MISSISSIPPI LEGISLATURE REGULAR SESSION 2018

By: Representative Scott To: Medicaid

HOUSE BILL NO. 521

AN ACT TO REQUIRE ALL PERSONS WHO ARE RECIPIENTS OF BENEFITS UNDER THE MEDICAID PROGRAM, THE CHILDREN'S HEALTH INSURANCE PROGRAM, AND THE STATE AND SCHOOL EMPLOYEES HEALTH INSURANCE PLAN TO BE TESTED OR SCREENED ANNUALLY FOR THE USE OF ILLEGAL DRUGS, ABUSE OF ALCOHOL, HEPATITIS B AND C, TUBERCULOSIS AND SEXUALLY TRANSMITTED DISEASES; TO PROVIDE THAT THE COST OF THAT TESTING OR SCREENING SHALL BE COVERED AS A BENEFIT UNDER EACH RESPECTIVE PROGRAM OR PLAN; TO AMEND SECTIONS 25-15-9 AND 43-13-117, MISSISSIPPI CODE OF 1972, TO CONFORM TO THE PRECEDING PROVISIONS; TO FURTHER AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO EXTEND THE DATE OF THE REPEALER ON THAT SECTION; AND FOR RELATED PURPOSES.

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

SECTION 1. All persons who are recipients of benefits under the Medicaid program, the Children's Health Insurance Program, and the State and School Employees Health Insurance Plan shall be tested or screened annually for the use of illegal drugs, abuse of alcohol, Hepatitis B and C, tuberculosis and sexually transmitted diseases. The cost of the testing or screening required by this section shall be covered as a benefit under each respective program or plan. The State and School Employees Health Insurance Management Board, for the State and School Employees Health Insurance Plan, and the Executive Director of the Division of

Medicaid, for the Medicaid program and the Children's Health Insurance Program, may adopt any rules or regulations as necessary to carry out the provisions of this section.

SECTION 2. Section 25-15-9, Mississippi Code of 1972, is amended as follows:

25-15-9. (1) (a) The board shall design a plan of health insurance for state employees that provides benefits for semiprivate rooms in addition to other incidental coverages that the board deems necessary. The amount of the coverages shall be in such reasonable amount as may be determined by the board to be adequate, after due consideration of current health costs in Mississippi. The plan shall also include major medical benefits in such amounts as the board determines. The plan shall provide for coverage for telemedicine services as provided in Section 83-9-351, and shall include coverage for the services necessary for the testing and screening required under Section 1 of this act. The board is also authorized to accept bids for such alternate coverage and optional benefits as the board deems proper. The board is authorized to accept bids for surgical services that include assistance in locating a surgeon, setting up initial consultation, travel, a negotiated single case rate bundle and payment for orthopedic, spine, bariatric, cardiovascular and general surgeries. The surgical services may only utilize surgeons and facilities located in the State of Mississippi unless otherwise provided by the board. Any contract for alternative

coverage and optional benefits shall be awarded by the board after it has carefully studied and evaluated the bids and selected the best and most cost-effective bid. The board may reject all of the bids; however, the board shall notify all bidders of the rejection and shall actively solicit new bids if all bids are rejected. The board may employ or contract for such consulting or actuarial services as may be necessary to formulate the plan, and to assist the board in the preparation of specifications and in the process of advertising for the bids for the plan. Those contracts shall be solicited and entered into in accordance with Section 25-15-5. The board shall keep a record of all persons, agents and corporations who contract with or assist the board in preparing and developing the plan. The board in a timely manner shall provide copies of this record to the members of the advisory council created in this section and those legislators, or their designees, who may attend meetings of the advisory council. The board shall provide copies of this record in the solicitation of bids for the administration or servicing of the self-insured program. Each person, agent or corporation that, during the previous fiscal year, has assisted in the development of the plan or employed or compensated any person who assisted in the development of the plan, and that bids on the administration or servicing of the plan, shall submit to the board a statement accompanying the bid explaining in detail its participation with the development of the plan. This statement shall include the

amount of compensation paid by the bidder to any such employee during the previous fiscal year. The board shall make all such information available to the members of the advisory council and those legislators, or their designees, who may attend meetings of the advisory council before any action is taken by the board on the bids submitted. The failure of any bidder to fully and accurately comply with this paragraph shall result in the rejection of any bid submitted by that bidder or the cancellation of any contract executed when the failure is discovered after the acceptance of that bid. The board is authorized to promulgate rules and regulations to implement the provisions of this subsection.

The board shall develop plans for the insurance plan authorized by this section in accordance with the provisions of Section 25-15-5.

Any corporation, association, company or individual that contracts with the board for the third-party claims administration of the self-insured plan shall prepare and keep on file an explanation of benefits for each claim processed. The explanation of benefits shall contain such information relative to each processed claim that the board deems necessary, and, at a minimum, each explanation shall provide the claimant's name, claim number, provider number, provider name, service dates, type of services, amount of charges, amount allowed to the claimant and reason codes. The information contained in the explanation of benefits

shall be available for inspection upon request by the board. The board shall have access to all claims information utilized in the issuance of payments to employees and providers.

(b) There is created an advisory council to advise the board in the formulation of the State and School Employees Health Insurance Plan. The council shall be composed of the State Insurance Commissioner, or his designee, an employee-representative of the institutions of higher learning appointed by the board of trustees thereof, an employee-representative of the Department of Transportation appointed by the director thereof, an employee-representative of the Department of Revenue appointed by the Commissioner of Revenue, an employee-representative of the Mississippi Department of Health appointed by the State Health Officer, an employee-representative of the Mississippi Department of Corrections appointed by the Commissioner of Corrections, and an employee-representative of the Department of Human Services appointed by the Executive Director of Human Services, two (2) certificated public school administrators appointed by the State Board of Education, two (2) certificated classroom teachers appointed by the State Board of Education, a noncertificated school employee appointed by the State Board of Education and a community/junior college employee appointed by the Mississippi Community College Board.

The Lieutenant Governor may designate the Secretary of the Senate, the Chairman of the Senate Appropriations Committee, the Chairman of the Senate Education Committee and the Chairman of the Senate Insurance Committee, and the Speaker of the House of Representatives may designate the Clerk of the House, the Chairman of the House Appropriations Committee, the Chairman of the House Education Committee and the Chairman of the House Insurance Committee, to attend any meeting of the State and School Employees Insurance Advisory Council. The appointing authorities may designate an alternate member from their respective houses to serve when the regular designee is unable to attend the meetings of the council. Those designees shall have no jurisdiction or vote on any matter within the jurisdiction of the council. For attending meetings of the council, the legislators shall receive per diem and expenses, which shall be paid from the contingent expense funds of their respective houses in the same amounts as provided for committee meetings when the Legislature is not in session; however, no per diem and expenses for attending meetings of the council will be paid while the Legislature is in session. No per diem and expenses will be paid except for attending meetings of the council without prior approval of the proper committee in their respective houses.

(c) No change in the terms of the State and School Employees Health Insurance Plan may be made effective unless the board, or its designee, has provided notice to the State and

School Employees Health Insurance Advisory Council and has called a meeting of the council at least fifteen (15) days before the effective date of the change. If the State and School Employees Health Insurance Advisory Council does not meet to advise the board on the proposed changes, the changes to the plan shall become effective at such time as the board has informed the council that the changes shall become effective.

(d) **Medical benefits for retired employees and dependents under age sixty-five (65) years and not eligible for Medicare benefits.** For employees who retire before July 1, 2005, and for employees retiring due to work-related disability under the Public Employees' Retirement System, the same health insurance coverage as for all other active employees and their dependents shall be available to retired employees and all dependents under age sixty-five (65) years who are not eligible for Medicare benefits, the level of benefits to be the same level as for all other active participants. For employees who retire on or after July 1, 2005, and not retiring due to work-related disability under the Public Employees' Retirement System, the same health insurance coverage as for all other active employees and their dependents shall be available to those retiring employees and all dependents under age sixty-five (65) years who are not eligible for Medicare benefits only if the retiring employees were participants in the State and School Employees Health Insurance Plan for four (4) years or more before their retirement, the level

of benefits to be the same level as for all other active participants. This section will apply to those employees who retire due to one hundred percent (100%) medical disability as well as those employees electing early retirement.

(e) **Medical benefits for retired employees and dependents over age sixty-five (65) years or otherwise eligible for Medicare benefits.** For employees who retire before July 1, 2005, and for employees retiring due to work-related disability under the Public Employees' Retirement System, the health insurance coverage available to retired employees over age sixty-five (65) years or otherwise eligible for Medicare benefits, and all dependents over age sixty-five (65) years or otherwise eligible for Medicare benefits, shall be the major medical coverage. For employees retiring on or after July 1, 2005, and not retiring due to work-related disability under the Public Employees' Retirement System, the health insurance coverage described in this paragraph (e) shall be available to those retiring employees only if they were participants in the State and School Employees Health Insurance Plan for four (4) years or more and are over age sixty-five (65) years or otherwise eligible for Medicare benefits, and to all dependents over age sixty-five (65) years or otherwise eligible for Medicare benefits. Benefits shall be reduced by Medicare benefits as though the Medicare benefits were the base plan.

All covered individuals shall be assumed to have full Medicare coverage, Parts A and B; and any Medicare payments under both Parts A and B shall be computed to reduce benefits payable under this plan.

(f) Lifetime maximum: The lifetime maximum amount of benefits payable under the health insurance plan for each participant is Two Million Dollars ($2,000,000.00).

(2) Nonduplication of benefits — reduction of benefits by Title XIX benefits: When benefits would be payable under more than one (1) group plan, benefits under those plans will be coordinated to the extent that the total benefits under all plans will not exceed the total expenses incurred.

Benefits for hospital or surgical or medical benefits shall be reduced by any similar benefits payable in accordance with Title XIX of the Social Security Act or under any amendments thereto, or any implementing legislation.

Benefits for hospital or surgical or medical benefits shall be reduced by any similar benefits payable by workers' compensation.

No health care benefits under the state plan shall restrict coverage for medically appropriate treatment prescribed by a physician and agreed to by a fully informed insured, or if the insured lacks legal capacity to consent by a person who has legal authority to consent on his or her behalf, based on an insured's diagnosis with a terminal condition. As used in this paragraph,

"terminal condition" means any aggressive malignancy, chronic end-stage cardiovascular or cerebral vascular disease, or any other disease, illness or condition which physician diagnoses as terminal.

Not later than January 1, 2016, the state health plan shall not require a higher co-payment, deductible or coinsurance amount for patient-administered anti-cancer medications, including, but not limited to, those orally administered or self-injected, than it requires for anti-cancer medications that are injected or intravenously administered by a health care provider, regardless of the formulation or benefit category determination by the plan. For the purposes of this paragraph, the term "anti-cancer medications" has the meaning as defined in Section 83-9-24.

(3) (a) Schedule of life insurance benefits — group term: The amount of term life insurance for each active employee of a department, agency or institution of the state government shall not be in excess of One Hundred Thousand Dollars ($100,000.00), or twice the amount of the employee's annual wage to the next highest One Thousand Dollars ($1,000.00), whichever may be less, but in no case less than Thirty Thousand Dollars ($30,000.00), with a like amount for accidental death and dismemberment on a twenty-four-hour basis. The plan will further contain a premium waiver provision if a covered employee becomes totally and permanently disabled before age sixty-five (65) years. Employees retiring after June 30, 1999, shall be eligible to continue life

insurance coverage in an amount of Five Thousand Dollars ($5,000.00), Ten Thousand Dollars ($10,000.00) or Twenty Thousand Dollars ($20,000.00) into retirement.

(b) Effective October 1, 1999, schedule of life insurance benefits — group term: The amount of term life insurance for each active employee of any school district, community/junior college, public library or university-based program authorized under Section 37-23-31 for deaf, aphasic and emotionally disturbed children or any regular nonstudent bus driver shall not be in excess of One Hundred Thousand Dollars ($100,000.00), or twice the amount of the employee's annual wage to the next highest One Thousand Dollars ($1,000.00), whichever may be less, but in no case less than Thirty Thousand Dollars ($30,000.00), with a like amount for accidental death and dismemberment on a twenty-four-hour basis. The plan will further contain a premium waiver provision if a covered employee of any school district, community/junior college, public library or university-based program authorized under Section 37-23-31 for deaf, aphasic and emotionally disturbed children or any regular nonstudent bus driver becomes totally and permanently disabled before age sixty-five (65) years. Employees of any school district, community/junior college, public library or university-based program authorized under Section 37-23-31 for deaf, aphasic and emotionally disturbed children or any regular nonstudent bus driver retiring after September 30, 1999, shall be

eligible to continue life insurance coverage in an amount of Five Thousand Dollars ($5,000.00), Ten Thousand Dollars ($10,000.00) or Twenty Thousand Dollars ($20,000.00) into retirement.

(4) Any eligible employee who on March 1, 1971, was participating in a group life insurance program that has provisions different from those included in this article and for which the State of Mississippi was paying a part of the premium may, at his discretion, continue to participate in that plan. The employee shall pay in full all additional costs, if any, above the minimum program established by this article. Under no circumstances shall any individual who begins employment with the state after March 1, 1971, be eligible for the provisions of this subsection.

(5) The board may offer medical savings accounts as defined in Section 71-9-3 as a plan option.

(6) Any premium differentials, differences in coverages, discounts determined by risk or by any other factors shall be uniformly applied to all active employees participating in the insurance plan. It is the intent of the Legislature that the state contribution to the plan be the same for each employee throughout the state.

(7) On October 1, 1999, any school district, community/junior college district or public library may elect to remain with an existing policy or policies of group life insurance with an insurance company approved by the State and School

Employees Health Insurance Management Board, in lieu of participation in the State and School Life Insurance Plan. On or after July 1, 2004, until October 1, 2004, any school district, community/junior college district or public library may elect to choose a policy or policies of group life insurance existing on October 1, 1999, with an insurance company approved by the State and School Employees Health Insurance Management Board in lieu of participation in the State and School Life Insurance Plan. The state's contribution of up to fifty percent (50%) of the active employee's premium under the State and School Life Insurance Plan may be applied toward the cost of coverage for full-time employees participating in the approved life insurance company group plan. For purposes of this subsection (7), "life insurance company group plan" means a plan administered or sold by a private insurance company. After October 1, 1999, the board may assess charges in addition to the existing State and School Life Insurance Plan rates to such employees as a condition of enrollment in the State and School Life Insurance Plan. In order for any life insurance company group plan to be approved by the State and School Employees Health Insurance Management Board under this subsection (7), it shall meet the following criteria:

(a) The insurance company offering the group life insurance plan shall be rated "A-" or better by A.M. Best state insurance rating service and be licensed as an admitted carrier in

the State of Mississippi by the Mississippi Department of Insurance.

(b) The insurance company group life insurance plan shall provide the same life insurance, accidental death and dismemberment insurance and waiver of premium benefits as provided in the State and School Life Insurance Plan.

(c) The insurance company group life insurance plan shall be fully insured, and no form of self-funding life insurance by the company shall be approved.

(d) The insurance company group life insurance plan shall have one (1) composite rate per One Thousand Dollars ($1,000.00) of coverage for active employees regardless of age and one (1) composite rate per One Thousand Dollars ($1,000.00) of coverage for all retirees regardless of age or type of retiree.

(e) The insurance company and its group life insurance plan shall comply with any administrative requirements of the State and School Employees Health Insurance Management Board. If any insurance company providing group life insurance benefits to employees under this subsection (7) fails to comply with any requirements specified in this subsection or any administrative requirements of the board, the state shall discontinue providing funding for the cost of that insurance.

SECTION 3. Section 43-13-117, Mississippi Code of 1972, is amended as follows:

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

(1) Inpatient hospital services.

(a) The division shall allow thirty (30) days of inpatient hospital care annually for all Medicaid recipients. Medicaid recipients requiring transplants shall not have those days included in the transplant hospital stay count against the thirty-day limit for inpatient hospital care. Precertification of inpatient days must be obtained as required by the division.

(b) From and after July 1, 1994, the Executive Director of the Division of Medicaid shall amend the Mississippi Title XIX Inpatient Hospital Reimbursement Plan to remove the occupancy rate penalty from the calculation of the Medicaid Capital Cost Component utilized to determine total hospital costs allocated to the Medicaid program.

(c) Hospitals will receive an additional payment for the implantable programmable baclofen drug pump used to treat spasticity that is implanted on an inpatient basis. The payment pursuant to written invoice will be in addition to the facility's per diem reimbursement and will represent a reduction of costs on

the facility's annual cost report, and shall not exceed Ten Thousand Dollars ($10,000.00) per year per recipient.

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

(e) No service benefits or reimbursement limitations in this section shall apply to payments under an APR-DRG or Ambulatory Payment Classification (APC) model or a managed care program or similar model described in subsection (H) of this section.

(2) Outpatient hospital services.

(a) Emergency services.

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

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

(c) The division is authorized to implement an Ambulatory Payment Classification (APC) methodology for outpatient hospital services.

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

(3) Laboratory and x-ray services.

(4) Nursing facility services.

(a) The division shall make full payment to nursing facilities for each day, not exceeding fifty-two (52) days per year, that a patient is absent from the facility on home leave. Payment may be made for the following home leave days in addition to the fifty-two-day limitation: Christmas, the day before Christmas, the day after Christmas, Thanksgiving, the day before Thanksgiving and the day after Thanksgiving.

(b) From and after July 1, 1997, the division shall implement the integrated case-mix payment and quality monitoring system, which includes the fair rental system for property costs and in which recapture of depreciation is eliminated. The division may reduce the payment for hospital leave and therapeutic home leave days to the lower of the case-mix category as computed for the resident on leave using the

assessment being utilized for payment at that point in time, or a case-mix score of 1.000 for nursing facilities, and shall compute case-mix scores of residents so that only services provided at the nursing facility are considered in calculating a facility's per diem.

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

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

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

nursing facilities to convert or construct beds for residents with Alzheimer's or other related dementia.

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

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

(5) Periodic screening and diagnostic services for individuals under age twenty-one (21) years as are needed to identify physical and mental defects and to provide health care treatment and other measures designed to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services, regardless of whether these services are included in the state plan. The division may include in its periodic screening and diagnostic program those discretionary services authorized under the federal regulations adopted to implement Title XIX of the federal Social Security Act, as amended. The division, in obtaining physical therapy services, occupational therapy services, and services for individuals with speech, hearing and language disorders, may enter into a cooperative agreement with the State Department of Education for the provision of those services to handicapped students by public

school districts using state funds that are provided from the appropriation to the Department of Education to obtain federal matching funds through the division. The division, in obtaining medical and mental health assessments, treatment, care and services for children who are in, or at risk of being put in, the custody of the Mississippi Department of Human Services may enter into a cooperative agreement with the Mississippi Department of Human Services for the provision of those services using state funds that are provided from the appropriation to the Department of Human Services to obtain federal matching funds through the division.

(6) Physician's services. The division shall allow twelve (12) physician visits annually. The division may develop and implement a different reimbursement model or schedule for physician's services provided by physicians based at an academic health care center and by physicians at rural health centers that are associated with an academic health care center. From and after January 1, 2010, all fees for physician's services that are covered only by Medicaid shall be increased to ninety percent (90%) of the rate established on January 1, 2010, and as may be adjusted each July thereafter, under Medicare. The division may provide for a reimbursement rate for physician's services of up to one hundred percent (100%) of the rate established under Medicare for physician's services that are provided after the normal working hours of the physician, as determined in accordance with

regulations of the division. The division may reimburse eligible providers as determined by the Patient Protection and Affordable Care Act for certain primary care services as defined by the act at one hundred percent (100%) of the rate established under Medicare.

(7) (a) Home health services for eligible persons, not to exceed in cost the prevailing cost of nursing facility services, not to exceed twenty-five (25) visits per year. All home health visits must be precertified as required by the division.

(b) [Repealed]

(8) Emergency medical transportation services. On January 1, 1994, emergency medical transportation services shall be reimbursed at seventy percent (70%) of the rate established under Medicare (Title XVIII of the federal Social Security Act, as amended). "Emergency medical transportation services" shall mean, but shall not be limited to, the following services by a properly permitted ambulance operated by a properly licensed provider in accordance with the Emergency Medical Services Act of 1974 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi) disposable supplies, (vii) similar services.

(9) (a) Legend and other drugs as may be determined by the division.

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

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

The division shall allow for a combination of prescriptions for single source and innovator multiple source drugs and generic drugs to meet the needs of the beneficiaries, not to exceed five (5) prescriptions per month for each noninstitutionalized Medicaid beneficiary, with not more than two (2) of those prescriptions being for single source or innovator multiple source drugs unless the single source or innovator multiple source drug is less expensive than the generic equivalent.

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

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

The voluntary preferred drug list shall be expanded to function in the interim in order to have a manageable prior authorization system, thereby minimizing disruption of service to beneficiaries.

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

The division shall develop and implement a program of payment for additional pharmacist services, with payment to be based on

demonstrated savings, but in no case shall the total payment exceed twice the amount of the dispensing fee.

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

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

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

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

(b) Payment by the division for covered multisource drugs shall be limited to the lower of the upper limits established and published by the Centers for Medicare and Medicaid Services (CMS) plus a dispensing fee, or the estimated acquisition cost (EAC) as determined by the division, plus a dispensing fee, or the providers' usual and customary charge to the general public.

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

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

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

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

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

(10) (a) Dental care that is an adjunct to treatment of an acute medical or surgical condition; services of oral surgeons and dentists in connection with surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone; and emergency dental extractions and treatment related thereto. On July 1, 2007, fees for dental care and surgery under authority of this paragraph (10) shall be reimbursed as provided in subparagraph (b). It is the intent of the Legislature that this rate revision for dental services will be an incentive designed to increase the number of dentists who actively provide Medicaid services. This dental services rate revision shall be known as the "James Russell Dumas Medicaid Dental Incentive Program."

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

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

(c) For fiscal year 2008, the amount of state funds appropriated for reimbursement for dental care and surgery shall be increased by ten percent (10%) of the amount of state fund expenditures for that purpose for fiscal year 2007. For each of fiscal years 2009 and 2010, the amount of state funds appropriated for reimbursement for dental care and surgery shall be increased by ten percent (10%) of the amount of state fund expenditures for that purpose for the preceding fiscal year.

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

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

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

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

(12) Intermediate care facility services.

(a) The division shall make full payment to all intermediate care facilities for individuals with intellectual disabilities for each day, not exceeding eighty-four (84) days per year, that a patient is absent from the facility on home leave. Payment may be made for the following home leave days in addition to the eighty-four-day limitation: Christmas, the day before Christmas, the day after Christmas, Thanksgiving, the day before Thanksgiving and the day after Thanksgiving.

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

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

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

(14) Clinic services. Such diagnostic, preventive, therapeutic, rehabilitative or palliative services furnished to an outpatient by or under the supervision of a physician or dentist in a facility that is not a part of a hospital but that is organized and operated to provide medical care to outpatients. Clinic services shall include any services reimbursed as outpatient hospital services that may be rendered in such a facility, including those that become so after July 1, 1991. On July 1, 1999, all fees for physicians' services reimbursed under authority of this paragraph (14) shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as may be adjusted each July thereafter, under Medicare (Title XVIII of the federal Social Security Act, as amended). The division may develop and implement a different reimbursement model or schedule for physician's services provided by physicians based at an academic health care center and by physicians at rural health centers that are associated with an academic health care center. The division may provide for a reimbursement rate for physician's clinic services of up to one hundred percent (100%) of the rate

established under Medicare for physician's services that are provided after the normal working hours of the physician, as determined in accordance with regulations of the division.

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

The Division of Medicaid is directed to apply for a waiver amendment to increase payments for all adult day care facilities based on acuity of individual patients, with a maximum of Seventy-five Dollars ($75.00) per day for the most acute patients.

(16) Mental health services. Approved therapeutic and case management services (a) provided by an approved regional mental health/intellectual disability center established under Sections 41-19-31 through 41-19-39, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/intellectual disability center if determined necessary by the Department of Mental Health, using state funds that are provided in the appropriation to the division to match federal funds, or (b) provided by a facility that is certified by the State Department of Mental Health to provide therapeutic and case management services, to be reimbursed on a fee for service basis, or (c) provided in the community by a facility or program operated by the

Department of Mental Health. Any such services provided by a facility described in subparagraph (b) must have the prior approval of the division to be reimbursable under this section. *** * ***

(17) Durable medical equipment services and medical supplies. Precertification of durable medical equipment and medical supplies must be obtained as required by the division. The Division of Medicaid may require durable medical equipment providers to obtain a surety bond in the amount and to the specifications as established by the Balanced Budget Act of 1997.

(18) (a) Notwithstanding any other provision of this section to the contrary, as provided in the Medicaid state plan amendment or amendments as defined in Section 43-13-145(10), the division shall make additional reimbursement to hospitals that serve a disproportionate share of low-income patients and that meet the federal requirements for those payments as provided in Section 1923 of the federal Social Security Act and any applicable regulations. It is the intent of the Legislature that the division shall draw down all available federal funds allotted to the state for disproportionate share hospitals. However, from and after January 1, 1999, public hospitals participating in the Medicaid disproportionate share program may be required to participate in an intergovernmental transfer program as provided in Section 1903 of the federal Social Security Act and any applicable regulations.

(b) The division shall establish a Medicare Upper Payment Limits Program, as defined in Section 1902(a)(30) of the federal Social Security Act and any applicable federal regulations, for hospitals, and may establish a Medicare Upper Payment Limits Program for nursing facilities, and may establish a Medicare Upper Payment Limits Program for physicians employed or contracted by public hospitals. Upon successful implementation of a Medicare Upper Payment Limits Program for physicians employed by public hospitals, the division may develop a plan for implementing an Upper Payment Limits Program for physicians employed by other classes of hospitals. The division shall assess each hospital and, if the program is established for nursing facilities, shall assess each nursing facility, for the sole purpose of financing the state portion of the Medicare Upper Payment Limits Program. The hospital assessment shall be as provided in Section 43-13-145(4)(a) and the nursing facility assessment, if established, shall be based on Medicaid utilization or other appropriate method consistent with federal regulations. The assessment will remain in effect as long as the state participates in the Medicare Upper Payment Limits Program. Public hospitals with physicians participating in the Medicare Upper Payment Limits Program shall be required to participate in an intergovernmental transfer program. As provided in the Medicaid state plan amendment or amendments as defined in Section 43-13-145(10), the division shall make additional reimbursement to hospitals and, if

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

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

(ii) Subject only to approval by the Centers for Medicare and Medicaid Services (CMS) where required, the MHAP shall provide increased inpatient capitation (PMPM) payments to managed care entities contracting with the division pursuant to subsection (H) of this section to support availability of hospital services or such other payments permissible under federal law necessary to accomplish the intent of this subsection. For inpatient services rendered after July 1, 2015, but prior to the effective date of CMS approval and full implementation of this program, the division may pay lump-sum enhanced, transition payments, prorated inpatient UPL payments based upon fiscal year 2015 June distribution levels, enhanced hospital access (PMPM) payments or such other methodologies as are approved by CMS such that the level of additional reimbursement required by this section is paid for all Medicaid hospital inpatient services delivered in fiscal year 2016.

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

(iv) The division shall assess each hospital as provided in Section 43-13-145(4)(a) for the purpose of

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

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

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

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

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

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

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

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

(22) Ambulatory services delivered in federally qualified health centers, rural health centers and clinics of the local health departments of the State Department of Health for individuals eligible for Medicaid under this article based on reasonable costs as determined by the division.

(23) Inpatient psychiatric services. Inpatient psychiatric services to be determined by the division for recipients under age twenty-one (21) that are provided under the direction of a physician in an inpatient program in a licensed acute care psychiatric facility or in a licensed psychiatric residential treatment facility, before the recipient reaches age twenty-one (21) or, if the recipient was receiving the services

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

(24) [Deleted]

(25) [Deleted]

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

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

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

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

(30) Pediatric skilled nursing services for eligible persons under twenty-one (21) years of age.

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

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

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

(33) Podiatrist services.

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

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

(36) Nonemergency transportation services for Medicaid-eligible persons, to be provided by the Division of Medicaid. The division may contract with additional entities to administer nonemergency transportation services as it deems necessary. All providers shall have a valid driver's license, vehicle inspection sticker, valid vehicle license tags and a

standard liability insurance policy covering the vehicle. The division may pay providers a flat fee based on mileage tiers, or in the alternative, may reimburse on actual miles traveled. The division may apply to the Center for Medicare and Medicaid Services (CMS) for a waiver to draw federal matching funds for nonemergency transportation services as a covered service instead of an administrative cost. The PEER Committee shall conduct a performance evaluation of the nonemergency transportation program to evaluate the administration of the program and the providers of transportation services to determine the most cost-effective ways of providing nonemergency transportation services to the patients served under the program. The performance evaluation shall be completed and provided to the members of the Senate Public Health and Welfare Committee and the House Medicaid Committee not later than January 15, 2008.

(37) [Deleted]

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

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

(40) [Deleted]

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

(42) Notwithstanding any other provision in this article to the contrary, the division may develop a population health management program for women and children health services through the age of one (1) year. This program is primarily for obstetrical care associated with low birth weight and preterm babies. The division may apply to the federal Centers for

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

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

(44) Nursing facility services for the severely disabled.

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

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

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

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

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

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

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

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

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

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

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

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

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

Rehabilitation Services or if funds are voluntarily provided by another agency.

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

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

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

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

(54) Adult foster care services pilot program. Social and protective services on a pilot program basis in an approved foster care facility for vulnerable adults who would otherwise need care in a long-term care facility, to be implemented in an area of the state with the greatest need for such program, under the Medicaid Waivers for the Elderly and Disabled program or an assisted living waiver. The division may use grants, waivers, demonstrations or other projects as necessary in the development and implementation of this adult foster care services pilot program.

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

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

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

(58) Testing and screening services. The division shall provide reimbursement for the services necessary for the testing and screening required under Section 1 of this act.

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

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

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

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

(D) Notwithstanding any provision of this article, except as authorized in the following subsection and in Section 43-13-139, neither * * * (1) the limitations on quantity or frequency of use of or the fees or charges for any of the care or services available to recipients under this section, nor * * * (2) the payments, payment methodology as provided below in this subsection (D), or rates of reimbursement to providers rendering care or services authorized under this section to recipients, may be increased, decreased or otherwise changed from the levels in effect on July 1, 1999, unless they are authorized by an amendment to this section by the Legislature. However, the restriction in this subsection shall not prevent the division from changing the payments, payment methodology as provided below in this subsection (D), or rates of reimbursement to providers without an amendment to this section whenever those changes are required by federal law or regulation, or whenever those changes are necessary to correct administrative errors or omissions in calculating those payments or rates of reimbursement. The prohibition on any changes in payment methodology provided in this subsection (D) shall apply only to payment methodologies used for determining the rates of reimbursement for inpatient hospital services, outpatient hospital

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

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

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

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

assessment not to exceed Ten Million Dollars ($10,000,000.00) as provided in Section 43-13-145(4)(a)(ii). If Medicaid expenditures are projected to exceed the amount of funds appropriated to the division in any fiscal year in excess of the expenditure reductions to providers, then funds shall be transferred by the State Fiscal Officer from the Health Care Trust Fund into the Health Care Expendable Fund and to the Governor's Office, Division of Medicaid, from the Health Care Expendable Fund, in the amount and at such time as requested by the Governor to reconcile the deficit. If the cost containment measures described above have been implemented and there are insufficient funds in the Health Care Trust Fund to reconcile any remaining deficit in any fiscal year, the Governor shall institute any other additional cost containment measures on any program or programs authorized under this article to the extent allowed under federal law. Hospitals shall be responsible for twenty-five percent (25%) of any additional imposed provider cuts. However, instead of implementing hospital expenditure reductions, the hospital reductions shall be in the form of an additional assessment not to exceed twenty-five percent (25%) of provider expenditure reductions as provided in Section 43-13-145(4)(a)(ii). It is the intent of the Legislature that the expenditures of the division during any fiscal year shall not exceed the amounts appropriated to the division for that fiscal year.

(G) Notwithstanding any other provision of this article, it shall be the duty of each nursing facility, intermediate care facility for individuals with intellectual disabilities, psychiatric residential treatment facility, and nursing facility for the severely disabled that is participating in the Medicaid program to keep and maintain books, documents and other records as prescribed by the Division of Medicaid in substantiation of its cost reports for a period of three (3) years after the date of submission to the Division of Medicaid of an original cost report, or three (3) years after the date of submission to the Division of Medicaid of an amended cost report.

(H) (1) Notwithstanding any other provision of this article, the division is authorized to implement (a) a managed care program, (b) a coordinated care program, (c) a coordinated care organization program, (d) a health maintenance organization program, (e) a patient-centered medical home program, (f) an accountable care organization program, (g) provider-sponsored health plan, or (h) any combination of the above programs. Managed care programs, coordinated care programs, coordinated care organization programs, health maintenance organization programs, patient-centered medical home programs, accountable care organization programs, provider-sponsored health plans, or any combination of the above programs or other similar programs implemented by the division under this section shall be limited to the greater of (i) forty-five percent (45%) of the total

enrollment of Medicaid beneficiaries, or (ii) the categories of beneficiaries participating in the program as of January 1, 2014, plus the categories of beneficiaries composed primarily of persons younger than nineteen (19) years of age, and the division is authorized to enroll categories of beneficiaries in such program(s) as long as the appropriate limitations are not exceeded in the aggregate. As a condition for the approval of any program under this subsection (H)(1), the division shall require that no program may:

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

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

(c) Pay providers at a rate that is less than the normal Medicaid reimbursement rate; however, the division may approve use of innovative payment models that recognize alternative payment models, including quality and value-based payments, provided both parties mutually agree and the Division of

Medicaid approves of said models. Participation in the provider network of any managed care, coordinated care, provider-sponsored health plan, or similar contractor shall not be conditioned on the provider's agreement to accept such alternative payment models;

(d) Implement a prior authorization program for prescription drugs that is more stringent than the prior authorization processes used by the division in its administration of the Medicaid program;

(e) Implement a policy that does not comply with the prescription drugs payment requirements established in subsection (A)(9) of this section;

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

(g) Implement a policy which denies beneficiaries with hemophilia access to the federally funded hemophilia treatment centers as part of the Medicaid Managed Care network of providers. All Medicaid beneficiaries with hemophilia shall receive unrestricted access to anti-hemophilia factor products through noncapitated reimbursement programs.

(2) Any contractors providing direct patient care under a managed care program established in this section shall provide to the Legislature and the division statistical data to be shared with provider groups in order to improve patient access, appropriate utilization, cost savings and health outcomes.

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

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

(I) [Deleted]

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

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

SECTION 4. This act shall take effect and be in force from and after June 30, 2018.