated for that purpose
1380 by the Legislature.

1381 (16) Mental health services. Certain services provided
1382 by a psychiatrist shall be reimbursed at up to one hundred percent
1383 (100%) of the Medicare rate. Approved therapeutic and case
1384 management services (a) provided by an approved regional mental
1385 health/intellectual disability center established under Sections
1386 41-19-31 through 41-19-39, or by another community mental health
1387 service provider meeting the requirements of the Department of
1388 Mental Health to be an approved mental health/intellectual
1389 disability center if determined necessary by the Department of
1390 Mental Health, using state funds that are provided in the
1391 appropriation to the division to match federal funds, or (b)
1392 provided by a facility that is certified by the State Department
1393 of Mental Health to provide therapeutic and case management
1394 services, to be reimbursed on a fee for service basis, or (c)



1395 provided in the community by a facility or program operated by the
1396 Department of Mental Health. Any such services provided by a
1397 facility described in subparagraph (b) must have the prior
1398 approval of the division to be reimbursable under this section.

1399 (17) Durable medical equipment services and medical
1400 supplies. Precertification of durable medical equipment and
1401 medical supplies must be obtained as required by the division.
1402 The Division of Medicaid may require durable medical equipment
1403 providers to obtain a surety bond in the amount and to the
1404 specifications as established by the Balanced Budget Act of 1997.
1405 A maximum dollar amount of reimbursement for noninvasive
1406 ventilators or ventilation treatments properly ordered and being
1407 used in an appropriate care setting shall not be set by any health
1408 maintenance organization, coordinated care organization,
1409 provider-sponsored health plan, or other organization paid for
1410 services on a capitated basis by the division under any managed
1411 care program or coordinated care program implemented by the
1412 division under this section. Reimbursement by these organizations
1413 to durable medical equipment suppliers for home use of noninvasive
1414 and invasive ventilators shall be on a continuous monthly payment
1415 basis for the duration of medical need throughout a patient's
1416 valid prescription period.

1417 (18) (a) Notwithstanding any other provision of this
1418 section to the contrary, as provided in the Medicaid state plan
1419 amendment or amendments as defined in Section 43-13-145(10), the



1420 division shall make additional reimbursement to hospitals that
1421 serve a disproportionate share of low-income patients and that
1422 meet the federal requirements for those payments as provided in
1423 Section 1923 of the federal Social Security Act and any applicable
1424 regulations. It is the intent of the Legislature that the
1425 division shall draw down all available federal funds allotted to
1426 the state for disproportionate share hospitals. However, from and
1427 after January 1, 1999, public hospitals participating in the
1428 Medicaid disproportionate share program may be required to
1429 participate in an intergovernmental transfer program as provided
1430 in Section 1903 of the federal Social Security Act and any
1431 applicable regulations.

1432 (b) (i) 1. The division may establish a Medicare
1433 Upper Payment Limits Program, as defined in Section 1902(a)(30) of
1434 the federal Social Security Act and any applicable federal
1435 regulations, or an allowable delivery system or provider payment
1436 initiative authorized under 42 CFR 438.6(c), for hospitals,
1437 nursing facilities and physicians employed or contracted by
1438 hospitals.

1439 2. The division shall establish a
1440 Medicaid Supplemental Payment Program, as permitted by the federal
1441 Social Security Act and a comparable allowable delivery system or
1442 provider payment initiative authorized under 42 CFR 438.6(c), for
1443 emergency ambulance transportation providers in accordance with
1444 this subsection (A)(18)(b).



1445 (ii) The division shall assess each hospital,
1446 nursing facility, and emergency ambulance transportation provider
1447 for the sole purpose of financing the state portion of the
1448 Medicare Upper Payment Limits Program or other program(s)
1449 authorized under this subsection (A) (18) (b). The hospital
1450 assessment shall be as provided in Section 43-13-145(4) (a), and
1451 the nursing facility and the emergency ambulance transportation
1452 assessments, if established, shall be based on Medicaid
1453 utilization or other appropriate method, as determined by the
1454 division, consistent with federal regulations. The assessments
1455 will remain in effect as long as the state participates in the
1456 Medicare Upper Payment Limits Program or other program(s)
1457 authorized under this subsection (A) (18) (b). In addition to the
1458 hospital assessment provided in Section 43-13-145(4) (a), hospitals
1459 with physicians participating in the Medicare Upper Payment Limits
1460 Program or other program(s) authorized under this subsection
1461 (A) (18) (b) shall be required to participate in an
1462 intergovernmental transfer or assessment, as determined by the
1463 division, for the purpose of financing the state portion of the
1464 physician UPL payments or other payment(s) authorized under this
1465 subsection (A) (18) (b).

1466 (iii) Subject to approval by the Centers for
1467 Medicare and Medicaid Services (CMS) and the provisions of this
1468 subsection (A) (18) (b), the division shall make additional
1469 reimbursement to hospitals, nursing facilities, and emergency



1470 ambulance transportation providers for the Medicare Upper Payment
1471 Limits Program or other program(s) authorized under this
1472 subsection (A)(18)(b), and, if the program is established for
1473 physicians, shall make additional reimbursement for physicians, as
1474 defined in Section 1902(a)(30) of the federal Social Security Act
1475 and any applicable federal regulations, provided the assessment in
1476 this subsection (A)(18)(b) is in effect.

1477 (iv) Notwithstanding any other provision of
1478 this article to the contrary, effective upon implementation of the
1479 Mississippi Hospital Access Program (MHAP) provided in
1480 subparagraph (c)(i) below, the hospital portion of the inpatient
1481 Upper Payment Limits Program shall transition into and be replaced
1482 by the MHAP program. However, the division is authorized to
1483 develop and implement an alternative fee-for-service Upper Payment
1484 Limits model in accordance with federal laws and regulations if
1485 necessary to preserve supplemental funding. Further, the
1486 division, in consultation with the hospital industry shall develop
1487 alternative models for distribution of medical claims and
1488 supplemental payments for inpatient and outpatient hospital
1489 services, and such models may include, but shall not be limited to
1490 the following: increasing rates for inpatient and outpatient
1491 services; creating a low-income utilization pool of funds to
1492 reimburse hospitals for the costs of uncompensated care, charity
1493 care and bad debts as permitted and approved pursuant to federal
1494 regulations and the Centers for Medicare and Medicaid Services;



1495 supplemental payments based upon Medicaid utilization, quality,
1496 service lines and/or costs of providing such services to Medicaid
1497 beneficiaries and to uninsured patients. The goals of such
1498 payment models shall be to ensure access to inpatient and
1499 outpatient care and to maximize any federal funds that are
1500 available to reimburse hospitals for services provided. Any such
1501 documents required to achieve the goals described in this
1502 paragraph shall be submitted to the Centers for Medicare and
1503 Medicaid Services, with a proposed effective date of July 1, 2019,
1504 to the extent possible, but in no event shall the effective date
1505 of such payment models be later than July 1, 2020. The Chairmen
1506 of the Senate and House Medicaid Committees shall be provided a
1507 copy of the proposed payment model(s) prior to submission.
1508 Effective July 1, 2018, and until such time as any payment
1509 model(s) as described above become effective, the division, in
1510 consultation with the hospital industry, is authorized to
1511 implement a transitional program for inpatient and outpatient
1512 payments and/or supplemental payments (including, but not limited
1513 to, MHAP and directed payments), to redistribute available
1514 supplemental funds among hospital providers, provided that when
1515 compared to a hospital's prior year supplemental payments,
1516 supplemental payments made pursuant to any such transitional
1517 program shall not result in a decrease of more than five percent
1518 (5%) and shall not increase by more than the amount needed to
1519 maximize the distribution of the available funds.



1520 (v) 1. To preserve and improve access to
1521 ambulance transportation provider services, the division shall
1522 seek CMS approval to make ambulance service access payments as set
1523 forth in this subsection (A) (18) (b) for all covered emergency
1524 ambulance services rendered on or after July 1, 2022, and shall
1525 make such ambulance service access payments for all covered
1526 services rendered on or after the effective date of CMS approval.

1527 2. The division shall calculate the
1528 ambulance service access payment amount as the balance of the
1529 portion of the Medical Care Fund related to ambulance
1530 transportation service provider assessments plus any federal
1531 matching funds earned on the balance, up to, but not to exceed,
1532 the upper payment limit gap for all emergency ambulance service
1533 providers.

1534 3. a. Except for ambulance services
1535 exempt from the assessment provided in this paragraph (18) (b), all
1536 ambulance transportation service providers shall be eligible for
1537 ambulance service access payments each state fiscal year as set
1538 forth in this paragraph (18) (b).

1539 b. In addition to any other funds
1540 paid to ambulance transportation service providers for emergency
1541 medical services provided to Medicaid beneficiaries, each eligible
1542 ambulance transportation service provider shall receive ambulance
1543 service access payments each state fiscal year equal to the
1544 ambulance transportation service provider's upper payment limit



1545 gap. Subject to approval by the Centers for Medicare and Medicaid
1546 Services, ambulance service access payments shall be made no less
1547 than on a quarterly basis.

1548 c. As used in this paragraph
1549 (18) (b) (v), the term "upper payment limit gap" means the
1550 difference between the total amount that the ambulance
1551 transportation service provider received from Medicaid and the
1552 average amount that the ambulance transportation service provider
1553 would have received from commercial insurers for those services
1554 reimbursed by Medicaid.

1555 4. An ambulance service access payment
1556 shall not be used to offset any other payment by the division for
1557 emergency or nonemergency services to Medicaid beneficiaries.

1558 (c) (i) Not later than December 1, 2015, the
1559 division shall, subject to approval by the Centers for Medicare
1560 and Medicaid Services (CMS), establish, implement and operate a
1561 Mississippi Hospital Access Program (MHAP) for the purpose of
1562 protecting patient access to hospital care through hospital
1563 inpatient reimbursement programs provided in this section designed
1564 to maintain total hospital reimbursement for inpatient services
1565 rendered by in-state hospitals and the out-of-state hospital that
1566 is authorized by federal law to submit intergovernmental transfers
1567 (IGTs) to the State of Mississippi and is classified as Level I
1568 trauma center located in a county contiguous to the state line at
1569 the maximum levels permissible under applicable federal statutes



1570 and regulations, at which time the current inpatient Medicare
1571 Upper Payment Limits (UPL) Program for hospital inpatient services
1572 shall transition to the MHAP.

1573 (ii) Subject to approval by the Centers for
1574 Medicare and Medicaid Services (CMS), the MHAP shall provide
1575 increased inpatient capitation (PMPM) payments to managed care
1576 entities contracting with the division pursuant to subsection (H)
1577 of this section to support availability of hospital services or
1578 such other payments permissible under federal law necessary to
1579 accomplish the intent of this subsection.

1580 (iii) The intent of this subparagraph (c) is
1581 that effective for all inpatient hospital Medicaid services during
1582 state fiscal year 2016, and so long as this provision shall remain
1583 in effect hereafter, the division shall to the fullest extent
1584 feasible replace the additional reimbursement for hospital
1585 inpatient services under the inpatient Medicare Upper Payment
1586 Limits (UPL) Program with additional reimbursement under the MHAP
1587 and other payment programs for inpatient and/or outpatient
1588 payments which may be developed under the authority of this
1589 paragraph.

1590 (iv) The division shall assess each hospital
1591 as provided in Section 43-13-145(4) (a) for the purpose of
1592 financing the state portion of the MHAP, supplemental payments and
1593 such other purposes as specified in Section 43-13-145. The



1594 assessment will remain in effect as long as the MHAP and
1595 supplemental payments are in effect.

1596 (19) (a) Perinatal risk management services. The
1597 division shall promulgate regulations to be effective from and
1598 after October 1, 1988, to establish a comprehensive perinatal
1599 system for risk assessment of all pregnant and infant Medicaid
1600 recipients and for management, education and follow-up for those
1601 who are determined to be at risk. Services to be performed
1602 include case management, nutrition assessment/counseling,
1603 psychosocial assessment/counseling and health education. The
1604 division shall contract with the State Department of Health to
1605 provide services within this paragraph (Perinatal High Risk
1606 Management/Infant Services System (PHRM/ISS)). The State
1607 Department of Health shall be reimbursed on a full reasonable cost
1608 basis for services provided under this subparagraph (a).

1609 (b) Early intervention system services. The
1610 division shall cooperate with the State Department of Health,
1611 acting as lead agency, in the development and implementation of a
1612 statewide system of delivery of early intervention services, under
1613 Part C of the Individuals with Disabilities Education Act (IDEA).
1614 The State Department of Health shall certify annually in writing
1615 to the executive director of the division the dollar amount of
1616 state early intervention funds available that will be utilized as
1617 a certified match for Medicaid matching funds. Those funds then
1618 shall be used to provide expanded targeted case management



1619 services for Medicaid eligible children with special needs who are
1620 eligible for the state's early intervention system.

1621 Qualifications for persons providing service coordination shall be
1622 determined by the State Department of Health and the Division of
1623 Medicaid.

1624 (20) Home- and community-based services for physically
1625 disabled approved services as allowed by a waiver from the United
1626 States Department of Health and Human Services for home- and
1627 community-based services for physically disabled people using
1628 state funds that are provided from the appropriation to the State
1629 Department of Rehabilitation Services and used to match federal
1630 funds under a cooperative agreement between the division and the
1631 department, provided that funds for these services are
1632 specifically appropriated to the Department of Rehabilitation
1633 Services.

1634 (21) Nurse practitioner services. Services furnished
1635 by a registered nurse who is licensed and certified by the
1636 Mississippi Board of Nursing as a nurse practitioner, including,
1637 but not limited to, nurse anesthetists, nurse midwives, family
1638 nurse practitioners, family planning nurse practitioners,
1639 pediatric nurse practitioners, obstetrics-gynecology nurse
1640 practitioners and neonatal nurse practitioners, under regulations
1641 adopted by the division. Reimbursement for those services shall
1642 not exceed ninety percent (90%) of the reimbursement rate for
1643 comparable services rendered by a physician. The division may



1644 provide for a reimbursement rate for nurse practitioner services
1645 of up to one hundred percent (100%) of the reimbursement rate for
1646 comparable services rendered by a physician for nurse practitioner
1647 services that are provided after the normal working hours of the
1648 nurse practitioner, as determined in accordance with regulations
1649 of the division.

1650 (22) Ambulatory services delivered in federally
1651 qualified health centers, rural health centers and clinics of the
1652 local health departments of the State Department of Health for
1653 individuals eligible for Medicaid under this article based on
1654 reasonable costs as determined by the division. Federally
1655 qualified health centers shall be reimbursed by the Medicaid
1656 prospective payment system as approved by the Centers for Medicare
1657 and Medicaid Services. The division shall recognize federally
1658 qualified health centers (FQHCs), rural health clinics (RHCs) and
1659 community mental health centers (CMHCs) as both an originating and
1660 distant site provider for the purposes of telehealth
1661 reimbursement. The division is further authorized and directed to
1662 reimburse FQHCs, RHCs and CMHCs for both distant site and
1663 originating site services when such services are appropriately
1664 provided by the same organization.

1665 (23) Inpatient psychiatric services.

1666 (a) Inpatient psychiatric services to be
1667 determined by the division for recipients under age twenty-one
1668 (21) that are provided under the direction of a physician in an



1669 inpatient program in a licensed acute care psychiatric facility or
1670 in a licensed psychiatric residential treatment facility, before
1671 the recipient reaches age twenty-one (21) or, if the recipient was
1672 receiving the services immediately before he or she reached age
1673 twenty-one (21), before the earlier of the date he or she no
1674 longer requires the services or the date he or she reaches age
1675 twenty-two (22), as provided by federal regulations. From and
1676 after January 1, 2015, the division shall update the fair rental
1677 reimbursement system for psychiatric residential treatment
1678 facilities. Precertification of inpatient days and residential
1679 treatment days must be obtained as required by the division. From
1680 and after July 1, 2009, all state-owned and state-operated
1681 facilities that provide inpatient psychiatric services to persons
1682 under age twenty-one (21) who are eligible for Medicaid
1683 reimbursement shall be reimbursed for those services on a full
1684 reasonable cost basis.

1685 (b) The division may reimburse for services
1686 provided by a licensed freestanding psychiatric hospital to
1687 Medicaid recipients over the age of twenty-one (21) in a method
1688 and manner consistent with the provisions of Section 43-13-117.5.

1689 (24) [Deleted]

1690 (25) [Deleted]

1691 (26) Hospice care. As used in this paragraph, the term
1692 "hospice care" means a coordinated program of active professional
1693 medical attention within the home and outpatient and inpatient



1694 care that treats the terminally ill patient and family as a unit,
1695 employing a medically directed interdisciplinary team. The
1696 program provides relief of severe pain or other physical symptoms
1697 and supportive care to meet the special needs arising out of
1698 physical, psychological, spiritual, social and economic stresses
1699 that are experienced during the final stages of illness and during
1700 dying and bereavement and meets the Medicare requirements for
1701 participation as a hospice as provided in federal regulations.

1702 (27) Group health plan premiums and cost-sharing if it
1703 is cost-effective as defined by the United States Secretary of
1704 Health and Human Services.

1705 (28) Other health insurance premiums that are
1706 cost-effective as defined by the United States Secretary of Health
1707 and Human Services. Medicare eligible must have Medicare Part B
1708 before other insurance premiums can be paid.

1709 (29) The Division of Medicaid may apply for a waiver
1710 from the United States Department of Health and Human Services for
1711 home- and community-based services for developmentally disabled
1712 people using state funds that are provided from the appropriation
1713 to the State Department of Mental Health and/or funds transferred
1714 to the department by a political subdivision or instrumentality of
1715 the state and used to match federal funds under a cooperative
1716 agreement between the division and the department, provided that
1717 funds for these services are specifically appropriated to the



1718 Department of Mental Health and/or transferred to the department
1719 by a political subdivision or instrumentality of the state.

1720 (30) Pediatric skilled nursing services as determined
1721 by the division and in a manner consistent with regulations
1722 promulgated by the Mississippi State Department of Health.

1723 (31) Targeted case management services for children
1724 with special needs, under waivers from the United States
1725 Department of Health and Human Services, using state funds that
1726 are provided from the appropriation to the Mississippi Department
1727 of Human Services and used to match federal funds under a
1728 cooperative agreement between the division and the department.

1729 (32) Care and services provided in Christian Science
1730 Sanatoria listed and certified by the Commission for Accreditation
1731 of Christian Science Nursing Organizations/Facilities, Inc.,
1732 rendered in connection with treatment by prayer or spiritual means
1733 to the extent that those services are subject to reimbursement
1734 under Section 1903 of the federal Social Security Act.

1735 (33) Podiatrist services.

1736 (34) Assisted living services as provided through
1737 home- and community-based services under Title XIX of the federal
1738 Social Security Act, as amended, subject to the availability of
1739 funds specifically appropriated for that purpose by the
1740 Legislature.

1741 (35) Services and activities authorized in Sections
1742 43-27-101 and 43-27-103, using state funds that are provided from



1743 the appropriation to the Mississippi Department of Human Services
1744 and used to match federal funds under a cooperative agreement
1745 between the division and the department.

1746 (36) Nonemergency transportation services for
1747 Medicaid-eligible persons as determined by the division. The PEER
1748 Committee shall conduct a performance evaluation of the
1749 nonemergency transportation program to evaluate the administration
1750 of the program and the providers of transportation services to
1751 determine the most cost-effective ways of providing nonemergency
1752 transportation services to the patients served under the program.
1753 The performance evaluation shall be completed and provided to the
1754 members of the Senate Medicaid Committee and the House Medicaid
1755 Committee not later than January 1, 2019, and every two (2) years
1756 thereafter.

1757 (37) [Deleted]

1758 (38) Chiropractic services. A chiropractor's manual
1759 manipulation of the spine to correct a subluxation, if x-ray
1760 demonstrates that a subluxation exists and if the subluxation has
1761 resulted in a neuromusculoskeletal condition for which
1762 manipulation is appropriate treatment, and related spinal x-rays
1763 performed to document these conditions. Reimbursement for
1764 chiropractic services shall not exceed Seven Hundred Dollars
1765 (\$700.00) per year per beneficiary.

1766 (39) Dually eligible Medicare/Medicaid beneficiaries.
1767 The division shall pay the Medicare deductible and coinsurance



1768 amounts for services available under Medicare, as determined by
1769 the division. From and after July 1, 2009, the division shall
1770 reimburse crossover claims for inpatient hospital services and
1771 crossover claims covered under Medicare Part B in the same manner
1772 that was in effect on January 1, 2008, unless specifically
1773 authorized by the Legislature to change this method.

1774 (40) [Deleted]

1775 (41) Services provided by the State Department of
1776 Rehabilitation Services for the care and rehabilitation of persons
1777 with spinal cord injuries or traumatic brain injuries, as allowed
1778 under waivers from the United States Department of Health and
1779 Human Services, using up to seventy-five percent (75%) of the
1780 funds that are appropriated to the Department of Rehabilitation
1781 Services from the Spinal Cord and Head Injury Trust Fund
1782 established under Section 37-33-261 and used to match federal
1783 funds under a cooperative agreement between the division and the
1784 department.

1785 (42) [Deleted]

1786 (43) The division shall provide reimbursement,
1787 according to a payment schedule developed by the division, for
1788 smoking cessation medications for pregnant women during their
1789 pregnancy and other Medicaid-eligible women who are of
1790 child-bearing age.

1791 (44) Nursing facility services for the severely
1792 disabled.



1793 (a) Severe disabilities include, but are not
1794 limited to, spinal cord injuries, closed-head injuries and
1795 ventilator-dependent patients.

1796 (b) Those services must be provided in a long-term
1797 care nursing facility dedicated to the care and treatment of
1798 persons with severe disabilities.

1799 (45) Physician assistant services. Services furnished
1800 by a physician assistant who is licensed by the State Board of
1801 Medical Licensure and is practicing with physician supervision
1802 under regulations adopted by the board, under regulations adopted
1803 by the division. Reimbursement for those services shall not
1804 exceed ninety percent (90%) of the reimbursement rate for
1805 comparable services rendered by a physician. The division may
1806 provide for a reimbursement rate for physician assistant services
1807 of up to one hundred percent (100%) or the reimbursement rate for
1808 comparable services rendered by a physician for physician
1809 assistant services that are provided after the normal working
1810 hours of the physician assistant, as determined in accordance with
1811 regulations of the division.

1812 (46) The division shall make application to the federal
1813 Centers for Medicare and Medicaid Services (CMS) for a waiver to
1814 develop and provide services for children with serious emotional
1815 disturbances as defined in Section 43-14-1(1), which may include
1816 home- and community-based services, case management services or
1817 managed care services through mental health providers certified by



1818 the Department of Mental Health. The division may implement and
1819 provide services under this waived program only if funds for
1820 these services are specifically appropriated for this purpose by
1821 the Legislature, or if funds are voluntarily provided by affected
1822 agencies.

1823 (47) (a) The division may develop and implement
1824 disease management programs for individuals with high-cost chronic
1825 diseases and conditions, including the use of grants, waivers,
1826 demonstrations or other projects as necessary.

1827 (b) Participation in any disease management
1828 program implemented under this paragraph (47) is optional with the
1829 individual. An individual must affirmatively elect to participate
1830 in the disease management program in order to participate, and may
1831 elect to discontinue participation in the program at any time.

1832 (48) Pediatric long-term acute care hospital services.

1833 (a) Pediatric long-term acute care hospital
1834 services means services provided to eligible persons under
1835 twenty-one (21) years of age by a freestanding Medicare-certified
1836 hospital that has an average length of inpatient stay greater than
1837 twenty-five (25) days and that is primarily engaged in providing
1838 chronic or long-term medical care to persons under twenty-one (21)
1839 years of age.

1840 (b) The services under this paragraph (48) shall
1841 be reimbursed as a separate category of hospital services.



1842 (49) The division may establish copayments and/or
1843 coinsurance for any Medicaid services for which copayments and/or
1844 coinsurance are allowable under federal law or regulation.

1845 (50) Services provided by the State Department of
1846 Rehabilitation Services for the care and rehabilitation of persons
1847 who are deaf and blind, as allowed under waivers from the United
1848 States Department of Health and Human Services to provide home-
1849 and community-based services using state funds that are provided
1850 from the appropriation to the State Department of Rehabilitation
1851 Services or if funds are voluntarily provided by another agency.

1852 (51) Upon determination of Medicaid eligibility and in
1853 association with annual redetermination of Medicaid eligibility,
1854 beneficiaries shall be encouraged to undertake a physical
1855 examination that will establish a base-line level of health and
1856 identification of a usual and customary source of care (a medical
1857 home) to aid utilization of disease management tools. This
1858 physical examination and utilization of these disease management
1859 tools shall be consistent with current United States Preventive
1860 Services Task Force or other recognized authority recommendations.

1861 For persons who are determined ineligible for Medicaid, the
1862 division will provide information and direction for accessing
1863 medical care and services in the area of their residence.

1864 (52) Notwithstanding any provisions of this article,
1865 the division may pay enhanced reimbursement fees related to trauma
1866 care, as determined by the division in conjunction with the State



1867 Department of Health, using funds appropriated to the State
1868 Department of Health for trauma care and services and used to
1869 match federal funds under a cooperative agreement between the
1870 division and the State Department of Health. The division, in
1871 conjunction with the State Department of Health, may use grants,
1872 waivers, demonstrations, enhanced reimbursements, Upper Payment
1873 Limits Programs, supplemental payments, or other projects as
1874 necessary in the development and implementation of this
1875 reimbursement program.

1876 (53) Targeted case management services for high-cost
1877 beneficiaries may be developed by the division for all services
1878 under this section.

1879 (54) [Deleted]

1880 (55) Therapy services. The plan of care for therapy
1881 services may be developed to cover a period of treatment for up to
1882 six (6) months, but in no event shall the plan of care exceed a
1883 six-month period of treatment. The projected period of treatment
1884 must be indicated on the initial plan of care and must be updated
1885 with each subsequent revised plan of care. Based on medical
1886 necessity, the division shall approve certification periods for
1887 less than or up to six (6) months, but in no event shall the
1888 certification period exceed the period of treatment indicated on
1889 the plan of care. The appeal process for any reduction in therapy
1890 services shall be consistent with the appeal process in federal
1891 regulations.



1892 (56) Prescribed pediatric extended care centers
1893 services for medically dependent or technologically dependent
1894 children with complex medical conditions that require continual
1895 care as prescribed by the child's attending physician, as
1896 determined by the division.

1897 (57) No Medicaid benefit shall restrict coverage for
1898 medically appropriate treatment prescribed by a physician and
1899 agreed to by a fully informed individual, or if the individual
1900 lacks legal capacity to consent by a person who has legal
1901 authority to consent on his or her behalf, based on an
1902 individual's diagnosis with a terminal condition. As used in this
1903 paragraph (57), "terminal condition" means any aggressive
1904 malignancy, chronic end-stage cardiovascular or cerebral vascular
1905 disease, or any other disease, illness or condition which a
1906 physician diagnoses as terminal.

1907 (58) Treatment services for persons with opioid
1908 dependency or other highly addictive substance use disorders. The
1909 division is authorized to reimburse eligible providers for
1910 treatment of opioid dependency and other highly addictive
1911 substance use disorders, as determined by the division. Treatment
1912 related to these conditions shall not count against any physician
1913 visit limit imposed under this section.

1914 (59) The division shall allow beneficiaries between the
1915 ages of ten (10) and eighteen (18) years to receive vaccines
1916 through a pharmacy venue. The division and the State Department



1917 of Health shall coordinate and notify OB-GYN providers that the
1918 Vaccines for Children program is available to providers free of
1919 charge.

1920 (60) Border city university-affiliated pediatric
1921 teaching hospital.

1922 (a) Payments may only be made to a border city
1923 university-affiliated pediatric teaching hospital if the Centers
1924 for Medicare and Medicaid Services (CMS) approve an increase in
1925 the annual request for the provider payment initiative authorized
1926 under 42 CFR Section 438.6(c) in an amount equal to or greater
1927 than the estimated annual payment to be made to the border city
1928 university-affiliated pediatric teaching hospital. The estimate
1929 shall be based on the hospital's prior year Mississippi managed
1930 care utilization.

1931 (b) As used in this paragraph (60), the term
1932 "border city university-affiliated pediatric teaching hospital"
1933 means an out-of-state hospital located within a city bordering the
1934 eastern bank of the Mississippi River and the State of Mississippi
1935 that submits to the division a copy of a current and effective
1936 affiliation agreement with an accredited university and other
1937 documentation establishing that the hospital is
1938 university-affiliated, is licensed and designated as a pediatric
1939 hospital or pediatric primary hospital within its home state,
1940 maintains at least five (5) different pediatric specialty training
1941 programs, and maintains at least one hundred (100) operated beds



1942 dedicated exclusively for the treatment of patients under the age
1943 of twenty-one (21) years.

1944 (c) The cost of providing services to Mississippi
1945 Medicaid beneficiaries under the age of twenty-one (21) years who
1946 are treated by a border city university-affiliated pediatric
1947 teaching hospital shall not exceed the cost of providing the same
1948 services to individuals in hospitals in the state.

1949 (d) It is the intent of the Legislature that
1950 payments shall not result in any in-state hospital receiving
1951 payments lower than they would otherwise receive if not for the
1952 payments made to any border city university-affiliated pediatric
1953 teaching hospital.

1954 (e) This paragraph (60) shall stand repealed on
1955 July 1, 2024.

1956 (B) Planning and development districts participating in the
1957 home- and community-based services program for the elderly and
1958 disabled as case management providers shall be reimbursed for case
1959 management services at the maximum rate approved by the Centers
1960 for Medicare and Medicaid Services (CMS).

1961 (C) The division may pay to those providers who participate
1962 in and accept patient referrals from the division's emergency room
1963 redirection program a percentage, as determined by the division,
1964 of savings achieved according to the performance measures and
1965 reduction of costs required of that program. Federally qualified
1966 health centers may participate in the emergency room redirection



1967 program, and the division may pay those centers a percentage of
1968 any savings to the Medicaid program achieved by the centers'
1969 accepting patient referrals through the program, as provided in
1970 this subsection (C).

1971 (D) (1) As used in this subsection (D), the following terms
1972 shall be defined as provided in this paragraph, except as
1973 otherwise provided in this subsection:

1974 (a) "Committees" means the Medicaid Committees of
1975 the House of Representatives and the Senate, and "committee" means
1976 either one of those committees.

1977 (b) "Rate change" means an increase, decrease or
1978 other change in the payments or rates of reimbursement, or a
1979 change in any payment methodology that results in an increase,
1980 decrease or other change in the payments or rates of
1981 reimbursement, to any Medicaid provider that renders any services
1982 authorized to be provided to Medicaid recipients under this
1983 article.

1984 (2) Whenever the Division of Medicaid proposes a rate
1985 change, the division shall give notice to the chairmen of the
1986 committees at least thirty (30) calendar days before the proposed
1987 rate change is scheduled to take effect. The division shall
1988 furnish the chairmen with a concise summary of each proposed rate
1989 change along with the notice, and shall furnish the chairmen with
1990 a copy of any proposed rate change upon request. The division



1991 also shall provide a summary and copy of any proposed rate change
1992 to any other member of the Legislature upon request.

1993 (3) If the chairman of either committee or both
1994 chairmen jointly object to the proposed rate change or any part
1995 thereof, the chairman or chairmen shall notify the division and
1996 provide the reasons for their objection in writing not later than
1997 seven (7) calendar days after receipt of the notice from the
1998 division. The chairman or chairmen may make written
1999 recommendations to the division for changes to be made to a
2000 proposed rate change.

2001 (4) (a) The chairman of either committee or both
2002 chairmen jointly may hold a committee meeting to review a proposed
2003 rate change. If either chairman or both chairmen decide to hold a
2004 meeting, they shall notify the division of their intention in
2005 writing within seven (7) calendar days after receipt of the notice
2006 from the division, and shall set the date and time for the meeting
2007 in their notice to the division, which shall not be later than
2008 fourteen (14) calendar days after receipt of the notice from the
2009 division.

2010 (b) After the committee meeting, the committee or
2011 committees may object to the proposed rate change or any part
2012 thereof. The committee or committees shall notify the division
2013 and the reasons for their objection in writing not later than
2014 seven (7) calendar days after the meeting. The committee or



2015 committees may make written recommendations to the division for
2016 changes to be made to a proposed rate change.

2017 (5) If both chairmen notify the division in writing
2018 within seven (7) calendar days after receipt of the notice from
2019 the division that they do not object to the proposed rate change
2020 and will not be holding a meeting to review the proposed rate
2021 change, the proposed rate change will take effect on the original
2022 date as scheduled by the division or on such other date as
2023 specified by the division.

2024 (6) (a) If there are any objections to a proposed rate
2025 change or any part thereof from either or both of the chairmen or
2026 the committees, the division may withdraw the proposed rate
2027 change, make any of the recommended changes to the proposed rate
2028 change, or not make any changes to the proposed rate change.

2029 (b) If the division does not make any changes to
2030 the proposed rate change, it shall notify the chairmen of that
2031 fact in writing, and the proposed rate change shall take effect on
2032 the original date as scheduled by the division or on such other
2033 date as specified by the division.

2034 (c) If the division makes any changes to the
2035 proposed rate change, the division shall notify the chairmen of
2036 its actions in writing, and the revised proposed rate change shall
2037 take effect on the date as specified by the division.

2038 (7) Nothing in this subsection (D) shall be construed
2039 as giving the chairmen or the committees any authority to veto,



2040 nullify or revise any rate change proposed by the division. The
2041 authority of the chairmen or the committees under this subsection
2042 shall be limited to reviewing, making objections to and making
2043 recommendations for changes to rate changes proposed by the
2044 division.

2045 (E) Notwithstanding any provision of this article, no new
2046 groups or categories of recipients and new types of care and
2047 services may be added without enabling legislation from the
2048 Mississippi Legislature, except that the division may authorize
2049 those changes without enabling legislation when the addition of
2050 recipients or services is ordered by a court of proper authority.

2051 (F) The executive director shall keep the Governor advised
2052 on a timely basis of the funds available for expenditure and the
2053 projected expenditures. Notwithstanding any other provisions of
2054 this article, if current or projected expenditures of the division
2055 are reasonably anticipated to exceed the amount of funds
2056 appropriated to the division for any fiscal year, the Governor,
2057 after consultation with the executive director, shall take all
2058 appropriate measures to reduce costs, which may include, but are
2059 not limited to:

2060 (1) Reducing or discontinuing any or all services that
2061 are deemed to be optional under Title XIX of the Social Security
2062 Act;

2063 (2) Reducing reimbursement rates for any or all service
2064 types;



2065 (3) Imposing additional assessments on health care
2066 providers; or

2067 (4) Any additional cost-containment measures deemed
2068 appropriate by the Governor.

2069 To the extent allowed under federal law, any reduction to
2070 services or reimbursement rates under this subsection (F) shall be
2071 accompanied by a reduction, to the fullest allowable amount, to
2072 the profit margin and administrative fee portions of capitated
2073 payments to organizations described in paragraph (1) of subsection
2074 (H).

2075 Beginning in fiscal year 2010 and in fiscal years thereafter,
2076 when Medicaid expenditures are projected to exceed funds available
2077 for the fiscal year, the division shall submit the expected
2078 shortfall information to the PEER Committee not later than
2079 December 1 of the year in which the shortfall is projected to
2080 occur. PEER shall review the computations of the division and
2081 report its findings to the Legislative Budget Office not later
2082 than January 7 in any year.

2083 (G) Notwithstanding any other provision of this article, it
2084 shall be the duty of each provider participating in the Medicaid
2085 program to keep and maintain books, documents and other records as
2086 prescribed by the Division of Medicaid in accordance with federal
2087 laws and regulations.

2088 (H) (1) Notwithstanding any other provision of this
2089 article, the division is authorized to implement (a) a managed



2090 care program, (b) a coordinated care program, (c) a coordinated
2091 care organization program, (d) a health maintenance organization
2092 program, (e) a patient-centered medical home program, (f) an
2093 accountable care organization program, (g) provider-sponsored
2094 health plan, or (h) any combination of the above programs. As a
2095 condition for the approval of any program under this subsection
2096 (H)(1), the division shall require that no managed care program,
2097 coordinated care program, coordinated care organization program,
2098 health maintenance organization program, or provider-sponsored
2099 health plan may:

2100 (a) Pay providers at a rate that is less than the
2101 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
2102 reimbursement rate;

2103 (b) Override the medical decisions of hospital
2104 physicians or staff regarding patients admitted to a hospital for
2105 an emergency medical condition as defined by 42 US Code Section
2106 1395dd. This restriction (b) does not prohibit the retrospective
2107 review of the appropriateness of the determination that an
2108 emergency medical condition exists by chart review or coding
2109 algorithm, nor does it prohibit prior authorization for
2110 nonemergency hospital admissions;

2111 (c) Pay providers at a rate that is less than the
2112 normal Medicaid reimbursement rate. It is the intent of the
2113 Legislature that all managed care entities described in this
2114 subsection (H), in collaboration with the division, develop and



2115 implement innovative payment models that incentivize improvements
2116 in health care quality, outcomes, or value, as determined by the
2117 division. Participation in the provider network of any managed
2118 care, coordinated care, provider-sponsored health plan, or similar
2119 contractor shall not be conditioned on the provider's agreement to
2120 accept such alternative payment models;

2121 (d) Implement a prior authorization and
2122 utilization review program for medical services, transportation
2123 services and prescription drugs that is more stringent than the
2124 prior authorization processes used by the division in its
2125 administration of the Medicaid program. Not later than December
2126 2, 2021, the contractors that are receiving capitated payments
2127 under a managed care delivery system established under this
2128 subsection (H) shall submit a report to the Chairmen of the House
2129 and Senate Medicaid Committees on the status of the prior
2130 authorization and utilization review program for medical services,
2131 transportation services and prescription drugs that is required to
2132 be implemented under this subparagraph (d);

2133 (e) [Deleted]

2134 (f) Implement a preferred drug list that is more
2135 stringent than the mandatory preferred drug list established by
2136 the division under subsection (A) (9) of this section;

2137 (g) Implement a policy which denies beneficiaries
2138 with hemophilia access to the federally funded hemophilia



2139 treatment centers as part of the Medicaid Managed Care network of
2140 providers.

2141 Each health maintenance organization, coordinated care
2142 organization, provider-sponsored health plan, or other
2143 organization paid for services on a capitated basis by the
2144 division under any managed care program or coordinated care
2145 program implemented by the division under this section shall use a
2146 clear set of level of care guidelines in the determination of
2147 medical necessity and in all utilization management practices,
2148 including the prior authorization process, concurrent reviews,
2149 retrospective reviews and payments, that are consistent with
2150 widely accepted professional standards of care. Organizations
2151 participating in a managed care program or coordinated care
2152 program implemented by the division may not use any additional
2153 criteria that would result in denial of care that would be
2154 determined appropriate and, therefore, medically necessary under
2155 those levels of care guidelines.

2156 (2) Notwithstanding any provision of this section, the
2157 recipients eligible for enrollment into a Medicaid Managed Care
2158 Program authorized under this subsection (H) may include only
2159 those categories of recipients eligible for participation in the
2160 Medicaid Managed Care Program as of January 1, 2021, the
2161 Children's Health Insurance Program (CHIP), and the CMS-approved
2162 Section 1115 demonstration waivers in operation as of January 1,
2163 2021. No expansion of Medicaid Managed Care Program contracts may



2164 be implemented by the division without enabling legislation from
2165 the Mississippi Legislature.

2166 (3) (a) Any contractors receiving capitated payments
2167 under a managed care delivery system established in this section
2168 shall provide to the Legislature and the division statistical data
2169 to be shared with provider groups in order to improve patient
2170 access, appropriate utilization, cost savings and health outcomes
2171 not later than October 1 of each year. Additionally, each
2172 contractor shall disclose to the Chairmen of the Senate and House
2173 Medicaid Committees the administrative expenses costs for the
2174 prior calendar year, and the number of full-equivalent employees
2175 located in the State of Mississippi dedicated to the Medicaid and
2176 CHIP lines of business as of June 30 of the current year.

2177 (b) The division and the contractors participating
2178 in the managed care program, a coordinated care program or a
2179 provider-sponsored health plan shall be subject to annual program
2180 reviews or audits performed by the Office of the State Auditor,
2181 the PEER Committee, the Department of Insurance and/or independent
2182 third parties.

2183 (c) Those reviews shall include, but not be
2184 limited to, at least two (2) of the following items:

2185 (i) The financial benefit to the State of
2186 Mississippi of the managed care program,



2187 (ii) The difference between the premiums paid
2188 to the managed care contractors and the payments made by those
2189 contractors to health care providers,
2190 (iii) Compliance with performance measures
2191 required under the contracts,
2192 (iv) Administrative expense allocation
2193 methodologies,
2194 (v) Whether nonprovider payments assigned as
2195 medical expenses are appropriate,
2196 (vi) Capitated arrangements with related
2197 party subcontractors,
2198 (vii) Reasonableness of corporate
2199 allocations,
2200 (viii) Value-added benefits and the extent to
2201 which they are used,
2202 (ix) The effectiveness of subcontractor
2203 oversight, including subcontractor review,
2204 (x) Whether health care outcomes have been
2205 improved, and
2206 (xi) The most common claim denial codes to
2207 determine the reasons for the denials.

2208 The audit reports shall be considered public documents and
2209 shall be posted in their entirety on the division's website.

2210 (4) All health maintenance organizations, coordinated
2211 care organizations, provider-sponsored health plans, or other



2212 organizations paid for services on a capitated basis by the
2213 division under any managed care program or coordinated care
2214 program implemented by the division under this section shall
2215 reimburse all providers in those organizations at rates no lower
2216 than those provided under this section for beneficiaries who are
2217 not participating in those programs.

2218 (5) No health maintenance organization, coordinated
2219 care organization, provider-sponsored health plan, or other
2220 organization paid for services on a capitated basis by the
2221 division under any managed care program or coordinated care
2222 program implemented by the division under this section shall
2223 require its providers or beneficiaries to use any pharmacy that
2224 ships, mails or delivers prescription drugs or legend drugs or
2225 devices.

2226 (6) (a) Not later than December 1, 2021, the
2227 contractors who are receiving capitated payments under a managed
2228 care delivery system established under this subsection (H) shall
2229 develop and implement a uniform credentialing process for
2230 providers. Under that uniform credentialing process, a provider
2231 who meets the criteria for credentialing will be credentialed with
2232 all of those contractors and no such provider will have to be
2233 separately credentialed by any individual contractor in order to
2234 receive reimbursement from the contractor. Not later than
2235 December 2, 2021, those contractors shall submit a report to the
2236 Chairmen of the House and Senate Medicaid Committees on the status



2237 of the uniform credentialing process for providers that is
2238 required under this subparagraph (a).

2239 (b) If those contractors have not implemented a
2240 uniform credentialing process as described in subparagraph (a) by
2241 December 1, 2021, the division shall develop and implement, not
2242 later than July 1, 2022, a single, consolidated credentialing
2243 process by which all providers will be credentialed. Under the
2244 division's single, consolidated credentialing process, no such
2245 contractor shall require its providers to be separately
2246 credentialed by the contractor in order to receive reimbursement
2247 from the contractor, but those contractors shall recognize the
2248 credentialing of the providers by the division's credentialing
2249 process.

2250 (c) The division shall require a uniform provider
2251 credentialing application that shall be used in the credentialing
2252 process that is established under subparagraph (a) or (b). If the
2253 contractor or division, as applicable, has not approved or denied
2254 the provider credentialing application within sixty (60) days of
2255 receipt of the completed application that includes all required
2256 information necessary for credentialing, then the contractor or
2257 division, upon receipt of a written request from the applicant and
2258 within five (5) business days of its receipt, shall issue a
2259 temporary provider credential/enrollment to the applicant if the
2260 applicant has a valid Mississippi professional or occupational
2261 license to provide the health care services to which the



2262 credential/enrollment would apply. The contractor or the division
2263 shall not issue a temporary credential/enrollment if the applicant
2264 has reported on the application a history of medical or other
2265 professional or occupational malpractice claims, a history of
2266 substance abuse or mental health issues, a criminal record, or a
2267 history of medical or other licensing board, state or federal
2268 disciplinary action, including any suspension from participation
2269 in a federal or state program. The temporary
2270 credential/enrollment shall be effective upon issuance and shall
2271 remain in effect until the provider's credentialing/enrollment
2272 application is approved or denied by the contractor or division.
2273 The contractor or division shall render a final decision regarding
2274 credentialing/enrollment of the provider within sixty (60) days
2275 from the date that the temporary provider credential/enrollment is
2276 issued to the applicant.

2277 (d) If the contractor or division does not render
2278 a final decision regarding credentialing/enrollment of the
2279 provider within the time required in subparagraph (c), the
2280 provider shall be deemed to be credentialed by and enrolled with
2281 all of the contractors and eligible to receive reimbursement from
2282 the contractors.

2283 (7) (a) Each contractor that is receiving capitated
2284 payments under a managed care delivery system established under
2285 this subsection (H) shall provide to each provider for whom the
2286 contractor has denied the coverage of a procedure that was ordered



2287 or requested by the provider for or on behalf of a patient, a
2288 letter that provides a detailed explanation of the reasons for the
2289 denial of coverage of the procedure and the name and the
2290 credentials of the person who denied the coverage. The letter
2291 shall be sent to the provider in electronic format.

2292 (b) After a contractor that is receiving capitated
2293 payments under a managed care delivery system established under
2294 this subsection (H) has denied coverage for a claim submitted by a
2295 provider, the contractor shall issue to the provider within sixty
2296 (60) days a final ruling of denial of the claim that allows the
2297 provider to have a state fair hearing and/or agency appeal with
2298 the division. If a contractor does not issue a final ruling of
2299 denial within sixty (60) days as required by this subparagraph
2300 (b), the provider's claim shall be deemed to be automatically
2301 approved and the contractor shall pay the amount of the claim to
2302 the provider.

2303 (c) After a contractor has issued a final ruling
2304 of denial of a claim submitted by a provider, the division shall
2305 conduct a state fair hearing and/or agency appeal on the matter of
2306 the disputed claim between the contractor and the provider within
2307 sixty (60) days, and shall render a decision on the matter within
2308 thirty (30) days after the date of the hearing and/or appeal.

2309 (8) It is the intention of the Legislature that the
2310 division evaluate the feasibility of using a single vendor to
2311 administer pharmacy benefits provided under a managed care



2312 delivery system established under this subsection (H). Providers
2313 of pharmacy benefits shall cooperate with the division in any
2314 transition to a carve-out of pharmacy benefits under managed care.

2315 (9) The division shall evaluate the feasibility of
2316 using a single vendor to administer dental benefits provided under
2317 a managed care delivery system established in this subsection (H).
2318 Providers of dental benefits shall cooperate with the division in
2319 any transition to a carve-out of dental benefits under managed
2320 care.

2321 (10) It is the intent of the Legislature that any
2322 contractor receiving capitated payments under a managed care
2323 delivery system established in this section shall implement
2324 innovative programs to improve the health and well-being of
2325 members diagnosed with prediabetes and diabetes.

2326 (11) It is the intent of the Legislature that any
2327 contractors receiving capitated payments under a managed care
2328 delivery system established under this subsection (H) shall work
2329 with providers of Medicaid services to improve the utilization of
2330 long-acting reversible contraceptives (LARCs). Not later than
2331 December 1, 2021, any contractors receiving capitated payments
2332 under a managed care delivery system established under this
2333 subsection (H) shall provide to the Chairmen of the House and
2334 Senate Medicaid Committees and House and Senate Public Health
2335 Committees a report of LARC utilization for State Fiscal Years
2336 2018 through 2020 as well as any programs, initiatives, or efforts



2337 made by the contractors and providers to increase LARC
2338 utilization. This report shall be updated annually to include
2339 information for subsequent state fiscal years.

2340 (12) The division is authorized to make not more than
2341 one (1) emergency extension of the contracts that are in effect on
2342 July 1, 2021, with contractors who are receiving capitated
2343 payments under a managed care delivery system established under
2344 this subsection (H), as provided in this paragraph (12). The
2345 maximum period of any such extension shall be one (1) year, and
2346 under any such extensions, the contractors shall be subject to all
2347 of the provisions of this subsection (H). The extended contracts
2348 shall be revised to incorporate any provisions of this subsection
2349 (H).

2350 (I) [Deleted]

2351 (J) There shall be no cuts in inpatient and outpatient
2352 hospital payments, or allowable days or volumes, as long as the
2353 hospital assessment provided in Section 43-13-145 is in effect.
2354 This subsection (J) shall not apply to decreases in payments that
2355 are a result of: reduced hospital admissions, audits or payments
2356 under the APR-DRG or APC models, or a managed care program or
2357 similar model described in subsection (H) of this section.

2358 (K) In the negotiation and execution of such contracts
2359 involving services performed by actuarial firms, the Executive
2360 Director of the Division of Medicaid may negotiate a limitation on
2361 liability to the state of prospective contractors.



2362 (L) The Division of Medicaid shall reimburse for services
2363 provided to eligible Medicaid beneficiaries by a licensed birthing
2364 center in a method and manner to be determined by the division in
2365 accordance with federal laws and federal regulations. The
2366 division shall seek any necessary waivers, make any required
2367 amendments to its State Plan or revise any contracts authorized
2368 under subsection (H) of this section as necessary to provide the
2369 services authorized under this subsection. As used in this
2370 subsection, the term "birthing centers" shall have the meaning as
2371 defined in Section 41-77-1(a), which is a publicly or privately
2372 owned facility, place or institution constructed, renovated,
2373 leased or otherwise established where nonemergency births are
2374 planned to occur away from the mother's usual residence following
2375 a documented period of prenatal care for a normal uncomplicated
2376 pregnancy which has been determined to be low risk through a
2377 formal risk-scoring examination.

2378 (M) This section shall stand repealed on July 1, 2024.

2379 **SECTION 11.** Section 43-13-121, Mississippi Code of 1972, is
2380 brought forward as follows:

2381 43-13-121. (1) The division shall administer the Medicaid
2382 program under the provisions of this article, and may do the
2383 following:

2384 (a) Adopt and promulgate reasonable rules, regulations
2385 and standards, with approval of the Governor, and in accordance



2386 with the Administrative Procedures Law, Section 25-43-1.101 et
2387 seq.:

2388 (i) Establishing methods and procedures as may be
2389 necessary for the proper and efficient administration of this
2390 article;

2391 (ii) Providing Medicaid to all qualified
2392 recipients under the provisions of this article as the division
2393 may determine and within the limits of appropriated funds;

2394 (iii) Establishing reasonable fees, charges and
2395 rates for medical services and drugs; in doing so, the division
2396 shall fix all of those fees, charges and rates at the minimum
2397 levels absolutely necessary to provide the medical assistance
2398 authorized by this article, and shall not change any of those
2399 fees, charges or rates except as may be authorized in Section
2400 43-13-117;

2401 (iv) Providing for fair and impartial hearings;

2402 (v) Providing safeguards for preserving the
2403 confidentiality of records; and

2404 (vi) For detecting and processing fraudulent
2405 practices and abuses of the program;

2406 (b) Receive and expend state, federal and other funds
2407 in accordance with court judgments or settlements and agreements
2408 between the State of Mississippi and the federal government, the
2409 rules and regulations promulgated by the division, with the
2410 approval of the Governor, and within the limitations and



2411 restrictions of this article and within the limits of funds
2412 available for that purpose;

2413 (c) Subject to the limits imposed by this article and
2414 subject to the provisions of subsection (8) of this section, to
2415 submit a Medicaid plan to the United States Department of Health
2416 and Human Services for approval under the provisions of the
2417 federal Social Security Act, to act for the state in making
2418 negotiations relative to the submission and approval of that plan,
2419 to make such arrangements, not inconsistent with the law, as may
2420 be required by or under federal law to obtain and retain that
2421 approval and to secure for the state the benefits of the
2422 provisions of that law.

2423 No agreements, specifically including the general plan for
2424 the operation of the Medicaid program in this state, shall be made
2425 by and between the division and the United States Department of
2426 Health and Human Services unless the Attorney General of the State
2427 of Mississippi has reviewed the agreements, specifically including
2428 the operational plan, and has certified in writing to the Governor
2429 and to the executive director of the division that the agreements,
2430 including the plan of operation, have been drawn strictly in
2431 accordance with the terms and requirements of this article;

2432 (d) In accordance with the purposes and intent of this
2433 article and in compliance with its provisions, provide for aged
2434 persons otherwise eligible for the benefits provided under Title



2435 XVIII of the federal Social Security Act by expenditure of funds
2436 available for those purposes;

2437 (e) To make reports to the United States Department of
2438 Health and Human Services as from time to time may be required by
2439 that federal department and to the Mississippi Legislature as
2440 provided in this section;

2441 (f) Define and determine the scope, duration and amount
2442 of Medicaid that may be provided in accordance with this article
2443 and establish priorities therefor in conformity with this article;

2444 (g) Cooperate and contract with other state agencies
2445 for the purpose of coordinating Medicaid provided under this
2446 article and eliminating duplication and inefficiency in the
2447 Medicaid program;

2448 (h) Adopt and use an official seal of the division;

2449 (i) Sue in its own name on behalf of the State of
2450 Mississippi and employ legal counsel on a contingency basis with
2451 the approval of the Attorney General;

2452 (j) To recover any and all payments incorrectly made by
2453 the division to a recipient or provider from the recipient or
2454 provider receiving the payments. The division shall be authorized
2455 to collect any overpayments to providers sixty (60) days after the
2456 conclusion of any administrative appeal unless the matter is
2457 appealed to a court of proper jurisdiction and bond is posted.
2458 Any appeal filed after July 1, 2015, shall be to the Chancery
2459 Court of the First Judicial District of Hinds County, Mississippi,



2460 within sixty (60) days after the date that the division has
2461 notified the provider by certified mail sent to the proper address
2462 of the provider on file with the division and the provider has
2463 signed for the certified mail notice, or sixty (60) days after the
2464 date of the final decision if the provider does not sign for the
2465 certified mail notice. To recover those payments, the division
2466 may use the following methods, in addition to any other methods
2467 available to the division:

2468 (i) The division shall report to the Department of
2469 Revenue the name of any current or former Medicaid recipient who
2470 has received medical services rendered during a period of
2471 established Medicaid ineligibility and who has not reimbursed the
2472 division for the related medical service payment(s). The
2473 Department of Revenue shall withhold from the state tax refund of
2474 the individual, and pay to the division, the amount of the
2475 payment(s) for medical services rendered to the ineligible
2476 individual that have not been reimbursed to the division for the
2477 related medical service payment(s).

2478 (ii) The division shall report to the Department
2479 of Revenue the name of any Medicaid provider to whom payments were
2480 incorrectly made that the division has not been able to recover by
2481 other methods available to the division. The Department of
2482 Revenue shall withhold from the state tax refund of the provider,
2483 and pay to the division, the amount of the payments that were



2484 incorrectly made to the provider that have not been recovered by
2485 other available methods;

2486 (k) To recover any and all payments by the division
2487 fraudulently obtained by a recipient or provider. Additionally,
2488 if recovery of any payments fraudulently obtained by a recipient
2489 or provider is made in any court, then, upon motion of the
2490 Governor, the judge of the court may award twice the payments
2491 recovered as damages;

2492 (l) Have full, complete and plenary power and authority
2493 to conduct such investigations as it may deem necessary and
2494 requisite of alleged or suspected violations or abuses of the
2495 provisions of this article or of the regulations adopted under
2496 this article, including, but not limited to, fraudulent or
2497 unlawful act or deed by applicants for Medicaid or other benefits,
2498 or payments made to any person, firm or corporation under the
2499 terms, conditions and authority of this article, to suspend or
2500 disqualify any provider of services, applicant or recipient for
2501 gross abuse, fraudulent or unlawful acts for such periods,
2502 including permanently, and under such conditions as the division
2503 deems proper and just, including the imposition of a legal rate of
2504 interest on the amount improperly or incorrectly paid. Recipients
2505 who are found to have misused or abused Medicaid benefits may be
2506 locked into one (1) physician and/or one (1) pharmacy of the
2507 recipient's choice for a reasonable amount of time in order to
2508 educate and promote appropriate use of medical services, in



2509 accordance with federal regulations. If an administrative hearing
2510 becomes necessary, the division may, if the provider does not
2511 succeed in his or her defense, tax the costs of the administrative
2512 hearing, including the costs of the court reporter or stenographer
2513 and transcript, to the provider. The convictions of a recipient
2514 or a provider in a state or federal court for abuse, fraudulent or
2515 unlawful acts under this chapter shall constitute an automatic
2516 disqualification of the recipient or automatic disqualification of
2517 the provider from participation under the Medicaid program.

2518 A conviction, for the purposes of this chapter, shall include
2519 a judgment entered on a plea of nolo contendere or a
2520 nonadjudicated guilty plea and shall have the same force as a
2521 judgment entered pursuant to a guilty plea or a conviction
2522 following trial. A certified copy of the judgment of the court of
2523 competent jurisdiction of the conviction shall constitute prima
2524 facie evidence of the conviction for disqualification purposes;

2525 (m) Establish and provide such methods of
2526 administration as may be necessary for the proper and efficient
2527 operation of the Medicaid program, fully utilizing computer
2528 equipment as may be necessary to oversee and control all current
2529 expenditures for purposes of this article, and to closely monitor
2530 and supervise all recipient payments and vendors rendering
2531 services under this article. Notwithstanding any other provision
2532 of state law, the division is authorized to enter into a ten-year
2533 contract(s) with a vendor(s) to provide services described in this



2534 paragraph (m). Notwithstanding any provision of law to the
2535 contrary, the division is authorized to extend its Medicaid
2536 Management Information System, including all related components
2537 and services, and Decision Support System, including all related
2538 components and services, contracts in effect on June 30, 2020, for
2539 a period not to exceed two (2) years without complying with state
2540 procurement regulations;

2541 (n) To cooperate and contract with the federal
2542 government for the purpose of providing Medicaid to Vietnamese and
2543 Cambodian refugees, under the provisions of Public Law 94-23 and
2544 Public Law 94-24, including any amendments to those laws, only to
2545 the extent that the Medicaid assistance and the administrative
2546 cost related thereto are one hundred percent (100%) reimbursable
2547 by the federal government. For the purposes of Section 43-13-117,
2548 persons receiving Medicaid under Public Law 94-23 and Public Law
2549 94-24, including any amendments to those laws, shall not be
2550 considered a new group or category of recipient; and

2551 (o) The division shall impose penalties upon Medicaid
2552 only, Title XIX participating long-term care facilities found to
2553 be in noncompliance with division and certification standards in
2554 accordance with federal and state regulations, including interest
2555 at the same rate calculated by the United States Department of
2556 Health and Human Services and/or the Centers for Medicare and
2557 Medicaid Services (CMS) under federal regulations.



2558 (2) The division also shall exercise such additional powers
2559 and perform such other duties as may be conferred upon the
2560 division by act of the Legislature.

2561 (3) The division, and the State Department of Health as the
2562 agency for licensure of health care facilities and certification
2563 and inspection for the Medicaid and/or Medicare programs, shall
2564 contract for or otherwise provide for the consolidation of on-site
2565 inspections of health care facilities that are necessitated by the
2566 respective programs and functions of the division and the
2567 department.

2568 (4) The division and its hearing officers shall have power
2569 to preserve and enforce order during hearings; to issue subpoenas
2570 for, to administer oaths to and to compel the attendance and
2571 testimony of witnesses, or the production of books, papers,
2572 documents and other evidence, or the taking of depositions before
2573 any designated individual competent to administer oaths; to
2574 examine witnesses; and to do all things conformable to law that
2575 may be necessary to enable them effectively to discharge the
2576 duties of their office. In compelling the attendance and
2577 testimony of witnesses, or the production of books, papers,
2578 documents and other evidence, or the taking of depositions, as
2579 authorized by this section, the division or its hearing officers
2580 may designate an individual employed by the division or some other
2581 suitable person to execute and return that process, whose action
2582 in executing and returning that process shall be as lawful as if



2583 done by the sheriff or some other proper officer authorized to
2584 execute and return process in the county where the witness may
2585 reside. In carrying out the investigatory powers under the
2586 provisions of this article, the executive director or other
2587 designated person or persons may examine, obtain, copy or
2588 reproduce the books, papers, documents, medical charts,
2589 prescriptions and other records relating to medical care and
2590 services furnished by the provider to a recipient or designated
2591 recipients of Medicaid services under investigation. In the
2592 absence of the voluntary submission of the books, papers,
2593 documents, medical charts, prescriptions and other records, the
2594 Governor, the executive director, or other designated person may
2595 issue and serve subpoenas instantly upon the provider, his or her
2596 agent, servant or employee for the production of the books,
2597 papers, documents, medical charts, prescriptions or other records
2598 during an audit or investigation of the provider. If any provider
2599 or his or her agent, servant or employee refuses to produce the
2600 records after being duly subpoenaed, the executive director may
2601 certify those facts and institute contempt proceedings in the
2602 manner, time and place as authorized by law for administrative
2603 proceedings. As an additional remedy, the division may recover
2604 all amounts paid to the provider covering the period of the audit
2605 or investigation, inclusive of a legal rate of interest and a
2606 reasonable attorney's fee and costs of court if suit becomes
2607 necessary. Division staff shall have immediate access to the



2608 provider's physical location, facilities, records, documents,
2609 books, and any other records relating to medical care and services
2610 rendered to recipients during regular business hours.

2611 (5) If any person in proceedings before the division
2612 disobeys or resists any lawful order or process, or misbehaves
2613 during a hearing or so near the place thereof as to obstruct the
2614 hearing, or neglects to produce, after having been ordered to do
2615 so, any pertinent book, paper or document, or refuses to appear
2616 after having been subpoenaed, or upon appearing refuses to take
2617 the oath as a witness, or after having taken the oath refuses to
2618 be examined according to law, the executive director shall certify
2619 the facts to any court having jurisdiction in the place in which
2620 it is sitting, and the court shall thereupon, in a summary manner,
2621 hear the evidence as to the acts complained of, and if the
2622 evidence so warrants, punish that person in the same manner and to
2623 the same extent as for a contempt committed before the court, or
2624 commit that person upon the same condition as if the doing of the
2625 forbidden act had occurred with reference to the process of, or in
2626 the presence of, the court.

2627 (6) In suspending or terminating any provider from
2628 participation in the Medicaid program, the division shall preclude
2629 the provider from submitting claims for payment, either personally
2630 or through any clinic, group, corporation or other association to
2631 the division or its fiscal agents for any services or supplies
2632 provided under the Medicaid program except for those services or



2633 supplies provided before the suspension or termination. No
2634 clinic, group, corporation or other association that is a provider
2635 of services shall submit claims for payment to the division or its
2636 fiscal agents for any services or supplies provided by a person
2637 within that organization who has been suspended or terminated from
2638 participation in the Medicaid program except for those services or
2639 supplies provided before the suspension or termination. When this
2640 provision is violated by a provider of services that is a clinic,
2641 group, corporation or other association, the division may suspend
2642 or terminate that organization from participation. Suspension may
2643 be applied by the division to all known affiliates of a provider,
2644 provided that each decision to include an affiliate is made on a
2645 case-by-case basis after giving due regard to all relevant facts
2646 and circumstances. The violation, failure or inadequacy of
2647 performance may be imputed to a person with whom the provider is
2648 affiliated where that conduct was accomplished within the course
2649 of his or her official duty or was effectuated by him or her with
2650 the knowledge or approval of that person.

2651 (7) The division may deny or revoke enrollment in the
2652 Medicaid program to a provider if any of the following are found
2653 to be applicable to the provider, his or her agent, a managing
2654 employee or any person having an ownership interest equal to five
2655 percent (5%) or greater in the provider:

2656 (a) Failure to truthfully or fully disclose any and all
2657 information required, or the concealment of any and all



2658 information required, on a claim, a provider application or a
2659 provider agreement, or the making of a false or misleading
2660 statement to the division relative to the Medicaid program.

2661 (b) Previous or current exclusion, suspension,
2662 termination from or the involuntary withdrawing from participation
2663 in the Medicaid program, any other state's Medicaid program,
2664 Medicare or any other public or private health or health insurance
2665 program. If the division ascertains that a provider has been
2666 convicted of a felony under federal or state law for an offense
2667 that the division determines is detrimental to the best interest
2668 of the program or of Medicaid beneficiaries, the division may
2669 refuse to enter into an agreement with that provider, or may
2670 terminate or refuse to renew an existing agreement.

2671 (c) Conviction under federal or state law of a criminal
2672 offense relating to the delivery of any goods, services or
2673 supplies, including the performance of management or
2674 administrative services relating to the delivery of the goods,
2675 services or supplies, under the Medicaid program, any other
2676 state's Medicaid program, Medicare or any other public or private
2677 health or health insurance program.

2678 (d) Conviction under federal or state law of a criminal
2679 offense relating to the neglect or abuse of a patient in
2680 connection with the delivery of any goods, services or supplies.



2681 (e) Conviction under federal or state law of a criminal
2682 offense relating to the unlawful manufacture, distribution,
2683 prescription or dispensing of a controlled substance.

2684 (f) Conviction under federal or state law of a criminal
2685 offense relating to fraud, theft, embezzlement, breach of
2686 fiduciary responsibility or other financial misconduct.

2687 (g) Conviction under federal or state law of a criminal
2688 offense punishable by imprisonment of a year or more that involves
2689 moral turpitude, or acts against the elderly, children or infirm.

2690 (h) Conviction under federal or state law of a criminal
2691 offense in connection with the interference or obstruction of any
2692 investigation into any criminal offense listed in paragraphs (c)
2693 through (i) of this subsection.

2694 (i) Sanction for a violation of federal or state laws
2695 or rules relative to the Medicaid program, any other state's
2696 Medicaid program, Medicare or any other public health care or
2697 health insurance program.

2698 (j) Revocation of license or certification.

2699 (k) Failure to pay recovery properly assessed or
2700 pursuant to an approved repayment schedule under the Medicaid
2701 program.

2702 (l) Failure to meet any condition of enrollment.

2703 (8) (a) As used in this subsection (8), the following terms
2704 shall be defined as provided in this paragraph, except as
2705 otherwise provided in this subsection:



2706 (i) "Committees" means the Medicaid Committees of
2707 the House of Representatives and the Senate, and "committee" means
2708 either one of those committees.

2709 (ii) "State Plan" means the agreement between the
2710 State of Mississippi and the federal government regarding the
2711 nature and scope of Mississippi's Medicaid Program.

2712 (iii) "State Plan Amendment" means a change to the
2713 State Plan, which must be approved by the Centers for Medicare and
2714 Medicaid Services (CMS) before its implementation.

2715 (b) Whenever the Division of Medicaid proposes a State
2716 Plan Amendment, the division shall give notice to the chairmen of
2717 the committees at least thirty (30) calendar days before the
2718 proposed State Plan Amendment is filed with CMS. The division
2719 shall furnish the chairmen with a concise summary of each proposed
2720 State Plan Amendment along with the notice, and shall furnish the
2721 chairmen with a copy of any proposed State Plan Amendment upon
2722 request. The division also shall provide a summary and copy of
2723 any proposed State Plan Amendment to any other member of the
2724 Legislature upon request.

2725 (c) If the chairman of either committee or both
2726 chairmen jointly object to the proposed State Plan Amendment or
2727 any part thereof, the chairman or chairmen shall notify the
2728 division and provide the reasons for their objection in writing
2729 not later than seven (7) calendar days after receipt of the notice
2730 from the division. The chairman or chairmen may make written



2731 recommendations to the division for changes to be made to a
2732 proposed State Plan Amendment.

2733 (d) (i) The chairman of either committee or both
2734 chairmen jointly may hold a committee meeting to review a proposed
2735 State Plan Amendment. If either chairman or both chairmen decide
2736 to hold a meeting, they shall notify the division of their
2737 intention in writing within seven (7) calendar days after receipt
2738 of the notice from the division, and shall set the date and time
2739 for the meeting in their notice to the division, which shall not
2740 be later than fourteen (14) calendar days after receipt of the
2741 notice from the division.

2742 (ii) After the committee meeting, the committee or
2743 committees may object to the proposed State Plan Amendment or any
2744 part thereof. The committee or committees shall notify the
2745 division and the reasons for their objection in writing not later
2746 than seven (7) calendar days after the meeting. The committee or
2747 committees may make written recommendations to the division for
2748 changes to be made to a proposed State Plan Amendment.

2749 (e) If both chairmen notify the division in writing
2750 within seven (7) calendar days after receipt of the notice from
2751 the division that they do not object to the proposed State Plan
2752 Amendment and will not be holding a meeting to review the proposed
2753 State Plan Amendment, the division may proceed to file the
2754 proposed State Plan Amendment with CMS.



2755 (f) (i) If there are any objections to a proposed rate
2756 change or any part thereof from either or both of the chairmen or
2757 the committees, the division may withdraw the proposed State Plan
2758 Amendment, make any of the recommended changes to the proposed
2759 State Plan Amendment, or not make any changes to the proposed
2760 State Plan Amendment.

2761 (ii) If the division does not make any changes to
2762 the proposed State Plan Amendment, it shall notify the chairmen of
2763 that fact in writing, and may proceed to file the State Plan
2764 Amendment with CMS.

2765 (iii) If the division makes any changes to the
2766 proposed State Plan Amendment, the division shall notify the
2767 chairmen of its actions in writing, and may proceed to file the
2768 State Plan Amendment with CMS.

2769 (g) Nothing in this subsection (8) shall be construed
2770 as giving the chairmen or the committees any authority to veto,
2771 nullify or revise any State Plan Amendment proposed by the
2772 division. The authority of the chairmen or the committees under
2773 this subsection shall be limited to reviewing, making objections
2774 to and making recommendations for changes to State Plan Amendments
2775 proposed by the division.

2776 (i) If the division does not make any changes to
2777 the proposed State Plan Amendment, it shall notify the chairmen of
2778 that fact in writing, and may proceed to file the proposed State
2779 Plan Amendment with CMS.



2780 (ii) If the division makes any changes to the
2781 proposed State Plan Amendment, the division shall notify the
2782 chairmen of the changes in writing, and may proceed to file the
2783 proposed State Plan Amendment with CMS.

2784 (h) Nothing in this subsection (8) shall be construed
2785 as giving the chairmen of the committees any authority to veto,
2786 nullify or revise any State Plan Amendment proposed by the
2787 division. The authority of the chairmen of the committees under
2788 this subsection shall be limited to reviewing, making objections
2789 to and making recommendations for suggested changes to State Plan
2790 Amendments proposed by the division.

2791 **SECTION 12.** Section 43-13-122, Mississippi Code of 1972, is
2792 brought forward as follows:

2793 43-13-122. (1) The division is authorizedu to apply to the
2794 Center for Medicare and Medicaid Services of the United States
2795 Department of Health and Human Services for waivers and research
2796 and demonstration grants.

2797 (2) The division is further authorized to accept and expend
2798 any grants, donations or contributions from any public or private
2799 organization together with any additional federal matching funds
2800 that may accrue andu, including, but not limited to, one hundred
2801 percent (100%) federal grant funds or funds from any governmental
2802 entity or instrumentality thereof in furthering the purposes and
2803 objectives of the Mississippi Medicaid program, provided that such
2804 receipts and expenditures are reported and otherwise handled in



2805 accordance with the General Fund Stabilization Act. The
2806 Department of Finance and Administration is authorized to transfer
2807 monies to the division from special funds in the State Treasury in
2808 amounts not exceeding the amounts authorized in the appropriation
2809 to the division.

2810 **SECTION 13.** Section 43-13-123, Mississippi Code of 1972, is
2811 brought forward as follows:

2812 43-13-123. The determination of the method of providing
2813 payment of claims under this article shall be made by the
2814 division, with approval of the Governor, which methods may be:

2815 (a) By contract with insurance companies licensed to do
2816 business in the State of Mississippi or with nonprofit hospital
2817 service corporations, medical or dental service corporations,
2818 authorized to do business in Mississippi to underwrite on an
2819 insured premium approach, such medical assistance benefits as may
2820 be available, and any carrier selected under the provisions of
2821 this article is expressly authorized and empowered to undertake
2822 the performance of the requirements of that contract.

2823 (b) By contract with an insurance company licensed to
2824 do business in the State of Mississippi or with nonprofit hospital
2825 service, medical or dental service organizations, or other
2826 organizations including data processing companies, authorized to
2827 do business in Mississippi to act as fiscal agent.



2828 The division shall obtain services to be provided under
2829 either of the above-described provisions in accordance with the
2830 Personal Service Contract Review Board Procurement Regulations.

2831 The authorization of the foregoing methods shall not preclude
2832 other methods of providing payment of claims through direct
2833 operation of the program by the state or its agencies.

2834 **SECTION 14.** Section 43-13-126, Mississippi Code of 1972, is
2835 brought forward as follows:

2836 43-13-126. As a condition of doing business in the state,
2837 health insurers, including self-insured plans, group health plans
2838 (as defined in Section 607(1) of the Employee Retirement Income
2839 Security Act of 1974), service benefit plans, managed care
2840 organizations, pharmacy benefit managers, or other parties that
2841 are by statute, contract, or agreement, legally responsible for
2842 payment of a claim for a health care item or service, are required
2843 to:

2844 (a) Provide, with respect to individuals who are
2845 eligible for, or are provided, medical assistance under the state
2846 plan, upon the request of the Division of Medicaid, information to
2847 determine during what period the individual or their spouses or
2848 their dependents may be (or may have been) covered by a health
2849 insurer and the nature of the coverage that is or was provided by
2850 the health insurer (including the name, address and identifying
2851 number of the plan) in a manner prescribed by the Secretary of the
2852 Department of Health and Human Services;



2853 (b) Accept the Division of Medicaid's right of recovery
2854 and the assignment to the division of any right of an individual
2855 or other entity to payment from the party for an item or service
2856 for which payment has been made under the state plan;

2857 (c) Respond to any inquiry by the Division of Medicaid
2858 regarding a claim for payment for any health care item or service
2859 that is submitted not later than three (3) years after the date of
2860 the provision of that health care item or service; and

2861 (d) Agree not to deny a claim submitted by the Division
2862 of Medicaid solely on the basis of the date of submission of the
2863 claim, the type or format of the claim form, or a failure to
2864 present proper documentation at the point of sale that is the
2865 basis of the claim, if:

2866 (i) The claim is submitted by the division within
2867 the three-year period beginning on the date on which the item or
2868 service was furnished; and

2869 (ii) Any action by the division to enforce its
2870 rights with respect to the claim is begun within six (6) years of
2871 the division's submission of the claim.

2872 **SECTION 15.** Section 43-13-133, Mississippi Code of 1972, is
2873 brought forward as follows:

2874 43-13-133. It is the intent of the Legislature that all
2875 federal matching funds for medical assistance under Titles V,
2876 XVIII and XIX of the federal Social Security Act paid into any
2877 state health agency after the passage of this article shall be



2878 used exclusively to defray the cost of medical assistance expended
2879 under the terms of this article.

2880 **SECTION 16.** Section 43-13-143, Mississippi Code of 1972, is
2881 brought forward as follows:

2882 43-13-143. There is created in the State Treasury a special
2883 fund to be known as the "Medical Care Fund," which shall be
2884 comprised of monies transferred by public or private health care
2885 providers, governing bodies of counties, municipalities, public or
2886 community hospitals and other political subdivisions of the state,
2887 individuals, corporations, associations and any other entities for
2888 the purpose of providing health care services. Any transfer made
2889 to the fund shall be paid to the State Treasurer for deposit into
2890 the fund, and all such transfers shall be considered as
2891 unconditional transfers to the fund. The monies in the Medical
2892 Care Fund shall be expended only for health care services, and may
2893 be expended only upon appropriation of the Legislature. All
2894 transfers of monies to the Division of Medicaid by health care
2895 providers and by governing bodies of counties, municipalities,
2896 public or community hospitals and other political subdivisions of
2897 the state shall be deposited into the fund. Unexpended monies
2898 remaining in the fund at the end of a fiscal year shall not lapse
2899 into the State General Fund, and any interest earned on monies in
2900 the fund shall be deposited to the credit of the fund.

2901 **SECTION 17.** Section 43-13-145, Mississippi Code of 1972, is
2902 brought forward as follows:



2903 43-13-145. (1) (a) Upon each nursing facility licensed by
2904 the State of Mississippi, there is levied an assessment in an
2905 amount set by the division, equal to the maximum rate allowed by
2906 federal law or regulation, for each licensed and occupied bed of
2907 the facility.

2908 (b) A nursing facility is exempt from the assessment
2909 levied under this subsection if the facility is operated under the
2910 direction and control of:

2911 (i) The United States Veterans Administration or
2912 other agency or department of the United States government; or

2913 (ii) The State Veterans Affairs Board.

2914 (2) (a) Upon each intermediate care facility for
2915 individuals with intellectual disabilities licensed by the State
2916 of Mississippi, there is levied an assessment in an amount set by
2917 the division, equal to the maximum rate allowed by federal law or
2918 regulation, for each licensed and occupied bed of the facility.

2919 (b) An intermediate care facility for individuals with
2920 intellectual disabilities is exempt from the assessment levied
2921 under this subsection if the facility is operated under the
2922 direction and control of:

2923 (i) The United States Veterans Administration or
2924 other agency or department of the United States government;

2925 (ii) The State Veterans Affairs Board; or

2926 (iii) The University of Mississippi Medical
2927 Center.



2928 (3) (a) Upon each psychiatric residential treatment
2929 facility licensed by the State of Mississippi, there is levied an
2930 assessment in an amount set by the division, equal to the maximum
2931 rate allowed by federal law or regulation, for each licensed and
2932 occupied bed of the facility.

2933 (b) A psychiatric residential treatment facility is
2934 exempt from the assessment levied under this subsection if the
2935 facility is operated under the direction and control of:

2936 (i) The United States Veterans Administration or
2937 other agency or department of the United States government;

2938 (ii) The University of Mississippi Medical Center;
2939 or

2940 (iii) A state agency or a state facility that
2941 either provides its own state match through intergovernmental
2942 transfer or certification of funds to the division.

2943 (4) Hospital assessment.

2944 (a) (i) Subject to and upon fulfillment of the
2945 requirements and conditions of paragraph (f) below, and
2946 notwithstanding any other provisions of this section, an annual
2947 assessment on each hospital licensed in the state is imposed on
2948 each non-Medicare hospital inpatient day as defined below at a
2949 rate that is determined by dividing the sum prescribed in this
2950 subparagraph (i), plus the nonfederal share necessary to maximize
2951 the Disproportionate Share Hospital (DSH) and Medicare Upper
2952 Payment Limits (UPL) Program payments and hospital access payments



2953 and such other supplemental payments as may be developed pursuant
2954 to Section 43-13-117(A)(18), by the total number of non-Medicare
2955 hospital inpatient days as defined below for all licensed
2956 Mississippi hospitals, except as provided in paragraph (d) below.
2957 If the state-matching funds percentage for the Mississippi
2958 Medicaid program is sixteen percent (16%) or less, the sum used in
2959 the formula under this subparagraph (i) shall be Seventy-four
2960 Million Dollars (\$74,000,000.00). If the state-matching funds
2961 percentage for the Mississippi Medicaid program is twenty-four
2962 percent (24%) or higher, the sum used in the formula under this
2963 subparagraph (i) shall be One Hundred Four Million Dollars
2964 (\$104,000,000.00). If the state-matching funds percentage for the
2965 Mississippi Medicaid program is between sixteen percent (16%) and
2966 twenty-four percent (24%), the sum used in the formula under this
2967 subparagraph (i) shall be a pro rata amount determined as follows:
2968 the current state-matching funds percentage rate minus sixteen
2969 percent (16%) divided by eight percent (8%) multiplied by Thirty
2970 Million Dollars (\$30,000,000.00) and add that amount to
2971 Seventy-four Million Dollars (\$74,000,000.00). However, no
2972 assessment in a quarter under this subparagraph (i) may exceed the
2973 assessment in the previous quarter by more than Three Million
2974 Seven Hundred Fifty Thousand Dollars (\$3,750,000.00) (which would
2975 be Fifteen Million Dollars (\$15,000,000.00) on an annualized
2976 basis). The division shall publish the state-matching funds
2977 percentage rate applicable to the Mississippi Medicaid program on



2978 the tenth day of the first month of each quarter and the
2979 assessment determined under the formula prescribed above shall be
2980 applicable in the quarter following any adjustment in that
2981 state-matching funds percentage rate. The division shall notify
2982 each hospital licensed in the state as to any projected increases
2983 or decreases in the assessment determined under this subparagraph
2984 (i). However, if the Centers for Medicare and Medicaid Services
2985 (CMS) does not approve the provision in Section 43-13-117(39)
2986 requiring the division to reimburse crossover claims for inpatient
2987 hospital services and crossover claims covered under Medicare Part
2988 B for dually eligible beneficiaries in the same manner that was in
2989 effect on January 1, 2008, the sum that otherwise would have been
2990 used in the formula under this subparagraph (i) shall be reduced
2991 by Seven Million Dollars (\$7,000,000.00).

2992 (ii) In addition to the assessment provided under
2993 subparagraph (i), an additional annual assessment on each hospital
2994 licensed in the state is imposed on each non-Medicare hospital
2995 inpatient day as defined below at a rate that is determined by
2996 dividing twenty-five percent (25%) of any provider reductions in
2997 the Medicaid program as authorized in Section 43-13-117(F) for
2998 that fiscal year up to the following maximum amount, plus the
2999 nonfederal share necessary to maximize the Disproportionate Share
3000 Hospital (DSH) and inpatient Medicare Upper Payment Limits (UPL)
3001 Program payments and inpatient hospital access payments, by the
3002 total number of non-Medicare hospital inpatient days as defined



3003 below for all licensed Mississippi hospitals: in fiscal year
3004 2010, the maximum amount shall be Twenty-four Million Dollars
3005 (\$24,000,000.00); in fiscal year 2011, the maximum amount shall be
3006 Thirty-two Million Dollars (\$32,000,000.00); and in fiscal year
3007 2012 and thereafter, the maximum amount shall be Forty Million
3008 Dollars (\$40,000,000.00). Any such deficit in the Medicaid
3009 program shall be reviewed by the PEER Committee as provided in
3010 Section 43-13-117(F).

3011 (iii) In addition to the assessments provided in
3012 subparagraphs (i) and (ii), an additional annual assessment on
3013 each hospital licensed in the state is imposed pursuant to the
3014 provisions of Section 43-13-117(F) if the cost-containment
3015 measures described therein have been implemented and there are
3016 insufficient funds in the Health Care Trust Fund to reconcile any
3017 remaining deficit in any fiscal year. If the Governor institutes
3018 any other additional cost-containment measures on any program or
3019 programs authorized under the Medicaid program pursuant to Section
3020 43-13-117(F), hospitals shall be responsible for twenty-five
3021 percent (25%) of any such additional imposed provider cuts, which
3022 shall be in the form of an additional assessment not to exceed the
3023 twenty-five percent (25%) of provider expenditure reductions.
3024 Such additional assessment shall be imposed on each non-Medicare
3025 hospital inpatient day in the same manner as assessments are
3026 imposed under subparagraphs (i) and (ii).

3027 (b) Definitions.



3028 (i) [Deleted]

3029 (ii) For purposes of this subsection (4):

3030 1. "Non-Medicare hospital inpatient day"

3031 means total hospital inpatient days including subcomponent days
3032 less Medicare inpatient days including subcomponent days from the
3033 hospital's most recent Medicare cost report for the second
3034 calendar year preceding the beginning of the state fiscal year, on
3035 file with CMS per the CMS HCRIS database, or cost report submitted
3036 to the Division if the HCRIS database is not available to the
3037 division, as of June 1 of each year.

3038 a. Total hospital inpatient days shall
3039 be the sum of Worksheet S-3, Part 1, column 8 row 14, column 8 row
3040 16, and column 8 row 17, excluding column 8 rows 5 and 6.

3041 b. Hospital Medicare inpatient days
3042 shall be the sum of Worksheet S-3, Part 1, column 6 row 14, column
3043 6 row 16.00, and column 6 row 17, excluding column 6 rows 5 and 6.

3044 c. Inpatient days shall not include
3045 residential treatment or long-term care days.

3046 2. "Subcomponent inpatient day" means the
3047 number of days of care charged to a beneficiary for inpatient
3048 hospital rehabilitation and psychiatric care services in units of
3049 full days. A day begins at midnight and ends twenty-four (24)
3050 hours later. A part of a day, including the day of admission and
3051 day on which a patient returns from leave of absence, counts as a
3052 full day. However, the day of discharge, death, or a day on which



3053 a patient begins a leave of absence is not counted as a day unless
3054 discharge or death occur on the day of admission. If admission
3055 and discharge or death occur on the same day, the day is
3056 considered a day of admission and counts as one (1) subcomponent
3057 inpatient day.

3058 (c) The assessment provided in this subsection is
3059 intended to satisfy and not be in addition to the assessment and
3060 intergovernmental transfers provided in Section 43-13-117(A)(18).
3061 Nothing in this section shall be construed to authorize any state
3062 agency, division or department, or county, municipality or other
3063 local governmental unit to license for revenue, levy or impose any
3064 other tax, fee or assessment upon hospitals in this state not
3065 authorized by a specific statute.

3066 (d) Hospitals operated by the United States Department
3067 of Veterans Affairs and state-operated facilities that provide
3068 only inpatient and outpatient psychiatric services shall not be
3069 subject to the hospital assessment provided in this subsection.

3070 (e) Multihospital systems, closure, merger, change of
3071 ownership and new hospitals.

3072 (i) If a hospital conducts, operates or maintains
3073 more than one (1) hospital licensed by the State Department of
3074 Health, the provider shall pay the hospital assessment for each
3075 hospital separately.

3076 (ii) Notwithstanding any other provision in this
3077 section, if a hospital subject to this assessment operates or



3078 conducts business only for a portion of a fiscal year, the
3079 assessment for the state fiscal year shall be adjusted by
3080 multiplying the assessment by a fraction, the numerator of which
3081 is the number of days in the year during which the hospital
3082 operates, and the denominator of which is three hundred sixty-five
3083 (365). Immediately upon ceasing to operate, the hospital shall
3084 pay the assessment for the year as so adjusted (to the extent not
3085 previously paid).

3086 (iii) The division shall determine the tax for new
3087 hospitals and hospitals that undergo a change of ownership in
3088 accordance with this section, using the best available
3089 information, as determined by the division.

3090 (f) Applicability.

3091 The hospital assessment imposed by this subsection shall not
3092 take effect and/or shall cease to be imposed if:

3093 (i) The assessment is determined to be an
3094 impermissible tax under Title XIX of the Social Security Act; or

3095 (ii) CMS revokes its approval of the division's
3096 2009 Medicaid State Plan Amendment for the methodology for DSH
3097 payments to hospitals under Section 43-13-117(A)(18).

3098 (5) Each health care facility that is subject to the
3099 provisions of this section shall keep and preserve such suitable
3100 books and records as may be necessary to determine the amount of
3101 assessment for which it is liable under this section. The books
3102 and records shall be kept and preserved for a period of not less



3103 than five (5) years, during which time those books and records
3104 shall be open for examination during business hours by the
3105 division, the Department of Revenue, the Office of the Attorney
3106 General and the State Department of Health.

3107 (6) [Deleted]

3108 (7) All assessments collected under this section shall be
3109 deposited in the Medical Care Fund created by Section 43-13-143.

3110 (8) The assessment levied under this section shall be in
3111 addition to any other assessments, taxes or fees levied by law,
3112 and the assessment shall constitute a debt due the State of
3113 Mississippi from the time the assessment is due until it is paid.

3114 (9) (a) If a health care facility that is liable for
3115 payment of an assessment levied by the division does not pay the
3116 assessment when it is due, the division shall give written notice
3117 to the health care facility demanding payment of the assessment
3118 within ten (10) days from the date of delivery of the notice. If
3119 the health care facility fails or refuses to pay the assessment
3120 after receiving the notice and demand from the division, the
3121 division shall withhold from any Medicaid reimbursement payments
3122 that are due to the health care facility the amount of the unpaid
3123 assessment and a penalty of ten percent (10%) of the amount of the
3124 assessment, plus the legal rate of interest until the assessment
3125 is paid in full. If the health care facility does not participate
3126 in the Medicaid program, the division shall turn over to the
3127 Office of the Attorney General the collection of the unpaid



3128 assessment by civil action. In any such civil action, the Office
3129 of the Attorney General shall collect the amount of the unpaid
3130 assessment and a penalty of ten percent (10%) of the amount of the
3131 assessment, plus the legal rate of interest until the assessment
3132 is paid in full.

3133 (b) As an additional or alternative method for
3134 collecting unpaid assessments levied by the division, if a health
3135 care facility fails or refuses to pay the assessment after
3136 receiving notice and demand from the division, the division may
3137 file a notice of a tax lien with the chancery clerk of the county
3138 in which the health care facility is located, for the amount of
3139 the unpaid assessment and a penalty of ten percent (10%) of the
3140 amount of the assessment, plus the legal rate of interest until
3141 the assessment is paid in full. Immediately upon receipt of
3142 notice of the tax lien for the assessment, the chancery clerk
3143 shall forward the notice to the circuit clerk who shall enter the
3144 notice of the tax lien as a judgment upon the judgment roll and
3145 show in the appropriate columns the name of the health care
3146 facility as judgment debtor, the name of the division as judgment
3147 creditor, the amount of the unpaid assessment, and the date and
3148 time of enrollment. The judgment shall be valid as against
3149 mortgagees, pledgees, entrusters, purchasers, judgment creditors
3150 and other persons from the time of filing with the clerk. The
3151 amount of the judgment shall be a debt due the State of
3152 Mississippi and remain a lien upon the tangible property of the



3153 health care facility until the judgment is satisfied. The
3154 judgment shall be the equivalent of any enrolled judgment of a
3155 court of record and shall serve as authority for the issuance of
3156 writs of execution, writs of attachment or other remedial writs.

3157 (10) (a) To further the provisions of Section
3158 43-13-117(A)(18), the Division of Medicaid shall submit to the
3159 Centers for Medicare and Medicaid Services (CMS) any documents
3160 regarding the hospital assessment established under subsection (4)
3161 of this section. In addition to defining the assessment
3162 established in subsection (4) of this section if necessary, the
3163 documents shall describe any supplement payment programs and/or
3164 payment methodologies as authorized in Section 43-13-117(A)(18) if
3165 necessary.

3166 (b) All hospitals satisfying the minimum federal DSH
3167 eligibility requirements (Section 1923(d) of the Social Security
3168 Act) may, subject to OBRA 1993 payment limitations, receive a DSH
3169 payment. This DSH payment shall expend the balance of the federal
3170 DSH allotment and associated state share not utilized in DSH
3171 payments to state-owned institutions for treatment of mental
3172 diseases. The payment to each hospital shall be calculated by
3173 applying a uniform percentage to the uninsured costs of each
3174 eligible hospital, excluding state-owned institutions for
3175 treatment of mental diseases; however, that percentage for a
3176 state-owned teaching hospital located in Hinds County shall be
3177 multiplied by a factor of two (2).



3178 (11) The division shall implement DSH and supplemental
3179 payment calculation methodologies that result in the maximization
3180 of available federal funds.

3181 (12) The DSH payments shall be paid on or before December
3182 31, March 31, and June 30 of each fiscal year, in increments of
3183 one-third (1/3) of the total calculated DSH amounts. Supplemental
3184 payments developed pursuant to Section 43-13-117(A)(18) shall be
3185 paid monthly.

3186 (13) Payment.

3187 (a) The hospital assessment as described in subsection
3188 (4) for the nonfederal share necessary to maximize the Medicare
3189 Upper Payments Limits (UPL) Program payments and hospital access
3190 payments and such other supplemental payments as may be developed
3191 pursuant to Section 43-3-117(A)(18) shall be assessed and
3192 collected monthly no later than the fifteenth calendar day of each
3193 month.

3194 (b) The hospital assessment as described in subsection
3195 (4) for the nonfederal share necessary to maximize the
3196 Disproportionate Share Hospital (DSH) payments shall be assessed
3197 and collected on December 15, March 15 and June 15.

3198 (c) The annual hospital assessment and any additional
3199 hospital assessment as described in subsection (4) shall be
3200 assessed and collected on September 15 and on the 15th of each
3201 month from December through June.



3202 (14) If for any reason any part of the plan for annual DSH
3203 and supplemental payment programs to hospitals provided under
3204 subsection (10) of this section and/or developed pursuant to
3205 Section 43-13-117(A) (18) is not approved by CMS, the remainder of
3206 the plan shall remain in full force and effect.

3207 (15) Nothing in this section shall prevent the Division of
3208 Medicaid from facilitating participation in Medicaid supplemental
3209 hospital payment programs by a hospital located in a county
3210 contiguous to the State of Mississippi that is also authorized by
3211 federal law to submit intergovernmental transfers (IGTs) to the
3212 State of Mississippi to fund the state share of the hospital's
3213 supplemental and/or MHAP payments.

3214 (16) This section shall stand repealed on July 1, 2024.

3215 **SECTION 18.** Section 27-15-103, Mississippi Code of 1972, is
3216 brought forward as follows:

3217 27-15-103. (1) Except as otherwise provided in Section
3218 83-61-11, in addition to the license tax now or hereafter provided
3219 by law, which tax shall be paid when the company enters or is
3220 admitted to do business in this state, there is hereby levied and
3221 imposed upon all foreign insurance companies and associations,
3222 including life insurance companies and associations, health,
3223 accident and industrial insurance companies and associations, fire
3224 and casualty insurance companies and associations, and all other
3225 foreign insurance companies and associations of every kind and
3226 description, an additional annual license or privilege tax of



3227 three percent (3%) of the gross amount of premium receipts
3228 received from, and on insurance policies and contracts written in,
3229 or covering risks located in this state, except for premiums
3230 received on policies issued to fund a deferred compensation plan
3231 qualified under Section 457 of the Federal Tax Code for federal
3232 tax exemption. In determining said amount of premiums, there
3233 shall be deducted therefrom premiums received for reinsurance from
3234 companies authorized to do business in this state, cash dividends
3235 paid under policy contracts in this state, and premiums returned
3236 to policyholders and cancellations on accounts of policies not
3237 taken, and, in the case of mutual insurance companies (including
3238 interinsurance and reciprocal exchanges, but not including mutual
3239 life, accident, health or industrial insurance companies) any
3240 refund made or credited to the policyholder other than for losses.
3241 The term "premium" as used herein shall also include policy fees,
3242 membership fees, and all other fees collected by the companies.
3243 No credit or deduction from gross premium receipts shall be
3244 allowed for any commission, fee or compensation paid to any agent,
3245 solicitor or representative. Provided, however, that any foreign
3246 insurance carrier selected to furnish service to the State of
3247 Mississippi under the State Employees Life and Health Insurance
3248 Plan shall not be required to pay the annual license or privilege
3249 tax on the premiums collected for coverage under the said plan.

3250 (2) In the event that the Mississippi Supreme Court or
3251 another court finally adjudicates that any tax levied prior to



3252 July 1, 1985, under the provisions of this section was collected
3253 unconstitutionally and that a liability for a credit or refund for
3254 such collection has accrued, then the rate of tax set forth above
3255 shall be increased to four percent (4%) for a period of six (6)
3256 years beginning July 1 following such adjudication.

3257 (3) The taxes herein levied and imposed for the calendar
3258 year 1982 and all calendar years thereafter shall be reduced by
3259 the net amount of income tax paid to this state for the preceding
3260 calendar year, provided, in no event may the credit be taken more
3261 than once. The credit herein authorized shall, in no event, be
3262 greater than the premium tax due under this section; it being the
3263 purpose and intent of this paragraph that whichever of the annual
3264 insurance premium tax or the income tax is greater in amount shall
3265 be paid.

3266 **SECTION 19.** Section 27-15-109, Mississippi Code of 1972, is
3267 brought forward as follows:

3268 27-15-109. (1) Except as otherwise provided in Section
3269 83-61-11, there is hereby levied and imposed upon each domestic
3270 company doing business in this state an annual tax of three
3271 percent (3%) of the gross amount of premiums collected by such
3272 domestic company on insurance policies and contracts written in,
3273 or covering risks located in this state, except for premiums
3274 received on policies issued to fund a retirement, thrift or
3275 deferred compensation plan qualified under Section 401, Section
3276 403 or Section 457 of the Federal Tax Code for federal tax



3277 exemption. Provided, however, that a domestic insurance company
3278 against which is levied additional premium tax under retaliatory
3279 laws of other states in which it does business, as a result of the
3280 tax increase provided by Sections 27-15-103 through 27-15-117, may
3281 deduct the total of such additional retaliatory tax from the state
3282 income tax due by it to the State of Mississippi. The insurance
3283 carriers selected to furnish service to the State of Mississippi,
3284 under the State Employees Life and Health Insurance Plan, shall
3285 not be required to pay the premium tax levied against insurance
3286 companies under this section on the premiums collected for
3287 coverage under the state employees plan.

3288 (2) Except as expressly provided by subsection (1) of this
3289 section, all of the provisions of Sections 27-15-103 through
3290 27-15-117 shall be applicable to such domestic insurance
3291 companies. However, the statement filed with the State Tax
3292 Commission by domestic insurance companies as provided in Section
3293 27-15-107 shall include therein a sworn statement of all
3294 additional retaliatory premium taxes paid by them to other states
3295 as a result of the increase in premium taxes imposed by Sections
3296 27-15-103 through 27-15-117, itemized by states to which paid.

3297 (3) In the event that the Mississippi Supreme Court or
3298 another court finally adjudicates that any tax levied prior to
3299 July 1, 1985, under the provisions of this section was collected
3300 unconstitutionally and that a liability for a credit or refund for
3301 such collection has accrued, then the rate of tax set forth above



3302 shall be increased to four percent (4%) for a period of six (6)
3303 years beginning July 1 following such adjudication.

3304 **SECTION 20.** Section 27-15-115, Mississippi Code of 1972, is
3305 brought forward as follows:

3306 27-15-115. In addition to all other taxes authorized by law,
3307 insurance companies shall pay the license and privilege taxes
3308 imposed by Sections 27-15-81 and 27-15-83, the taxes imposed by
3309 Sections 27-15-103 through 27-15-117, ad valorem taxes on real
3310 estate and tangible personal property, state income tax, sales tax
3311 levied on a vendor with a requirement of adding it to the sales
3312 price and use tax levied on the cost of tangible personal property
3313 purchased outside this state for use within this state.

3314 **SECTION 21.** Section 27-15-129, Mississippi Code of 1972, is
3315 brought forward as follows:

3316 27-15-129. (1) The amount of premium tax payable pursuant
3317 to Sections 27-15-103, 27-15-109, 27-15-119 and 83-31-45,
3318 Mississippi Code of 1972, shall be reduced from the amount
3319 otherwise fixed in such sections if the payer files a sworn
3320 statement with the required annual report showing as of the
3321 beginning of the reporting period that at least the following
3322 amounts of the total admitted assets of the payer were invested
3323 and maintained in qualifying Mississippi investments as
3324 hereinafter defined in subsection (2) of this section over the
3325 period covered by such report:

3326 Percentage of Total Admitted Percentage of Premium



3327	Assets in Qualifying	Tax Payable
3328	Mississippi Investments	
3329	1%	99%
3330	2%	98%
3331	3%	97%
3332	4%	96%
3333	5%	95%
3334	6%	94%
3335	7%	93%
3336	8%	92%
3337	9%	91%
3338	10%	80%
3339	15%	70%
3340	20%	60%
3341	25%	50%

3342 (2) For the purpose of this section, "a qualifying
3343 Mississippi investment" is hereby defined as follows:

3344 (a) Certificates of deposit issued by any bank or
3345 savings and loan association domiciled in this state;

3346 (b) Bonds of this state or bonds of municipal, school,
3347 road or levee districts, or other political subdivisions of this
3348 state;

3349 (c) Loans evidenced by notes and secured by deeds of
3350 trust on property located in this state;

3351 (d) Real property located in this state;



3352 (e) Policy loans to residents of Mississippi, or other
3353 loans to residents of this state, or to corporations domiciled in
3354 this state;

3355 (f) Common or preferred stock, bonds and other
3356 evidences of indebtedness of corporations domiciled in this state;
3357 and

3358 (g) Cash on deposit in any bank or savings and loan
3359 association domiciled in this state.

3360 "A qualifying Mississippi investment" shall not include any
3361 investment for which a credit is allocated under Section 57-105-1
3362 and/or Section 57-115-1 et seq.

3363 (3) If the credits, or any part thereof, authorized by the
3364 preceding provisions of this section shall be held by a court of
3365 final jurisdiction to be unconstitutional and void for any reason
3366 or to make the annual premium taxes levied by Sections 27-15-103,
3367 27-15-109, 27-15-119 and 83-31-45, Mississippi Code of 1972,
3368 unlawfully discriminatory or otherwise invalid under the
3369 Fourteenth Amendment or the Commerce Clause of the Constitution of
3370 the United States or under any state or other federal
3371 constitutional provisions, it is hereby expressly declared that
3372 such fact shall in no way affect the validity of the annual
3373 premium taxes levied thereby, and that such provisions would have
3374 been enacted even though the Legislature had known this credit
3375 section would be held invalid.



3376 (4) This section shall apply to taxes accruing and
3377 investments existing from and after July 1, 1985.

3378 **SECTION 22.** This act shall take effect and be in force from
3379 and after passage.

**Further, amend by striking the title in its entirety and
inserting in lieu thereof the following:**

1 AN ACT TO REQUIRE THE DIVISION OF MEDICAID TO ENTER INTO
2 NEGOTIATIONS WITH THE CENTERS FOR MEDICARE AND MEDICAID SERVICES
3 (CMS) TO OBTAIN A WAIVER FOR APPLICABLE PROVISIONS OF THE MEDICAID
4 LAWS AND REGULATIONS UNDER SECTION 1115 OF THE SOCIAL SECURITY ACT
5 TO CREATE A PLAN TO ALLOW MEDICAID COVERAGE IN MISSISSIPPI FOR
6 INDIVIDUALS WITHIN A CERTAIN COVERAGE GROUP; TO PROVIDE THAT THE
7 COVERAGE GROUP SHALL INCLUDE INDIVIDUALS WHO ARE 19 THROUGH 64
8 YEARS OF AGE WHOSE INCOME IS LESS THAN 100% OF THE FEDERAL POVERTY
9 LEVEL AND ARE EMPLOYED AT LEAST 120 HOURS PER MONTH IN A POSITION
10 FOR WHICH HEALTH INSURANCE IS NOT PAID FOR BY THE EMPLOYER, ARE
11 ENROLLED AS A FULL-TIME STUDENT OR IN WORKFORCE TRAINING, OR ARE
12 OTHERWISE ACTING AS A PRIMARY CAREGIVER FOR A DISABLED CHILD,
13 SPOUSE, OR PARENT; TO PROVIDE COVERAGE FOR OTHER CERTAIN GROUPS;
14 TO PROVIDE THAT ANY INDIVIDUAL OTHERWISE ELIGIBLE FOR COVERAGE
15 UNDER THE ACT WHO HAS HEALTH INSURANCE COVERAGE AND VOLUNTARILY
16 DISENROLLS SUCH COVERAGE SHALL NOT BE ELIGIBLE FOR COVERAGE UNTIL
17 12 MONTHS AFTER THE ENDING DATE OF THAT COVERAGE; TO PROHIBIT
18 COVERAGE FOR ANY INDIVIDUAL WHO IS NOT A U.S. CITIZEN; TO REQUIRE
19 THE DIVISION TO VERIFY ELIGIBILITY OF EACH BENEFICIARY NO LESS
20 THAN ON A QUARTERLY BASIS; TO PROVIDE THAT ALL INDIVIDUALS IN THE
21 COVERAGE GROUP SHALL BE ENROLLED IN AND THEIR SERVICES SHALL BE
22 PROVIDED BY THE MANAGED CARE ORGANIZATIONS (MCOS), COORDINATED
23 CARE ORGANIZATIONS (CCOS), PROVIDER-SPONSORED HEALTH PLANS (PSHPS)
24 AND OTHER SUCH ORGANIZATIONS PAID FOR SERVICES TO THE MEDICAID
25 POPULATION ON A CAPITATED BASIS BY THE DIVISION; TO PROVIDE THAT
26 INDIVIDUALS ENROLLED UNDER THIS ACT SHALL BE PROVIDED ESSENTIAL
27 HEALTH SERVICES AS DETERMINED BY THE DIVISION, WHICH SHALL, AT A
28 MINIMUM, INCLUDE AMBULATORY PATIENT SERVICES, EMERGENCY SERVICES,
29 HOSPITALIZATION, PRESCRIPTION DRUGS, REHABILITATIVE SERVICES,
30 LABORATORY SERVICES, PRIMARY CARE SERVICES AND PREVENTIVE AND
31 WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT; TO PROVIDE FOR
32 THE FUNDING OF THE PLAN; TO PROVIDE FOR THE LEVY OF AN ASSESSMENT
33 UPON EACH MANAGED CARE ORGANIZATION, COORDINATED CARE
34 ORGANIZATION, PROVIDER-SPONSORED HEALTH PLAN OR OTHER ORGANIZATION
35 PAID FOR SERVICES ON A CAPITATED BASIS BY THE DIVISION, IN THE
36 AMOUNT OF 3% ON THE TOTAL PAID CAPITATION; TO REQUIRE THE DIVISION



37 TO APPLY FOR A WAIVER OF THE APPLICABLE PROVISIONS OF THE MEDICAID
38 LAWS WITHIN 120 DAYS OF THE EFFECTIVE DATE OF THE ACT; TO PROVIDE
39 THAT IF CMS REJECTS THE DIVISION'S WORK REQUIREMENT WAIVER
40 REQUEST, THEN THIS ACT SHALL STAND REPEALED ON THE DATE OF SUCH
41 REJECTION; TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972,
42 TO CONFORM TO THE PROVISIONS OF THE ACT; TO BRING FORWARD SECTIONS
43 43-13-5, 43-13-11, 43-13-105, 43-13-113, 43-13-116, 43-13-117,
44 43-13-121, 43-13-122, 43-13-123, 43-13-126, 43-13-133, 43-13-143,
45 43-13-145, 27-15-109, 27-15-115 AND 27-15-129, MISSISSIPPI CODE OF
46 1972, FOR THE PURPOSE OF POSSIBLE AMENDMENT; AND FOR RELATED
47 PURPOSES.

