

By: Senator(s) Blackwell

To: Medicaid

SENATE BILL NO. 2386
(As Passed the Senate)

1 AN ACT TO BRING FORWARD SECTIONS 27-15-103, 27-15-109,
2 27-15-115 AND 27-15-129, MISSISSIPPI CODE OF 1972, WHICH PROVIDE
3 FOR CERTAIN PREMIUM TAXES APPLIED TO CERTAIN INSURANCE ENTITIES;
4 TO BRING FORWARD SECTIONS 43-13-5, 43-13-11, 43-13-105, 43-13-107,
5 43-13-111, 43-13-113, 43-13-115, 43-13-116, 43-13-117,
6 43-13-117.1, 43-13-121, 43-13-122, 43-13-123, 43-13-126,
7 43-13-133, 43-13-143, 43-13-145 AND 43-13-147, MISSISSIPPI CODE OF
8 1972, WHICH PROVIDE FOR VARIOUS PROVISIONS RELATED TO THE DIVISION
9 OF MEDICAID, REIMBURSEMENT, BENEFICIARIES, HOSPITAL ASSESSMENT AND
10 THE CHILDREN'S HEALTH INSURANCE PROGRAM, FOR THE PURPOSE OF
11 POSSIBLE AMENDMENT; AND FOR RELATED PURPOSES.

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

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

15 27-15-103. (1) Except as otherwise provided in Section
16 83-61-11, in addition to the license tax now or hereafter provided
17 by law, which tax shall be paid when the company enters or is
18 admitted to do business in this state, there is hereby levied and
19 imposed upon all foreign insurance companies and associations,
20 including life insurance companies and associations, health,
21 accident and industrial insurance companies and associations, fire
22 and casualty insurance companies and associations, and all other



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



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

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

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

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



73 deferred compensation plan qualified under Section 401, Section
74 403 or Section 457 of the Federal Tax Code for federal tax
75 exemption. Provided, however, that a domestic insurance company
76 against which is levied additional premium tax under retaliatory
77 laws of other states in which it does business, as a result of the
78 tax increase provided by Sections 27-15-103 through 27-15-117, may
79 deduct the total of such additional retaliatory tax from the state
80 income tax due by it to the State of Mississippi. The insurance
81 carriers selected to furnish service to the State of Mississippi,
82 under the State Employees Life and Health Insurance Plan, shall
83 not be required to pay the premium tax levied against insurance
84 companies under this section on the premiums collected for
85 coverage under the state employees plan.

86 (2) Except as expressly provided by subsection (1) of this
87 section, all of the provisions of Sections 27-15-103 through
88 27-15-117 shall be applicable to such domestic insurance
89 companies. However, the statement filed with the State Tax
90 Commission by domestic insurance companies as provided in Section
91 27-15-107 shall include therein a sworn statement of all
92 additional retaliatory premium taxes paid by them to other states
93 as a result of the increase in premium taxes imposed by Sections
94 27-15-103 through 27-15-117, itemized by states to which paid.

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



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

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

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

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

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



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

Percentage of Total Admitted	Percentage of Premium
Assets in Qualifying	Tax Payable
Mississippi Investments	

1%	99%
2%	98%
3%	97%
4%	96%
5%	95%
6%	94%
7%	93%
8%	92%
9%	91%
10%	80%
15%	70%
20%	60%
25%	50%

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

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

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



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

(d) Real property located in this state;

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

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

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

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

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



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

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

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

178 43-13-5. The State Department of Public Welfare, after
179 having made a determination with respect to eligibility with due
180 regard to the resources and income of the applicant, may make
181 vendor payments on behalf of eligible individuals for such care as
182 may be authorized within the limits of available funds, provided
183 that such medical or remedial care is rendered by or under the
184 supervision of a licensed practitioner, and provided further that
185 no regulation shall be promulgated which limits or abridges the
186 recipient's free choice of the provider of medical and remedial
187 care or service. Such recipients of medical assistance for the
188 aged shall only be persons:

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

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

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

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



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

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

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

208 43-13-11. The administering agency is authorized to contract
209 with other state government and nongovernment agencies and
210 organizations in the State of Mississippi for purposes of
211 performing all or part of the administrative aspects of medical or
212 remedial care programs herein authorized, paying a reasonable fee
213 for such service.

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

216 43-13-105. When used in this article, the following
217 definitions shall apply, unless the context requires otherwise:

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

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



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

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

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

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

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



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

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

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

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



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

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

283 (d) The executive director, with the approval of the
284 Governor and subject to the rules and regulations of the State
285 Personnel Board, shall employ such professional, administrative,
286 stenographic, secretarial, clerical and technical assistance as
287 may be necessary to perform the duties required in administering
288 this article and fix the compensation for those persons, all in
289 accordance with a state merit system meeting federal requirements.
290 When the salary of the executive director is not set by law, that
291 salary shall be set by the State Personnel Board. No employees of
292 the Division of Medicaid shall be considered to be staff members
293 of the immediate Office of the Governor; however, Section
294 25-9-107(c) (xv) shall apply to the executive director and other
295 administrative heads of the division.



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

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

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

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

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

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

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



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

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

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

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

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



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

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

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

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

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

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

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



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

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

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

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

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

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

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

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



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

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

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

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



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

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

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



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

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

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

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



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

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

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

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

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



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

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



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

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

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



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

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

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

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

557 (e) If a claim is neither paid nor denied for valid and
558 proper reasons by the end of the time periods as specified above,
559 the Division of Medicaid's fiscal agent must pay the provider
560 interest on the claim at the rate of one and one-half percent
561 (1-1/2%) per month on the amount of such claim until it is finally
562 settled or adjudicated.

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

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



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

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

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

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

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

(7) [Repealed.]

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



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

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

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

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



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

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

628 (4) [Deleted]

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

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



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

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

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

(9) Individuals who are:

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



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

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

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

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

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

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



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

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

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



719 The eligibility of individuals covered under this paragraph
720 shall be determined by the Division of Medicaid, and those
721 individuals determined eligible shall receive Medicare
722 cost-sharing expenses only as more fully defined by the Medicare
723 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
724 1997.

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

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

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

743 (14) [Deleted]



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

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

759 (17) In accordance with the terms of the federal
760 Personal Responsibility and Work Opportunity Reconciliation Act of
761 1996 (Public Law 104-193), persons who become ineligible for
762 assistance under Title IV-A of the federal Social Security Act, as
763 amended, because of increased income from or hours of employment
764 of the caretaker relative or because of the expiration of the
765 applicable earned income disregards, who were eligible for
766 Medicaid for at least three (3) of the six (6) months preceding
767 the month in which the ineligibility begins, shall be eligible for
768 Medicaid for up to twelve (12) months. The eligibility of the



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

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

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

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

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



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

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

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



819 1614(a) of the federal Social Security Act, as amended, if the
820 person does not receive items and services provided under
821 Medicaid.

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

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

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



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

846 (25) The division shall apply to the Centers for
847 Medicare and Medicaid Services (CMS) for any necessary waivers to
848 provide services to individuals who are sixty-five (65) years of
849 age or older or are disabled as determined under Section
850 1614(a)(3) of the federal Social Security Act, as amended, and
851 whose income does not exceed one hundred thirty-five percent
852 (135%) of the nonfarm official poverty level as defined by the
853 Office of Management and Budget and revised annually, and whose
854 resources do not exceed those established by the Division of
855 Medicaid, and who are not otherwise covered by Medicare. Nothing
856 contained in this paragraph (25) shall entitle an individual to
857 benefits. The eligibility of individuals covered under this
858 paragraph shall be determined by the Division of Medicaid.

859 (26) The division shall apply to the Centers for
860 Medicare and Medicaid Services (CMS) for any necessary waivers to
861 provide services to individuals who are sixty-five (65) years of
862 age or older or are disabled as determined under Section
863 1614(a)(3) of the federal Social Security Act, as amended, who are
864 end stage renal disease patients on dialysis, cancer patients on
865 chemotherapy or organ transplant recipients on antirejection
866 drugs, whose income does not exceed one hundred thirty-five
867 percent (135%) of the nonfarm official poverty level as defined by
868 the Office of Management and Budget and revised annually, and



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

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

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

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

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

890 43-13-116. (1) It shall be the duty of the Division of
891 Medicaid to fully implement and carry out the administrative
892 functions of determining the eligibility of those persons who
893 qualify for medical assistance under Section 43-13-115.



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

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



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

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



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

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

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



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

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

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

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



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

997 (iii) Upon receipt of a written request for a
998 hearing, the request will be acknowledged in writing within twenty
999 (20) days and a hearing scheduled. The claimant or representative
1000 will be given at least five (5) days' advance notice of the
1001 hearing date. The local and/or state level hearings will be held
1002 by telephone unless, at the hearing officer's discretion, it is
1003 determined that an in-person hearing is necessary. If a local
1004 hearing is requested, the regional office will notify the claimant
1005 or representative in writing of the time of the local hearing. If
1006 a state hearing is requested, the state office will notify the
1007 claimant or representative in writing of the time of the state
1008 hearing. If an in-person hearing is necessary, local hearings
1009 will be held at the regional office and state hearings will be
1010 held at the state office unless other arrangements are
1011 necessitated by the claimant's inability to travel.

1012 (iv) All persons attending a hearing will attend
1013 for the purpose of giving information on behalf of the claimant or
1014 rendering the claimant assistance in some other way, or for the
1015 purpose of representing the Division of Medicaid.



1016 (v) A state or local hearing request may be
1017 withdrawn at any time before the scheduled hearing, or after the
1018 hearing is held but before a decision is rendered. The withdrawal
1019 must be in writing and signed by the claimant or representative.
1020 A hearing request will be considered abandoned if the claimant or
1021 representative fails to appear at a scheduled hearing without good
1022 cause. If no one appears for a hearing, the appropriate office
1023 will notify the claimant in writing that the hearing is dismissed
1024 unless good cause is shown for not attending. The proposed agency
1025 action will be taken on the case following failure to appear for a
1026 hearing if the action has not already been effected.

1027 (vi) The claimant or his representative has the
1028 following rights in connection with a local or state hearing:

1029 (A) The right to examine at a reasonable time
1030 before the date of the hearing and during the hearing the content
1031 of the claimant's case record;

1032 (B) The right to have legal representation at
1033 the hearing and to bring witnesses;

1034 (C) The right to produce documentary evidence
1035 and establish all facts and circumstances concerning eligibility,
1036 services, or benefits;

1037 (D) The right to present an argument without
1038 undue interference;



1039 (E) The right to question or refute any
1040 testimony or evidence including an opportunity to confront and
1041 cross-examine adverse witnesses.

1042 (vii) When a request for a local hearing is
1043 received by the regional office or if the regional office is
1044 notified by the state office that a local hearing has been
1045 requested, the Medicaid specialist supervisor in the regional
1046 office will review the case record, reexamine the action taken on
1047 the case, and determine if policy and procedures have been
1048 followed. If any adjustments or corrections should be made, the
1049 Medicaid specialist supervisor will ensure that corrective action
1050 is taken. If the request for hearing was timely made such that
1051 continuation of benefits applies, the Medicaid specialist
1052 supervisor will ensure that benefits continue at the level before
1053 the proposed adverse action that is the subject of the appeal.
1054 The Medicaid specialist supervisor will also ensure that all
1055 needed information, verification, and evidence is in the case
1056 record for the hearing.

1057 (viii) When a state hearing is requested that
1058 appeals the action or inaction of a regional office, the regional
1059 office will prepare copies of the case record and forward it to
1060 the appropriate division in the state office no later than five
1061 (5) days after receipt of the request for a state hearing. The
1062 original case record will remain in the regional office. Either
1063 the original case record in the regional office or the copy



1064 forwarded to the state office will be available for inspection by
1065 the claimant or claimant's representative a reasonable time before
1066 the date of the hearing.

1067 (ix) The Medicaid specialist supervisor will serve
1068 as the hearing officer for a local hearing unless the Medicaid
1069 specialist supervisor actually participated in the eligibility,
1070 benefits, or services decision under appeal, in which case the
1071 Medicaid specialist supervisor must appoint a Medicaid specialist
1072 in the regional office who did not actually participate in the
1073 decision under appeal to serve as hearing officer. The local
1074 hearing will be an informal proceeding in which the claimant or
1075 representative may present new or additional information, may
1076 question the action taken on the client's case, and will hear an
1077 explanation from agency staff as to the regulations and
1078 requirements that were applied to claimant's case in making the
1079 decision.

1080 (x) After the hearing, the hearing officer will
1081 prepare a written summary of the hearing procedure and file it
1082 with the case record. The hearing officer will consider the facts
1083 presented at the local hearing in reaching a decision. The
1084 claimant will be notified of the local hearing decision on the
1085 appropriate form that will state clearly the reason for the
1086 decision, the policy that governs the decision, the claimant's
1087 right to appeal the decision to the state office, and, if the
1088 original adverse action is upheld, the new effective date of the



1089 reduction or termination of benefits or services if continuation
1090 of benefits applied during the hearing process. The new effective
1091 date of the reduction or termination of benefits or services must
1092 be at the end of the fifteen-day advance notice period from the
1093 mailing date of the notice of hearing decision. The notice to
1094 claimant will be made part of the case record.

1095 (xi) The claimant has the right to appeal a local
1096 hearing decision by requesting a state hearing in writing within
1097 fifteen (15) days of the mailing date of the notice of local
1098 hearing decision. The state hearing request should be made to the
1099 regional office. If benefits have been continued pending the
1100 local hearing process, then benefits will continue throughout the
1101 fifteen-day advance notice period for an adverse local hearing
1102 decision. If a state hearing is timely requested within the
1103 fifteen-day period, then benefits will continue pending the state
1104 hearing process. State hearings requested after the fifteen-day
1105 local hearing advance notice period will not be accepted unless
1106 the initial thirty-day period for filing a hearing request has not
1107 expired because the local hearing was held early, in which case a
1108 state hearing request will be accepted as timely within the number
1109 of days remaining of the unexpired initial thirty-day period in
1110 addition to the fifteen-day time period. Continuation of benefits
1111 during the state hearing process, however, will only apply if the
1112 state hearing request is received within the fifteen-day advance
1113 notice period.



1114 (xii) When a request for a state hearing is
1115 received in the regional office, the request will be made part of
1116 the case record and the regional office will prepare the case
1117 record and forward it to the appropriate division in the state
1118 office within five (5) days of receipt of the state hearing
1119 request. A request for a state hearing received in the state
1120 office will be forwarded to the regional office for inclusion in
1121 the case record and the regional office will prepare the case
1122 record and forward it to the appropriate division in the state
1123 office within five (5) days of receipt of the state hearing
1124 request.

1125 (xiii) Upon receipt of the hearing record, an
1126 impartial hearing officer will be assigned to hear the case either
1127 by the Executive Director of the Division of Medicaid or his or
1128 her designee. Hearing officers will be individuals with
1129 appropriate expertise employed by the division and who have not
1130 been involved in any way with the action or decision on appeal in
1131 the case. The hearing officer will review the case record and if
1132 the review shows that an error was made in the action of the
1133 agency or in the interpretation of policy, or that a change of
1134 policy has been made, the hearing officer will discuss these
1135 matters with the appropriate agency personnel and request that an
1136 appropriate adjustment be made. Appropriate agency personnel will
1137 discuss the matter with the claimant and if the claimant is
1138 agreeable to the adjustment of the claim, then agency personnel



1139 will request in writing dismissal of the hearing and the reason
1140 therefor, to be placed in the case record. If the hearing is to
1141 go forward, it shall be scheduled by the hearing officer in the
1142 manner set forth in subparagraph (iii) of this paragraph (e).

1143 (xiv) In conducting the hearing, the state hearing
1144 officer will inform those present of the following:

1145 (A) That the hearing will be recorded on tape
1146 and that a transcript of the proceedings will be typed for the
1147 record;

1148 (B) The action taken by the agency which
1149 prompted the appeal;

1150 (C) An explanation of the claimant's rights
1151 during the hearing as outlined in subparagraph (vi) of this
1152 paragraph (e);

1153 (D) That the purpose of the hearing is for
1154 the claimant to express dissatisfaction and present additional
1155 information or evidence;

1156 (E) That the case record is available for
1157 review by the claimant or representative during the hearing;

1158 (F) That the final hearing decision will be
1159 rendered by the Executive Director of the Division of Medicaid on
1160 the basis of facts presented at the hearing and the case record
1161 and that the claimant will be notified by letter of the final
1162 decision.



1163 (xv) During the hearing, the claimant and/or
1164 representative will be allowed an opportunity to make a full
1165 statement concerning the appeal and will be assisted, if
1166 necessary, in disclosing all information on which the claim is
1167 based. All persons representing the claimant and those
1168 representing the Division of Medicaid will have the opportunity to
1169 state all facts pertinent to the appeal. The hearing officer may
1170 recess or continue the hearing for a reasonable time should
1171 additional information or facts be required or if some change in
1172 the claimant's circumstances occurs during the hearing process
1173 which impacts the appeal. When all information has been
1174 presented, the hearing officer will close the hearing and stop the
1175 recorder.

1176 (xvi) Immediately following the hearing the
1177 hearing tape will be transcribed and a copy of the transcription
1178 forwarded to the regional office for filing in the case record.
1179 As soon as possible, the hearing officer shall review the evidence
1180 and record of the proceedings, testimony, exhibits, and other
1181 supporting documents, prepare a written summary of the facts as
1182 the hearing officer finds them, and prepare a written
1183 recommendation of action to be taken by the agency, citing
1184 appropriate policy and regulations that govern the recommendation.
1185 The decision cannot be based on any material, oral or written, not
1186 available to the claimant before or during the hearing. The
1187 hearing officer's recommendation will become part of the case



1188 record which will be submitted to the Executive Director of the
1189 Division of Medicaid for further review and decision.

1190 (xvii) The Executive Director of the Division of
1191 Medicaid, upon review of the recommendation, proceedings and the
1192 record, may sustain the recommendation of the hearing officer,
1193 reject the same, or remand the matter to the hearing officer to
1194 take additional testimony and evidence, in which case, the hearing
1195 officer thereafter shall submit to the executive director a new
1196 recommendation. The executive director shall prepare a written
1197 decision summarizing the facts and identifying policies and
1198 regulations that support the decision, which shall be mailed to
1199 the claimant and the representative, with a copy to the regional
1200 office if appropriate, as soon as possible after submission of a
1201 recommendation by the hearing officer. The decision notice will
1202 specify any action to be taken by the agency, specify any revised
1203 eligibility dates or, if continuation of benefits applies, will
1204 notify the claimant of the new effective date of reduction or
1205 termination of benefits or services, which will be fifteen (15)
1206 days from the mailing date of the notice of decision. The
1207 decision rendered by the Executive Director of the Division of
1208 Medicaid is final and binding. The claimant is entitled to seek
1209 judicial review in a court of proper jurisdiction.

1210 (xviii) The Division of Medicaid must take final
1211 administrative action on a hearing, whether state or local, within



1212 ninety (90) days from the date of the initial request for a
1213 hearing.

1214 (xix) A group hearing may be held for a number of
1215 claimants under the following circumstances:

1216 (A) The Division of Medicaid may consolidate
1217 the cases and conduct a single group hearing when the only issue
1218 involved is one (1) of a single law or agency policy;

1219 (B) The claimants may request a group hearing
1220 when there is one (1) issue of agency policy common to all of
1221 them.

1222 In all group hearings, whether initiated by the Division of
1223 Medicaid or by the claimants, the policies governing fair hearings
1224 must be followed. Each claimant in a group hearing must be
1225 permitted to present his or her own case and be represented by his
1226 or her own representative, or to withdraw from the group hearing
1227 and have his or her appeal heard individually. As in individual
1228 hearings, the hearing will be conducted only on the issue being
1229 appealed, and each claimant will be expected to keep individual
1230 testimony within a reasonable time frame as a matter of
1231 consideration to the other claimants involved.

1232 (xx) Any specific matter necessitating an
1233 administrative hearing not otherwise provided under this article
1234 or agency policy shall be afforded under the hearing procedures as
1235 outlined above. If the specific time frames of such a unique
1236 matter relating to requesting, granting, and concluding of the



1237 hearing is contrary to the time frames as set out in the hearing
1238 procedures above, the specific time frames will govern over the
1239 time frames as set out within these procedures.

1240 (4) The Executive Director of the Division of Medicaid, with
1241 the approval of the Governor, shall be authorized to employ
1242 eligibility, technical, clerical and supportive staff as may be
1243 required in carrying out and fully implementing the determination
1244 of Medicaid eligibility, including conducting quality control
1245 reviews and the investigation of the improper receipt of medical
1246 assistance. Staffing needs will be set forth in the annual
1247 appropriation act for the division. Additional office space as
1248 needed in performing eligibility, quality control and
1249 investigative functions shall be obtained by the division.

1250 **SECTION 13.** Section 43-13-117, Mississippi Code of 1972, is
1251 brought forward as follows:

1252 43-13-117. (A) Medicaid as authorized by this article shall
1253 include payment of part or all of the costs, at the discretion of
1254 the division, with approval of the Governor and the Centers for
1255 Medicare and Medicaid Services, of the following types of care and
1256 services rendered to eligible applicants who have been determined
1257 to be eligible for that care and services, within the limits of
1258 state appropriations and federal matching funds:

1259 (1) Inpatient hospital services.



1260 (a) The division is authorized to implement an All
1261 Patient Refined Diagnosis Related Groups (APR-DRG) reimbursement
1262 methodology for inpatient hospital services.

1263 (b) No service benefits or reimbursement
1264 limitations in this subsection (A)(1) shall apply to payments
1265 under an APR-DRG or Ambulatory Payment Classification (APC) model
1266 or a managed care program or similar model described in subsection
1267 (H) of this section unless specifically authorized by the
1268 division.

1269 (2) Outpatient hospital services.

1270 (a) Emergency services.

1271 (b) Other outpatient hospital services. The
1272 division shall allow benefits for other medically necessary
1273 outpatient hospital services (such as chemotherapy, radiation,
1274 surgery and therapy), including outpatient services in a clinic or
1275 other facility that is not located inside the hospital, but that
1276 has been designated as an outpatient facility by the hospital, and
1277 that was in operation or under construction on July 1, 2009,
1278 provided that the costs and charges associated with the operation
1279 of the hospital clinic are included in the hospital's cost report.
1280 In addition, the Medicare thirty-five-mile rule will apply to
1281 those hospital clinics not located inside the hospital that are
1282 constructed after July 1, 2009. Where the same services are
1283 reimbursed as clinic services, the division may revise the rate or



1284 methodology of outpatient reimbursement to maintain consistency,
1285 efficiency, economy and quality of care.

1286 (c) The division is authorized to implement an
1287 Ambulatory Payment Classification (APC) methodology for outpatient
1288 hospital services. The division shall give rural hospitals that
1289 have fifty (50) or fewer licensed beds the option to not be
1290 reimbursed for outpatient hospital services using the APC
1291 methodology, but reimbursement for outpatient hospital services
1292 provided by those hospitals shall be based on one hundred one
1293 percent (101%) of the rate established under Medicare for
1294 outpatient hospital services. Those hospitals choosing to not be
1295 reimbursed under the APC methodology shall remain under cost-based
1296 reimbursement for a two-year period.

1297 (d) No service benefits or reimbursement
1298 limitations in this subsection (A)(2) shall apply to payments
1299 under an APR-DRG or APC model or a managed care program or similar
1300 model described in subsection (H) of this section unless
1301 specifically authorized by the division.

1302 (3) Laboratory and x-ray services.

1303 (4) Nursing facility services.

1304 (a) The division shall make full payment to
1305 nursing facilities for each day, not exceeding forty-two (42) days
1306 per year, that a patient is absent from the facility on home
1307 leave. Payment may be made for the following home leave days in
1308 addition to the forty-two-day limitation: Christmas, the day



1309 before Christmas, the day after Christmas, Thanksgiving, the day
1310 before Thanksgiving and the day after Thanksgiving.

1311 (b) From and after July 1, 1997, the division
1312 shall implement the integrated case-mix payment and quality
1313 monitoring system, which includes the fair rental system for
1314 property costs and in which recapture of depreciation is
1315 eliminated. The division may reduce the payment for hospital
1316 leave and therapeutic home leave days to the lower of the case-mix
1317 category as computed for the resident on leave using the
1318 assessment being utilized for payment at that point in time, or a
1319 case-mix score of 1.000 for nursing facilities, and shall compute
1320 case-mix scores of residents so that only services provided at the
1321 nursing facility are considered in calculating a facility's per
1322 diem.

1323 (c) From and after July 1, 1997, all state-owned
1324 nursing facilities shall be reimbursed on a full reasonable cost
1325 basis.

1326 (d) On or after January 1, 2015, the division
1327 shall update the case-mix payment system resource utilization
1328 grouper and classifications and fair rental reimbursement system.
1329 The division shall develop and implement a payment add-on to
1330 reimburse nursing facilities for ventilator-dependent resident
1331 services.

1332 (e) The division shall develop and implement, not
1333 later than January 1, 2001, a case-mix payment add-on determined



1334 by time studies and other valid statistical data that will
1335 reimburse a nursing facility for the additional cost of caring for
1336 a resident who has a diagnosis of Alzheimer's or other related
1337 dementia and exhibits symptoms that require special care. Any
1338 such case-mix add-on payment shall be supported by a determination
1339 of additional cost. The division shall also develop and implement
1340 as part of the fair rental reimbursement system for nursing
1341 facility beds, an Alzheimer's resident bed depreciation enhanced
1342 reimbursement system that will provide an incentive to encourage
1343 nursing facilities to convert or construct beds for residents with
1344 Alzheimer's or other related dementia.

1345 (f) The division shall develop and implement an
1346 assessment process for long-term care services. The division may
1347 provide the assessment and related functions directly or through
1348 contract with the area agencies on aging.

1349 The division shall apply for necessary federal waivers to
1350 assure that additional services providing alternatives to nursing
1351 facility care are made available to applicants for nursing
1352 facility care.

1353 (5) Periodic screening and diagnostic services for
1354 individuals under age twenty-one (21) years as are needed to
1355 identify physical and mental defects and to provide health care
1356 treatment and other measures designed to correct or ameliorate
1357 defects and physical and mental illness and conditions discovered
1358 by the screening services, regardless of whether these services



1359 are included in the state plan. The division may include in its
1360 periodic screening and diagnostic program those discretionary
1361 services authorized under the federal regulations adopted to
1362 implement Title XIX of the federal Social Security Act, as
1363 amended. The division, in obtaining physical therapy services,
1364 occupational therapy services, and services for individuals with
1365 speech, hearing and language disorders, may enter into a
1366 cooperative agreement with the State Department of Education for
1367 the provision of those services to handicapped students by public
1368 school districts using state funds that are provided from the
1369 appropriation to the Department of Education to obtain federal
1370 matching funds through the division. The division, in obtaining
1371 medical and mental health assessments, treatment, care and
1372 services for children who are in, or at risk of being put in, the
1373 custody of the Mississippi Department of Human Services may enter
1374 into a cooperative agreement with the Mississippi Department of
1375 Human Services for the provision of those services using state
1376 funds that are provided from the appropriation to the Department
1377 of Human Services to obtain federal matching funds through the
1378 division.

1379 (6) Physician services. Fees for physician's services
1380 that are covered only by Medicaid shall be reimbursed at ninety
1381 percent (90%) of the rate established on January 1, 2018, and as
1382 may be adjusted each July thereafter, under Medicare. The
1383 division may provide for a reimbursement rate for physician's



1384 services of up to one hundred percent (100%) of the rate
1385 established under Medicare for physician's services that are
1386 provided after the normal working hours of the physician, as
1387 determined in accordance with regulations of the division. The
1388 division may reimburse eligible providers, as determined by the
1389 division, for certain primary care services at one hundred percent
1390 (100%) of the rate established under Medicare. The division shall
1391 reimburse obstetricians and gynecologists for certain primary care
1392 services as defined by the division at one hundred percent (100%)
1393 of the rate established under Medicare.

1394 (7) (a) Home health services for eligible persons, not
1395 to exceed in cost the prevailing cost of nursing facility
1396 services. All home health visits must be precertified as required
1397 by the division. In addition to physicians, certified registered
1398 nurse practitioners, physician assistants and clinical nurse
1399 specialists are authorized to prescribe or order home health
1400 services and plans of care, sign home health plans of care,
1401 certify and recertify eligibility for home health services and
1402 conduct the required initial face-to-face visit with the recipient
1403 of the services.

1404 (b) [Repealed]

1405 (8) Emergency medical transportation services as
1406 determined by the division.

1407 (9) Prescription drugs and other covered drugs and
1408 services as determined by the division.



1409 The division shall establish a mandatory preferred drug list.
1410 Drugs not on the mandatory preferred drug list shall be made
1411 available by utilizing prior authorization procedures established
1412 by the division.

1413 The division may seek to establish relationships with other
1414 states in order to lower acquisition costs of prescription drugs
1415 to include single-source and innovator multiple-source drugs or
1416 generic drugs. In addition, if allowed by federal law or
1417 regulation, the division may seek to establish relationships with
1418 and negotiate with other countries to facilitate the acquisition
1419 of prescription drugs to include single-source and innovator
1420 multiple-source drugs or generic drugs, if that will lower the
1421 acquisition costs of those prescription drugs.

1422 The division may allow for a combination of prescriptions for
1423 single-source and innovator multiple-source drugs and generic
1424 drugs to meet the needs of the beneficiaries.

1425 The executive director may approve specific maintenance drugs
1426 for beneficiaries with certain medical conditions, which may be
1427 prescribed and dispensed in three-month supply increments.

1428 Drugs prescribed for a resident of a psychiatric residential
1429 treatment facility must be provided in true unit doses when
1430 available. The division may require that drugs not covered by
1431 Medicare Part D for a resident of a long-term care facility be
1432 provided in true unit doses when available. Those drugs that were
1433 originally billed to the division but are not used by a resident



1434 in any of those facilities shall be returned to the billing
1435 pharmacy for credit to the division, in accordance with the
1436 guidelines of the State Board of Pharmacy and any requirements of
1437 federal law and regulation. Drugs shall be dispensed to a
1438 recipient and only one (1) dispensing fee per month may be
1439 charged. The division shall develop a methodology for reimbursing
1440 for restocked drugs, which shall include a restock fee as
1441 determined by the division not exceeding Seven Dollars and
1442 Eighty-two Cents (\$7.82).

1443 Except for those specific maintenance drugs approved by the
1444 executive director, the division shall not reimburse for any
1445 portion of a prescription that exceeds a thirty-one-day supply of
1446 the drug based on the daily dosage.

1447 The division is authorized to develop and implement a program
1448 of payment for additional pharmacist services as determined by the
1449 division.

1450 All claims for drugs for dually eligible Medicare/Medicaid
1451 beneficiaries that are paid for by Medicare must be submitted to
1452 Medicare for payment before they may be processed by the
1453 division's online payment system.

1454 The division shall develop a pharmacy policy in which drugs
1455 in tamper-resistant packaging that are prescribed for a resident
1456 of a nursing facility but are not dispensed to the resident shall
1457 be returned to the pharmacy and not billed to Medicaid, in
1458 accordance with guidelines of the State Board of Pharmacy.



1459 The division shall develop and implement a method or methods
1460 by which the division will provide on a regular basis to Medicaid
1461 providers who are authorized to prescribe drugs, information about
1462 the costs to the Medicaid program of single-source drugs and
1463 innovator multiple-source drugs, and information about other drugs
1464 that may be prescribed as alternatives to those single-source
1465 drugs and innovator multiple-source drugs and the costs to the
1466 Medicaid program of those alternative drugs.

1467 Notwithstanding any law or regulation, information obtained
1468 or maintained by the division regarding the prescription drug
1469 program, including trade secrets and manufacturer or labeler
1470 pricing, is confidential and not subject to disclosure except to
1471 other state agencies.

1472 The dispensing fee for each new or refill prescription,
1473 including nonlegend or over-the-counter drugs covered by the
1474 division, shall be not less than Three Dollars and Ninety-one
1475 Cents (\$3.91), as determined by the division.

1476 The division shall not reimburse for single-source or
1477 innovator multiple-source drugs if there are equally effective
1478 generic equivalents available and if the generic equivalents are
1479 the least expensive.

1480 It is the intent of the Legislature that the pharmacists
1481 providers be reimbursed for the reasonable costs of filling and
1482 dispensing prescriptions for Medicaid beneficiaries.



1483 The division shall allow certain drugs, including
1484 physician-administered drugs, and implantable drug system devices,
1485 and medical supplies, with limited distribution or limited access
1486 for beneficiaries and administered in an appropriate clinical
1487 setting, to be reimbursed as either a medical claim or pharmacy
1488 claim, as determined by the division.

1489 It is the intent of the Legislature that the division and any
1490 managed care entity described in subsection (H) of this section
1491 encourage the use of Alpha-Hydroxyprogesterone Caproate (17P) to
1492 prevent recurrent preterm birth.

1493 (10) Dental and orthodontic services to be determined
1494 by the division.

1495 The division shall increase the amount of the reimbursement
1496 rate for diagnostic and preventative dental services for each of
1497 the fiscal years 2022, 2023 and 2024 by five percent (5%) above
1498 the amount of the reimbursement rate for the previous fiscal year.
1499 The division shall increase the amount of the reimbursement rate
1500 for restorative dental services for each of the fiscal years 2023,
1501 2024 and 2025 by five percent (5%) above the amount of the
1502 reimbursement rate for the previous fiscal year. It is the intent
1503 of the Legislature that the reimbursement rate revision for
1504 preventative dental services will be an incentive to increase the
1505 number of dentists who actively provide Medicaid services. This
1506 dental services reimbursement rate revision shall be known as the
1507 "James Russell Dumas Medicaid Dental Services Incentive Program."



1508 The Medical Care Advisory Committee, assisted by the Division
1509 of Medicaid, shall annually determine the effect of this incentive
1510 by evaluating the number of dentists who are Medicaid providers,
1511 the number who and the degree to which they are actively billing
1512 Medicaid, the geographic trends of where dentists are offering
1513 what types of Medicaid services and other statistics pertinent to
1514 the goals of this legislative intent. This data shall annually be
1515 presented to the Chair of the Senate Medicaid Committee and the
1516 Chair of the House Medicaid Committee.

1517 The division shall include dental services as a necessary
1518 component of overall health services provided to children who are
1519 eligible for services.

1520 (11) Eyeglasses for all Medicaid beneficiaries who have
1521 (a) had surgery on the eyeball or ocular muscle that results in a
1522 vision change for which eyeglasses or a change in eyeglasses is
1523 medically indicated within six (6) months of the surgery and is in
1524 accordance with policies established by the division, or (b) one
1525 (1) pair every five (5) years and in accordance with policies
1526 established by the division. In either instance, the eyeglasses
1527 must be prescribed by a physician skilled in diseases of the eye
1528 or an optometrist, whichever the beneficiary may select.

1529 (12) Intermediate care facility services.

1530 (a) The division shall make full payment to all
1531 intermediate care facilities for individuals with intellectual
1532 disabilities for each day, not exceeding sixty-three (63) days per



1533 year, that a patient is absent from the facility on home leave.
1534 Payment may be made for the following home leave days in addition
1535 to the sixty-three-day limitation: Christmas, the day before
1536 Christmas, the day after Christmas, Thanksgiving, the day before
1537 Thanksgiving and the day after Thanksgiving.

1538 (b) All state-owned intermediate care facilities
1539 for individuals with intellectual disabilities shall be reimbursed
1540 on a full reasonable cost basis.

1541 (c) Effective January 1, 2015, the division shall
1542 update the fair rental reimbursement system for intermediate care
1543 facilities for individuals with intellectual disabilities.

1544 (13) Family planning services, including drugs,
1545 supplies and devices, when those services are under the
1546 supervision of a physician or nurse practitioner.

1547 (14) Clinic services. Preventive, diagnostic,
1548 therapeutic, rehabilitative or palliative services that are
1549 furnished by a facility that is not part of a hospital but is
1550 organized and operated to provide medical care to outpatients.
1551 Clinic services include, but are not limited to:

1552 (a) Services provided by ambulatory surgical
1553 centers (ACSS) as defined in Section 41-75-1(a); and

1554 (b) Dialysis center services.

1555 (15) Home- and community-based services for the elderly
1556 and disabled, as provided under Title XIX of the federal Social
1557 Security Act, as amended, under waivers, subject to the



1558 availability of funds specifically appropriated for that purpose
1559 by the Legislature.

1560 (16) Mental health services. Certain services provided
1561 by a psychiatrist shall be reimbursed at up to one hundred percent
1562 (100%) of the Medicare rate. Approved therapeutic and case
1563 management services (a) provided by an approved regional mental
1564 health/intellectual disability center established under Sections
1565 41-19-31 through 41-19-39, or by another community mental health
1566 service provider meeting the requirements of the Department of
1567 Mental Health to be an approved mental health/intellectual
1568 disability center if determined necessary by the Department of
1569 Mental Health, using state funds that are provided in the
1570 appropriation to the division to match federal funds, or (b)
1571 provided by a facility that is certified by the State Department
1572 of Mental Health to provide therapeutic and case management
1573 services, to be reimbursed on a fee for service basis, or (c)
1574 provided in the community by a facility or program operated by the
1575 Department of Mental Health. Any such services provided by a
1576 facility described in subparagraph (b) must have the prior
1577 approval of the division to be reimbursable under this section.

1578 (17) Durable medical equipment services and medical
1579 supplies. Precertification of durable medical equipment and
1580 medical supplies must be obtained as required by the division.
1581 The Division of Medicaid may require durable medical equipment
1582 providers to obtain a surety bond in the amount and to the



1583 specifications as established by the Balanced Budget Act of 1997.
1584 A maximum dollar amount of reimbursement for noninvasive
1585 ventilators or ventilation treatments properly ordered and being
1586 used in an appropriate care setting shall not be set by any health
1587 maintenance organization, coordinated care organization,
1588 provider-sponsored health plan, or other organization paid for
1589 services on a capitated basis by the division under any managed
1590 care program or coordinated care program implemented by the
1591 division under this section. Reimbursement by these organizations
1592 to durable medical equipment suppliers for home use of noninvasive
1593 and invasive ventilators shall be on a continuous monthly payment
1594 basis for the duration of medical need throughout a patient's
1595 valid prescription period.

1596 (18) (a) Notwithstanding any other provision of this
1597 section to the contrary, as provided in the Medicaid state plan
1598 amendment or amendments as defined in Section 43-13-145(10), the
1599 division shall make additional reimbursement to hospitals that
1600 serve a disproportionate share of low-income patients and that
1601 meet the federal requirements for those payments as provided in
1602 Section 1923 of the federal Social Security Act and any applicable
1603 regulations. It is the intent of the Legislature that the
1604 division shall draw down all available federal funds allotted to
1605 the state for disproportionate share hospitals. However, from and
1606 after January 1, 1999, public hospitals participating in the
1607 Medicaid disproportionate share program may be required to



1608 participate in an intergovernmental transfer program as provided
1609 in Section 1903 of the federal Social Security Act and any
1610 applicable regulations.

1611 (b) (i) 1. The division may establish a Medicare
1612 Upper Payment Limits Program, as defined in Section 1902(a)(30) of
1613 the federal Social Security Act and any applicable federal
1614 regulations, or an allowable delivery system or provider payment
1615 initiative authorized under 42 CFR 438.6(c), for hospitals,
1616 nursing facilities and physicians employed or contracted by
1617 hospitals.

1618 2. The division shall establish a
1619 Medicaid Supplemental Payment Program, as permitted by the federal
1620 Social Security Act and a comparable allowable delivery system or
1621 provider payment initiative authorized under 42 CFR 438.6(c), for
1622 emergency ambulance transportation providers in accordance with
1623 this subsection (A)(18)(b).

1624 (ii) The division shall assess each hospital,
1625 nursing facility, and emergency ambulance transportation provider
1626 for the sole purpose of financing the state portion of the
1627 Medicare Upper Payment Limits Program or other program(s)
1628 authorized under this subsection (A)(18)(b). The hospital
1629 assessment shall be as provided in Section 43-13-145(4)(a), and
1630 the nursing facility and the emergency ambulance transportation
1631 assessments, if established, shall be based on Medicaid
1632 utilization or other appropriate method, as determined by the



1633 division, consistent with federal regulations. The assessments
1634 will remain in effect as long as the state participates in the
1635 Medicare Upper Payment Limits Program or other program(s)
1636 authorized under this subsection (A)(18)(b). In addition to the
1637 hospital assessment provided in Section 43-13-145(4)(a), hospitals
1638 with physicians participating in the Medicare Upper Payment Limits
1639 Program or other program(s) authorized under this subsection
1640 (A)(18)(b) shall be required to participate in an
1641 intergovernmental transfer or assessment, as determined by the
1642 division, for the purpose of financing the state portion of the
1643 physician UPL payments or other payment(s) authorized under this
1644 subsection (A)(18)(b).

1645 (iii) Subject to approval by the Centers for
1646 Medicare and Medicaid Services (CMS) and the provisions of this
1647 subsection (A)(18)(b), the division shall make additional
1648 reimbursement to hospitals, nursing facilities, and emergency
1649 ambulance transportation providers for the Medicare Upper Payment
1650 Limits Program or other program(s) authorized under this
1651 subsection (A)(18)(b), and, if the program is established for
1652 physicians, shall make additional reimbursement for physicians, as
1653 defined in Section 1902(a)(30) of the federal Social Security Act
1654 and any applicable federal regulations, provided the assessment in
1655 this subsection (A)(18)(b) is in effect.

1656 (iv) Notwithstanding any other provision of
1657 this article to the contrary, effective upon implementation of the



1658 Mississippi Hospital Access Program (MHAP) provided in
1659 subparagraph (c)(i) below, the hospital portion of the inpatient
1660 Upper Payment Limits Program shall transition into and be replaced
1661 by the MHAP program. However, the division is authorized to
1662 develop and implement an alternative fee-for-service Upper Payment
1663 Limits model in accordance with federal laws and regulations if
1664 necessary to preserve supplemental funding. Further, the
1665 division, in consultation with the hospital industry shall develop
1666 alternative models for distribution of medical claims and
1667 supplemental payments for inpatient and outpatient hospital
1668 services, and such models may include, but shall not be limited to
1669 the following: increasing rates for inpatient and outpatient
1670 services; creating a low-income utilization pool of funds to
1671 reimburse hospitals for the costs of uncompensated care, charity
1672 care and bad debts as permitted and approved pursuant to federal
1673 regulations and the Centers for Medicare and Medicaid Services;
1674 supplemental payments based upon Medicaid utilization, quality,
1675 service lines and/or costs of providing such services to Medicaid
1676 beneficiaries and to uninsured patients. The goals of such
1677 payment models shall be to ensure access to inpatient and
1678 outpatient care and to maximize any federal funds that are
1679 available to reimburse hospitals for services provided. Any such
1680 documents required to achieve the goals described in this
1681 paragraph shall be submitted to the Centers for Medicare and
1682 Medicaid Services, with a proposed effective date of July 1, 2019,



1683 to the extent possible, but in no event shall the effective date
1684 of such payment models be later than July 1, 2020. The Chairmen
1685 of the Senate and House Medicaid Committees shall be provided a
1686 copy of the proposed payment model(s) prior to submission.
1687 Effective July 1, 2018, and until such time as any payment
1688 model(s) as described above become effective, the division, in
1689 consultation with the hospital industry, is authorized to
1690 implement a transitional program for inpatient and outpatient
1691 payments and/or supplemental payments (including, but not limited
1692 to, MHAP and directed payments), to redistribute available
1693 supplemental funds among hospital providers, provided that when
1694 compared to a hospital's prior year supplemental payments,
1695 supplemental payments made pursuant to any such transitional
1696 program shall not result in a decrease of more than five percent
1697 (5%) and shall not increase by more than the amount needed to
1698 maximize the distribution of the available funds.

1699 (v) 1. To preserve and improve access to
1700 ambulance transportation provider services, the division shall
1701 seek CMS approval to make ambulance service access payments as set
1702 forth in this subsection (A)(18)(b) for all covered emergency
1703 ambulance services rendered on or after July 1, 2022, and shall
1704 make such ambulance service access payments for all covered
1705 services rendered on or after the effective date of CMS approval.

1706 2. The division shall calculate the
1707 ambulance service access payment amount as the balance of the



1708 portion of the Medical Care Fund related to ambulance
1709 transportation service provider assessments plus any federal
1710 matching funds earned on the balance, up to, but not to exceed,
1711 the upper payment limit gap for all emergency ambulance service
1712 providers.

1713 3. a. Except for ambulance services
1714 exempt from the assessment provided in this paragraph (18)(b), all
1715 ambulance transportation service providers shall be eligible for
1716 ambulance service access payments each state fiscal year as set
1717 forth in this paragraph (18)(b).

1718 b. In addition to any other funds
1719 paid to ambulance transportation service providers for emergency
1720 medical services provided to Medicaid beneficiaries, each eligible
1721 ambulance transportation service provider shall receive ambulance
1722 service access payments each state fiscal year equal to the
1723 ambulance transportation service provider's upper payment limit
1724 gap. Subject to approval by the Centers for Medicare and Medicaid
1725 Services, ambulance service access payments shall be made no less
1726 than on a quarterly basis.

1727 c. As used in this paragraph
1728 (18)(b)(v), the term "upper payment limit gap" means the
1729 difference between the total amount that the ambulance
1730 transportation service provider received from Medicaid and the
1731 average amount that the ambulance transportation service provider



1732 would have received from commercial insurers for those services
1733 reimbursed by Medicaid.

1734 4. An ambulance service access payment
1735 shall not be used to offset any other payment by the division for
1736 emergency or nonemergency services to Medicaid beneficiaries.

1737 (c) (i) Not later than December 1, 2015, the
1738 division shall, subject to approval by the Centers for Medicare
1739 and Medicaid Services (CMS), establish, implement and operate a
1740 Mississippi Hospital Access Program (MHAP) for the purpose of
1741 protecting patient access to hospital care through hospital
1742 inpatient reimbursement programs provided in this section designed
1743 to maintain total hospital reimbursement for inpatient services
1744 rendered by in-state hospitals and the out-of-state hospital that
1745 is authorized by federal law to submit intergovernmental transfers
1746 (IGTs) to the State of Mississippi and is classified as Level I
1747 trauma center located in a county contiguous to the state line at
1748 the maximum levels permissible under applicable federal statutes
1749 and regulations, at which time the current inpatient Medicare
1750 Upper Payment Limits (UPL) Program for hospital inpatient services
1751 shall transition to the MHAP.

1752 (ii) Subject to approval by the Centers for
1753 Medicare and Medicaid Services (CMS), the MHAP shall provide
1754 increased inpatient capitation (PMPM) payments to managed care
1755 entities contracting with the division pursuant to subsection (H)
1756 of this section to support availability of hospital services or



1757 such other payments permissible under federal law necessary to
1758 accomplish the intent of this subsection.

1759 (iii) The intent of this subparagraph (c) is
1760 that effective for all inpatient hospital Medicaid services during
1761 state fiscal year 2016, and so long as this provision shall remain
1762 in effect hereafter, the division shall to the fullest extent
1763 feasible replace the additional reimbursement for hospital
1764 inpatient services under the inpatient Medicare Upper Payment
1765 Limits (UPL) Program with additional reimbursement under the MHAP
1766 and other payment programs for inpatient and/or outpatient
1767 payments which may be developed under the authority of this
1768 paragraph.

1769 (iv) The division shall assess each hospital
1770 as provided in Section 43-13-145(4) (a) for the purpose of
1771 financing the state portion of the MHAP, supplemental payments and
1772 such other purposes as specified in Section 43-13-145. The
1773 assessment will remain in effect as long as the MHAP and
1774 supplemental payments are in effect.

1775 (19) (a) Perinatal risk management services. The
1776 division shall promulgate regulations to be effective from and
1777 after October 1, 1988, to establish a comprehensive perinatal
1778 system for risk assessment of all pregnant and infant Medicaid
1779 recipients and for management, education and follow-up for those
1780 who are determined to be at risk. Services to be performed
1781 include case management, nutrition assessment/counseling,



1782 psychosocial assessment/counseling and health education. The
1783 division shall contract with the State Department of Health to
1784 provide services within this paragraph (Perinatal High Risk
1785 Management/Infant Services System (PHRM/ISS)). The State
1786 Department of Health shall be reimbursed on a full reasonable cost
1787 basis for services provided under this subparagraph (a).

1788 (b) Early intervention system services. The
1789 division shall cooperate with the State Department of Health,
1790 acting as lead agency, in the development and implementation of a
1791 statewide system of delivery of early intervention services, under
1792 Part C of the Individuals with Disabilities Education Act (IDEA).
1793 The State Department of Health shall certify annually in writing
1794 to the executive director of the division the dollar amount of
1795 state early intervention funds available that will be utilized as
1796 a certified match for Medicaid matching funds. Those funds then
1797 shall be used to provide expanded targeted case management
1798 services for Medicaid eligible children with special needs who are
1799 eligible for the state's early intervention system.

1800 Qualifications for persons providing service coordination shall be
1801 determined by the State Department of Health and the Division of
1802 Medicaid.

1803 (20) Home- and community-based services for physically
1804 disabled approved services as allowed by a waiver from the United
1805 States Department of Health and Human Services for home- and
1806 community-based services for physically disabled people using



1807 state funds that are provided from the appropriation to the State
1808 Department of Rehabilitation Services and used to match federal
1809 funds under a cooperative agreement between the division and the
1810 department, provided that funds for these services are
1811 specifically appropriated to the Department of Rehabilitation
1812 Services.

1813 (21) Nurse practitioner services. Services furnished
1814 by a registered nurse who is licensed and certified by the
1815 Mississippi Board of Nursing as a nurse practitioner, including,
1816 but not limited to, nurse anesthetists, nurse midwives, family
1817 nurse practitioners, family planning nurse practitioners,
1818 pediatric nurse practitioners, obstetrics-gynecology nurse
1819 practitioners and neonatal nurse practitioners, under regulations
1820 adopted by the division. Reimbursement for those services shall
1821 not exceed ninety percent (90%) of the reimbursement rate for
1822 comparable services rendered by a physician. The division may
1823 provide for a reimbursement rate for nurse practitioner services
1824 of up to one hundred percent (100%) of the reimbursement rate for
1825 comparable services rendered by a physician for nurse practitioner
1826 services that are provided after the normal working hours of the
1827 nurse practitioner, as determined in accordance with regulations
1828 of the division.

1829 (22) Ambulatory services delivered in federally
1830 qualified health centers, rural health centers and clinics of the
1831 local health departments of the State Department of Health for



1832 individuals eligible for Medicaid under this article based on
1833 reasonable costs as determined by the division. Federally
1834 qualified health centers shall be reimbursed by the Medicaid
1835 prospective payment system as approved by the Centers for Medicare
1836 and Medicaid Services. The division shall recognize federally
1837 qualified health centers (FQHCs), rural health clinics (RHCs) and
1838 community mental health centers (CMHCs) as both an originating and
1839 distant site provider for the purposes of telehealth
1840 reimbursement. The division is further authorized and directed to
1841 reimburse FQHCs, RHCs and CMHCs for both distant site and
1842 originating site services when such services are appropriately
1843 provided by the same organization.

1844 (23) Inpatient psychiatric services.

1845 (a) Inpatient psychiatric services to be
1846 determined by the division for recipients under age twenty-one
1847 (21) that are provided under the direction of a physician in an
1848 inpatient program in a licensed acute care psychiatric facility or
1849 in a licensed psychiatric residential treatment facility, before
1850 the recipient reaches age twenty-one (21) or, if the recipient was
1851 receiving the services immediately before he or she reached age
1852 twenty-one (21), before the earlier of the date he or she no
1853 longer requires the services or the date he or she reaches age
1854 twenty-two (22), as provided by federal regulations. From and
1855 after January 1, 2015, the division shall update the fair rental
1856 reimbursement system for psychiatric residential treatment



1857 facilities. Precertification of inpatient days and residential
1858 treatment days must be obtained as required by the division. From
1859 and after July 1, 2009, all state-owned and state-operated
1860 facilities that provide inpatient psychiatric services to persons
1861 under age twenty-one (21) who are eligible for Medicaid
1862 reimbursement shall be reimbursed for those services on a full
1863 reasonable cost basis.

1864 (b) The division may reimburse for services
1865 provided by a licensed freestanding psychiatric hospital to
1866 Medicaid recipients over the age of twenty-one (21) in a method
1867 and manner consistent with the provisions of Section 43-13-117.5.

1868 (24) [Deleted]

1869 (25) [Deleted]

1870 (26) Hospice care. As used in this paragraph, the term
1871 "hospice care" means a coordinated program of active professional
1872 medical attention within the home and outpatient and inpatient
1873 care that treats the terminally ill patient and family as a unit,
1874 employing a medically directed interdisciplinary team. The
1875 program provides relief of severe pain or other physical symptoms
1876 and supportive care to meet the special needs arising out of
1877 physical, psychological, spiritual, social and economic stresses
1878 that are experienced during the final stages of illness and during
1879 dying and bereavement and meets the Medicare requirements for
1880 participation as a hospice as provided in federal regulations.



1881 (27) Group health plan premiums and cost-sharing if it
1882 is cost-effective as defined by the United States Secretary of
1883 Health and Human Services.

1884 (28) Other health insurance premiums that are
1885 cost-effective as defined by the United States Secretary of Health
1886 and Human Services. Medicare eligible must have Medicare Part B
1887 before other insurance premiums can be paid.

1888 (29) The Division of Medicaid may apply for a waiver
1889 from the United States Department of Health and Human Services for
1890 home- and community-based services for developmentally disabled
1891 people using state funds that are provided from the appropriation
1892 to the State Department of Mental Health and/or funds transferred
1893 to the department by a political subdivision or instrumentality of
1894 the state and used to match federal funds under a cooperative
1895 agreement between the division and the department, provided that
1896 funds for these services are specifically appropriated to the
1897 Department of Mental Health and/or transferred to the department
1898 by a political subdivision or instrumentality of the state.

1899 (30) Pediatric skilled nursing services as determined
1900 by the division and in a manner consistent with regulations
1901 promulgated by the Mississippi State Department of Health.

1902 (31) Targeted case management services for children
1903 with special needs, under waivers from the United States
1904 Department of Health and Human Services, using state funds that
1905 are provided from the appropriation to the Mississippi Department



1906 of Human Services and used to match federal funds under a
1907 cooperative agreement between the division and the department.

1908 (32) Care and services provided in Christian Science
1909 Sanatoria listed and certified by the Commission for Accreditation
1910 of Christian Science Nursing Organizations/Facilities, Inc.,
1911 rendered in connection with treatment by prayer or spiritual means
1912 to the extent that those services are subject to reimbursement
1913 under Section 1903 of the federal Social Security Act.

1914 (33) Podiatrist services.

1915 (34) Assisted living services as provided through
1916 home- and community-based services under Title XIX of the federal
1917 Social Security Act, as amended, subject to the availability of
1918 funds specifically appropriated for that purpose by the
1919 Legislature.

1920 (35) Services and activities authorized in Sections
1921 43-27-101 and 43-27-103, using state funds that are provided from
1922 the appropriation to the Mississippi Department of Human Services
1923 and used to match federal funds under a cooperative agreement
1924 between the division and the department.

1925 (36) Nonemergency transportation services for
1926 Medicaid-eligible persons as determined by the division. The PEER
1927 Committee shall conduct a performance evaluation of the
1928 nonemergency transportation program to evaluate the administration
1929 of the program and the providers of transportation services to
1930 determine the most cost-effective ways of providing nonemergency



1931 transportation services to the patients served under the program.
1932 The performance evaluation shall be completed and provided to the
1933 members of the Senate Medicaid Committee and the House Medicaid
1934 Committee not later than January 1, 2019, and every two (2) years
1935 thereafter.

1936 (37) [Deleted]

1937 (38) Chiropractic services. A chiropractor's manual
1938 manipulation of the spine to correct a subluxation, if x-ray
1939 demonstrates that a subluxation exists and if the subluxation has
1940 resulted in a neuromusculoskeletal condition for which
1941 manipulation is appropriate treatment, and related spinal x-rays
1942 performed to document these conditions. Reimbursement for
1943 chiropractic services shall not exceed Seven Hundred Dollars
1944 (\$700.00) per year per beneficiary.

1945 (39) Dually eligible Medicare/Medicaid beneficiaries.
1946 The division shall pay the Medicare deductible and coinsurance
1947 amounts for services available under Medicare, as determined by
1948 the division. From and after July 1, 2009, the division shall
1949 reimburse crossover claims for inpatient hospital services and
1950 crossover claims covered under Medicare Part B in the same manner
1951 that was in effect on January 1, 2008, unless specifically
1952 authorized by the Legislature to change this method.

1953 (40) [Deleted]

1954 (41) Services provided by the State Department of
1955 Rehabilitation Services for the care and rehabilitation of persons



1956 with spinal cord injuries or traumatic brain injuries, as allowed
1957 under waivers from the United States Department of Health and
1958 Human Services, using up to seventy-five percent (75%) of the
1959 funds that are appropriated to the Department of Rehabilitation
1960 Services from the Spinal Cord and Head Injury Trust Fund
1961 established under Section 37-33-261 and used to match federal
1962 funds under a cooperative agreement between the division and the
1963 department.

1964 (42) [Deleted]

1965 (43) The division shall provide reimbursement,
1966 according to a payment schedule developed by the division, for
1967 smoking cessation medications for pregnant women during their
1968 pregnancy and other Medicaid-eligible women who are of
1969 child-bearing age.

1970 (44) Nursing facility services for the severely
1971 disabled.

1972 (a) Severe disabilities include, but are not
1973 limited to, spinal cord injuries, closed-head injuries and
1974 ventilator-dependent patients.

1975 (b) Those services must be provided in a long-term
1976 care nursing facility dedicated to the care and treatment of
1977 persons with severe disabilities.

1978 (45) Physician assistant services. Services furnished
1979 by a physician assistant who is licensed by the State Board of
1980 Medical Licensure and is practicing with physician supervision



1981 under regulations adopted by the board, under regulations adopted
1982 by the division. Reimbursement for those services shall not
1983 exceed ninety percent (90%) of the reimbursement rate for
1984 comparable services rendered by a physician. The division may
1985 provide for a reimbursement rate for physician assistant services
1986 of up to one hundred percent (100%) or the reimbursement rate for
1987 comparable services rendered by a physician for physician
1988 assistant services that are provided after the normal working
1989 hours of the physician assistant, as determined in accordance with
1990 regulations of the division.

1991 (46) The division shall make application to the federal
1992 Centers for Medicare and Medicaid Services (CMS) for a waiver to
1993 develop and provide services for children with serious emotional
1994 disturbances as defined in Section 43-14-1(1), which may include
1995 home- and community-based services, case management services or
1996 managed care services through mental health providers certified by
1997 the Department of Mental Health. The division may implement and
1998 provide services under this waived program only if funds for
1999 these services are specifically appropriated for this purpose by
2000 the Legislature, or if funds are voluntarily provided by affected
2001 agencies.

2002 (47) (a) The division may develop and implement
2003 disease management programs for individuals with high-cost chronic
2004 diseases and conditions, including the use of grants, waivers,
2005 demonstrations or other projects as necessary.



2006 (b) Participation in any disease management
2007 program implemented under this paragraph (47) is optional with the
2008 individual. An individual must affirmatively elect to participate
2009 in the disease management program in order to participate, and may
2010 elect to discontinue participation in the program at any time.

2011 (48) Pediatric long-term acute care hospital services.

2012 (a) Pediatric long-term acute care hospital
2013 services means services provided to eligible persons under
2014 twenty-one (21) years of age by a freestanding Medicare-certified
2015 hospital that has an average length of inpatient stay greater than
2016 twenty-five (25) days and that is primarily engaged in providing
2017 chronic or long-term medical care to persons under twenty-one (21)
2018 years of age.

2019 (b) The services under this paragraph (48) shall
2020 be reimbursed as a separate category of hospital services.

2021 (49) The division may establish copayments and/or
2022 coinsurance for any Medicaid services for which copayments and/or
2023 coinsurance are allowable under federal law or regulation.

2024 (50) Services provided by the State Department of
2025 Rehabilitation Services for the care and rehabilitation of persons
2026 who are deaf and blind, as allowed under waivers from the United
2027 States Department of Health and Human Services to provide home-
2028 and community-based services using state funds that are provided
2029 from the appropriation to the State Department of Rehabilitation
2030 Services or if funds are voluntarily provided by another agency.



2031 (51) Upon determination of Medicaid eligibility and in
2032 association with annual redetermination of Medicaid eligibility,
2033 beneficiaries shall be encouraged to undertake a physical
2034 examination that will establish a base-line level of health and
2035 identification of a usual and customary source of care (a medical
2036 home) to aid utilization of disease management tools. This
2037 physical examination and utilization of these disease management
2038 tools shall be consistent with current United States Preventive
2039 Services Task Force or other recognized authority recommendations.

2040 For persons who are determined ineligible for Medicaid, the
2041 division will provide information and direction for accessing
2042 medical care and services in the area of their residence.

2043 (52) Notwithstanding any provisions of this article,
2044 the division may pay enhanced reimbursement fees related to trauma
2045 care, as determined by the division in conjunction with the State
2046 Department of Health, using funds appropriated to the State
2047 Department of Health for trauma care and services and used to
2048 match federal funds under a cooperative agreement between the
2049 division and the State Department of Health. The division, in
2050 conjunction with the State Department of Health, may use grants,
2051 waivers, demonstrations, enhanced reimbursements, Upper Payment
2052 Limits Programs, supplemental payments, or other projects as
2053 necessary in the development and implementation of this
2054 reimbursement program.



2055 (53) Targeted case management services for high-cost
2056 beneficiaries may be developed by the division for all services
2057 under this section.

2058 (54) [Deleted]

2059 (55) Therapy services. The plan of care for therapy
2060 services may be developed to cover a period of treatment for up to
2061 six (6) months, but in no event shall the plan of care exceed a
2062 six-month period of treatment. The projected period of treatment
2063 must be indicated on the initial plan of care and must be updated
2064 with each subsequent revised plan of care. Based on medical
2065 necessity, the division shall approve certification periods for
2066 less than or up to six (6) months, but in no event shall the
2067 certification period exceed the period of treatment indicated on
2068 the plan of care. The appeal process for any reduction in therapy
2069 services shall be consistent with the appeal process in federal
2070 regulations.

2071 (56) Prescribed pediatric extended care centers
2072 services for medically dependent or technologically dependent
2073 children with complex medical conditions that require continual
2074 care as prescribed by the child's attending physician, as
2075 determined by the division.

2076 (57) No Medicaid benefit shall restrict coverage for
2077 medically appropriate treatment prescribed by a physician and
2078 agreed to by a fully informed individual, or if the individual
2079 lacks legal capacity to consent by a person who has legal



2080 authority to consent on his or her behalf, based on an
2081 individual's diagnosis with a terminal condition. As used in this
2082 paragraph (57), "terminal condition" means any aggressive
2083 malignancy, chronic end-stage cardiovascular or cerebral vascular
2084 disease, or any other disease, illness or condition which a
2085 physician diagnoses as terminal.

2086 (58) Treatment services for persons with opioid
2087 dependency or other highly addictive substance use disorders. The
2088 division is authorized to reimburse eligible providers for
2089 treatment of opioid dependency and other highly addictive
2090 substance use disorders, as determined by the division. Treatment
2091 related to these conditions shall not count against any physician
2092 visit limit imposed under this section.

2093 (59) The division shall allow beneficiaries between the
2094 ages of ten (10) and eighteen (18) years to receive vaccines
2095 through a pharmacy venue. The division and the State Department
2096 of Health shall coordinate and notify OB-GYN providers that the
2097 Vaccines for Children program is available to providers free of
2098 charge.

2099 (60) Border city university-affiliated pediatric
2100 teaching hospital.

2101 (a) Payments may only be made to a border city
2102 university-affiliated pediatric teaching hospital if the Centers
2103 for Medicare and Medicaid Services (CMS) approve an increase in
2104 the annual request for the provider payment initiative authorized



2105 under 42 CFR Section 438.6(c) in an amount equal to or greater
2106 than the estimated annual payment to be made to the border city
2107 university-affiliated pediatric teaching hospital. The estimate
2108 shall be based on the hospital's prior year Mississippi managed
2109 care utilization.

2110 (b) As used in this paragraph (60), the term
2111 "border city university-affiliated pediatric teaching hospital"
2112 means an out-of-state hospital located within a city bordering the
2113 eastern bank of the Mississippi River and the State of Mississippi
2114 that submits to the division a copy of a current and effective
2115 affiliation agreement with an accredited university and other
2116 documentation establishing that the hospital is
2117 university-affiliated, is licensed and designated as a pediatric
2118 hospital or pediatric primary hospital within its home state,
2119 maintains at least five (5) different pediatric specialty training
2120 programs, and maintains at least one hundred (100) operated beds
2121 dedicated exclusively for the treatment of patients under the age
2122 of twenty-one (21) years.

2123 (c) The cost of providing services to Mississippi
2124 Medicaid beneficiaries under the age of twenty-one (21) years who
2125 are treated by a border city university-affiliated pediatric
2126 teaching hospital shall not exceed the cost of providing the same
2127 services to individuals in hospitals in the state.

2128 (d) It is the intent of the Legislature that
2129 payments shall not result in any in-state hospital receiving



2130 payments lower than they would otherwise receive if not for the
2131 payments made to any border city university-affiliated pediatric
2132 teaching hospital.

2133 (e) This paragraph (60) shall stand repealed on
2134 July 1, 2024.

2135 (B) Planning and development districts participating in the
2136 home- and community-based services program for the elderly and
2137 disabled as case management providers shall be reimbursed for case
2138 management services at the maximum rate approved by the Centers
2139 for Medicare and Medicaid Services (CMS).

2140 (C) The division may pay to those providers who participate
2141 in and accept patient referrals from the division's emergency room
2142 redirection program a percentage, as determined by the division,
2143 of savings achieved according to the performance measures and
2144 reduction of costs required of that program. Federally qualified
2145 health centers may participate in the emergency room redirection
2146 program, and the division may pay those centers a percentage of
2147 any savings to the Medicaid program achieved by the centers'
2148 accepting patient referrals through the program, as provided in
2149 this subsection (C).

2150 (D) (1) As used in this subsection (D), the following terms
2151 shall be defined as provided in this paragraph, except as
2152 otherwise provided in this subsection:



2153 (a) "Committees" means the Medicaid Committees of
2154 the House of Representatives and the Senate, and "committee" means
2155 either one of those committees.

2156 (b) "Rate change" means an increase, decrease or
2157 other change in the payments or rates of reimbursement, or a
2158 change in any payment methodology that results in an increase,
2159 decrease or other change in the payments or rates of
2160 reimbursement, to any Medicaid provider that renders any services
2161 authorized to be provided to Medicaid recipients under this
2162 article.

2163 (2) Whenever the Division of Medicaid proposes a rate
2164 change, the division shall give notice to the chairmen of the
2165 committees at least thirty (30) calendar days before the proposed
2166 rate change is scheduled to take effect. The division shall
2167 furnish the chairmen with a concise summary of each proposed rate
2168 change along with the notice, and shall furnish the chairmen with
2169 a copy of any proposed rate change upon request. The division
2170 also shall provide a summary and copy of any proposed rate change
2171 to any other member of the Legislature upon request.

2172 (3) If the chairman of either committee or both
2173 chairmen jointly object to the proposed rate change or any part
2174 thereof, the chairman or chairmen shall notify the division and
2175 provide the reasons for their objection in writing not later than
2176 seven (7) calendar days after receipt of the notice from the
2177 division. The chairman or chairmen may make written



2178 recommendations to the division for changes to be made to a
2179 proposed rate change.

2180 (4) (a) The chairman of either committee or both
2181 chairmen jointly may hold a committee meeting to review a proposed
2182 rate change. If either chairman or both chairmen decide to hold a
2183 meeting, they shall notify the division of their intention in
2184 writing within seven (7) calendar days after receipt of the notice
2185 from the division, and shall set the date and time for the meeting
2186 in their notice to the division, which shall not be later than
2187 fourteen (14) calendar days after receipt of the notice from the
2188 division.

2189 (b) After the committee meeting, the committee or
2190 committees may object to the proposed rate change or any part
2191 thereof. The committee or committees shall notify the division
2192 and the reasons for their objection in writing not later than
2193 seven (7) calendar days after the meeting. The committee or
2194 committees may make written recommendations to the division for
2195 changes to be made to a proposed rate change.

2196 (5) If both chairmen notify the division in writing
2197 within seven (7) calendar days after receipt of the notice from
2198 the division that they do not object to the proposed rate change
2199 and will not be holding a meeting to review the proposed rate
2200 change, the proposed rate change will take effect on the original
2201 date as scheduled by the division or on such other date as
2202 specified by the division.



2203 (6) (a) If there are any objections to a proposed rate
2204 change or any part thereof from either or both of the chairmen or
2205 the committees, the division may withdraw the proposed rate
2206 change, make any of the recommended changes to the proposed rate
2207 change, or not make any changes to the proposed rate change.

2208 (b) If the division does not make any changes to
2209 the proposed rate change, it shall notify the chairmen of that
2210 fact in writing, and the proposed rate change shall take effect on
2211 the original date as scheduled by the division or on such other
2212 date as specified by the division.

2213 (c) If the division makes any changes to the
2214 proposed rate change, the division shall notify the chairmen of
2215 its actions in writing, and the revised proposed rate change shall
2216 take effect on the date as specified by the division.

2217 (7) Nothing in this subsection (D) shall be construed
2218 as giving the chairmen or the committees any authority to veto,
2219 nullify or revise any rate change proposed by the division. The
2220 authority of the chairmen or the committees under this subsection
2221 shall be limited to reviewing, making objections to and making
2222 recommendations for changes to rate changes proposed by the
2223 division.

2224 (E) Notwithstanding any provision of this article, no new
2225 groups or categories of recipients and new types of care and
2226 services may be added without enabling legislation from the
2227 Mississippi Legislature, except that the division may authorize



2228 those changes without enabling legislation when the addition of
2229 recipients or services is ordered by a court of proper authority.

2230 (F) The executive director shall keep the Governor advised
2231 on a timely basis of the funds available for expenditure and the
2232 projected expenditures. Notwithstanding any other provisions of
2233 this article, if current or projected expenditures of the division
2234 are reasonably anticipated to exceed the amount of funds
2235 appropriated to the division for any fiscal year, the Governor,
2236 after consultation with the executive director, shall take all
2237 appropriate measures to reduce costs, which may include, but are
2238 not limited to:

2239 (1) Reducing or discontinuing any or all services that
2240 are deemed to be optional under Title XIX of the Social Security
2241 Act;

2242 (2) Reducing reimbursement rates for any or all service
2243 types;

2244 (3) Imposing additional assessments on health care
2245 providers; or

2246 (4) Any additional cost-containment measures deemed
2247 appropriate by the Governor.

2248 To the extent allowed under federal law, any reduction to
2249 services or reimbursement rates under this subsection (F) shall be
2250 accompanied by a reduction, to the fullest allowable amount, to
2251 the profit margin and administrative fee portions of capitated



2252 payments to organizations described in paragraph (1) of subsection
2253 (H) .

2254 Beginning in fiscal year 2010 and in fiscal years thereafter,
2255 when Medicaid expenditures are projected to exceed funds available
2256 for the fiscal year, the division shall submit the expected
2257 shortfall information to the PEER Committee not later than
2258 December 1 of the year in which the shortfall is projected to
2259 occur. PEER shall review the computations of the division and
2260 report its findings to the Legislative Budget Office not later
2261 than January 7 in any year.

2262 (G) Notwithstanding any other provision of this article, it
2263 shall be the duty of each provider participating in the Medicaid
2264 program to keep and maintain books, documents and other records as
2265 prescribed by the Division of Medicaid in accordance with federal
2266 laws and regulations.

2267 (H) (1) Notwithstanding any other provision of this
2268 article, the division is authorized to implement (a) a managed
2269 care program, (b) a coordinated care program, (c) a coordinated
2270 care organization program, (d) a health maintenance organization
2271 program, (e) a patient-centered medical home program, (f) an
2272 accountable care organization program, (g) provider-sponsored
2273 health plan, or (h) any combination of the above programs. As a
2274 condition for the approval of any program under this subsection
2275 (H)(1), the division shall require that no managed care program,
2276 coordinated care program, coordinated care organization program,



2277 health maintenance organization program, or provider-sponsored
2278 health plan may:

2279 (a) Pay providers at a rate that is less than the
2280 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
2281 reimbursement rate;

2282 (b) Override the medical decisions of hospital
2283 physicians or staff regarding patients admitted to a hospital for
2284 an emergency medical condition as defined by 42 US Code Section
2285 1395dd. This restriction (b) does not prohibit the retrospective
2286 review of the appropriateness of the determination that an
2287 emergency medical condition exists by chart review or coding
2288 algorithm, nor does it prohibit prior authorization for
2289 nonemergency hospital admissions;

2290 (c) Pay providers at a rate that is less than the
2291 normal Medicaid reimbursement rate. It is the intent of the
2292 Legislature that all managed care entities described in this
2293 subsection (H), in collaboration with the division, develop and
2294 implement innovative payment models that incentivize improvements
2295 in health care quality, outcomes, or value, as determined by the
2296 division. Participation in the provider network of any managed
2297 care, coordinated care, provider-sponsored health plan, or similar
2298 contractor shall not be conditioned on the provider's agreement to
2299 accept such alternative payment models;

2300 (d) Implement a prior authorization and
2301 utilization review program for medical services, transportation



2302 services and prescription drugs that is more stringent than the
2303 prior authorization processes used by the division in its
2304 administration of the Medicaid program. Not later than December
2305 2, 2021, the contractors that are receiving capitated payments
2306 under a managed care delivery system established under this
2307 subsection (H) shall submit a report to the Chairmen of the House
2308 and Senate Medicaid Committees on the status of the prior
2309 authorization and utilization review program for medical services,
2310 transportation services and prescription drugs that is required to
2311 be implemented under this subparagraph (d);

2312 (e) [Deleted]

2313 (f) Implement a preferred drug list that is more
2314 stringent than the mandatory preferred drug list established by
2315 the division under subsection (A)(9) of this section;

2316 (g) Implement a policy which denies beneficiaries
2317 with hemophilia access to the federally funded hemophilia
2318 treatment centers as part of the Medicaid Managed Care network of
2319 providers.

2320 Each health maintenance organization, coordinated care
2321 organization, provider-sponsored health plan, or other
2322 organization paid for services on a capitated basis by the
2323 division under any managed care program or coordinated care
2324 program implemented by the division under this section shall use a
2325 clear set of level of care guidelines in the determination of
2326 medical necessity and in all utilization management practices,



2327 including the prior authorization process, concurrent reviews,
2328 retrospective reviews and payments, that are consistent with
2329 widely accepted professional standards of care. Organizations
2330 participating in a managed care program or coordinated care
2331 program implemented by the division may not use any additional
2332 criteria that would result in denial of care that would be
2333 determined appropriate and, therefore, medically necessary under
2334 those levels of care guidelines.

2335 (2) Notwithstanding any provision of this section, the
2336 recipients eligible for enrollment into a Medicaid Managed Care
2337 Program authorized under this subsection (H) may include only
2338 those categories of recipients eligible for participation in the
2339 Medicaid Managed Care Program as of January 1, 2021, the
2340 Children's Health Insurance Program (CHIP), and the CMS-approved
2341 Section 1115 demonstration waivers in operation as of January 1,
2342 2021. No expansion of Medicaid Managed Care Program contracts may
2343 be implemented by the division without enabling legislation from
2344 the Mississippi Legislature.

2345 (3) (a) Any contractors receiving capitated payments
2346 under a managed care delivery system established in this section
2347 shall provide to the Legislature and the division statistical data
2348 to be shared with provider groups in order to improve patient
2349 access, appropriate utilization, cost savings and health outcomes
2350 not later than October 1 of each year. Additionally, each
2351 contractor shall disclose to the Chairmen of the Senate and House



2352 Medicaid Committees the administrative expenses costs for the
2353 prior calendar year, and the number of full-equivalent employees
2354 located in the State of Mississippi dedicated to the Medicaid and
2355 CHIP lines of business as of June 30 of the current year.

2356 (b) The division and the contractors participating
2357 in the managed care program, a coordinated care program or a
2358 provider-sponsored health plan shall be subject to annual program
2359 reviews or audits performed by the Office of the State Auditor,
2360 the PEER Committee, the Department of Insurance and/or independent
2361 third parties.

2362 (c) Those reviews shall include, but not be
2363 limited to, at least two (2) of the following items:

2364 (i) The financial benefit to the State of
2365 Mississippi of the managed care program,

2366 (ii) The difference between the premiums paid
2367 to the managed care contractors and the payments made by those
2368 contractors to health care providers,

2369 (iii) Compliance with performance measures
2370 required under the contracts,

2371 (iv) Administrative expense allocation
2372 methodologies,

2373 (v) Whether nonprovider payments assigned as
2374 medical expenses are appropriate,

2375 (vi) Capitated arrangements with related
2376 party subcontractors,



2377 (vii) Reasonableness of corporate
2378 allocations,
2379 (viii) Value-added benefits and the extent to
2380 which they are used,
2381 (ix) The effectiveness of subcontractor
2382 oversight, including subcontractor review,
2383 (x) Whether health care outcomes have been
2384 improved, and
2385 (xi) The most common claim denial codes to
2386 determine the reasons for the denials.

2387 The audit reports shall be considered public documents and
2388 shall be posted in their entirety on the division's website.

2389 (4) All health maintenance organizations, coordinated
2390 care organizations, provider-sponsored health plans, or other
2391 organizations paid for services on a capitated basis by the
2392 division under any managed care program or coordinated care
2393 program implemented by the division under this section shall
2394 reimburse all providers in those organizations at rates no lower
2395 than those provided under this section for beneficiaries who are
2396 not participating in those programs.

2397 (5) No health maintenance organization, coordinated
2398 care organization, provider-sponsored health plan, or other
2399 organization paid for services on a capitated basis by the
2400 division under any managed care program or coordinated care
2401 program implemented by the division under this section shall



2402 require its providers or beneficiaries to use any pharmacy that
2403 ships, mails or delivers prescription drugs or legend drugs or
2404 devices.

2405 (6) (a) Not later than December 1, 2021, the
2406 contractors who are receiving capitated payments under a managed
2407 care delivery system established under this subsection (H) shall
2408 develop and implement a uniform credentialing process for
2409 providers. Under that uniform credentialing process, a provider
2410 who meets the criteria for credentialing will be credentialed with
2411 all of those contractors and no such provider will have to be
2412 separately credentialed by any individual contractor in order to
2413 receive reimbursement from the contractor. Not later than
2414 December 2, 2021, those contractors shall submit a report to the
2415 Chairmen of the House and Senate Medicaid Committees on the status
2416 of the uniform credentialing process for providers that is
2417 required under this subparagraph (a).

2418 (b) If those contractors have not implemented a
2419 uniform credentialing process as described in subparagraph (a) by
2420 December 1, 2021, the division shall develop and implement, not
2421 later than July 1, 2022, a single, consolidated credentialing
2422 process by which all providers will be credentialed. Under the
2423 division's single, consolidated credentialing process, no such
2424 contractor shall require its providers to be separately
2425 credentialed by the contractor in order to receive reimbursement
2426 from the contractor, but those contractors shall recognize the



2427 credentialing of the providers by the division's credentialing
2428 process.

2429 (c) The division shall require a uniform provider
2430 credentialing application that shall be used in the credentialing
2431 process that is established under subparagraph (a) or (b). If the
2432 contractor or division, as applicable, has not approved or denied
2433 the provider credentialing application within sixty (60) days of
2434 receipt of the completed application that includes all required
2435 information necessary for credentialing, then the contractor or
2436 division, upon receipt of a written request from the applicant and
2437 within five (5) business days of its receipt, shall issue a
2438 temporary provider credential/enrollment to the applicant if the
2439 applicant has a valid Mississippi professional or occupational
2440 license to provide the health care services to which the
2441 credential/enrollment would apply. The contractor or the division
2442 shall not issue a temporary credential/enrollment if the applicant
2443 has reported on the application a history of medical or other
2444 professional or occupational malpractice claims, a history of
2445 substance abuse or mental health issues, a criminal record, or a
2446 history of medical or other licensing board, state or federal
2447 disciplinary action, including any suspension from participation
2448 in a federal or state program. The temporary
2449 credential/enrollment shall be effective upon issuance and shall
2450 remain in effect until the provider's credentialing/enrollment
2451 application is approved or denied by the contractor or division.



2452 The contractor or division shall render a final decision regarding
2453 credentialing/enrollment of the provider within sixty (60) days
2454 from the date that the temporary provider credential/enrollment is
2455 issued to the applicant.

2456 (d) If the contractor or division does not render
2457 a final decision regarding credentialing/enrollment of the
2458 provider within the time required in subparagraph (c), the
2459 provider shall be deemed to be credentialed by and enrolled with
2460 all of the contractors and eligible to receive reimbursement from
2461 the contractors.

2462 (7) (a) Each contractor that is receiving capitated
2463 payments under a managed care delivery system established under
2464 this subsection (H) shall provide to each provider for whom the
2465 contractor has denied the coverage of a procedure that was ordered
2466 or requested by the provider for or on behalf of a patient, a
2467 letter that provides a detailed explanation of the reasons for the
2468 denial of coverage of the procedure and the name and the
2469 credentials of the person who denied the coverage. The letter
2470 shall be sent to the provider in electronic format.

2471 (b) After a contractor that is receiving capitated
2472 payments under a managed care delivery system established under
2473 this subsection (H) has denied coverage for a claim submitted by a
2474 provider, the contractor shall issue to the provider within sixty
2475 (60) days a final ruling of denial of the claim that allows the
2476 provider to have a state fair hearing and/or agency appeal with



2477 the division. If a contractor does not issue a final ruling of
2478 denial within sixty (60) days as required by this subparagraph
2479 (b), the provider's claim shall be deemed to be automatically
2480 approved and the contractor shall pay the amount of the claim to
2481 the provider.

2482 (c) After a contractor has issued a final ruling
2483 of denial of a claim submitted by a provider, the division shall
2484 conduct a state fair hearing and/or agency appeal on the matter of
2485 the disputed claim between the contractor and the provider within
2486 sixty (60) days, and shall render a decision on the matter within
2487 thirty (30) days after the date of the hearing and/or appeal.

2488 (8) It is the intention of the Legislature that the
2489 division evaluate the feasibility of using a single vendor to
2490 administer pharmacy benefits provided under a managed care
2491 delivery system established under this subsection (H). Providers
2492 of pharmacy benefits shall cooperate with the division in any
2493 transition to a carve-out of pharmacy benefits under managed care.

2494 (9) The division shall evaluate the feasibility of
2495 using a single vendor to administer dental benefits provided under
2496 a managed care delivery system established in this subsection (H).
2497 Providers of dental benefits shall cooperate with the division in
2498 any transition to a carve-out of dental benefits under managed
2499 care.

2500 (10) It is the intent of the Legislature that any
2501 contractor receiving capitated payments under a managed care



2502 delivery system established in this section shall implement
2503 innovative programs to improve the health and well-being of
2504 members diagnosed with prediabetes and diabetes.

2505 (11) It is the intent of the Legislature that any
2506 contractors receiving capitated payments under a managed care
2507 delivery system established under this subsection (H) shall work
2508 with providers of Medicaid services to improve the utilization of
2509 long-acting reversible contraceptives (LARCs). Not later than
2510 December 1, 2021, any contractors receiving capitated payments
2511 under a managed care delivery system established under this
2512 subsection (H) shall provide to the Chairmen of the House and
2513 Senate Medicaid Committees and House and Senate Public Health
2514 Committees a report of LARC utilization for State Fiscal Years
2515 2018 through 2020 as well as any programs, initiatives, or efforts
2516 made by the contractors and providers to increase LARC
2517 utilization. This report shall be updated annually to include
2518 information for subsequent state fiscal years.

2519 (12) The division is authorized to make not more than
2520 one (1) emergency extension of the contracts that are in effect on
2521 July 1, 2021, with contractors who are receiving capitated
2522 payments under a managed care delivery system established under
2523 this subsection (H), as provided in this paragraph (12). The
2524 maximum period of any such extension shall be one (1) year, and
2525 under any such extensions, the contractors shall be subject to all
2526 of the provisions of this subsection (H). The extended contracts



2527 shall be revised to incorporate any provisions of this subsection
2528 (H) .

2529 (I) [Deleted]

2530 (J) There shall be no cuts in inpatient and outpatient
2531 hospital payments, or allowable days or volumes, as long as the
2532 hospital assessment provided in Section 43-13-145 is in effect.
2533 This subsection (J) shall not apply to decreases in payments that
2534 are a result of: reduced hospital admissions, audits or payments
2535 under the APR-DRG or APC models, or a managed care program or
2536 similar model described in subsection (H) of this section.

2537 (K) In the negotiation and execution of such contracts
2538 involving services performed by actuarial firms, the Executive
2539 Director of the Division of Medicaid may negotiate a limitation on
2540 liability to the state of prospective contractors.

2541 (L) The Division of Medicaid shall reimburse for services
2542 provided to eligible Medicaid beneficiaries by a licensed birthing
2543 center in a method and manner to be determined by the division in
2544 accordance with federal laws and federal regulations. The
2545 division shall seek any necessary waivers, make any required
2546 amendments to its State Plan or revise any contracts authorized
2547 under subsection (H) of this section as necessary to provide the
2548 services authorized under this subsection. As used in this
2549 subsection, the term "birthing centers" shall have the meaning as
2550 defined in Section 41-77-1(a), which is a publicly or privately
2551 owned facility, place or institution constructed, renovated,



2552 leased or otherwise established where nonemergency births are
2553 planned to occur away from the mother's usual residence following
2554 a documented period of prenatal care for a normal uncomplicated
2555 pregnancy which has been determined to be low risk through a
2556 formal risk-scoring examination.

2557 (M) This section shall stand repealed on July 1, 2028.

2558 **SECTION 14.** Section 43-13-117.1, Mississippi Code of 1972,
2559 is brought forward as follows:

2560 43-13-117.1. It is the intent of the Legislature to expand
2561 access to Medicaid-funded home- and community-based services for
2562 eligible nursing facility residents who choose those services.
2563 The Executive Director of the Division of Medicaid is authorized
2564 to transfer funds allocated for nursing facility services for
2565 eligible residents to cover the cost of services available through
2566 the Independent Living Waiver, the Traumatic Brain Injury/Spinal
2567 Cord Injury Waiver, the Elderly and Disabled Waiver, and the
2568 Assisted Living Waiver programs when eligible residents choose
2569 those community services. The amount of funding transferred by
2570 the division shall be sufficient to cover the cost of home- and
2571 community-based waiver services for each eligible nursing
2572 facility * * * ~~residents~~ resident who * * * ~~choose~~ chooses those
2573 services. The number of nursing facility residents who return to
2574 the community and home- and community-based waiver services shall
2575 not count against the total number of waiver slots for which the
2576 Legislature appropriates funding each year. Any funds remaining



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

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

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

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

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

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

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



2602 (iv) Providing for fair and impartial hearings;
2603 (v) Providing safeguards for preserving the
2604 confidentiality of records; and
2605 (vi) For detecting and processing fraudulent
2606 practices and abuses of the program;
2607 (b) Receive and expend state, federal and other funds
2608 in accordance with court judgments or settlements and agreements
2609 between the State of Mississippi and the federal government, the
2610 rules and regulations promulgated by the division, with the
2611 approval of the Governor, and within the limitations and
2612 restrictions of this article and within the limits of funds
2613 available for that purpose;
2614 (c) Subject to the limits imposed by this article and
2615 subject to the provisions of subsection (8) of this section, to
2616 submit a Medicaid plan to the United States Department of Health
2617 and Human Services for approval under the provisions of the
2618 federal Social Security Act, to act for the state in making
2619 negotiations relative to the submission and approval of that plan,
2620 to make such arrangements, not inconsistent with the law, as may
2621 be required by or under federal law to obtain and retain that
2622 approval and to secure for the state the benefits of the
2623 provisions of that law.
2624 No agreements, specifically including the general plan for
2625 the operation of the Medicaid program in this state, shall be made
2626 by and between the division and the United States Department of



2627 Health and Human Services unless the Attorney General of the State
2628 of Mississippi has reviewed the agreements, specifically including
2629 the operational plan, and has certified in writing to the Governor
2630 and to the executive director of the division that the agreements,
2631 including the plan of operation, have been drawn strictly in
2632 accordance with the terms and requirements of this article;

2633 (d) In accordance with the purposes and intent of this
2634 article and in compliance with its provisions, provide for aged
2635 persons otherwise eligible for the benefits provided under Title
2636 XVIII of the federal Social Security Act by expenditure of funds
2637 available for those purposes;

2638 (e) To make reports to the United States Department of
2639 Health and Human Services as from time to time may be required by
2640 that federal department and to the Mississippi Legislature as
2641 provided in this section;

2642 (f) Define and determine the scope, duration and amount
2643 of Medicaid that may be provided in accordance with this article
2644 and establish priorities therefor in conformity with this article;

2645 (g) Cooperate and contract with other state agencies
2646 for the purpose of coordinating Medicaid provided under this
2647 article and eliminating duplication and inefficiency in the
2648 Medicaid program;

2649 (h) Adopt and use an official seal of the division;



2650 (i) Sue in its own name on behalf of the State of
2651 Mississippi and employ legal counsel on a contingency basis with
2652 the approval of the Attorney General;

2653 (j) To recover any and all payments incorrectly made by
2654 the division to a recipient or provider from the recipient or
2655 provider receiving the payments. The division shall be authorized
2656 to collect any overpayments to providers sixty (60) days after the
2657 conclusion of any administrative appeal unless the matter is
2658 appealed to a court of proper jurisdiction and bond is posted.
2659 Any appeal filed after July 1, 2015, shall be to the Chancery
2660 Court of the First Judicial District of Hinds County, Mississippi,
2661 within sixty (60) days after the date that the division has
2662 notified the provider by certified mail sent to the proper address
2663 of the provider on file with the division and the provider has
2664 signed for the certified mail notice, or sixty (60) days after the
2665 date of the final decision if the provider does not sign for the
2666 certified mail notice. To recover those payments, the division
2667 may use the following methods, in addition to any other methods
2668 available to the division:

2669 (i) The division shall report to the Department of
2670 Revenue the name of any current or former Medicaid recipient who
2671 has received medical services rendered during a period of
2672 established Medicaid ineligibility and who has not reimbursed the
2673 division for the related medical service payment(s). The
2674 Department of Revenue shall withhold from the state tax refund of



2675 the individual, and pay to the division, the amount of the
2676 payment(s) for medical services rendered to the ineligible
2677 individual that have not been reimbursed to the division for the
2678 related medical service payment(s).

2679 (ii) The division shall report to the Department
2680 of Revenue the name of any Medicaid provider to whom payments were
2681 incorrectly made that the division has not been able to recover by
2682 other methods available to the division. The Department of
2683 Revenue shall withhold from the state tax refund of the provider,
2684 and pay to the division, the amount of the payments that were
2685 incorrectly made to the provider that have not been recovered by
2686 other available methods;

2687 (k) To recover any and all payments by the division
2688 fraudulently obtained by a recipient or provider. Additionally,
2689 if recovery of any payments fraudulently obtained by a recipient
2690 or provider is made in any court, then, upon motion of the
2691 Governor, the judge of the court may award twice the payments
2692 recovered as damages;

2693 (l) Have full, complete and plenary power and authority
2694 to conduct such investigations as it may deem necessary and
2695 requisite of alleged or suspected violations or abuses of the
2696 provisions of this article or of the regulations adopted under
2697 this article, including, but not limited to, fraudulent or
2698 unlawful act or deed by applicants for Medicaid or other benefits,
2699 or payments made to any person, firm or corporation under the



2700 terms, conditions and authority of this article, to suspend or
2701 disqualify any provider of services, applicant or recipient for
2702 gross abuse, fraudulent or unlawful acts for such periods,
2703 including permanently, and under such conditions as the division
2704 deems proper and just, including the imposition of a legal rate of
2705 interest on the amount improperly or incorrectly paid. Recipients
2706 who are found to have misused or abused Medicaid benefits may be
2707 locked into one (1) physician and/or one (1) pharmacy of the
2708 recipient's choice for a reasonable amount of time in order to
2709 educate and promote appropriate use of medical services, in
2710 accordance with federal regulations. If an administrative hearing
2711 becomes necessary, the division may, if the provider does not
2712 succeed in his or her defense, tax the costs of the administrative
2713 hearing, including the costs of the court reporter or stenographer
2714 and transcript, to the provider. The convictions of a recipient
2715 or a provider in a state or federal court for abuse, fraudulent or
2716 unlawful acts under this chapter shall constitute an automatic
2717 disqualification of the recipient or automatic disqualification of
2718 the provider from participation under the Medicaid program.

2719 A conviction, for the purposes of this chapter, shall include
2720 a judgment entered on a plea of nolo contendere or a
2721 nonadjudicated guilty plea and shall have the same force as a
2722 judgment entered pursuant to a guilty plea or a conviction
2723 following trial. A certified copy of the judgment of the court of



2724 competent jurisdiction of the conviction shall constitute prima
2725 facie evidence of the conviction for disqualification purposes;
2726 (m) Establish and provide such methods of
2727 administration as may be necessary for the proper and efficient
2728 operation of the Medicaid program, fully utilizing computer
2729 equipment as may be necessary to oversee and control all current
2730 expenditures for purposes of this article, and to closely monitor
2731 and supervise all recipient payments and vendors rendering
2732 services under this article. Notwithstanding any other provision
2733 of state law, the division is authorized to enter into a ten-year
2734 contract(s) with a vendor(s) to provide services described in this
2735 paragraph (m). Notwithstanding any provision of law to the
2736 contrary, the division is authorized to extend its Medicaid
2737 Management Information System, including all related components
2738 and services, and Decision Support System, including all related
2739 components and services, contracts in effect on June 30, 2020, for
2740 a period not to exceed two (2) years without complying with state
2741 procurement regulations;

2742 (n) To cooperate and contract with the federal
2743 government for the purpose of providing Medicaid to Vietnamese and
2744 Cambodian refugees, under the provisions of Public Law 94-23 and
2745 Public Law 94-24, including any amendments to those laws, only to
2746 the extent that the Medicaid assistance and the administrative
2747 cost related thereto are one hundred percent (100%) reimbursable
2748 by the federal government. For the purposes of Section 43-13-117,



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

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

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

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

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



2774 any designated individual competent to administer oaths; to
2775 examine witnesses; and to do all things conformable to law that
2776 may be necessary to enable them effectively to discharge the
2777 duties of their office. In compelling the attendance and
2778 testimony of witnesses, or the production of books, papers,
2779 documents and other evidence, or the taking of depositions, as
2780 authorized by this section, the division or its hearing officers
2781 may designate an individual employed by the division or some other
2782 suitable person to execute and return that process, whose action
2783 in executing and returning that process shall be as lawful as if
2784 done by the sheriff or some other proper officer authorized to
2785 execute and return process in the county where the witness may
2786 reside. In carrying out the investigatory powers under the
2787 provisions of this article, the executive director or other
2788 designated person or persons may examine, obtain, copy or
2789 reproduce the books, papers, documents, medical charts,
2790 prescriptions and other records relating to medical care and
2791 services furnished by the provider to a recipient or designated
2792 recipients of Medicaid services under investigation. In the
2793 absence of the voluntary submission of the books, papers,
2794 documents, medical charts, prescriptions and other records, the
2795 Governor, the executive director, or other designated person may
2796 issue and serve subpoenas instantly upon the provider, his or her
2797 agent, servant or employee for the production of the books,
2798 papers, documents, medical charts, prescriptions or other records



2799 during an audit or investigation of the provider. If any provider
2800 or his or her agent, servant or employee refuses to produce the
2801 records after being duly subpoenaed, the executive director may
2802 certify those facts and institute contempt proceedings in the
2803 manner, time and place as authorized by law for administrative
2804 proceedings. As an additional remedy, the division may recover
2805 all amounts paid to the provider covering the period of the audit
2806 or investigation, inclusive of a legal rate of interest and a
2807 reasonable attorney's fee and costs of court if suit becomes
2808 necessary. Division staff shall have immediate access to the
2809 provider's physical location, facilities, records, documents,
2810 books, and any other records relating to medical care and services
2811 rendered to recipients during regular business hours.

2812 (5) If any person in proceedings before the division
2813 disobeys or resists any lawful order or process, or misbehaves
2814 during a hearing or so near the place thereof as to obstruct the
2815 hearing, or neglects to produce, after having been ordered to do
2816 so, any pertinent book, paper or document, or refuses to appear
2817 after having been subpoenaed, or upon appearing refuses to take
2818 the oath as a witness, or after having taken the oath refuses to
2819 be examined according to law, the executive director shall certify
2820 the facts to any court having jurisdiction in the place in which
2821 it is sitting, and the court shall thereupon, in a summary manner,
2822 hear the evidence as to the acts complained of, and if the
2823 evidence so warrants, punish that person in the same manner and to



2824 the same extent as for a contempt committed before the court, or
2825 commit that person upon the same condition as if the doing of the
2826 forbidden act had occurred with reference to the process of, or in
2827 the presence of, the court.

2828 (6) In suspending or terminating any provider from
2829 participation in the Medicaid program, the division shall preclude
2830 the provider from submitting claims for payment, either personally
2831 or through any clinic, group, corporation or other association to
2832 the division or its fiscal agents for any services or supplies
2833 provided under the Medicaid program except for those services or
2834 supplies provided before the suspension or termination. No
2835 clinic, group, corporation or other association that is a provider
2836 of services shall submit claims for payment to the division or its
2837 fiscal agents for any services or supplies provided by a person
2838 within that organization who has been suspended or terminated from
2839 participation in the Medicaid program except for those services or
2840 supplies provided before the suspension or termination. When this
2841 provision is violated by a provider of services that is a clinic,
2842 group, corporation or other association, the division may suspend
2843 or terminate that organization from participation. Suspension may
2844 be applied by the division to all known affiliates of a provider,
2845 provided that each decision to include an affiliate is made on a
2846 case-by-case basis after giving due regard to all relevant facts
2847 and circumstances. The violation, failure or inadequacy of
2848 performance may be imputed to a person with whom the provider is



2849 affiliated where that conduct was accomplished within the course
2850 of his or her official duty or was effectuated by him or her with
2851 the knowledge or approval of that person.

2852 (7) The division may deny or revoke enrollment in the
2853 Medicaid program to a provider if any of the following are found
2854 to be applicable to the provider, his or her agent, a managing
2855 employee or any person having an ownership interest equal to five
2856 percent (5%) or greater in the provider:

2857 (a) Failure to truthfully or fully disclose any and all
2858 information required, or the concealment of any and all
2859 information required, on a claim, a provider application or a
2860 provider agreement, or the making of a false or misleading
2861 statement to the division relative to the Medicaid program.

2862 (b) Previous or current exclusion, suspension,
2863 termination from or the involuntary withdrawing from participation
2864 in the Medicaid program, any other state's Medicaid program,
2865 Medicare or any other public or private health or health insurance
2866 program. If the division ascertains that a provider has been
2867 convicted of a felony under federal or state law for an offense
2868 that the division determines is detrimental to the best interest
2869 of the program or of Medicaid beneficiaries, the division may
2870 refuse to enter into an agreement with that provider, or may
2871 terminate or refuse to renew an existing agreement.

2872 (c) Conviction under federal or state law of a criminal
2873 offense relating to the delivery of any goods, services or



2874 supplies, including the performance of management or
2875 administrative services relating to the delivery of the goods,
2876 services or supplies, under the Medicaid program, any other
2877 state's Medicaid program, Medicare or any other public or private
2878 health or health insurance program.

2879 (d) Conviction under federal or state law of a criminal
2880 offense relating to the neglect or abuse of a patient in
2881 connection with the delivery of any goods, services or supplies.

2882 (e) Conviction under federal or state law of a criminal
2883 offense relating to the unlawful manufacture, distribution,
2884 prescription or dispensing of a controlled substance.

2885 (f) Conviction under federal or state law of a criminal
2886 offense relating to fraud, theft, embezzlement, breach of
2887 fiduciary responsibility or other financial misconduct.

2888 (g) Conviction under federal or state law of a criminal
2889 offense punishable by imprisonment of a year or more that involves
2890 moral turpitude, or acts against the elderly, children or infirm.

2891 (h) Conviction under federal or state law of a criminal
2892 offense in connection with the interference or obstruction of any
2893 investigation into any criminal offense listed in paragraphs (c)
2894 through (i) of this subsection.

2895 (i) Sanction for a violation of federal or state laws
2896 or rules relative to the Medicaid program, any other state's
2897 Medicaid program, Medicare or any other public health care or
2898 health insurance program.



2899 (j) Revocation of license or certification.

2900 (k) Failure to pay recovery properly assessed or

2901 pursuant to an approved repayment schedule under the Medicaid

2902 program.

2903 (l) Failure to meet any condition of enrollment.

2904 (8) (a) As used in this subsection (8), the following terms

2905 shall be defined as provided in this paragraph, except as

2906 otherwise provided in this subsection:

2907 (i) "Committees" means the Medicaid Committees of

2908 the House of Representatives and the Senate, and "committee" means

2909 either one of those committees.

2910 (ii) "State Plan" means the agreement between the

2911 State of Mississippi and the federal government regarding the

2912 nature and scope of Mississippi's Medicaid Program.

2913 (iii) "State Plan Amendment" means a change to the

2914 State Plan, which must be approved by the Centers for Medicare and

2915 Medicaid Services (CMS) before its implementation.

2916 (b) Whenever the Division of Medicaid proposes a State

2917 Plan Amendment, the division shall give notice to the chairmen of

2918 the committees at least thirty (30) calendar days before the

2919 proposed State Plan Amendment is filed with CMS. The division

2920 shall furnish the chairmen with a concise summary of each proposed

2921 State Plan Amendment along with the notice, and shall furnish the

2922 chairmen with a copy of any proposed State Plan Amendment upon

2923 request. The division also shall provide a summary and copy of



2924 any proposed State Plan Amendment to any other member of the
2925 Legislature upon request.

2926 (c) If the chairman of either committee or both
2927 chairmen jointly object to the proposed State Plan Amendment or
2928 any part thereof, the chairman or chairmen shall notify the
2929 division and provide the reasons for their objection in writing
2930 not later than seven (7) calendar days after receipt of the notice
2931 from the division. The chairman or chairmen may make written
2932 recommendations to the division for changes to be made to a
2933 proposed State Plan Amendment.

2934 (d) (i) The chairman of either committee or both
2935 chairmen jointly may hold a committee meeting to review a proposed
2936 State Plan Amendment. If either chairman or both chairmen decide
2937 to hold a meeting, they shall notify the division of their
2938 intention in writing within seven (7) calendar days after receipt
2939 of the notice from the division, and shall set the date and time
2940 for the meeting in their notice to the division, which shall not
2941 be later than fourteen (14) calendar days after receipt of the
2942 notice from the division.

2943 (ii) After the committee meeting, the committee or
2944 committees may object to the proposed State Plan Amendment or any
2945 part thereof. The committee or committees shall notify the
2946 division and the reasons for their objection in writing not later
2947 than seven (7) calendar days after the meeting. The committee or



2948 committees may make written recommendations to the division for
2949 changes to be made to a proposed State Plan Amendment.

2950 (e) If both chairmen notify the division in writing
2951 within seven (7) calendar days after receipt of the notice from
2952 the division that they do not object to the proposed State Plan
2953 Amendment and will not be holding a meeting to review the proposed
2954 State Plan Amendment, the division may proceed to file the
2955 proposed State Plan Amendment with CMS.

2956 (f) (i) If there are any objections to a proposed rate
2957 change or any part thereof from either or both of the chairmen or
2958 the committees, the division may withdraw the proposed State Plan
2959 Amendment, make any of the recommended changes to the proposed
2960 State Plan Amendment, or not make any changes to the proposed
2961 State Plan Amendment.

2962 (ii) If the division does not make any changes to
2963 the proposed State Plan Amendment, it shall notify the chairmen of
2964 that fact in writing, and may proceed to file the State Plan
2965 Amendment with CMS.

2966 (iii) If the division makes any changes to the
2967 proposed State Plan Amendment, the division shall notify the
2968 chairmen of its actions in writing, and may proceed to file the
2969 State Plan Amendment with CMS.

2970 (g) Nothing in this subsection (8) shall be construed
2971 as giving the chairmen or the committees any authority to veto,
2972 nullify or revise any State Plan Amendment proposed by the



2973 division. The authority of the chairmen or the committees under
2974 this subsection shall be limited to reviewing, making objections
2975 to and making recommendations for changes to State Plan Amendments
2976 proposed by the division.

2977 (i) If the division does not make any changes to
2978 the proposed State Plan Amendment, it shall notify the chairmen of
2979 that fact in writing, and may proceed to file the proposed State
2980 Plan Amendment with CMS.

2981 (ii) If the division makes any changes to the
2982 proposed State Plan Amendment, the division shall notify the
2983 chairmen of the changes in writing, and may proceed to file the
2984 proposed State Plan Amendment with CMS.

2985 (h) Nothing in this subsection (8) shall be construed
2986 as giving the chairmen of the committees any authority to veto,
2987 nullify or revise any State Plan Amendment proposed by the
2988 division. The authority of the chairmen of the committees under
2989 this subsection shall be limited to reviewing, making objections
2990 to and making recommendations for suggested changes to State Plan
2991 Amendments proposed by the division.

2992 **SECTION 16.** Section 43-13-122, Mississippi Code of 1972, is
2993 brought forward as follows:

2994 43-13-122. (1) The division is authorizeded to apply to the
2995 Center for Medicare and Medicaid Services of the United States
2996 Department of Health and Human Services for waivers and research
2997 and demonstration grants.



2998 (2) The division is further authorized to accept and expend
2999 any grants, donations or contributions from any public or private
3000 organization together with any additional federal matching funds
3001 that may accrue and, including, but not limited to, one hundred
3002 percent (100%) federal grant funds or funds from any governmental
3003 entity or instrumentality thereof in furthering the purposes and
3004 objectives of the Mississippi Medicaid program, provided that such
3005 receipts and expenditures are reported and otherwise handled in
3006 accordance with the General Fund Stabilization Act. The
3007 Department of Finance and Administration is authorized to transfer
3008 monies to the division from special funds in the State Treasury in
3009 amounts not exceeding the amounts authorized in the appropriation
3010 to the division.

3011 **SECTION 17.** Section 43-13-123, Mississippi Code of 1972, is
3012 brought forward as follows:

3013 43-13-123. The determination of the method of providing
3014 payment of claims under this article shall be made by the
3015 division, with approval of the Governor, which methods may be:

3016 (a) By contract with insurance companies licensed to do
3017 business in the State of Mississippi or with nonprofit hospital
3018 service corporations, medical or dental service corporations,
3019 authorized to do business in Mississippi to underwrite on an
3020 insured premium approach, such medical assistance benefits as may
3021 be available, and any carrier selected under the provisions of



3022 this article is expressly authorized and empowered to undertake
3023 the performance of the requirements of that contract.

3024 (b) By contract with an insurance company licensed to
3025 do business in the State of Mississippi or with nonprofit hospital
3026 service, medical or dental service organizations, or other
3027 organizations including data processing companies, authorized to
3028 do business in Mississippi to act as fiscal agent.

3029 The division shall obtain services to be provided under
3030 either of the above-described provisions in accordance with the
3031 Personal Service Contract Review Board Procurement Regulations.

3032 The authorization of the foregoing methods shall not preclude
3033 other methods of providing payment of claims through direct
3034 operation of the program by the state or its agencies.

3035 **SECTION 18.** Section 43-13-126, Mississippi Code of 1972, is
3036 brought forward as follows:

3037 43-13-126. As a condition of doing business in the state,
3038 health insurers, including self-insured plans, group health plans
3039 (as defined in Section 607(1) of the Employee Retirement Income
3040 Security Act of 1974), service benefit plans, managed care
3041 organizations, pharmacy benefit managers, or other parties that
3042 are by statute, contract, or agreement, legally responsible for
3043 payment of a claim for a health care item or service, are required
3044 to:

3045 (a) Provide, with respect to individuals who are
3046 eligible for, or are provided, medical assistance under the state



3047 plan, upon the request of the Division of Medicaid, information to
3048 determine during what period the individual or their spouses or
3049 their dependents may be (or may have been) covered by a health
3050 insurer and the nature of the coverage that is or was provided by
3051 the health insurer (including the name, address and identifying
3052 number of the plan) in a manner prescribed by the Secretary of the
3053 Department of Health and Human Services;

3054 (b) Accept the Division of Medicaid's right of recovery
3055 and the assignment to the division of any right of an individual
3056 or other entity to payment from the party for an item or service
3057 for which payment has been made under the state plan;

3058 (c) Respond to any inquiry by the Division of Medicaid
3059 regarding a claim for payment for any health care item or service
3060 that is submitted not later than three (3) years after the date of
3061 the provision of that health care item or service; and

3062 (d) Agree not to deny a claim submitted by the Division
3063 of Medicaid solely on the basis of the date of submission of the
3064 claim, the type or format of the claim form, or a failure to
3065 present proper documentation at the point of sale that is the
3066 basis of the claim, if:

3067 (i) The claim is submitted by the division within
3068 the three-year period beginning on the date on which the item or
3069 service was furnished; and



3070 (ii) Any action by the division to enforce its
3071 rights with respect to the claim is begun within six (6) years of
3072 the division's submission of the claim.

3073 **SECTION 19.** Section 43-13-133, Mississippi Code of 1972, is
3074 brought forward as follows:

3075 43-13-133. It is the intent of the Legislature that all
3076 federal matching funds for medical assistance under Titles V,
3077 XVIII and XIX of the federal Social Security Act paid into any
3078 state health agency after the passage of this article shall be
3079 used exclusively to defray the cost of medical assistance expended
3080 under the terms of this article.

3081 **SECTION 20.** Section 43-13-143, Mississippi Code of 1972, is
3082 brought forward as follows:

3083 43-13-143. There is created in the State Treasury a special
3084 fund to be known as the "Medical Care Fund," which shall be
3085 comprised of monies transferred by public or private health care
3086 providers, governing bodies of counties, municipalities, public or
3087 community hospitals and other political subdivisions of the state,
3088 individuals, corporations, associations and any other entities for
3089 the purpose of providing health care services. Any transfer made
3090 to the fund shall be paid to the State Treasurer for deposit into
3091 the fund, and all such transfers shall be considered as
3092 unconditional transfers to the fund. The monies in the Medical
3093 Care Fund shall be expended only for health care services, and may
3094 be expended only upon appropriation of the Legislature. All



3095 transfers of monies to the Division of Medicaid by health care
3096 providers and by governing bodies of counties, municipalities,
3097 public or community hospitals and other political subdivisions of
3098 the state shall be deposited into the fund. Unexpended monies
3099 remaining in the fund at the end of a fiscal year shall not lapse
3100 into the State General Fund, and any interest earned on monies in
3101 the fund shall be deposited to the credit of the fund.

3102 **SECTION 21.** Section 43-13-145, Mississippi Code of 1972, is
3103 brought forward as follows:

3104 43-13-145. (1) (a) Upon each nursing facility licensed by
3105 the State of Mississippi, there is levied an assessment in an
3106 amount set by the division, equal to the maximum rate allowed by
3107 federal law or regulation, for each licensed and occupied bed of
3108 the facility.

3109 (b) A nursing facility is exempt from the assessment
3110 levied under this subsection if the facility is operated under the
3111 direction and control of:

3112 (i) The United States Veterans Administration or
3113 other agency or department of the United States government; or

3114 (ii) The State Veterans Affairs Board.

3115 (2) (a) Upon each intermediate care facility for
3116 individuals with intellectual disabilities licensed by the State
3117 of Mississippi, there is levied an assessment in an amount set by
3118 the division, equal to the maximum rate allowed by federal law or
3119 regulation, for each licensed and occupied bed of the facility.



3120 (b) An intermediate care facility for individuals with
3121 intellectual disabilities is exempt from the assessment levied
3122 under this subsection if the facility is operated under the
3123 direction and control of:

3124 (i) The United States Veterans Administration or
3125 other agency or department of the United States government;

3126 (ii) The State Veterans Affairs Board; or

3127 (iii) The University of Mississippi Medical
3128 Center.

3129 (3) (a) Upon each psychiatric residential treatment
3130 facility licensed by the State of Mississippi, there is levied an
3131 assessment in an amount set by the division, equal to the maximum
3132 rate allowed by federal law or regulation, for each licensed and
3133 occupied bed of the facility.

3134 (b) A psychiatric residential treatment facility is
3135 exempt from the assessment levied under this subsection if the
3136 facility is operated under the direction and control of:

3137 (i) The United States Veterans Administration or
3138 other agency or department of the United States government;

3139 (ii) The University of Mississippi Medical Center;
3140 or

3141 (iii) A state agency or a state facility that
3142 either provides its own state match through intergovernmental
3143 transfer or certification of funds to the division.

3144 (4) Hospital assessment.



3145 (a) (i) Subject to and upon fulfillment of the
3146 requirements and conditions of paragraph (f) below, and
3147 notwithstanding any other provisions of this section, an annual
3148 assessment on each hospital licensed in the state is imposed on
3149 each non-Medicare hospital inpatient day as defined below at a
3150 rate that is determined by dividing the sum prescribed in this
3151 subparagraph (i), plus the nonfederal share necessary to maximize
3152 the Disproportionate Share Hospital (DSH) and Medicare Upper
3153 Payment Limits (UPL) Program payments and hospital access payments
3154 and such other supplemental payments as may be developed pursuant
3155 to Section 43-13-117(A)(18), by the total number of non-Medicare
3156 hospital inpatient days as defined below for all licensed
3157 Mississippi hospitals, except as provided in paragraph (d) below.
3158 If the state-matching funds percentage for the Mississippi
3159 Medicaid program is sixteen percent (16%) or less, the sum used in
3160 the formula under this subparagraph (i) shall be Seventy-four
3161 Million Dollars (\$74,000,000.00). If the state-matching funds
3162 percentage for the Mississippi Medicaid program is twenty-four
3163 percent (24%) or higher, the sum used in the formula under this
3164 subparagraph (i) shall be One Hundred Four Million Dollars
3165 (\$104,000,000.00). If the state-matching funds percentage for the
3166 Mississippi Medicaid program is between sixteen percent (16%) and
3167 twenty-four percent (24%), the sum used in the formula under this
3168 subparagraph (i) shall be a pro rata amount determined as follows:
3169 the current state-matching funds percentage rate minus sixteen



3170 percent (16%) divided by eight percent (8%) multiplied by Thirty
3171 Million Dollars (\$30,000,000.00) and add that amount to
3172 Seventy-four Million Dollars (\$74,000,000.00). However, no
3173 assessment in a quarter under this subparagraph (i) may exceed the
3174 assessment in the previous quarter by more than Three Million
3175 Seven Hundred Fifty Thousand Dollars (\$3,750,000.00) (which would
3176 be Fifteen Million Dollars (\$15,000,000.00) on an annualized
3177 basis). The division shall publish the state-matching funds
3178 percentage rate applicable to the Mississippi Medicaid program on
3179 the tenth day of the first month of each quarter and the
3180 assessment determined under the formula prescribed above shall be
3181 applicable in the quarter following any adjustment in that
3182 state-matching funds percentage rate. The division shall notify
3183 each hospital licensed in the state as to any projected increases
3184 or decreases in the assessment determined under this subparagraph
3185 (i). However, if the Centers for Medicare and Medicaid Services
3186 (CMS) does not approve the provision in Section 43-13-117(39)
3187 requiring the division to reimburse crossover claims for inpatient
3188 hospital services and crossover claims covered under Medicare Part
3189 B for dually eligible beneficiaries in the same manner that was in
3190 effect on January 1, 2008, the sum that otherwise would have been
3191 used in the formula under this subparagraph (i) shall be reduced
3192 by Seven Million Dollars (\$7,000,000.00).

3193 (ii) In addition to the assessment provided under
3194 subparagraph (i), an additional annual assessment on each hospital



3195 licensed in the state is imposed on each non-Medicare hospital
3196 inpatient day as defined below at a rate that is determined by
3197 dividing twenty-five percent (25%) of any provider reductions in
3198 the Medicaid program as authorized in Section 43-13-117(F) for
3199 that fiscal year up to the following maximum amount, plus the
3200 nonfederal share necessary to maximize the Disproportionate Share
3201 Hospital (DSH) and inpatient Medicare Upper Payment Limits (UPL)
3202 Program payments and inpatient hospital access payments, by the
3203 total number of non-Medicare hospital inpatient days as defined
3204 below for all licensed Mississippi hospitals: in fiscal year
3205 2010, the maximum amount shall be Twenty-four Million Dollars
3206 (\$24,000,000.00); in fiscal year 2011, the maximum amount shall be
3207 Thirty-two Million Dollars (\$32,000,000.00); and in fiscal year
3208 2012 and thereafter, the maximum amount shall be Forty Million
3209 Dollars (\$40,000,000.00). Any such deficit in the Medicaid
3210 program shall be reviewed by the PEER Committee as provided in
3211 Section 43-13-117(F).

3212 (iii) In addition to the assessments provided in
3213 subparagraphs (i) and (ii), an additional annual assessment on
3214 each hospital licensed in the state is imposed pursuant to the
3215 provisions of Section 43-13-117(F) if the cost-containment
3216 measures described therein have been implemented and there are
3217 insufficient funds in the Health Care Trust Fund to reconcile any
3218 remaining deficit in any fiscal year. If the Governor institutes
3219 any other additional cost-containment measures on any program or



3220 programs authorized under the Medicaid program pursuant to Section
3221 43-13-117(F), hospitals shall be responsible for twenty-five
3222 percent (25%) of any such additional imposed provider cuts, which
3223 shall be in the form of an additional assessment not to exceed the
3224 twenty-five percent (25%) of provider expenditure reductions.
3225 Such additional assessment shall be imposed on each non-Medicare
3226 hospital inpatient day in the same manner as assessments are
3227 imposed under subparagraphs (i) and (ii).

3228 (b) Definitions.

3229 (i) [Deleted]

3230 (ii) For purposes of this subsection (4):

3231 1. "Non-Medicare hospital inpatient day"

3232 means total hospital inpatient days including subcomponent days
3233 less Medicare inpatient days including subcomponent days from the
3234 hospital's most recent Medicare cost report for the second
3235 calendar year preceding the beginning of the state fiscal year, on
3236 file with CMS per the CMS HCRIS database, or cost report submitted
3237 to the Division if the HCRIS database is not available to the
3238 division, as of June 1 of each year.

3239 a. Total hospital inpatient days shall
3240 be the sum of Worksheet S-3, Part 1, column 8 row 14, column 8 row
3241 16, and column 8 row 17, excluding column 8 rows 5 and 6.

3242 b. Hospital Medicare inpatient days
3243 shall be the sum of Worksheet S-3, Part 1, column 6 row 14, column
3244 6 row 16.00, and column 6 row 17, excluding column 6 rows 5 and 6.



3245 c. Inpatient days shall not include
3246 residential treatment or long-term care days.

3247 2. "Subcomponent inpatient day" means the
3248 number of days of care charged to a beneficiary for inpatient
3249 hospital rehabilitation and psychiatric care services in units of
3250 full days. A day begins at midnight and ends twenty-four (24)
3251 hours later. A part of a day, including the day of admission and
3252 day on which a patient returns from leave of absence, counts as a
3253 full day. However, the day of discharge, death, or a day on which
3254 a patient begins a leave of absence is not counted as a day unless
3255 discharge or death occur on the day of admission. If admission
3256 and discharge or death occur on the same day, the day is
3257 considered a day of admission and counts as one (1) subcomponent
3258 inpatient day.

3259 (c) The assessment provided in this subsection is
3260 intended to satisfy and not be in addition to the assessment and
3261 intergovernmental transfers provided in Section 43-13-117(A)(18).
3262 Nothing in this section shall be construed to authorize any state
3263 agency, division or department, or county, municipality or other
3264 local governmental unit to license for revenue, levy or impose any
3265 other tax, fee or assessment upon hospitals in this state not
3266 authorized by a specific statute.

3267 (d) Hospitals operated by the United States Department
3268 of Veterans Affairs and state-operated facilities that provide



3269 only inpatient and outpatient psychiatric services shall not be
3270 subject to the hospital assessment provided in this subsection.

3271 (e) Multihospital systems, closure, merger, change of
3272 ownership and new hospitals.

3273 (i) If a hospital conducts, operates or maintains
3274 more than one (1) hospital licensed by the State Department of
3275 Health, the provider shall pay the hospital assessment for each
3276 hospital separately.

3277 (ii) Notwithstanding any other provision in this
3278 section, if a hospital subject to this assessment operates or
3279 conducts business only for a portion of a fiscal year, the
3280 assessment for the state fiscal year shall be adjusted by
3281 multiplying the assessment by a fraction, the numerator of which
3282 is the number of days in the year during which the hospital
3283 operates, and the denominator of which is three hundred sixty-five
3284 (365). Immediately upon ceasing to operate, the hospital shall
3285 pay the assessment for the year as so adjusted (to the extent not
3286 previously paid).

3287 (iii) The division shall determine the tax for new
3288 hospitals and hospitals that undergo a change of ownership in
3289 accordance with this section, using the best available
3290 information, as determined by the division.

3291 (f) Applicability.

3292 The hospital assessment imposed by this subsection shall not
3293 take effect and/or shall cease to be imposed if:



3294 (i) The assessment is determined to be an
3295 impermissible tax under Title XIX of the Social Security Act; or

3296 (ii) CMS revokes its approval of the division's
3297 2009 Medicaid State Plan Amendment for the methodology for DSH
3298 payments to hospitals under Section 43-13-117(A)(18).

3299 (5) Each health care facility that is subject to the
3300 provisions of this section shall keep and preserve such suitable
3301 books and records as may be necessary to determine the amount of
3302 assessment for which it is liable under this section. The books
3303 and records shall be kept and preserved for a period of not less
3304 than five (5) years, during which time those books and records
3305 shall be open for examination during business hours by the
3306 division, the Department of Revenue, the Office of the Attorney
3307 General and the State Department of Health.

3308 (6) [Deleted]

3309 (7) All assessments collected under this section shall be
3310 deposited in the Medical Care Fund created by Section 43-13-143.

3311 (8) The assessment levied under this section shall be in
3312 addition to any other assessments, taxes or fees levied by law,
3313 and the assessment shall constitute a debt due the State of
3314 Mississippi from the time the assessment is due until it is paid.

3315 (9) (a) If a health care facility that is liable for
3316 payment of an assessment levied by the division does not pay the
3317 assessment when it is due, the division shall give written notice
3318 to the health care facility demanding payment of the assessment



3319 within ten (10) days from the date of delivery of the notice. If
3320 the health care facility fails or refuses to pay the assessment
3321 after receiving the notice and demand from the division, the
3322 division shall withhold from any Medicaid reimbursement payments
3323 that are due to the health care facility the amount of the unpaid
3324 assessment and a penalty of ten percent (10%) of the amount of the
3325 assessment, plus the legal rate of interest until the assessment
3326 is paid in full. If the health care facility does not participate
3327 in the Medicaid program, the division shall turn over to the
3328 Office of the Attorney General the collection of the unpaid
3329 assessment by civil action. In any such civil action, the Office
3330 of the Attorney General shall collect the amount of the unpaid
3331 assessment and a penalty of ten percent (10%) of the amount of the
3332 assessment, plus the legal rate of interest until the assessment
3333 is paid in full.

3334 (b) As an additional or alternative method for
3335 collecting unpaid assessments levied by the division, if a health
3336 care facility fails or refuses to pay the assessment after
3337 receiving notice and demand from the division, the division may
3338 file a notice of a tax lien with the chancery clerk of the county
3339 in which the health care facility is located, for the amount of
3340 the unpaid assessment and a penalty of ten percent (10%) of the
3341 amount of the assessment, plus the legal rate of interest until
3342 the assessment is paid in full. Immediately upon receipt of
3343 notice of the tax lien for the assessment, the chancery clerk



3344 shall forward the notice to the circuit clerk who shall enter the
3345 notice of the tax lien as a judgment upon the judgment roll and
3346 show in the appropriate columns the name of the health care
3347 facility as judgment debtor, the name of the division as judgment
3348 creditor, the amount of the unpaid assessment, and the date and
3349 time of enrollment. The judgment shall be valid as against
3350 mortgagees, pledgees, entrusters, purchasers, judgment creditors
3351 and other persons from the time of filing with the clerk. The
3352 amount of the judgment shall be a debt due the State of
3353 Mississippi and remain a lien upon the tangible property of the
3354 health care facility until the judgment is satisfied. The
3355 judgment shall be the equivalent of any enrolled judgment of a
3356 court of record and shall serve as authority for the issuance of
3357 writs of execution, writs of attachment or other remedial writs.

3358 (10) (a) To further the provisions of Section
3359 43-13-117(A)(18), the Division of Medicaid shall submit to the
3360 Centers for Medicare and Medicaid Services (CMS) any documents
3361 regarding the hospital assessment established under subsection (4)
3362 of this section. In addition to defining the assessment
3363 established in subsection (4) of this section if necessary, the
3364 documents shall describe any supplement payment programs and/or
3365 payment methodologies as authorized in Section 43-13-117(A)(18) if
3366 necessary.

3367 (b) All hospitals satisfying the minimum federal DSH
3368 eligibility requirements (Section 1923(d) of the Social Security



3369 Act) may, subject to OBRA 1993 payment limitations, receive a DSH
3370 payment. This DSH payment shall expend the balance of the federal
3371 DSH allotment and associated state share not utilized in DSH
3372 payments to state-owned institutions for treatment of mental
3373 diseases. The payment to each hospital shall be calculated by
3374 applying a uniform percentage to the uninsured costs of each
3375 eligible hospital, excluding state-owned institutions for
3376 treatment of mental diseases; however, that percentage for a
3377 state-owned teaching hospital located in Hinds County shall be
3378 multiplied by a factor of two (2).

3379 (11) The division shall implement DSH and supplemental
3380 payment calculation methodologies that result in the maximization
3381 of available federal funds.

3382 (12) The DSH payments shall be paid on or before December
3383 31, March 31, and June 30 of each fiscal year, in increments of
3384 one-third (1/3) of the total calculated DSH amounts. Supplemental
3385 payments developed pursuant to Section 43-13-117(A)(18) shall be
3386 paid monthly.

3387 (13) Payment.

3388 (a) The hospital assessment as described in subsection
3389 (4) for the nonfederal share necessary to maximize the Medicare
3390 Upper Payments Limits (UPL) Program payments and hospital access
3391 payments and such other supplemental payments as may be developed
3392 pursuant to Section 43-3-117(A)(18) shall be assessed and



3393 collected monthly no later than the fifteenth calendar day of each
3394 month.

3395 (b) The hospital assessment as described in subsection
3396 (4) for the nonfederal share necessary to maximize the
3397 Disproportionate Share Hospital (DSH) payments shall be assessed
3398 and collected on December 15, March 15 and June 15.

3399 (c) The annual hospital assessment and any additional
3400 hospital assessment as described in subsection (4) shall be
3401 assessed and collected on September 15 and on the 15th of each
3402 month from December through June.

3403 (14) If for any reason any part of the plan for annual DSH
3404 and supplemental payment programs to hospitals provided under
3405 subsection (10) of this section and/or developed pursuant to
3406 Section 43-13-117(A)(18) is not approved by CMS, the remainder of
3407 the plan shall remain in full force and effect.

3408 (15) Nothing in this section shall prevent the Division of
3409 Medicaid from facilitating participation in Medicaid supplemental
3410 hospital payment programs by a hospital located in a county
3411 contiguous to the State of Mississippi that is also authorized by
3412 federal law to submit intergovernmental transfers (IGTs) to the
3413 State of Mississippi to fund the state share of the hospital's
3414 supplemental and/or MHAP payments.

3415 (16) This section shall stand repealed on July 1, 2028.

3416 **SECTION 22.** Section 43-13-147, Mississippi Code of 1972, is
3417 brought forward as follows:



3418 43-13-147. (1) The Mississippi Medicaid Program and the
3419 Children's Health Insurance Program, in consultation with
3420 statewide organizations focused on premature infant health care,
3421 shall:

3422 (a) Examine and improve hospital discharge and
3423 follow-up care procedures for premature infants born earlier than
3424 thirty-seven (37) weeks gestational age to ensure standardized and
3425 coordinated processes are followed as premature infants leave the
3426 hospital from either a Level 1 (well baby nursery), Level 2 (step
3427 down or transitional nursery) or Level 3 (neonatal intensive care
3428 unit) unit and transition to follow-up care by a health care
3429 provider in the community; and

3430 (b) Use guidance from the Centers for Medicare and
3431 Medicaid Services' Neonatal Outcomes Improvement Project to
3432 implement programs to improve newborn outcomes, reduce newborn
3433 health costs and establish ongoing quality improvement for
3434 newborns.

3435 (2) Data regarding the incidence and cause of
3436 rehospitalization in the first six (6) months of life for infants
3437 born premature at earlier than thirty-seven (37) weeks gestational
3438 age shall be reported to the Chairman of the House Public Health
3439 and Human Services Committee and the Chairman of the Senate Public
3440 Health and Welfare Committee by the Mississippi State Department
3441 of Health utilizing the mandated hospital discharge data system
3442 authorized in Section 41-63-4.



3443 **SECTION 23.** This act shall take effect and be in force from
3444 and after July 1, 2025, and shall stand repealed on June 30, 2025.

