MISSISSIPPI LEGISLATURE REGULAR SESSION 2018

By: Representative Scott To: Medicaid

HOUSE BILL NO. 482

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO REQUIRE MEDICAID BENEFICIARIES TO PARTICIPATE IN A
3 PATIENT-CENTERED MEDICAL HOME; TO PROVIDE THAT THE REQUIRED
4 PHYSICAL EXAMINATION OF THOSE PARTICIPANTS SHALL INCLUDE A
5 MEASUREMENT OF THEIR BODY MASS INDEX (BMI); TO PROVIDE THAT THOSE
6 BENEFICIARIES WHO ARE DETERMINED TO BE OBESE BASED ON THEIR BMI
7 MEASUREMENT MUST PARTICIPATE IN AN ONLINE INTERACTIVE PROGRAM
8 DELIVERED VIA THE INTERNET THAT IS DESIGNED TO PREVENT AND REDUCE
9 OBESITY; TO SPECIFY THE CONTENTS OF THE ONLINE PROGRAM; TO PROVIDE
10 THAT COMPUTERS SHALL BE AVAILABLE AT CERTAIN LOCATIONS THROUGHOUT
11 THE STATE FOR THE USE OF PERSONS REQUIRED TO PARTICIPATE IN THE
12 ONLINE PROGRAM WHO DO NOT HAVE ACCESS TO THE INTERNET AT THEIR
13 HOMES; TO PENALIZE BENEFICIARIES REQUIRED TO PARTICIPATE IN THE
14 ONLINE PROGRAM WHO FAIL TO PARTICIPATE BY INCREASING THEIR
15 CO-PAYMENTS FOR MEDICAID SERVICES; TO EXTEND THE DATE OF THE
16 REPEALER ON THIS SECTION; AND FOR RELATED PURPOSES.

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

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

20 43-13-117. (A) Medicaid as authorized by this article shall
21 include payment of part or all of the costs, at the discretion of
22 the division, with approval of the Governor, of the following
23 types of care and services rendered to eligible applicants who
24 have been determined to be eligible for that care and services,

25 within the limits of state appropriations and federal matching
26 funds:
27 (1) Inpatient hospital services.
28 (a) The division shall allow thirty (30) days of
29 inpatient hospital care annually for all Medicaid recipients.
30 Medicaid recipients requiring transplants shall not have those
31 days included in the transplant hospital stay count against the
32 thirty-day limit for inpatient hospital care. Precertification of
33 inpatient days must be obtained as required by the division.
34 (b) From and after July 1, 1994, the Executive
35 Director of the Division of Medicaid shall amend the Mississippi
36 Title XIX Inpatient Hospital Reimbursement Plan to remove the
37 occupancy rate penalty from the calculation of the Medicaid
38 Capital Cost Component utilized to determine total hospital costs
39 allocated to the Medicaid program.
40 (c) Hospitals will receive an additional payment
41 for the implantable programmable baclofen drug pump used to treat
42 spasticity that is implanted on an inpatient basis. The payment
43 pursuant to written invoice will be in addition to the facility's
44 per diem reimbursement and will represent a reduction of costs on
45 the facility's annual cost report, and shall not exceed Ten
46 Thousand Dollars ($10,000.00) per year per recipient.
47 (d) The division is authorized to implement an
48 All-Patient Refined-Diagnosis Related Groups (APR-DRG)
49 reimbursement methodology for inpatient hospital services.

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

75 (d) No service benefits or reimbursement
76 limitations in this section shall apply to payments under an
77 APR-DRG or APC model or a managed care program or similar model
78 described in subsection (H) of this section.
79 (3) Laboratory and x-ray services.
80 (4) Nursing facility services.
81 (a) The division shall make full payment to
82 nursing facilities for each day, not exceeding fifty-two (52) days
83 per year, that a patient is absent from the facility on home
84 leave. Payment may be made for the following home leave days in
85 addition to the fifty-two-day limitation: Christmas, the day
86 before Christmas, the day after Christmas, Thanksgiving, the day
87 before Thanksgiving and the day after Thanksgiving.
88 (b) From and after July 1, 1997, the division
89 shall implement the integrated case-mix payment and quality
90 monitoring system, which includes the fair rental system for
91 property costs and in which recapture of depreciation is
92 eliminated. The division may reduce the payment for hospital
93 leave and therapeutic home leave days to the lower of the case-mix
94 category as computed for the resident on leave using the
95 assessment being utilized for payment at that point in time, or a
96 case-mix score of 1.000 for nursing facilities, and shall compute
97 case-mix scores of residents so that only services provided at the
98 nursing facility are considered in calculating a facility's per
99 diem.

100 (c) From and after July 1, 1997, all state-owned
101 nursing facilities shall be reimbursed on a full reasonable cost
102 basis.
103 (d) On or after January 1, 2015, the division
104 shall update the case-mix payment system resource utilization
105 grouper and classifications and fair rental reimbursement system.
106 The division shall develop and implement a payment add-on to
107 reimburse nursing facilities for ventilator dependent resident
108 services.
109 (e) The division shall develop and implement, not
110 later than January 1, 2001, a case-mix payment add-on determined
111 by time studies and other valid statistical data that will
112 reimburse a nursing facility for the additional cost of caring for
113 a resident who has a diagnosis of Alzheimer's or other related
114 dementia and exhibits symptoms that require special care. Any
115 such case-mix add-on payment shall be supported by a determination
116 of additional cost. The division shall also develop and implement
117 as part of the fair rental reimbursement system for nursing
118 facility beds, an Alzheimer's resident bed depreciation enhanced
119 reimbursement system that will provide an incentive to encourage
120 nursing facilities to convert or construct beds for residents with
121 Alzheimer's or other related dementia.
122 (f) The division shall develop and implement an
123 assessment process for long-term care services. The division may

124 provide the assessment and related functions directly or through
125 contract with the area agencies on aging.
126 The division shall apply for necessary federal waivers to
127 assure that additional services providing alternatives to nursing
128 facility care are made available to applicants for nursing
129 facility care.
130 (5) Periodic screening and diagnostic services for
131 individuals under age twenty-one (21) years as are needed to
132 identify physical and mental defects and to provide health care
133 treatment and other measures designed to correct or ameliorate
134 defects and physical and mental illness and conditions discovered
135 by the screening services, regardless of whether these services
136 are included in the state plan. The division may include in its
137 periodic screening and diagnostic program those discretionary
138 services authorized under the federal regulations adopted to
139 implement Title XIX of the federal Social Security Act, as
140 amended. The division, in obtaining physical therapy services,
141 occupational therapy services, and services for individuals with
142 speech, hearing and language disorders, may enter into a
143 cooperative agreement with the State Department of Education for
144 the provision of those services to handicapped students by public
145 school districts using state funds that are provided from the
146 appropriation to the Department of Education to obtain federal
147 matching funds through the division. The division, in obtaining
148 medical and mental health assessments, treatment, care and

149 services for children who are in, or at risk of being put in, the
150 custody of the Mississippi Department of Human Services may enter
151 into a cooperative agreement with the Mississippi Department of
152 Human Services for the provision of those services using state
153 funds that are provided from the appropriation to the Department
154 of Human Services to obtain federal matching funds through the
155 division.

156 (6) Physician's services. The division shall allow
157 twelve (12) physician visits annually. The division may develop
158 and implement a different reimbursement model or schedule for
159 physician's services provided by physicians based at an academic
160 health care center and by physicians at rural health centers that
161 are associated with an academic health care center. From and
162 after January 1, 2010, all fees for physicians' services that are
163 covered only by Medicaid shall be increased to ninety percent
164 (90%) of the rate established on January 1, 2010, and as may be
165 adjusted each July thereafter, under Medicare. The division may
166 provide for a reimbursement rate for physician's services of up to
167 one hundred percent (100%) of the rate established under Medicare
168 for physician's services that are provided after the normal
169 working hours of the physician, as determined in accordance with
170 regulations of the division. The division may reimburse eligible
171 providers as determined by the Patient Protection and Affordable
172 Care Act for certain primary care services as defined by the act

173 at one hundred percent (100%) of the rate established under
174 Medicare.
175 (7) (a) Home health services for eligible persons, not
176 to exceed in cost the prevailing cost of nursing facility
177 services, not to exceed twenty-five (25) visits per year. All
178 home health visits must be precertified as required by the
179 division.
180 (b) [Repealed]
181 (8) Emergency medical transportation services. On
182 January 1, 1994, emergency medical transportation services shall
183 be reimbursed at seventy percent (70%) of the rate established
184 under Medicare (Title XVIII of the federal Social Security Act, as
185 amended). "Emergency medical transportation services" shall mean,
186 but shall not be limited to, the following services by a properly
187 permitted ambulance operated by a properly licensed provider in
188 accordance with the Emergency Medical Services Act of 1974
189 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
190 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
191 (vi) disposable supplies, (vii) similar services.
192 (9) (a) Legend and other drugs as may be determined by
193 the division.
194 The division shall establish a mandatory preferred drug list.
195 Drugs not on the mandatory preferred drug list shall be made
196 available by utilizing prior authorization procedures established
197 by the division.

198 The division may seek to establish relationships with other
199 states in order to lower acquisition costs of prescription drugs
200 to include single source and innovator multiple source drugs or
201 generic drugs. In addition, if allowed by federal law or
202 regulation, the division may seek to establish relationships with
203 and negotiate with other countries to facilitate the acquisition
204 of prescription drugs to include single source and innovator
205 multiple source drugs or generic drugs, if that will lower the
206 acquisition costs of those prescription drugs.
207 The division shall allow for a combination of prescriptions
208 for single source and innovator multiple source drugs and generic
209 drugs to meet the needs of the beneficiaries, not to exceed five
210 (5) prescriptions per month for each noninstitutionalized Medicaid
211 beneficiary, with not more than two (2) of those prescriptions
212 being for single source or innovator multiple source drugs unless
213 the single source or innovator multiple source drug is less
214 expensive than the generic equivalent.
215 The executive director may approve specific maintenance drugs
216 for beneficiaries with certain medical conditions, which may be
217 prescribed and dispensed in three-month supply increments.
218 Drugs prescribed for a resident of a psychiatric residential
219 treatment facility must be provided in true unit doses when
220 available. The division may require that drugs not covered by
221 Medicare Part D for a resident of a long-term care facility be
222 provided in true unit doses when available. Those drugs that were

223 originally billed to the division but are not used by a resident
224 in any of those facilities shall be returned to the billing
225 pharmacy for credit to the division, in accordance with the
226 guidelines of the State Board of Pharmacy and any requirements of
227 federal law and regulation. Drugs shall be dispensed to a
228 recipient and only one (1) dispensing fee per month may be
229 charged. The division shall develop a methodology for reimbursing
230 for restocked drugs, which shall include a restock fee as
231 determined by the division not exceeding Seven Dollars and
232 Eighty-two Cents ($7.82).
233 The voluntary preferred drug list shall be expanded to
234 function in the interim in order to have a manageable prior
235 authorization system, thereby minimizing disruption of service to
236 beneficiaries.
237 Except for those specific maintenance drugs approved by the
238 executive director, the division shall not reimburse for any
239 portion of a prescription that exceeds a thirty-one-day supply of
240 the drug based on the daily dosage.
241 The division shall develop and implement a program of payment
242 for additional pharmacist services, with payment to be based on
243 demonstrated savings, but in no case shall the total payment
244 exceed twice the amount of the dispensing fee.
245 All claims for drugs for dually eligible Medicare/Medicaid
246 beneficiaries that are paid for by Medicare must be submitted to

247 Medicare for payment before they may be processed by the
248 division's online payment system.
249 The division shall develop a pharmacy policy in which drugs
250 in tamper-resistant packaging that are prescribed for a resident
251 of a nursing facility but are not dispensed to the resident shall
252 be returned to the pharmacy and not billed to Medicaid, in
253 accordance with guidelines of the State Board of Pharmacy.
254 The division shall develop and implement a method or methods
255 by which the division will provide on a regular basis to Medicaid
256 providers who are authorized to prescribe drugs, information about
257 the costs to the Medicaid program of single source drugs and
258 innovator multiple source drugs, and information about other drugs
259 that may be prescribed as alternatives to those single source
260 drugs and innovator multiple source drugs and the costs to the
261 Medicaid program of those alternative drugs.
262 Notwithstanding any law or regulation, information obtained
263 or maintained by the division regarding the prescription drug
264 program, including trade secrets and manufacturer or labeler
265 pricing, is confidential and not subject to disclosure except to
266 other state agencies.
267 (b) Payment by the division for covered
268 multisource drugs shall be limited to the lower of the upper
269 limits established and published by the Centers for Medicare and
270 Medicaid Services (CMS) plus a dispensing fee, or the estimated
271 acquisition cost (EAC) as determined by the division, plus a

272 dispensing fee, or the providers' usual and customary charge to
273 the general public.

274 Payment for other covered drugs, other than multisource drugs
275 with CMS upper limits, shall not exceed the lower of the estimated
276 acquisition cost as determined by the division, plus a dispensing
277 fee or the providers' usual and customary charge to the general
278 public.

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

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

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

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

294 (10) (a) Dental care that is an adjunct to treatment
295 of an acute medical or surgical condition; services of oral
296 surgeons and dentists in connection with surgery related to the

297 jaw or any structure contiguous to the jaw or the reduction of any
298 fracture of the jaw or any facial bone; and emergency dental
299 extractions and treatment related thereto. On July 1, 2007, fees
300 for dental care and surgery under authority of this paragraph (10)
301 shall be reimbursed as provided in subparagraph (b). It is the
302 intent of the Legislature that this rate revision for dental
303 services will be an incentive designed to increase the number of
304 dentists who actively provide Medicaid services. This dental
305 services rate revision shall be known as the "James Russell Dumas
306 Medicaid Dental Incentive Program."

307 The division shall annually determine the effect of this
308 incentive by evaluating the number of dentists who are Medicaid
309 providers, the number who and the degree to which they are
310 actively billing Medicaid, the geographic trends of where dentists
311 are offering what types of Medicaid services and other statistics
312 pertinent to the goals of this legislative intent. This data
313 shall be presented to the Chair of the Senate Public Health and
314 Welfare Committee and the Chair of the House Medicaid Committee.

315 (b) The Division of Medicaid shall establish a fee
316 schedule, to be effective from and after July 1, 2007, for dental
317 services. The schedule shall provide for a fee for each dental
318 service that is equal to a percentile of normal and customary
319 private provider fees, as defined by the Ingenix Customized Fee
320 Analyzer Report, which percentile shall be determined by the
321 division. The schedule shall be reviewed annually by the division

322 and dental fees shall be adjusted to reflect the percentile
323 determined by the division.
324 (c) For fiscal year 2008, the amount of state
325 funds appropriated for reimbursement for dental care and surgery
326 shall be increased by ten percent (10%) of the amount of state
327 fund expenditures for that purpose for fiscal year 2007. For each
328 of fiscal years 2009 and 2010, the amount of state funds
329 appropriated for reimbursement for dental care and surgery shall
330 be increased by ten percent (10%) of the amount of state fund
331 expenditures for that purpose for the preceding fiscal year.
332 (d) The division shall establish an annual benefit
333 limit of Two Thousand Five Hundred Dollars ($2,500.00) in dental
334 expenditures per Medicaid-eligible recipient; however, a recipient
335 may exceed the annual limit on dental expenditures provided in
336 this paragraph with prior approval of the division.
337 (e) The division shall include dental services as
338 a necessary component of overall health services provided to
339 children who are eligible for services.
340 (f) This paragraph (10) shall stand repealed on
341 July 1, 2016.
342 (11) Eyeglasses for all Medicaid beneficiaries who have
343 (a) had surgery on the eyeball or ocular muscle that results in a
344 vision change for which eyeglasses or a change in eyeglasses is
345 medically indicated within six (6) months of the surgery and is in
346 accordance with policies established by the division, or (b) one

347 (1) pair every five (5) years and in accordance with policies
348 established by the division. In either instance, the eyeglasses
349 must be prescribed by a physician skilled in diseases of the eye
350 or an optometrist, whichever the beneficiary may select.
351 (12) Intermediate care facility services.
352 (a) The division shall make full payment to all
353 intermediate care facilities for individuals with intellectual
354 disabilities for each day, not exceeding eighty-four (84) days per
355 year, that a patient is absent from the facility on home leave.
356 Payment may be made for the following home leave days in addition
357 to the eighty-four-day limitation: Christmas, the day before
358 Christmas, the day after Christmas, Thanksgiving, the day before
359 Thanksgiving and the day after Thanksgiving.
360 (b) All state-owned intermediate care facilities
361 for individuals with intellectual disabilities shall be reimbursed
362 on a full reasonable cost basis.
363 (c) Effective January 1, 2015, the division shall
364 update the fair rental reimbursement system for intermediate care
365 facilities for individuals with intellectual disabilities.
366 (13) Family planning services, including drugs,
367 supplies and devices, when those services are under the
368 supervision of a physician or nurse practitioner.
369 (14) Clinic services. Such diagnostic, preventive,
370 therapeutic, rehabilitative or palliative services furnished to an
371 outpatient by or under the supervision of a physician or dentist

372 in a facility that is not a part of a hospital but that is
373 organized and operated to provide medical care to outpatients.
374 Clinic services shall include any services reimbursed as
375 outpatient hospital services that may be rendered in such a
376 facility, including those that become so after July 1, 1991. On
377 July 1, 1999, all fees for physicians' services reimbursed under
378 authority of this paragraph (14) shall be reimbursed at ninety
379 percent (90%) of the rate established on January 1, 1999, and as
380 may be adjusted each July thereafter, under Medicare (Title XVIII
381 of the federal Social Security Act, as amended). The division may
382 develop and implement a different reimbursement model or schedule
383 for physician's services provided by physicians based at an
384 academic health care center and by physicians at rural health
385 centers that are associated with an academic health care center.
386 The division may provide for a reimbursement rate for physician's
387 clinic services of up to one hundred percent (100%) of the rate
388 established under Medicare for physician's services that are
389 provided after the normal working hours of the physician, as
390 determined in accordance with regulations of the division.
391 (15) Home- and community-based services for the elderly
392 and disabled, as provided under Title XIX of the federal Social
393 Security Act, as amended, under waivers, subject to the
394 availability of funds specifically appropriated for that purpose
395 by the Legislature.

396 The Division of Medicaid is directed to apply for a waiver
397 amendment to increase payments for all adult day care facilities
398 based on acuity of individual patients, with a maximum of
399 Seventy-Five Dollars ($75.00) per day for the most acute patients.
400 (16) Mental health services. Approved therapeutic and
401 case management services (a) provided by an approved regional
402 mental health/intellectual disability center established under
403 Sections 41-19-31 through 41-19-39, or by another community mental
404 health service provider meeting the requirements of the Department
405 of Mental Health to be an approved mental health/intellectual
406 disability center if determined necessary by the Department of
407 Mental Health, using state funds that are provided in the
408 appropriation to the division to match federal funds, or (b)
409 provided by a facility that is certified by the State Department
410 of Mental Health to provide therapeutic and case management
411 services, to be reimbursed on a fee for service basis, or (c)
412 provided in the community by a facility or program operated by the
413 Department of Mental Health. Any such services provided by a
414 facility described in subparagraph (b) must have the prior
415 approval of the division to be reimbursable under this section.
416 After June 30, 1997, mental health services provided by regional
417 mental health/intellectual disability centers established under
418 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
419 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
420 psychiatric residential treatment facilities as defined in Section

421 43-11-1, or by another community mental health service provider
422 meeting the requirements of the Department of Mental Health to be
423 an approved mental health/intellectual disability center if
424 determined necessary by the Department of Mental Health, shall not
425 be included in or provided under any capitated managed care pilot
426 program provided for under paragraph (24) of this section.
427 (17) Durable medical equipment services and medical
428 supplies. Precertification of durable medical equipment and
429 medical supplies must be obtained as required by the division.
430 The Division of Medicaid may require durable medical equipment
431 providers to obtain a surety bond in the amount and to the
432 specifications as established by the Balanced Budget Act of 1997.
433 (18) (a) Notwithstanding any other provision of this
434 section to the contrary, as provided in the Medicaid state plan
435 amendment or amendments as defined in Section 43-13-145(10), the
436 division shall make additional reimbursement to hospitals that
437 serve a disproportionate share of low-income patients and that
438 meet the federal requirements for those payments as provided in
439 Section 1923 of the federal Social Security Act and any applicable
440 regulations. It is the intent of the Legislature that the
441 division shall draw down all available federal funds allotted to
442 the state for disproportionate share hospitals. However, from and
443 after January 1, 1999, public hospitals participating in the
444 Medicaid disproportionate share program may be required to
445 participate in an intergovernmental transfer program as provided

446 in Section 1903 of the federal Social Security Act and any
447 applicable regulations.
448 (b) The division shall establish a Medicare Upper
449 Payment Limits Program, as defined in Section 1902(a)(30) of the
450 federal Social Security Act and any applicable federal
451 regulations, for hospitals, and may establish a Medicare Upper
452 Payment Limits Program for nursing facilities, and may establish a
453 Medicare Upper Payment Limits Program for physicians employed or
454 contracted by public hospitals. Upon successful implementation of
455 a Medicare Upper Payment program for physicians employed by public
456 hospitals, the division may develop a plan for implementing an
457 Upper Payment Limit program for physicians employed by other
458 classes of hospitals. The division shall assess each hospital
459 and, if the program is established for nursing facilities, shall
460 assess each nursing facility, for the sole purpose of financing
461 the state portion of the Medicare Upper Payment Limits Program.
462 The hospital assessment shall be as provided in Section
463 43-13-145(4)(a) and the nursing facility assessment, if
464 established, shall be based on Medicaid utilization or other
465 appropriate method consistent with federal regulations. The
466 assessment will remain in effect as long as the state participates
467 in the Medicare Upper Payment Limits Program. Public hospitals
468 with physicians participating in the Medicare Upper Payment Limits
469 Program shall be required to participate in an intergovernmental
470 transfer program. As provided in the Medicaid state plan

471 amendment or amendments as defined in Section 43-13-145(10), the
472 division shall make additional reimbursement to hospitals and, if
473 the program is established for nursing facilities, shall make
474 additional reimbursement to nursing facilities, for the Medicare
475 Upper Payment Limits, and, if the program is established for
476 physicians, shall make additional reimbursement for physicians, as
477 defined in Section 1902(a)(30) of the federal Social Security Act
478 and any applicable federal regulations. Effective upon
479 implementation of the Mississippi Hospital Access Program (MHAP)
480 provided in subparagraph (c)(i) below, the hospital portion of the
481 inpatient Upper Payment Limits program shall transition into and
482 be replaced by the MHAP program.
483 (c) (i) Not later than December 1, 2015, the
484 division shall, subject to approval by the Centers for Medicare
485 and Medicaid Services (CMS), establish, implement and operate a
486 Mississippi Hospital Access Program (MHAP) for the purpose of
487 protecting patient access to hospital care through hospital
488 inpatient reimbursement programs provided in this section designed
489 to maintain total hospital reimbursement for inpatient services
490 rendered by in-state hospitals and the out-of-state hospital that
491 is authorized by federal law to submit intergovernmental transfers
492 (IGTs) to the State of Mississippi and is classified as Level I
493 trauma center located in a county contiguous to the state line at
494 the maximum levels permissible under applicable federal statutes
495 and regulations, at which time the current inpatient Medicare

496 Upper Payment Limits (UPL) program for hospital inpatient services
497 shall transition to the MHAP.
498 (ii) Subject only to approval by the Centers
499 for Medicare and Medicaid Services (CMS) where required, the MHAP
500 shall provide increased inpatient capitation (PMPM) payments to
501 managed care entities contracting with the division pursuant to
502 subsection (H) of this section to support availability of hospital
503 services or such other payments permissible under federal law
504 necessary to accomplish the intent of this subsection. For
505 inpatient services rendered after July 1, 2015, but prior to the
506 effective date of CMS approval and full implementation of this
507 program, the division may pay lump-sum enhanced, transition
508 payments, prorated inpatient UPL payments based upon fiscal year
509 2015 June distribution levels, enhanced hospital access (PMPM)
510 payments or such other methodologies as are approved by CMS such
511 that the level of additional reimbursement required by this
512 statute is paid for all Medicaid hospital inpatient services
513 delivered in fiscal year 2016.
514 (iii) The intent of this subparagraph (c) is
515 that effective for all inpatient hospital Medicaid services during
516 state fiscal year 2016, and so long as this provision shall remain
517 in effect hereafter, the division shall to the fullest extent
518 feasible replace the additional reimbursement for hospital
519 inpatient services under the inpatient Medicare Upper Payment
520 Limits (UPL) program with additional reimbursement under the MHAP.

521 (iv) The division shall assess each hospital
522 as provided in Section 43-13-145(4)(a) for the purpose of
523 financing the state portion of the MHAP and such other purposes as
524 specified in Section 43-13-145. The assessment will remain in
525 effect as long as the MHAP is in effect.

526 (v) In the event that the MHAP program under
527 this subparagraph (c) is not approved by CMS, the inpatient UPL
528 program under subparagraph (b) shall immediately become restored
529 in the manner required to provide the maximum permissible level of
530 UPL payments to hospital providers for all inpatient services
531 rendered from and after July 1, 2015.

532 (19) (a) Perinatal risk management services. The
533 division shall promulgate regulations to be effective from and
534 after October 1, 1988, to establish a comprehensive perinatal
535 system for risk assessment of all pregnant and infant Medicaid
536 recipients and for management, education and follow-up for those
537 who are determined to be at risk. Services to be performed
538 include case management, nutrition assessment/counseling,
539 psychosocial assessment/counseling and health education. The
540 division shall contract with the State Department of Health to
541 provide the services within this paragraph (Perinatal High Risk
542 Management/Infant Services System (PHRM/ISS)). The State
543 Department of Health as the agency for PHRM/ISS for the Division
544 of Medicaid shall be reimbursed on a full reasonable cost basis.

545 (b) Early intervention system services. The
546 division shall cooperate with the State Department of Health,
547 acting as lead agency, in the development and implementation of a
548 statewide system of delivery of early intervention services, under
549 Part C of the Individuals with Disabilities Education Act (IDEA).
550 The State Department of Health shall certify annually in writing
551 to the executive director of the division the dollar amount of
552 state early intervention funds available that will be utilized as
553 a certified match for Medicaid matching funds. Those funds then
554 shall be used to provide expanded targeted case management
555 services for Medicaid eligible children with special needs who are
556 eligible for the state's early intervention system.
557 Qualifications for persons providing service coordination shall be
558 determined by the State Department of Health and the Division of
559 Medicaid.
560 (20) Home- and community-based services for physically
561 disabled approved services as allowed by a waiver from the United
562 States Department of Health and Human Services for home- and
563 community-based services for physically disabled people using
564 state funds that are provided from the appropriation to the State
565 Department of Rehabilitation Services and used to match federal
566 funds under a cooperative agreement between the division and the
567 department, provided that funds for these services are
568 specifically appropriated to the Department of Rehabilitation
569 Services.

570 (21) Nurse practitioner services. Services furnished
571 by a registered nurse who is licensed and certified by the
572 Mississippi Board of Nursing as a nurse practitioner, including,
573 but not limited to, nurse anesthetists, nurse midwives, family
574 nurse practitioners, family planning nurse practitioners,
575 pediatric nurse practitioners, obstetrics-gynecology nurse
576 practitioners and neonatal nurse practitioners, under regulations
577 adopted by the division. Reimbursement for those services shall
578 not exceed ninety percent (90%) of the reimbursement rate for
579 comparable services rendered by a physician. The division may
580 provide for a reimbursement rate for nurse practitioner services
581 of up to one hundred percent (100%) of the reimbursement rate for
582 comparable services rendered by a physician for nurse practitioner
583 services that are provided after the normal working hours of the
584 nurse practitioner, as determined in accordance with regulations
585 of the division.
586 (22) Ambulatory services delivered in federally
587 qualified health centers, rural health centers and clinics of the
588 local health departments of the State Department of Health for
589 individuals eligible for Medicaid under this article based on
590 reasonable costs as determined by the division.
591 (23) Inpatient psychiatric services. Inpatient
592 psychiatric services to be determined by the division for
593 recipients under age twenty-one (21) that are provided under the
594 direction of a physician in an inpatient program in a licensed

595 acute care psychiatric facility or in a licensed psychiatric
596 residential treatment facility, before the recipient reaches age
597 twenty-one (21) or, if the recipient was receiving the services
598 immediately before he or she reached age twenty-one (21), before
599 the earlier of the date he or she no longer requires the services
600 or the date he or she reaches age twenty-two (22), as provided by
601 federal regulations. From and after January 1, 2015, the division
602 shall update the fair rental reimbursement system for psychiatric
603 residential treatment facilities. Precertification of inpatient
604 days and residential treatment days must be obtained as required
605 by the division. From and after July 1, 2009, all state-owned and
606 state-operated facilities that provide inpatient psychiatric
607 services to persons under age twenty-one (21) who are eligible for
608 Medicaid reimbursement shall be reimbursed for those services on a
609 full reasonable cost basis.

610 (24) [Deleted]

611 (25) [Deleted]

612 (26) Hospice care. As used in this paragraph, the term
613 "hospice care" means a coordinated program of active professional
614 medical attention within the home and outpatient and inpatient
615 care that treats the terminally ill patient and family as a unit,
616 employing a medically directed interdisciplinary team. The
617 program provides relief of severe pain or other physical symptoms
618 and supportive care to meet the special needs arising out of
619 physical, psychological, spiritual, social and economic stresses

620 that are experienced during the final stages of illness and during
621 dying and bereavement and meets the Medicare requirements for
622 participation as a hospice as provided in federal regulations.
623 (27) Group health plan premiums and cost sharing if it
624 is cost-effective as defined by the United States Secretary of
625 Health and Human Services.
626 (28) Other health insurance premiums that are
627 cost-effective as defined by the United States Secretary of Health
628 and Human Services. Medicare eligible must have Medicare Part B
629 before other insurance premiums can be paid.
630 (29) The Division of Medicaid may apply for a waiver
631 from the United States Department of Health and Human Services for
632 home- and community-based services for developmentally disabled
633 people using state funds that are provided from the appropriation
634 to the State Department of Mental Health and/or funds transferred
635 to the department by a political subdivision or instrumentality of
636 the state and used to match federal funds under a cooperative
637 agreement between the division and the department, provided that
638 funds for these services are specifically appropriated to the
639 Department of Mental Health and/or transferred to the department
640 by a political subdivision or instrumentality of the state.
641 (30) Pediatric skilled nursing services for eligible
642 persons under twenty-one (21) years of age.
643 (31) Targeted case management services for children
644 with special needs, under waivers from the United States

645 Department of Health and Human Services, using state funds that
646 are provided from the appropriation to the Mississippi Department
647 of Human Services and used to match federal funds under a
648 cooperative agreement between the division and the department.
649 (32) Care and services provided in Christian Science
650 Sanatoria listed and certified by the Commission for Accreditation
651 of Christian Science Nursing Organizations/Facilities, Inc.,
652 rendered in connection with treatment by prayer or spiritual means
653 to the extent that those services are subject to reimbursement
654 under Section 1903 of the federal Social Security Act.
655 (33) Podiatrist services.
656 (34) Assisted living services as provided through
657 home- and community-based services under Title XIX of the federal
658 Social Security Act, as amended, subject to the availability of
659 funds specifically appropriated for that purpose by the
660 Legislature.
661 (35) Services and activities authorized in Sections
662 43-27-101 and 43-27-103, using state funds that are provided from
663 the appropriation to the Mississippi Department of Human Services
664 and used to match federal funds under a cooperative agreement
665 between the division and the department.
666 (36) Nonemergency transportation services for
667 Medicaid-eligible persons, to be provided by the Division of
668 Medicaid. The division may contract with additional entities to
669 administer nonemergency transportation services as it deems

670 necessary. All providers shall have a valid driver's license,
671 vehicle inspection sticker, valid vehicle license tags and a
672 standard liability insurance policy covering the vehicle. The
673 division may pay providers a flat fee based on mileage tiers, or
674 in the alternative, may reimburse on actual miles traveled. The
675 division may apply to the Center for Medicare and Medicaid
676 Services (CMS) for a waiver to draw federal matching funds for
677 nonemergency transportation services as a covered service instead
678 of an administrative cost. The PEER Committee shall conduct a
679 performance evaluation of the nonemergency transportation program
680 to evaluate the administration of the program and the providers of
681 transportation services to determine the most cost-effective ways
682 of providing nonemergency transportation services to the patients
683 served under the program. The performance evaluation shall be
684 completed and provided to the members of the Senate Public Health
685 and Welfare Committee and the House Medicaid Committee not later
686 than January 15, 2008.
687 (37) [Deleted]
688 (38) Chiropractic services. A chiropractor's manual
689 manipulation of the spine to correct a subluxation, if x-ray
690 demonstrates that a subluxation exists and if the subluxation has
691 resulted in a neuromusculoskeletal condition for which
692 manipulation is appropriate treatment, and related spinal x-rays
693 performed to document these conditions. Reimbursement for

694 chiropractic services shall not exceed Seven Hundred Dollars
695 ($700.00) per year per beneficiary.
696 (39) Dually eligible Medicare/Medicaid beneficiaries.
697 The division shall pay the Medicare deductible and coinsurance
698 amounts for services available under Medicare, as determined by
699 the division. From and after July 1, 2009, the division shall
700 reimburse crossover claims for inpatient hospital services and
701 crossover claims covered under Medicare Part B in the same manner
702 that was in effect on January 1, 2008, unless specifically
703 authorized by the Legislature to change this method.
704 (40) [Deleted]
705 (41) Services provided by the State Department of
706 Rehabilitation Services for the care and rehabilitation of persons
707 with spinal cord injuries or traumatic brain injuries, as allowed
708 under waivers from the United States Department of Health and
709 Human Services, using up to seventy-five percent (75%) of the
710 funds that are appropriated to the Department of Rehabilitation
711 Services from the Spinal Cord and Head Injury Trust Fund
712 established under Section 37-33-261 and used to match federal
713 funds under a cooperative agreement between the division and the
714 department.
715 (42) Notwithstanding any other provision in this
716 article to the contrary, the division may develop a population
717 health management program for women and children health services
718 through the age of one (1) year. This program is primarily for

719 obstetrical care associated with low birth weight and preterm
720 babies. The division may apply to the federal Centers for
721 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
722 any other waivers that may enhance the program. In order to
723 effect cost savings, the division may develop a revised payment
724 methodology that may include at-risk capitated payments, and may
725 require member participation in accordance with the terms and
726 conditions of an approved federal waiver.
727 (43) The division shall provide reimbursement,
728 according to a payment schedule developed by the division, for
729 smoking cessation medications for pregnant women during their
730 pregnancy and other Medicaid-eligible women who are of
731 child-bearing age.
732 (44) Nursing facility services for the severely
733 disabled.
734 (a) Severe disabilities include, but are not
735 limited to, spinal cord injuries, closed-head injuries and
736 ventilator dependent patients.
737 (b) Those services must be provided in a long-term
738 care nursing facility dedicated to the care and treatment of
739 persons with severe disabilities.
740 (45) Physician assistant services. Services furnished
741 by a physician assistant who is licensed by the State Board of
742 Medical Licensure and is practicing with physician supervision
743 under regulations adopted by the board, under regulations adopted

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

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

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

769 (b) Participation in any disease management
770 program implemented under this paragraph (47) is optional with the
771 individual. An individual must affirmatively elect to participate
772 in the disease management program in order to participate, and may
773 elect to discontinue participation in the program at any time.
774 (48) Pediatric long-term acute care hospital services.
775 (a) Pediatric long-term acute care hospital
776 services means services provided to eligible persons under
777 twenty-one (21) years of age by a freestanding Medicare-certified
778 hospital that has an average length of inpatient stay greater than
779 twenty-five (25) days and that is primarily engaged in providing
780 chronic or long-term medical care to persons under twenty-one (21)
781 years of age.
782 (b) The services under this paragraph (48) shall
783 be reimbursed as a separate category of hospital services.
784 (49) The division shall establish copayments and/or
785 coinsurance for all Medicaid services for which copayments and/or
786 coinsurance are allowable under federal law or regulation, and
787 shall set the amount of the copayment and/or coinsurance for each
788 of those services at the maximum amount allowable under federal
789 law or regulation.
790 (50) Services provided by the State Department of
791 Rehabilitation Services for the care and rehabilitation of persons
792 who are deaf and blind, as allowed under waivers from the United
793 States Department of Health and Human Services to provide

794 home- and community-based services using state funds that are
795 provided from the appropriation to the State Department of
796 Rehabilitation Services or if funds are voluntarily provided by
797 another agency.

798 (51) (a) Upon determination of Medicaid eligibility
799 and in association with annual redetermination of Medicaid
800 eligibility, beneficiaries shall be *** * *** required to undertake a
801 physical examination that will establish a base-line level of
802 health and identification of a usual and customary source of care
803 (a patient-center medical home as provided for under subsection
804 (H) of this section) to aid utilization of disease management
805 tools. The physical examination shall include a measurement of
806 the body mass index (BMI) of the beneficiary. This physical
807 examination and utilization of these disease management tools
808 shall be consistent with current United States Preventive Services
809 Task Force or other recognized authority recommendations.

810 (b) Those beneficiaries who are determined to be
811 obese based on their BMI measurement must participate in an online
812 interactive program delivered via the Internet that is designed to
813 prevent and reduce obesity. Under the program, each participant
814 will have individualized access to nutritional counseling
815 information, frequently asked questions and answers regarding
816 nutrition and healthy living, a personalized healthy living plan
817 and nutritional plan, and the ability to interact with persons who
818 are trained and experienced in nutritional issues during regular

819 business hours. For those persons who do not have access to the
820 Internet at their homes, computers shall be made available for
821 their use at the county and regional offices of the Division of
822 Medicaid, the Department of Human Services, the State Department
823 of Health, the Department of Employment Security and the Women,
824 Infants and Children's Nutrition Program (WIC) and at the
825 University of Mississippi Medical Center.
826 (c) Any beneficiary who is required to participate
827 in the program established under subparagraph (b) of this
828 paragraph who fails to participate as required shall be penalized
829 by having his or her co-payments for Medicaid services increased
830 to the maximum amount permitted under federal law or regulations.
831 (d) For persons who are determined ineligible for
832 Medicaid, the division will provide information and direction for
833 accessing medical care and services in the area of their
834 residence.
835 (52) Notwithstanding any provisions of this article,
836 the division may pay enhanced reimbursement fees related to trauma
837 care, as determined by the division in conjunction with the State
838 Department of Health, using funds appropriated to the State
839 Department of Health for trauma care and services and used to
840 match federal funds under a cooperative agreement between the
841 division and the State Department of Health. The division, in
842 conjunction with the State Department of Health, may use grants,

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

868 services shall be consistent with the appeal process in federal
869 regulations.

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

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

885 (B) Notwithstanding any other provision of this article to
886 the contrary, the division shall reduce the rate of reimbursement
887 to providers for any service provided under this section by five
888 percent (5%) of the allowed amount for that service. However, the
889 reduction in the reimbursement rates required by this subsection
890 (B) shall not apply to inpatient hospital services, nursing
891 facility services, intermediate care facility services,
892 psychiatric residential treatment facility services, pharmacy

893 services provided under subsection (A)(9) of this section, or any
894 service provided by the University of Mississippi Medical Center
895 or a state agency, a state facility or a public agency that either
896 provides its own state match through intergovernmental transfer or
897 certification of funds to the division, or a service for which the
898 federal government sets the reimbursement methodology and rate.
899 From and after January 1, 2010, the reduction in the reimbursement
900 rates required by this subsection (B) shall not apply to
901 physicians' services. In addition, the reduction in the
902 reimbursement rates required by this subsection (B) shall not
903 apply to case management services and home-delivered meals
904 provided under the home- and community-based services program for
905 the elderly and disabled by a planning and development district
906 (PDD). Planning and development districts participating in the
907 home- and community-based services program for the elderly and
908 disabled as case management providers shall be reimbursed for case
909 management services at the maximum rate approved by the Centers
910 for Medicare and Medicaid Services (CMS).

911 (C) The division may pay to those providers who participate
912 in and accept patient referrals from the division's emergency room
913 redirection program a percentage, as determined by the division,
914 of savings achieved according to the performance measures and
915 reduction of costs required of that program. Federally qualified
916 health centers may participate in the emergency room redirection
917 program, and the division may pay those centers a percentage of

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

943 except as required by federal law, and the federally mandated
944 rebasing of rates as required by the Centers for Medicare and
945 Medicaid Services (CMS) shall not be considered payment
946 methodology for purposes of this subsection (D). No service
947 benefits or reimbursement limitations in this section shall apply
948 to payments under an APR-DRG or APC model or a managed care
949 program or similar model described in subsection (H) of this
950 section.

951 (E) Notwithstanding any provision of this article, no new
952 groups or categories of recipients and new types of care and
953 services may be added without enabling legislation from the
954 Mississippi Legislature, except that the division may authorize
955 those changes without enabling legislation when the addition of
956 recipients or services is ordered by a court of proper authority.

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

968 under the article to the extent allowed under the federal law
969 governing that program or programs. However, the Governor shall
970 not be authorized to discontinue or eliminate any service under
971 this section that is mandatory under federal law, or to
972 discontinue or eliminate, or adjust income limits or resource
973 limits for, any eligibility category or group under Section
974 43-13-115. Beginning in fiscal year 2010 and in fiscal years
975 thereafter, when Medicaid expenditures are projected to exceed
976 funds available for any quarter in the fiscal year, the division
977 shall submit the expected shortfall information to the PEER
978 Committee, which shall review the computations of the division and
979 report its findings to the Legislative Budget Office within thirty
980 (30) days of such notification by the division, and not later than
981 January 7 in any year. If expenditure reductions or cost
982 containments are implemented, the Governor may implement a maximum
983 amount of state share expenditure reductions to providers, of
984 which hospitals will be responsible for twenty-five percent (25%)
985 of provider reductions as follows: in fiscal year 2010, the
986 maximum amount shall be Twenty-four Million Dollars
987 ($24,000,000.00); in fiscal year 2011, the maximum amount shall be
988 Thirty-two Million Dollars ($32,000,000.00); and in fiscal year
989 2012 and thereafter, the maximum amount shall be Forty Million
990 Dollars ($40,000,000.00). However, instead of implementing cuts,
991 the hospital share shall be in the form of an additional
992 assessment not to exceed Ten Million Dollars ($10,000,000.00) as

993 provided in Section 43-13-145(4)(a)(ii). If Medicaid expenditures
994 are projected to exceed the amount of funds appropriated to the
995 division in any fiscal year in excess of the expenditure
996 reductions to providers, then funds shall be transferred by the
997 State Fiscal Officer from the Health Care Trust Fund into the
998 Health Care Expendable Fund and to the Governor's Office, Division
999 of Medicaid, from the Health Care Expendable Fund, in the amount
1000 and at such time as requested by the Governor to reconcile the
1001 deficit. If the cost containment measures described above have
1002 been implemented and there are insufficient funds in the Health
1003 Care Trust Fund to reconcile any remaining deficit in any fiscal
1004 year, the Governor shall institute any other additional cost
1005 containment measures on any program or programs authorized under
1006 this article to the extent allowed under federal law. Hospitals
1007 shall be responsible for twenty-five percent (25%) of any
1008 additional imposed provider cuts. However, instead of
1009 implementing hospital expenditure reductions, the hospital
1010 reductions shall be in the form of an additional assessment not to
1011 exceed twenty-five percent (25%) of provider expenditure
1012 reductions as provided in Section 43-13-145(4)(a)(ii). It is the
1013 intent of the Legislature that the expenditures of the division
1014 during any fiscal year shall not exceed the amounts appropriated
1015 to the division for that fiscal year.
1016 (G) Notwithstanding any other provision of this article, it
1017 shall be the duty of each nursing facility, intermediate care

1018 facility for individuals with intellectual disabilities,
1019 psychiatric residential treatment facility, and nursing facility
1020 for the severely disabled that is participating in the Medicaid
1021 program to keep and maintain books, documents and other records as
1022 prescribed by the Division of Medicaid in substantiation of its
1023 cost reports for a period of three (3) years after the date of
1024 submission to the Division of Medicaid of an original cost report,
1025 or three (3) years after the date of submission to the Division of
1026 Medicaid of an amended cost report.
1027 (H) (1) Notwithstanding any other provision of this
1028 article, the division is authorized to implement (a) a managed
1029 care program, (b) a coordinated care program, (c) a coordinated
1030 care organization program, (d) a health maintenance organization
1031 program, (e) a patient-centered medical home program, (f) an
1032 accountable care organization program, (g) provider-sponsored
1033 health plan, or (h) any combination of the above programs.
1034 Managed care programs, coordinated care programs, coordinated care
1035 organization programs, health maintenance organization programs,
1036 patient-centered medical home programs, accountable care
1037 organization programs, provider-sponsored health plans, or any
1038 combination of the above programs or other similar programs
1039 implemented by the division under this section shall be limited to
1040 the greater of (i) forty-five percent (45%) of the total
1041 enrollment of Medicaid beneficiaries, or (ii) the categories of
1042 beneficiaries participating in the program as of January 1, 2014,

1043 plus the categories of beneficiaries composed primarily of persons
1044 younger than nineteen (19) years of age, and the division is
1045 authorized to enroll categories of beneficiaries in such
1046 program(s) as long as the appropriate limitations are not exceeded
1047 in the aggregate. As a condition for the approval of any program
1048 under this subsection (H)(1), the division shall require that no
1049 program may:

1050 (a) Pay providers at a rate that is less than the
1051 Medicaid All-Patient Refined-Diagnosis Related Groups (APR-DRG)
1052 reimbursement rate;

1053 (b) Override the medical decisions of hospital
1054 physicians or staff regarding patients admitted to a hospital for
1055 an emergency medical condition as defined by 42 US Code Section
1056 1395dd. This restriction (b) does not prohibit the retrospective
1057 review of the appropriateness of the determination that an
1058 emergency medical condition exists by chart review or coding
1059 algorithm, nor does it prohibit prior authorization for
1060 nonemergency hospital admissions;

1061 (c) Pay providers at a rate that is less than the
1062 normal Medicaid reimbursement rate; however, the division may
1063 approve use of innovative payment models that recognize
1064 alternative payment models, including quality and value-based
1065 payments, provided both parties mutually agree and the Division of
1066 Medicaid approves of said models. Participation in the provider
1067 network of any managed care, coordinated care, provider-sponsored

1068 health plan, or similar contractor shall not be conditioned on the
1069 provider's agreement to accept such alternative payment models;
1070 (d) Implement a prior authorization program for
1071 prescription drugs that is more stringent than the prior
1072 authorization processes used by the division in its administration
1073 of the Medicaid program;
1074 (e) Implement a policy that does not comply with
1075 the prescription drugs payment requirements established in
1076 subsection (A)(9) of this section;
1077 (f) Implement a preferred drug list that is more
1078 stringent than the mandatory preferred drug list established by
1079 the division under subsection (A)(9) of this section;
1080 (g) Implement a policy which denies beneficiaries
1081 with hemophilia access to the federally funded hemophilia
1082 treatment centers as part of the Medicaid Managed Care network of
1083 providers. All Medicaid beneficiaries with hemophilia shall
1084 receive unrestricted access to anti-hemophilia factor products
1085 through noncapitated reimbursement programs.
1086 (2) Any contractors providing direct patient care under
1087 a managed care program established in this section shall provide
1088 to the Legislature and the division statistical data to be shared
1089 with provider groups in order to improve patient access,
1090 appropriate utilization, cost savings and health outcomes.
1091 (3) All health maintenance organizations, coordinated
1092 care organizations, provider-sponsored health plans, or other

1093 organizations paid for services on a capitated basis by the
1094 division under any managed care program or coordinated care
1095 program implemented by the division under this section shall
1096 reimburse all providers in those organizations at rates no lower
1097 than those provided under this section for beneficiaries who are
1098 not participating in those programs.

1099 (4) No health maintenance organization, coordinated
1100 care organization, provider-sponsored health plan, or other
1101 organization paid for services on a capitated basis by the
1102 division under any managed care program or coordinated care
1103 program implemented by the division under this section shall
1104 require its providers or beneficiaries to use any pharmacy that
1105 ships, mails or delivers prescription drugs or legend drugs or
1106 devices.

1107 (I) [Deleted]

1108 (J) There shall be no cuts in inpatient and outpatient
1109 hospital payments, or allowable days or volumes, as long as the
1110 hospital assessment provided in Section 43-13-145 is in effect.
1111 This subsection (J) shall not apply to decreases in payments that
1112 are a result of: reduced hospital admissions, audits or payments
1113 under the APR-DRG or APC models, or a managed care program or
1114 similar model described in subsection (H) of this section.

1115 (K) This section shall stand repealed on *** July 1, 2021.

1116 **SECTION 2.** This act shall take effect and be in force from
1117 and after June 30, 2018.