MISSISSIPPI LEGISLATURE REGULAR SESSION 2016

By: Senator(s) Hill

To: Medicaid; Appropriations

SENATE BILL NO. 2116

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO PRESCRIBE STANDARDS FOR THE PRIORITIZATION OF MEDICAID FUNDS TO
3 HEALTH CARE ENTITIES FOR FAMILY PLANNING SERVICES AND TO PROHIBIT
4 THE EXPENDITURE OF MEDICAID FUNDS FOR NONFEDERALLY QUALIFIED
5 ABORTIONS; TO PROVIDE FOR THE ENFORCEMENT OF THIS ACT BY THE
6 ATTORNEY GENERAL; AND FOR RELATED PURPOSES.

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

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

10 43-13-117. (A) Medicaid as authorized by this article shall
11 include payment of part or all of the costs, at the discretion of
12 the division, with approval of the Governor, of the following
13 types of care and services rendered to eligible applicants who
14 have been determined to be eligible for that care and services,
15 within the limits of state appropriations and federal matching
16 funds:

17 (1) Inpatient hospital services.

18 (a) The division shall allow thirty (30) days of
19 inpatient hospital care annually for all Medicaid recipients.
20 Medicaid recipients requiring transplants shall not have those

21 days included in the transplant hospital stay count against the
22 thirty-day limit for inpatient hospital care. Precertification of
23 inpatient days must be obtained as required by the division.
24 (b) From and after July 1, 1994, the Executive
25 Director of the Division of Medicaid shall amend the Mississippi
26 Title XIX Inpatient Hospital Reimbursement Plan to remove the
27 occupancy rate penalty from the calculation of the Medicaid
28 Capital Cost Component utilized to determine total hospital costs
29 allocated to the Medicaid program.
30 (c) Hospitals will receive an additional payment
31 for the implantable programmable baclofen drug pump used to treat
32 spasticity that is implanted on an inpatient basis. The payment
33 pursuant to written invoice will be in addition to the facility's
34 per diem reimbursement and will represent a reduction of costs on
35 the facility's annual cost report, and shall not exceed Ten
36 Thousand Dollars ($10,000.00) per year per recipient.
37 (d) The division is authorized to implement an
38 All-Patient Refined-Diagnosis Related Groups (APR-DRG)
39 reimbursement methodology for inpatient hospital services.
40 (e) No service benefits or reimbursement
41 limitations in this section shall apply to payments under an
42 APR-DRG or Ambulatory Payment Classification (APC) model or a
43 managed care program or similar model described in subsection (H)
44 of this section.
45 (2) Outpatient hospital services.

46 (a) Emergency services.
47 (b) Other outpatient hospital services. The
48 division shall allow benefits for other medically necessary
49 outpatient hospital services (such as chemotherapy, radiation,
50 surgery and therapy), including outpatient services in a clinic or
51 other facility that is not located inside the hospital, but that
52 has been designated as an outpatient facility by the hospital, and
53 that was in operation or under construction on July 1, 2009,
54 provided that the costs and charges associated with the operation
55 of the hospital clinic are included in the hospital's cost report.
56 In addition, the Medicare thirty-five-mile rule will apply to
57 those hospital clinics not located inside the hospital that are
58 constructed after July 1, 2009. Where the same services are
59 reimbursed as clinic services, the division may revise the rate or
60 methodology of outpatient reimbursement to maintain consistency,
61 efficiency, economy and quality of care.
62 (c) The division is authorized to implement an
63 Ambulatory Payment Classification (APC) methodology for outpatient
64 hospital services.
65 (d) No service benefits or reimbursement
66 limitations in this section shall apply to payments under an
67 APR-DRG or APC model or a managed care program or similar model
68 described in subsection (H) of this section.
69 (3) Laboratory and x-ray services.
70 (4) Nursing facility services.

71 (a) The division shall make full payment to
72 nursing facilities for each day, not exceeding fifty-two (52) days
73 per year, that a patient is absent from the facility on home
74 leave. Payment may be made for the following home leave days in
75 addition to the fifty-two-day limitation: Christmas, the day
76 before Christmas, the day after Christmas, Thanksgiving, the day
77 before Thanksgiving and the day after Thanksgiving.
78 (b) From and after July 1, 1997, the division
79 shall implement the integrated case-mix payment and quality
80 monitoring system, which includes the fair rental system for
81 property costs and in which recapture of depreciation is
82 eliminated. The division may reduce the payment for hospital
83 leave and therapeutic home leave days to the lower of the case-mix
84 category as computed for the resident on leave using the
85 assessment being utilized for payment at that point in time, or a
86 case-mix score of 1.000 for nursing facilities, and shall compute
87 case-mix scores of residents so that only services provided at the
88 nursing facility are considered in calculating a facility's per
89 diem.
90 (c) From and after July 1, 1997, all state-owned
91 nursing facilities shall be reimbursed on a full reasonable cost
92 basis.
93 (d) On or after January 1, 2015, the division
94 shall update the case-mix payment system resource utilization
95 grouper and classifications and fair rental reimbursement system.

96 The division shall develop and implement a payment add-on to
97 reimburse nursing facilities for ventilator dependent resident
98 services.

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

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

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

120 (5) Periodic screening and diagnostic services for
121 individuals under age twenty-one (21) years as are needed to
122 identify physical and mental defects and to provide health care
123 treatment and other measures designed to correct or ameliorate
124 defects and physical and mental illness and conditions discovered
125 by the screening services, regardless of whether these services
126 are included in the state plan. The division may include in its
127 periodic screening and diagnostic program those discretionary
128 services authorized under the federal regulations adopted to
129 implement Title XIX of the federal Social Security Act, as
130 amended. The division, in obtaining physical therapy services,
131 occupational therapy services, and services for individuals with
132 speech, hearing and language disorders, may enter into a
133 cooperative agreement with the State Department of Education for
134 the provision of those services to handicapped students by public
135 school districts using state funds that are provided from the
136 appropriation to the Department of Education to obtain federal
137 matching funds through the division. The division, in obtaining
138 medical and mental health assessments, treatment, care and
139 services for children who are in, or at risk of being put in, the
140 custody of the Mississippi Department of Human Services may enter
141 into a cooperative agreement with the Mississippi Department of
142 Human Services for the provision of those services using state
143 funds that are provided from the appropriation to the Department

144 of Human Services to obtain federal matching funds through the
145 division.
146 (6) Physician's services. The division shall allow
147 twelve (12) physician visits annually. The division may develop
148 and implement a different reimbursement model or schedule for
149 physician's services provided by physicians based at an academic
150 health care center and by physicians at rural health centers that
151 are associated with an academic health care center. From and
152 after January 1, 2010, all fees for physician's services that are
153 covered only by Medicaid shall be increased to ninety percent
154 (90%) of the rate established on January 1, 2010, and as may be
155 adjusted each July thereafter, under Medicare. The division may
156 provide for a reimbursement rate for physician's services of up to
157 one hundred percent (100%) of the rate established under Medicare
158 for physician's services that are provided after the normal
159 working hours of the physician, as determined in accordance with
160 regulations of the division. The division may reimburse eligible
161 providers as determined by the Patient Protection and Affordable
162 Care Act for certain primary care services as defined by the act
163 at one hundred percent (100%) of the rate established under
164 Medicare.
165 (7) (a) Home health services for eligible persons, not
166 to exceed in cost the prevailing cost of nursing facility
167 services, not to exceed twenty-five (25) visits per year. All

168 home health visits must be precertified as required by the
169 division.
170 (b) [Repealed]
171 (8) Emergency medical transportation services. On
172 January 1, 1994, emergency medical transportation services shall
173 be reimbursed at seventy percent (70%) of the rate established
174 under Medicare (Title XVIII of the federal Social Security Act, as
175 amended). "Emergency medical transportation services" shall mean,
176 but shall not be limited to, the following services by a properly
177 permitted ambulance operated by a properly licensed provider in
178 accordance with the Emergency Medical Services Act of 1974
179 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
180 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
181 (vi) disposable supplies, (vii) similar services.
182 (9) (a) Legend and other drugs as may be determined by
183 the division.
184 The division shall establish a mandatory preferred drug list.
185 Drugs not on the mandatory preferred drug list shall be made
186 available by utilizing prior authorization procedures established
187 by the division.
188 The division may seek to establish relationships with other
189 states in order to lower acquisition costs of prescription drugs
190 to include single source and innovator multiple source drugs or
191 generic drugs. In addition, if allowed by federal law or
192 regulation, the division may seek to establish relationships with

193 and negotiate with other countries to facilitate the acquisition
194 of prescription drugs to include single source and innovator
195 multiple source drugs or generic drugs, if that will lower the
196 acquisition costs of those prescription drugs.
197 The division shall allow for a combination of prescriptions
198 for single source and innovator multiple source drugs and generic
199 drugs to meet the needs of the beneficiaries, not to exceed five
200 (5) prescriptions per month for each noninstitutionalized Medicaid
201 beneficiary, with not more than two (2) of those prescriptions
202 being for single source or innovator multiple source drugs unless
203 the single source or innovator multiple source drug is less
204 expensive than the generic equivalent.
205 The executive director may approve specific maintenance drugs
206 for beneficiaries with certain medical conditions, which may be
207 prescribed and dispensed in three-month supply increments.
208 Drugs prescribed for a resident of a psychiatric residential
209 treatment facility must be provided in true unit doses when
210 available. The division may require that drugs not covered by
211 Medicare Part D for a resident of a long-term care facility be
212 provided in true unit doses when available. Those drugs that were
213 originally billed to the division but are not used by a resident
214 in any of those facilities shall be returned to the billing
215 pharmacy for credit to the division, in accordance with the
216 guidelines of the State Board of Pharmacy and any requirements of
217 federal law and regulation. Drugs shall be dispensed to a

218 recipient and only one (1) dispensing fee per month may be
219 charged. The division shall develop a methodology for reimbursing
220 for restocked drugs, which shall include a restock fee as
221 determined by the division not exceeding Seven Dollars and
222 Eighty-two Cents ($7.82).
223 The voluntary preferred drug list shall be expanded to
224 function in the interim in order to have a manageable prior
225 authorization system, thereby minimizing disruption of service to
226 beneficiaries.
227 Except for those specific maintenance drugs approved by the
228 executive director, the division shall not reimburse for any
229 portion of a prescription that exceeds a thirty-one-day supply of
230 the drug based on the daily dosage.
231 The division shall develop and implement a program of payment
232 for additional pharmacist services, with payment to be based on
233 demonstrated savings, but in no case shall the total payment
234 exceed twice the amount of the dispensing fee.
235 All claims for drugs for dually eligible Medicare/Medicaid
236 beneficiaries that are paid for by Medicare must be submitted to
237 Medicare for payment before they may be processed by the
238 division's online payment system.
239 The division shall develop a pharmacy policy in which drugs
240 in tamper-resistant packaging that are prescribed for a resident
241 of a nursing facility but are not dispensed to the resident shall

242 be returned to the pharmacy and not billed to Medicaid, in
243 accordance with guidelines of the State Board of Pharmacy.
244 The division shall develop and implement a method or methods
245 by which the division will provide on a regular basis to Medicaid
246 providers who are authorized to prescribe drugs, information about
247 the costs to the Medicaid program of single source drugs and
248 innovator multiple source drugs, and information about other drugs
249 that may be prescribed as alternatives to those single source
250 drugs and innovator multiple source drugs and the costs to the
251 Medicaid program of those alternative drugs.
252 Notwithstanding any law or regulation, information obtained
253 or maintained by the division regarding the prescription drug
254 program, including trade secrets and manufacturer or labeler
255 pricing, is confidential and not subject to disclosure except to
256 other state agencies.
257 (b) Payment by the division for covered
258 multisource drugs shall be limited to the lower of the upper
259 limits established and published by the Centers for Medicare and
260 Medicaid Services (CMS) plus a dispensing fee, or the estimated
261 acquisition cost (EAC) as determined by the division, plus a
262 dispensing fee, or the providers' usual and customary charge to
263 the general public.
264 Payment for other covered drugs, other than multisource drugs
265 with CMS upper limits, shall not exceed the lower of the estimated
266 acquisition cost as determined by the division, plus a dispensing

267 fee or the providers' usual and customary charge to the general
268 public.

269 Payment for nonlegend or over-the-counter drugs covered by
270 the division shall be reimbursed at the lower of the division's
271 estimated shelf price or the providers' usual and customary charge
272 to the general public.

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

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

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

284 (10) (a) Dental care that is an adjunct to treatment
285 of an acute medical or surgical condition; services of oral
286 surgeons and dentists in connection with surgery related to the
287 jaw or any structure contiguous to the jaw or the reduction of any
288 fracture of the jaw or any facial bone; and emergency dental
289 extractions and treatment related thereto. On July 1, 2007, fees
290 for dental care and surgery under authority of this paragraph (10)
291 shall be reimbursed as provided in subparagraph (b). It is the

292 intent of the Legislature that this rate revision for dental
293 services will be an incentive designed to increase the number of
294 dentists who actively provide Medicaid services. This dental
295 services rate revision shall be known as the "James Russell Dumas
296 Medicaid Dental Incentive Program."

297 The division shall annually determine the effect of this
298 incentive by evaluating the number of dentists who are Medicaid
299 providers, the number who and the degree to which they are
300 actively billing Medicaid, the geographic trends of where dentists
301 are offering what types of Medicaid services and other statistics
302 pertinent to the goals of this legislative intent. This data
303 shall be presented to the Chair of the Senate Public Health and
304 Welfare Committee and the Chair of the House Medicaid Committee.

305 (b) The Division of Medicaid shall establish a fee
306 schedule, to be effective from and after July 1, 2007, for dental
307 services. The schedule shall provide for a fee for each dental
308 service that is equal to a percentile of normal and customary
309 private provider fees, as defined by the Ingenix Customized Fee
310 Analyzer Report, which percentile shall be determined by the
311 division. The schedule shall be reviewed annually by the division
312 and dental fees shall be adjusted to reflect the percentile
313 determined by the division.

314 (c) For fiscal year 2008, the amount of state
315 funds appropriated for reimbursement for dental care and surgery
316 shall be increased by ten percent (10%) of the amount of state

317 fund expenditures for that purpose for fiscal year 2007. For each
318 of fiscal years 2009 and 2010, the amount of state funds
319 appropriated for reimbursement for dental care and surgery shall
320 be increased by ten percent (10%) of the amount of state fund
321 expenditures for that purpose for the preceding fiscal year.

322 (d) The division shall establish an annual benefit
323 limit of Two Thousand Five Hundred Dollars ($2,500.00) in dental
324 expenditures per Medicaid-eligible recipient; however, a recipient
325 may exceed the annual limit on dental expenditures provided in
326 this paragraph with prior approval of the division.

327 (e) The division shall include dental services as
328 a necessary component of overall health services provided to
329 children who are eligible for services.

330 (f) This paragraph (10) shall stand repealed on
331 July 1, 2016.

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

341 (12) Intermediate care facility services.

342 (a) The division shall make full payment to all
343 intermediate care facilities for individuals with intellectual
344 disabilities for each day, not exceeding eighty-four (84) days per
345 year, that a patient is absent from the facility on home leave.
346 Payment may be made for the following home leave days in addition
347 to the eighty-four-day limitation: Christmas, the day before
348 Christmas, the day after Christmas, Thanksgiving, the day before
349 Thanksgiving and the day after Thanksgiving.
350 (b) All state-owned intermediate care facilities
351 for individuals with intellectual disabilities shall be reimbursed
352 on a full reasonable cost basis.
353 (c) Effective January 1, 2015, the division shall
354 update the fair rental reimbursement system for intermediate care
355 facilities for individuals with intellectual disabilities.
356 (13) Family planning services, including drugs,
357 supplies and devices, when those services are under the
358 supervision of a physician or nurse practitioner.
359 Subject to any applicable requirements of federal statutes,
360 rules, regulations or guidelines:
361 (a) Any expenditures or grants of public funds for
362 family planning services by the state by and through the Division
363 of Medicaid shall be made in the following order of priority:
364 (i) To public entities;
365 (ii) To nonpublic hospitals and federally
366 qualified health centers;

367 (iii) To rural health clinics;

368 (iv) To nonpublic health providers that have
369 as their primary purpose the provision of the primary health care
370 services enumerated in 42 UCS 254(a)(1);

371 (v) To nonpublic health providers that do not
372 have as their primary purpose the provision of the primary health
373 care services enumerated in 42 USC 254(a)(1).

374 (b) The Division of Medicaid shall not enter into
375 a contract with, or make a grant to, any entity that performs
376 nonfederally qualified abortions or maintains or operated a
377 facility where nonfederally qualified abortions are performed.

378 (c) The Attorney General shall have authority to
379 bring an action in law or equity to enforce the provisions of this
380 paragraph (13), and relief shall be available in appropriate
381 circumstances including recoupment and declaratory and injunctive
382 relief, including without limitation suspension or debarment.

383 (d) Any entity eligible for the receipt of
384 Medicaid shall possess standing to bring any action that the
385 Attorney General has authority to bring pursuant to the provisions
386 of subparagraph (a) of this paragraph (13) and shall in
387 appropriate circumstances be entitled to the same relief,
388 provided, however, that an expenditure or grant of Medicaid funds
389 made in violation of this paragraph has resulted in the reduction
390 of public funds available to such entity, and that any award of
391 monetary relief shall be made to the State Treasurer for deposit

392 into one or more accounts maintained by the state for Medicaid
393 funds.
394 (e) In an action brought pursuant to subparagraph
395 (d) of this paragraph (13), a prevailing plaintiff shall be
396 entitled to an award of reasonable attorneys' fees and costs.
397 (14) Clinic services. Such diagnostic, preventive,
398 therapeutic, rehabilitative or palliative services furnished to an
399 outpatient by or under the supervision of a physician or dentist
400 in a facility that is not a part of a hospital but that is
401 organized and operated to provide medical care to outpatients.
402 Clinic services shall include any services reimbursed as
403 outpatient hospital services that may be rendered in such a
404 facility, including those that become so after July 1, 1991. On
405 July 1, 1999, all fees for physicians' services reimbursed under
406 authority of this paragraph (14) shall be reimbursed at ninety
407 percent (90%) of the rate established on January 1, 1999, and as
408 may be adjusted each July thereafter, under Medicare (Title XVIII
409 of the federal Social Security Act, as amended). The division may
410 develop and implement a different reimbursement model or schedule
411 for physician's services provided by physicians based at an
412 academic health care center and by physicians at rural health
413 centers that are associated with an academic health care center.
414 The division may provide for a reimbursement rate for physician's
415 clinic services of up to one hundred percent (100%) of the rate
416 established under Medicare for physician's services that are

417 provided after the normal working hours of the physician, as
418 determined in accordance with regulations of the division.
419 (15) Home- and community-based services for the elderly
420 and disabled, as provided under Title XIX of the federal Social
421 Security Act, as amended, under waivers, subject to the
422 availability of funds specifically appropriated for that purpose
423 by the Legislature.
424 The Division of Medicaid is directed to apply for a waiver
425 amendment to increase payments for all adult day care facilities
426 based on acuity of individual patients, with a maximum of
427 Seventy-five Dollars ($75.00) per day for the most acute patients.
428 (16) Mental health services. Approved therapeutic and
429 case management services (a) provided by an approved regional
430 mental health/intellectual disability center established under
431 Sections 41-19-31 through 41-19-39, or by another community mental
432 health service provider meeting the requirements of the Department
433 of Mental Health to be an approved mental health/intellectual
434 disability center if determined necessary by the Department of
435 Mental Health, using state funds that are provided in the
436 appropriation to the division to match federal funds, or (b)
437 provided by a facility that is certified by the State Department
438 of Mental Health to provide therapeutic and case management
439 services, to be reimbursed on a fee for service basis, or (c)
440 provided in the community by a facility or program operated by the
441 Department of Mental Health. Any such services provided by a

442 facility described in subparagraph (b) must have the prior
443 approval of the division to be reimbursable under this
444 section. ***
445 (17) Durable medical equipment services and medical
446 supplies. Precertification of durable medical equipment and
447 medical supplies must be obtained as required by the division.
448 The Division of Medicaid may require durable medical equipment
449 providers to obtain a surety bond in the amount and to the
450 specifications as established by the Balanced Budget Act of 1997.
451 (18) (a) Notwithstanding any other provision of this
452 section to the contrary, as provided in the Medicaid state plan
453 amendment or amendments as defined in Section 43-13-145(10), the
454 division shall make additional reimbursement to hospitals that
455 serve a disproportionate share of low-income patients and that
456 meet the federal requirements for those payments as provided in
457 Section 1923 of the federal Social Security Act and any applicable
458 regulations. It is the intent of the Legislature that the
459 division shall draw down all available federal funds allotted to
460 the state for disproportionate share hospitals. However, from and
461 after January 1, 1999, public hospitals participating in the
462 Medicaid disproportionate share program may be required to
463 participate in an intergovernmental transfer program as provided
464 in Section 1903 of the federal Social Security Act and any
465 applicable regulations.

466 (b) The division shall establish a Medicare Upper
467 Payment Limits Program, as defined in Section 1902(a)(30) of the
468 federal Social Security Act and any applicable federal
469 regulations, for hospitals, and may establish a Medicare Upper
470 Payment Limits Program for nursing facilities, and may establish a
471 Medicare Upper Payment Limits Program for physicians employed or
472 contracted by public hospitals. Upon successful implementation of
473 a Medicare Upper Payment Limits Program for physicians employed by
474 public hospitals, the division may develop a plan for implementing
475 an Upper Payment Limits Program for physicians employed by other
476 classes of hospitals. The division shall assess each hospital
477 and, if the program is established for nursing facilities, shall
478 assess each nursing facility, for the sole purpose of financing
479 the state portion of the Medicare Upper Payment Limits Program.
480 The hospital assessment shall be as provided in Section
481 43-13-145(4)(a) and the nursing facility assessment, if
482 established, shall be based on Medicaid utilization or other
483 appropriate method consistent with federal regulations. The
484 assessment will remain in effect as long as the state participates
485 in the Medicare Upper Payment Limits Program. Public hospitals
486 with physicians participating in the Medicare Upper Payment Limits
487 Program shall be required to participate in an intergovernmental
488 transfer program. As provided in the Medicaid state plan
489 amendment or amendments as defined in Section 43-13-145(10), the
490 division shall make additional reimbursement to hospitals and, if

491 the program is established for nursing facilities, shall make
492 additional reimbursement to nursing facilities, for the Medicare
493 Upper Payment Limits, and, if the program is established for
494 physicians, shall make additional reimbursement for physicians, as
495 defined in Section 1902(a)(30) of the federal Social Security Act
496 and any applicable federal regulations. Effective upon
497 implementation of the Mississippi Hospital Access Program (MHAP)
498 provided in subparagraph (c)(i) below, the hospital portion of the
499 inpatient Upper Payment Limits Program shall transition into and
500 be replaced by the MHAP program.

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

516 (ii) Subject only to approval by the Centers
517 for Medicare and Medicaid Services (CMS) where required, the MHAP
518 shall provide increased inpatient capitation (PMPM) payments to
519 managed care entities contracting with the division pursuant to
520 subsection (H) of this section to support availability of hospital
521 services or such other payments permissible under federal law
522 necessary to accomplish the intent of this subsection. For
523 inpatient services rendered after July 1, 2015, but prior to the
524 effective date of CMS approval and full implementation of this
525 program, the division may pay lump-sum enhanced, transition
526 payments, prorated inpatient UPL payments based upon fiscal year
527 2015 June distribution levels, enhanced hospital access (PMPM)
528 payments or such other methodologies as are approved by CMS such
529 that the level of additional reimbursement required by this
530 section is paid for all Medicaid hospital inpatient services
531 delivered in fiscal year 2016.
532 (iii) The intent of this subparagraph (c) is
533 that effective for all inpatient hospital Medicaid services during
534 state fiscal year 2016, and so long as this provision shall remain
535 in effect hereafter, the division shall to the fullest extent
536 feasible replace the additional reimbursement for hospital
537 inpatient services under the inpatient Medicare Upper Payment
538 Limits (UPL) Program with additional reimbursement under the MHAP.
539 (iv) The division shall assess each hospital
540 as provided in Section 43-13-145(4)(a) for the purpose of

541 financing the state portion of the MHAP and such other purposes as
542 specified in Section 43-13-145. The assessment will remain in
543 effect as long as the MHAP is in effect.

544 (v) In the event that the MHAP program under
545 this subparagraph (c) is not approved by CMS, the inpatient UPL
546 Program under subparagraph (b) shall immediately become restored
547 in the manner required to provide the maximum permissible level of
548 UPL payments to hospital providers for all inpatient services
549 rendered from and after July 1, 2015.

550 (19) (a) Perinatal risk management services. The
551 division shall promulgate regulations to be effective from and
552 after October 1, 1988, to establish a comprehensive perinatal
553 system for risk assessment of all pregnant and infant Medicaid
554 recipients and for management, education and follow-up for those
555 who are determined to be at risk. Services to be performed
556 include case management, nutrition assessment/counseling,
557 psychosocial assessment/counseling and health education. The
558 division shall contract with the State Department of Health to
559 provide the services within this paragraph (Perinatal High Risk
560 Management/Infant Services System (PHRM/ISS)). The State
561 Department of Health as the agency for PHRM/ISS for the Division
562 of Medicaid shall be reimbursed on a full reasonable cost basis.

563 (b) Early intervention system services. The
564 division shall cooperate with the State Department of Health,
565 acting as lead agency, in the development and implementation of a

566 statewide system of delivery of early intervention services, under
567 Part C of the Individuals with Disabilities Education Act (IDEA).
568 The State Department of Health shall certify annually in writing
569 to the executive director of the division the dollar amount of
570 state early intervention funds available that will be utilized as
571 a certified match for Medicaid matching funds. Those funds then
572 shall be used to provide expanded targeted case management
573 services for Medicaid eligible children with special needs who are
574 eligible for the state's early intervention system.
575 Qualifications for persons providing service coordination shall be
576 determined by the State Department of Health and the Division of
577 Medicaid.

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

588 (21) Nurse practitioner services. Services furnished
589 by a registered nurse who is licensed and certified by the
590 Mississippi Board of Nursing as a nurse practitioner, including,

591 but not limited to, nurse anesthetists, nurse midwives, family
592 nurse practitioners, family planning nurse practitioners,
593 pediatric nurse practitioners, obstetrics-gynecology nurse
594 practitioners and neonatal nurse practitioners, under regulations
595 adopted by the division. Reimbursement for those services shall
596 not exceed ninety percent (90%) of the reimbursement rate for
597 comparable services rendered by a physician. The division may
598 provide for a reimbursement rate for nurse practitioner services
599 of up to one hundred percent (100%) of the reimbursement rate for
600 comparable services rendered by a physician for nurse practitioner
601 services that are provided after the normal working hours of the
602 nurse practitioner, as determined in accordance with regulations
603 of the division.
604 (22) Ambulatory services delivered in federally
605 qualified health centers, rural health centers and clinics of the
606 local health departments of the State Department of Health for
607 individuals eligible for Medicaid under this article based on
608 reasonable costs as determined by the division.
609 (23) Inpatient psychiatric services. Inpatient
610 psychiatric services to be determined by the division for
611 recipients under age twenty-one (21) that are provided under the
612 direction of a physician in an inpatient program in a licensed
613 acute care psychiatric facility or in a licensed psychiatric
614 residential treatment facility, before the recipient reaches age
615 twenty-one (21) or, if the recipient was receiving the services

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

628 (24) [Deleted]

629 (25) [Deleted]

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

641 (27) Group health plan premiums and cost-sharing if it
642 is cost-effective as defined by the United States Secretary of
643 Health and Human Services.
644 (28) Other health insurance premiums that are
645 cost-effective as defined by the United States Secretary of Health
646 and Human Services. Medicare eligible must have Medicare Part B
647 before other insurance premiums can be paid.
648 (29) The Division of Medicaid may apply for a waiver
649 from the United States Department of Health and Human Services for
650 home- and community-based services for developmentally disabled
651 people using state funds that are provided from the appropriation
652 to the State Department of Mental Health and/or funds transferred
653 to the department by a political subdivision or instrumentality of
654 the state and used to match federal funds under a cooperative
655 agreement between the division and the department, provided that
656 funds for these services are specifically appropriated to the
657 Department of Mental Health and/or transferred to the department
658 by a political subdivision or instrumentality of the state.
659 (30) Pediatric skilled nursing services for eligible
660 persons under twenty-one (21) years of age.
661 (31) Targeted case management services for children
662 with special needs, under waivers from the United States
663 Department of Health and Human Services, using state funds that
664 are provided from the appropriation to the Mississippi Department

665 of Human Services and used to match federal funds under a
666 cooperative agreement between the division and the department.
667 (32) Care and services provided in Christian Science
668 Sanatoria listed and certified by the Commission for Accreditation
669 of Christian Science Nursing Organizations/Facilities, Inc.,
670 rendered in connection with treatment by prayer or spiritual means
671 to the extent that those services are subject to reimbursement
672 under Section 1903 of the federal Social Security Act.
673 (33) Podiatrist services.
674 (34) Assisted living services as provided through
675 home- and community-based services under Title XIX of the federal
676 Social Security Act, as amended, subject to the availability of
677 funds specifically appropriated for that purpose by the
678 Legislature.
679 (35) Services and activities authorized in Sections
680 43-27-101 and 43-27-103, using state funds that are provided from
681 the appropriation to the Mississippi Department of Human Services
682 and used to match federal funds under a cooperative agreement
683 between the division and the department.
684 (36) Nonemergency transportation services for
685 Medicaid-eligible persons, to be provided by the Division of
686 Medicaid. The division may contract with additional entities to
687 administer nonemergency transportation services as it deems
688 necessary. All providers shall have a valid driver's license,
689 vehicle inspection sticker, valid vehicle license tags and a

690 standard liability insurance policy covering the vehicle. The
691 division may pay providers a flat fee based on mileage tiers, or
692 in the alternative, may reimburse on actual miles traveled. The
693 division may apply to the Center for Medicare and Medicaid
694 Services (CMS) for a waiver to draw federal matching funds for
695 nonemergency transportation services as a covered service instead
696 of an administrative cost. The PEER Committee shall conduct a
697 performance evaluation of the nonemergency transportation program
698 to evaluate the administration of the program and the providers of
699 transportation services to determine the most cost-effective ways
700 of providing nonemergency transportation services to the patients
701 served under the program. The performance evaluation shall be
702 completed and provided to the members of the Senate Public Health
703 and Welfare Committee and the House Medicaid Committee not later
704 than January 15, 2008.
705 (37) [Deleted]
706 (38) Chiropractic services. A chiropractor's manual
707 manipulation of the spine to correct a subluxation, if x-ray
708 demonstrates that a subluxation exists and if the subluxation has
709 resulted in a neuromusculoskeletal condition for which
710 manipulation is appropriate treatment, and related spinal x-rays
711 performed to document these conditions. Reimbursement for
712 chiropractic services shall not exceed Seven Hundred Dollars
713 ($700.00) per year per beneficiary.

714 (39) Dually eligible Medicare/Medicaid beneficiaries.
715 The division shall pay the Medicare deductible and coinsurance
716 amounts for services available under Medicare, as determined by
717 the division. From and after July 1, 2009, the division shall
718 reimburse crossover claims for inpatient hospital services and
719 crossover claims covered under Medicare Part B in the same manner
720 that was in effect on January 1, 2008, unless specifically
721 authorized by the Legislature to change this method.
722 (40) [Deleted]
723 (41) Services provided by the State Department of
724 Rehabilitation Services for the care and rehabilitation of persons
725 with spinal cord injuries or traumatic brain injuries, as allowed
726 under waivers from the United States Department of Health and
727 Human Services, using up to seventy-five percent (75%) of the
728 funds that are appropriated to the Department of Rehabilitation
729 Services from the Spinal Cord and Head Injury Trust Fund
730 established under Section 37-33-261 and used to match federal
731 funds under a cooperative agreement between the division and the
732 department.
733 (42) Notwithstanding any other provision in this
734 article to the contrary, the division may develop a population
735 health management program for women and children health services
736 through the age of one (1) year. This program is primarily for
737 obstetrical care associated with low birth weight and preterm
738 babies. The division may apply to the federal Centers for

739 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
740 any other waivers that may enhance the program. In order to
741 effect cost savings, the division may develop a revised payment
742 methodology that may include at-risk capitated payments, and may
743 require member participation in accordance with the terms and
744 conditions of an approved federal waiver.

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

750 (44) Nursing facility services for the severely
751 disabled.

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

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

758 (45) Physician assistant services. Services furnished
759 by a physician assistant who is licensed by the State Board of
760 Medical Licensure and is practicing with physician supervision
761 under regulations adopted by the board, under regulations adopted
762 by the division. Reimbursement for those services shall not
763 exceed ninety percent (90%) of the reimbursement rate for

764 comparable services rendered by a physician. The division may
765 provide for a reimbursement rate for physician assistant services
766 of up to one hundred percent (100%) or the reimbursement rate for
767 comparable services rendered by a physician for physician
768 assistant services that are provided after the normal working
769 hours of the physician assistant, as determined in accordance with
770 regulations of the division.

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

782 (47) (a) Notwithstanding any other provision in this
783 article to the contrary, the division may develop and implement
784 disease management programs for individuals with high-cost chronic
785 diseases and conditions, including the use of grants, waivers,
786 demonstrations or other projects as necessary.

787 (b) Participation in any disease management
788 program implemented under this paragraph (47) is optional with the

789 individual. An individual must affirmatively elect to participate
790 in the disease management program in order to participate, and may
791 elect to discontinue participation in the program at any time.

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

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

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

802 (49) The division shall establish copayments and/or
803 coinsurance for all Medicaid services for which copayments and/or
804 coinsurance are allowable under federal law or regulation, and
805 shall set the amount of the copayment and/or coinsurance for each
806 of those services at the maximum amount allowable under federal
807 law or regulation.

808 (50) Services provided by the State Department of
809 Rehabilitation Services for the care and rehabilitation of persons
810 who are deaf and blind, as allowed under waivers from the United
811 States Department of Health and Human Services to provide
812 home- and community-based services using state funds that are
813 provided from the appropriation to the State Department of

814 Rehabilitation Services or if funds are voluntarily provided by
815 another agency.
816 (51) Upon determination of Medicaid eligibility and in
817 association with annual redetermination of Medicaid eligibility,
818 beneficiaries shall be encouraged to undertake a physical
819 examination that will establish a base-line level of health and
820 identification of a usual and customary source of care (a medical
821 home) to aid utilization of disease management tools. This
822 physical examination and utilization of these disease management
823 tools shall be consistent with current United States Preventive
824 Services Task Force or other recognized authority recommendations.
825 For persons who are determined ineligible for Medicaid, the
826 division will provide information and direction for accessing
827 medical care and services in the area of their residence.
828 (52) Notwithstanding any provisions of this article,
829 the division may pay enhanced reimbursement fees related to trauma
830 care, as determined by the division in conjunction with the State
831 Department of Health, using funds appropriated to the State
832 Department of Health for trauma care and services and used to
833 match federal funds under a cooperative agreement between the
834 division and the State Department of Health. The division, in
835 conjunction with the State Department of Health, may use grants,
836 waivers, demonstrations, or other projects as necessary in the
837 development and implementation of this reimbursement program.

838 (53) Targeted case management services for high-cost
839 beneficiaries shall be developed by the division for all services
840 under this section.
841 (54) Adult foster care services pilot program. Social
842 and protective services on a pilot program basis in an approved
843 foster care facility for vulnerable adults who would otherwise
844 need care in a long-term care facility, to be implemented in an
845 area of the state with the greatest need for such program, under
846 the Medicaid Waivers for the Elderly and Disabled program or an
847 assisted living waiver. The division may use grants, waivers,
848 demonstrations or other projects as necessary in the development
849 and implementation of this adult foster care services pilot
850 program.
851 (55) Therapy services. The plan of care for therapy
852 services may be developed to cover a period of treatment for up to
853 six (6) months, but in no event shall the plan of care exceed a
854 six-month period of treatment. The projected period of treatment
855 must be indicated on the initial plan of care and must be updated
856 with each subsequent revised plan of care. Based on medical
857 necessity, the division shall approve certification periods for
858 less than or up to six (6) months, but in no event shall the
859 certification period exceed the period of treatment indicated on
860 the plan of care. The appeal process for any reduction in therapy
861 services shall be consistent with the appeal process in federal
862 regulations.

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

868 (57) No Medicaid benefit shall restrict coverage for
869 medically appropriate treatment prescribed by a physician and
870 agreed to by a fully informed individual, or if the individual
871 lacks legal capacity to consent by a person who has legal
872 authority to consent on his or her behalf, based on an
873 individual's diagnosis with a terminal condition. As used in this
874 paragraph (57), "terminal condition" means any aggressive
875 malignancy, chronic end-stage cardiovascular or cerebral vascular
876 disease, or any other disease, illness or condition which a
877 physician diagnoses as terminal.

878 (B) Notwithstanding any other provision of this article to
879 the contrary, the division shall reduce the rate of reimbursement
880 to providers for any service provided under this section by five
881 percent (5%) of the allowed amount for that service. However, the
882 reduction in the reimbursement rates required by this subsection
883 (B) shall not apply to inpatient hospital services, nursing
884 facility services, intermediate care facility services,
885 psychiatric residential treatment facility services, pharmacy
886 services provided under subsection (A)(9) of this section, or any
887 service provided by the University of Mississippi Medical Center

888 or a state agency, a state facility or a public agency that either
889 provides its own state match through intergovernmental transfer or
890 certification of funds to the division, or a service for which the
891 federal government sets the reimbursement methodology and rate.
892 From and after January 1, 2010, the reduction in the reimbursement
893 rates required by this subsection (B) shall not apply to
894 physicians' services. In addition, the reduction in the
895 reimbursement rates required by this subsection (B) shall not
896 apply to case management services and home-delivered meals
897 provided under the home- and community-based services program for
898 the elderly and disabled by a planning and development district
899 (PDD). Planning and development districts participating in the
900 home- and community-based services program for the elderly and
901 disabled as case management providers shall be reimbursed for case
902 management services at the maximum rate approved by the Centers
903 for Medicare and Medicaid Services (CMS).

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

912 accepting patient referrals through the program, as provided in
913 this subsection (C).
914 (D) Notwithstanding any provision of this article, except as
915 authorized in the following subsection and in Section 43-13-139,
916 neither *** * *** (1) the limitations on quantity or frequency of use
917 of or the fees or charges for any of the care or services
918 available to recipients under this section, nor *** * *** (2) the
919 payments, payment methodology as provided below in this subsection
920 (D), or rates of reimbursement to providers rendering care or
921 services authorized under this section to recipients, may be
922 increased, decreased or otherwise changed from the levels in
923 effect on July 1, 1999, unless they are authorized by an amendment
924 to this section by the Legislature. However, the restriction in
925 this subsection shall not prevent the division from changing the
926 payments, payment methodology as provided below in this subsection
927 (D), or rates of reimbursement to providers without an amendment
928 to this section whenever those changes are required by federal law
929 or regulation, or whenever those changes are necessary to correct
930 administrative errors or omissions in calculating those payments
931 or rates of reimbursement. The prohibition on any changes in
932 payment methodology provided in this subsection (D) shall apply
933 only to payment methodologies used for determining the rates of
934 reimbursement for inpatient hospital services, outpatient hospital
935 services, nursing facility services, and/or pharmacy services,
936 except as required by federal law, and the federally mandated

937 rebasing of rates as required by the Centers for Medicare and
938 Medicaid Services (CMS) shall not be considered payment
939 methodology for purposes of this subsection (D). No service
940 benefits or reimbursement limitations in this section shall apply
941 to payments under an APR-DRG or APC model or a managed care
942 program or similar model described in subsection (H) of this
943 section.

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

950 (F) The executive director shall keep the Governor advised
951 on a timely basis of the funds available for expenditure and the
952 projected expenditures. If current or projected expenditures of
953 the division are reasonably anticipated to exceed the amount of
954 funds appropriated to the division for any fiscal year, the
955 Governor, after consultation with the executive director, shall
956 discontinue any or all of the payment of the types of care and
957 services as provided in this section that are deemed to be
958 optional services under Title XIX of the federal Social Security
959 Act, as amended, and when necessary, shall institute any other
960 cost containment measures on any program or programs authorized
961 under the article to the extent allowed under the federal law

962 governing that program or programs. However, the Governor shall
963 not be authorized to discontinue or eliminate any service under
964 this section that is mandatory under federal law, or to
965 discontinue or eliminate, or adjust income limits or resource
966 limits for, any eligibility category or group under Section
967 43-13-115. Beginning in fiscal year 2010 and in fiscal years
968 thereafter, when Medicaid expenditures are projected to exceed
969 funds available for any quarter in the fiscal year, the division
970 shall submit the expected shortfall information to the PEER
971 Committee, which shall review the computations of the division and
972 report its findings to the Legislative Budget Office within thirty
973 (30) days of such notification by the division, and not later than
974 January 7 in any year. If expenditure reductions or cost
975 containments are implemented, the Governor may implement a maximum
976 amount of state share expenditure reductions to providers, of
977 which hospitals will be responsible for twenty-five percent (25%)
978 of provider reductions as follows: in fiscal year 2010, the
979 maximum amount shall be Twenty-four Million Dollars
980 ($24,000,000.00); in fiscal year 2011, the maximum amount shall be
981 Thirty-two Million Dollars ($32,000,000.00); and in fiscal year
982 2012 and thereafter, the maximum amount shall be Forty Million
983 Dollars ($40,000,000.00). However, instead of implementing cuts,
984 the hospital share shall be in the form of an additional
985 assessment not to exceed Ten Million Dollars ($10,000,000.00) as
986 provided in Section 43-13-145(4)(a)(ii). If Medicaid expenditures

987 are projected to exceed the amount of funds appropriated to the
988 division in any fiscal year in excess of the expenditure
989 reductions to providers, then funds shall be transferred by the
990 State Fiscal Officer from the Health Care Trust Fund into the
991 Health Care Expendable Fund and to the Governor's Office, Division
992 of Medicaid, from the Health Care Expendable Fund, in the amount
993 and at such time as requested by the Governor to reconcile the
994 deficit. If the cost containment measures described above have
995 been implemented and there are insufficient funds in the Health
996 Care Trust Fund to reconcile any remaining deficit in any fiscal
997 year, the Governor shall institute any other additional cost
998 containment measures on any program or programs authorized under
999 this article to the extent allowed under federal law. Hospitals
1000 shall be responsible for twenty-five percent (25%) of any
1001 additional imposed provider cuts. However, instead of
1002 implementing hospital expenditure reductions, the hospital
1003 reductions shall be in the form of an additional assessment not to
1004 exceed twenty-five percent (25%) of provider expenditure
1005 reductions as provided in Section 43-13-145(4)(a)(ii). It is the
1006 intent of the Legislature that the expenditures of the division
1007 during any fiscal year shall not exceed the amounts appropriated
1008 to the division for that fiscal year.

1009 (G) Notwithstanding any other provision of this article, it
1010 shall be the duty of each nursing facility, intermediate care
1011 facility for individuals with intellectual disabilities,

1012 psychiatric residential treatment facility, and nursing facility
1013 for the severely disabled that is participating in the Medicaid
1014 program to keep and maintain books, documents and other records as
1015 prescribed by the Division of Medicaid in substantiation of its
1016 cost reports for a period of three (3) years after the date of
1017 submission to the Division of Medicaid of an original cost report,
1018 or three (3) years after the date of submission to the Division of
1019 Medicaid of an amended cost report.

1020 (H) (1) Notwithstanding any other provision of this
1021 article, the division is authorized to implement (a) a managed
1022 care program, (b) a coordinated care program, (c) a coordinated
1023 care organization program, (d) a health maintenance organization
1024 program, (e) a patient-centered medical home program, (f) an
1025 accountable care organization program, (g) provider-sponsored
1026 health plan, or (h) any combination of the above programs.
1027 Managed care programs, coordinated care programs, coordinated care
1028 organization programs, health maintenance organization programs,
1029 patient-centered medical home programs, accountable care
1030 organization programs, provider-sponsored health plans, or any
1031 combination of the above programs or other similar programs
1032 implemented by the division under this section shall be limited to
1033 the greater of (i) forty-five percent (45%) of the total
1034 enrollment of Medicaid beneficiaries, or (ii) the categories of
1035 beneficiaries participating in the program as of January 1, 2014,
1036 plus the categories of beneficiaries composed primarily of persons

1037 younger than nineteen (19) years of age, and the division is
1038 authorized to enroll categories of beneficiaries in such
1039 program(s) as long as the appropriate limitations are not exceeded
1040 in the aggregate. As a condition for the approval of any program
1041 under this subsection (H)(1), the division shall require that no
1042 program may:

1043 (a) Pay providers at a rate that is less than the
1044 Medicaid All-Patient Refined-Diagnosis Related Groups (APR-DRG)
1045 reimbursement rate;

1046 (b) Override the medical decisions of hospital
1047 physicians or staff regarding patients admitted to a hospital for
1048 an emergency medical condition as defined by 42 US Code Section
1049 1395dd. This restriction (b) does not prohibit the retrospective
1050 review of the appropriateness of the determination that an
1051 emergency medical condition exists by chart review or coding
1052 algorithm, nor does it prohibit prior authorization for
1053 nonemergency hospital admissions;

1054 (c) Pay providers at a rate that is less than the
1055 normal Medicaid reimbursement rate; however, the division may
1056 approve use of innovative payment models that recognize
1057 alternative payment models, including quality and value-based
1058 payments, provided both parties mutually agree and the Division of
1059 Medicaid approves of said models. Participation in the provider
1060 network of any managed care, coordinated care, provider-sponsored

1061 health plan, or similar contractor shall not be conditioned on the
1062 provider's agreement to accept such alternative payment models;
1063 (d) Implement a prior authorization program for
1064 prescription drugs that is more stringent than the prior
1065 authorization processes used by the division in its administration
1066 of the Medicaid program;
1067 (e) Implement a policy that does not comply with
1068 the prescription drugs payment requirements established in
1069 subsection (A)(9) of this section;
1070 (f) Implement a preferred drug list that is more
1071 stringent than the mandatory preferred drug list established by
1072 the division under subsection (A)(9) of this section;
1073 (g) Implement a policy which denies beneficiaries
1074 with hemophilia access to the federally funded hemophilia
1075 treatment centers as part of the Medicaid Managed Care network of
1076 providers. All Medicaid beneficiaries with hemophilia shall
1077 receive unrestricted access to anti-hemophilia factor products
1078 through noncapitated reimbursement programs.
1079 (2) Any contractors providing direct patient care under
1080 a managed care program established in this section shall provide
1081 to the Legislature and the division statistical data to be shared
1082 with provider groups in order to improve patient access,
1083 appropriate utilization, cost savings and health outcomes.
1084 (3) All health maintenance organizations, coordinated
1085 care organizations, provider-sponsored health plans, or other

1086 organizations paid for services on a capitated basis by the
1087 division under any managed care program or coordinated care
1088 program implemented by the division under this section shall
1089 reimburse all providers in those organizations at rates no lower
1090 than those provided under this section for beneficiaries who are
1091 not participating in those programs.

1092 (4) No health maintenance organization, coordinated
1093 care organization, provider-sponsored health plan, or other
1094 organization paid for services on a capitated basis by the
1095 division under any managed care program or coordinated care
1096 program implemented by the division under this section shall
1097 require its providers or beneficiaries to use any pharmacy that
1098 ships, mails or delivers prescription drugs or legend drugs or
1099 devices.

1100 (I) [Deleted]

1101 (J) There shall be no cuts in inpatient and outpatient
1102 hospital payments, or allowable days or volumes, as long as the
1103 hospital assessment provided in Section 43-13-145 is in effect.
1104 This subsection (J) shall not apply to decreases in payments that
1105 are a result of: reduced hospital admissions, audits or payments
1106 under the APR-DRG or APC models, or a managed care program or
1107 similar model described in subsection (H) of this section.

1108 (K) This section shall stand repealed on June 30, 2018.

1109 **SECTION 2.** This act shall take effect and be in force from
1110 and after July 1, 2016.