MISSISSIPPI LEGISLATURE REGULAR SESSION 2018

By: Representatives Dortch, Wooten, Paden, Banks, Bell (65th), Karriem, Williams-Barnes

To: Insurance; Public Health and Human Services

HOUSE BILL NO. 874

1 AN ACT TO PROVIDE THAT CERTAIN INSURANCE POLICIES AND
2 CONTRACTS SHALL PROVIDE COVERAGE FOR FDA-APPROVED CONTRACEPTIVE
3 DRUGS, DEVICES AND OTHER PRODUCTS, FOR EMERGENCY CONTRACEPTION
4 AVAILABLE OVER-THE-COUNTER, FOR PRESCRIPTION CONTRACEPTIVES
5 INTENDED TO LAST FOR NOT MORE THAN A THREE-MONTH PERIOD FOR THE
6 FIRST TIME THE PRESCRIPTION CONTRACEPTIVE IS DISPENSED TO THE
7 COVERED PERSON AND FOR NOT MORE THAN A TWELVE-MONTH PERIOD FOR ANY
8 LATER DISPENSING OF THE SAME PRESCRIPTION, FOR VOLUNTARY FEMALE
9 STERILIZATION PROCEDURES, FOR PATIENT EDUCATION AND COUNSELING ON
10 CONTRACEPTION, AND FOR FOLLOW-UP SERVICES RELATED TO THE DRUGS,
11 DEVICES, PRODUCTS AND PROCEDURES COVERED UNDER THIS ACT; TO
12 PROVIDE THAT THE COVERAGE PROVIDED UNDER THIS ACT SHALL NOT BE
13 SUBJECT TO ANY DEDUCTIBLE, COINSURANCE, COPAYMENT OR ANY OTHER
14 COST-SHARING REQUIREMENT; TO AUTHORIZE AN EXEMPTION FROM THIS ACT
15 FOR POLICIES AND CONTRACTS PURCHASED BY AN EMPLOYER THAT IS A
16 CHURCH OR QUALIFIED CHURCH-CONTROLLED ORGANIZATION AT THE REQUEST
17 OF THE EMPLOYER; TO AMEND SECTION 25-15-9, MISSISSIPPI CODE OF
18 1972, TO REQUIRE THE STATE AND SCHOOL EMPLOYEES HEALTH INSURANCE
19 PLAN TO COVER THE SERVICES AND CONTRACEPTIVE METHODS PROVIDED FOR
20 IN THE PRECEDING PROVISIONS; TO CREATE NEW SECTION 43-13-117.3,
21 MISSISSIPPI CODE OF 1972, TO PROVIDE FOR MEDICAID COVERAGE FOR THE
22 SERVICES AND CONTRACEPTIVE METHODS PROVIDED FOR IN THE PRECEDING
23 PROVISIONS; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
24 TO CONFORM TO THE PRECEDING PROVISION AND TO EXTEND THE DATE OF
25 THE REPEALER ON THAT SECTION; AND FOR RELATED PURPOSES.

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

27 **SECTION 1.** (1) All individual and group health insurance
28 policies providing coverage on an expense-incurred basis,
29 individual and group service or indemnity type contracts issued by

30 a nonprofit corporation, individual and group service contracts
31 issued by a health maintenance organization, all self-insured
32 group arrangements to the extent not preempted by federal law and
33 all managed health care delivery entities of any type or
34 description that are delivered, issued for delivery, continued or
35 renewed on or after July 1, 2018, and providing coverage to any
36 resident of this state shall provide coverage for the following
37 services and contraceptive methods:
38 (a) Food and Drug Administration ("FDA") approved
39 contraceptive drugs, devices and other products; however, coverage
40 shall not be required for male condoms or FDA-approved oral
41 contraceptive drugs that do not have a therapeutic equivalent, and
42 provided that:
43 (i) If the FDA has approved one or more
44 therapeutic equivalents of a contraceptive drug, device or
45 product, the policy, contract, arrangement or entity shall not be
46 required to include all such therapeutically equivalent versions
47 in its formulary as long as at least one (1) is included and
48 covered without cost-sharing and in accordance with this section;
49 and
50 (ii) If there is a therapeutic equivalent of a
51 drug, device or other product for a FDA-approved contraceptive
52 method, the policy, contract, arrangement or entity may provide
53 coverage for more than one (1) drug, device or other product and
54 may impose cost-sharing requirements as long as at least one (1)

55 drug, device or other product for that method is available without
56 cost-sharing; however, if an individual's attending provider
57 recommends a particular FDA-approved contraceptive based on a
58 medical determination with respect to that individual, regardless
59 of whether the contraceptive has a therapeutic equivalent, the
60 policy, contract, arrangement or entity shall provide coverage,
61 subject to the utilization management procedures of the policy,
62 contract, arrangement or entity, for the prescribed contraceptive
63 drug, device or product without cost-sharing;
64 (b) FDA-approved emergency contraception available
65 over-the-counter, whether or not with a prescription;
66 (c) Prescription contraceptives intended to last: (i)
67 for not more than a three-month period for the first time the
68 prescription contraceptive is dispensed to the covered person; and
69 (ii) for not more than a twelve-month period for any later
70 dispensing of the same prescription, which may be dispensed all at
71 once or over the course of the twelve-month period, regardless of
72 whether the covered person was enrolled in the policy, contract,
73 arrangement or entity at the time the prescription contraceptive
74 was first dispensed; however, the insured may not fill more than
75 one (1) twelve-month prescription in a single dispensing per plan
76 year;
77 (d) Voluntary female sterilization procedures;
78 (e) Patient education and counseling on contraception;
79 and

80 (f) Follow-up services related to the drugs, devices, 81 products and procedures covered under this subsection including, 82 but not limited to, management of side effects, counseling for 83 continued adherence and device insertion and removal.

84 (2) (a) The coverage provided under this section shall not 85 be subject to any deductible, coinsurance, copayment or any other 86 cost-sharing requirement, except as provided for in paragraph 87 (a)(i) and (ii) of subsection (1) of this section or as otherwise 88 required under federal law. Coverage offered under this section 89 shall not impose unreasonable restrictions or delays in the 90 coverage; however, reasonable medical management techniques may be 91 applied to coverage within a method category, as defined by the 92 FDA, but not across types of methods.

93 (b) Benefits for an enrollee under this section shall 94 be the same for the enrollee's covered spouse and covered 95 dependents.

96 (3) A policy, contract, arrangement that is purchased by an 97 employer that is a church or qualified church-controlled 98 organization shall be exempt from this section at the request of 99 the employer. An employer that invokes the exemption under this 100 subsection shall provide written notice to prospective enrollees 101 before enrollment with the plan and the notice shall list the 102 contraceptive health care methods and services for which the 103 employer will not provide coverage for religious reasons.

104 (4) Nothing in this section shall be construed to exclude
105 coverage for contraceptive drugs, devices, products and procedures
106 prescribed by a provider for reasons other than contraceptive
107 purposes, including, but not limited to, decreasing the risk of
108 ovarian cancer, eliminating symptoms of menopause or providing
109 contraception that is necessary to preserve the life or health of
110 an enrollee or the enrollee's covered spouse or covered
111 dependents.
112 (5) Nothing in this section shall be construed to require a
113 policy, contract, arrangement or entity to cover experimental or
114 investigational treatments.
115 (6) The Commissioner of Insurance shall ensure that plans
116 issued under this section comply with this section.
117 (7) For the purposes of this section, the following words
118 shall have the meanings as defined in this subsection unless the
119 context clearly requires otherwise:
120 (a) "Church" means a church, a convention or
121 association of churches or an elementary or secondary school that
122 is controlled, operated or principally supported by a church or by
123 a convention or association of churches.
124 (b) "Provider" means an individual or facility
125 licensed, certified or otherwise authorized or permitted by law to
126 administer health care in the ordinary course of business or
127 professional practice acting within the scope of their license.

128 (c) "Qualified church-controlled organization," an
129 organization described in Section 501(c)(3) of the federal
130 Internal Revenue Code, other than an organization that:
131 (i) offers goods, services or facilities for sale, other than on
132 an incidental basis, to the general public, other than goods,
133 services or facilities that are sold at a nominal charge that is
134 substantially less than the cost of providing those goods,
135 services or facilities; and (ii) normally receives more than
136 twenty-five percent (25%) of its support from: 1. governmental
137 sources; 2. receipts from admissions, sales of merchandise,
138 performance of services or furnishing of facilities, in activities
139 that are not unrelated trades or businesses; or 3. both items 1
140 and 2.
141 (d) "Therapeutic equivalent" means a contraceptive
142 drug, device or product that is: (i) approved as safe and
143 effective; (ii) pharmaceutically equivalent to another
144 contraceptive drug, device or product in that it contains an
145 identical amount of the same active drug ingredient in the same
146 dosage form and route of administration and meets compendial or
147 other applicable standards of strength, quality, purity and
148 identity; and (iii) assigned the same therapeutic equivalence code
149 as another contraceptive drug, device or product by the FDA.
150 **SECTION 2.** Section 25-15-9, Mississippi Code of 1972, is
151 amended as follows:

152 25-15-9. (1) (a) The board shall design a plan of health
153 insurance for state employees that provides benefits for
154 semiprivate rooms in addition to other incidental coverages that
155 the board deems necessary. The amount of the coverages shall be
156 in such reasonable amount as may be determined by the board to be
157 adequate, after due consideration of current health costs in
158 Mississippi. The plan shall also include major medical benefits
159 in such amounts as the board determines. The plan shall also
160 cover the services and contraceptive methods provided for in
161 Section 1 of this act. The plan shall provide for coverage for
162 telemedicine services as provided in Section 83-9-351. The board
163 is also authorized to accept bids for such alternate coverage and
164 optional benefits as the board deems proper. The board is
165 authorized to accept bids for surgical services that include
166 assistance in locating a surgeon, setting up initial consultation,
167 travel, a negotiated single case rate bundle and payment for
168 orthopedic, spine, bariatric, cardiovascular and general
169 surgeries. The surgical services may only utilize surgeons and
170 facilities located in the State of Mississippi unless otherwise
171 provided by the board. Any contract for alternative coverage and
172 optional benefits shall be awarded by the board after it has
173 carefully studied and evaluated the bids and selected the best and
174 most cost-effective bid. The board may reject all of the bids;
175 however, the board shall notify all bidders of the rejection and
176 shall actively solicit new bids if all bids are rejected. The

177 board may employ or contract for such consulting or actuarial
178 services as may be necessary to formulate the plan, and to assist
179 the board in the preparation of specifications and in the process
180 of advertising for the bids for the plan. Those contracts shall
181 be solicited and entered into in accordance with Section 25-15-5.
182 The board shall keep a record of all persons, agents and
183 corporations who contract with or assist the board in preparing
184 and developing the plan. The board in a timely manner shall
185 provide copies of this record to the members of the advisory
186 council created in this section and those legislators, or their
187 designees, who may attend meetings of the advisory council. The
188 board shall provide copies of this record in the solicitation of
189 bids for the administration or servicing of the self-insured
190 program. Each person, agent or corporation that, during the
191 previous fiscal year, has assisted in the development of the plan
192 or employed or compensated any person who assisted in the
193 development of the plan, and that bids on the administration or
194 servicing of the plan, shall submit to the board a statement
195 accompanying the bid explaining in detail its participation with
196 the development of the plan. This statement shall include the
197 amount of compensation paid by the bidder to any such employee
198 during the previous fiscal year. The board shall make all such
199 information available to the members of the advisory council and
200 those legislators, or their designees, who may attend meetings of
201 the advisory council before any action is taken by the board on

202 the bids submitted. The failure of any bidder to fully and
203 accurately comply with this paragraph shall result in the
204 rejection of any bid submitted by that bidder or the cancellation
205 of any contract executed when the failure is discovered after the
206 acceptance of that bid. The board is authorized to promulgate
207 rules and regulations to implement the provisions of this
208 subsection.
209 The board shall develop plans for the insurance plan
210 authorized by this section in accordance with the provisions of
211 Section 25-15-5.
212 Any corporation, association, company or individual that
213 contracts with the board for the third-party claims administration
214 of the self-insured plan shall prepare and keep on file an
215 explanation of benefits for each claim processed. The explanation
216 of benefits shall contain such information relative to each
217 processed claim that the board deems necessary, and, at a minimum,
218 each explanation shall provide the claimant's name, claim number,
219 provider number, provider name, service dates, type of services,
220 amount of charges, amount allowed to the claimant and reason
221 codes. The information contained in the explanation of benefits
222 shall be available for inspection upon request by the board. The
223 board shall have access to all claims information utilized in the
224 issuance of payments to employees and providers.
225 (b) There is created an advisory council to advise the
226 board in the formulation of the State and School Employees Health

227 Insurance Plan. The council shall be composed of the State
228 Insurance Commissioner, or his designee, an
229 employee-representative of the institutions of higher learning
230 appointed by the board of trustees thereof, an
231 employee-representative of the Department of Transportation
232 appointed by the director thereof, an employee-representative of
233 the Department of Revenue appointed by the Commissioner of
234 Revenue, an employee-representative of the Mississippi Department
235 of Health appointed by the State Health Officer, an
236 employee-representative of the Mississippi Department of
237 Corrections appointed by the Commissioner of Corrections, and an
238 employee-representative of the Department of Human Services
239 appointed by the Executive Director of Human Services, two (2)
240 certificated public school administrators appointed by the State
241 Board of Education, two (2) certificated classroom teachers
242 appointed by the State Board of Education, a noncertificated
243 school employee appointed by the State Board of Education and a
244 community/junior college employee appointed by the Mississippi
245 Community College Board.

246 The Lieutenant Governor may designate the Secretary of the
247 Senate, the Chairman of the Senate Appropriations Committee, the
248 Chairman of the Senate Education Committee and the Chairman of the
249 Senate Insurance Committee, and the Speaker of the House of
250 Representatives may designate the Clerk of the House, the Chairman
251 of the House Appropriations Committee, the Chairman of the House

252 Education Committee and the Chairman of the House Insurance
253 Committee, to attend any meeting of the State and School Employees
254 Insurance Advisory Council. The appointing authorities may
255 designate an alternate member from their respective houses to
256 serve when the regular designee is unable to attend the meetings
257 of the council. Those designees shall have no jurisdiction or
258 vote on any matter within the jurisdiction of the council. For
259 attending meetings of the council, the legislators shall receive
260 per diem and expenses, which shall be paid from the contingent
261 expense funds of their respective houses in the same amounts as
262 provided for committee meetings when the Legislature is not in
263 session; however, no per diem and expenses for attending meetings
264 of the council will be paid while the Legislature is in session.
265 No per diem and expenses will be paid except for attending
266 meetings of the council without prior approval of the proper
267 committee in their respective houses.
268 (c) No change in the terms of the State and School
269 Employees Health Insurance Plan may be made effective unless the
270 board, or its designee, has provided notice to the State and
271 School Employees Health Insurance Advisory Council and has called
272 a meeting of the council at least fifteen (15) days before the
273 effective date of the change. If the State and School Employees
274 Health Insurance Advisory Council does not meet to advise the
275 board on the proposed changes, the changes to the plan shall

276 become effective at such time as the board has informed the
277 council that the changes shall become effective.

278 (d) **Medical benefits for retired employees and**
279 **dependents under age sixty-five (65) years and not eligible for**
280 **Medicare benefits.** For employees who retire before July 1, 2005,
281 and for employees retiring due to work-related disability under
282 the Public Employees' Retirement System, the same health insurance
283 coverage as for all other active employees and their dependents
284 shall be available to retired employees and all dependents under
285 age sixty-five (65) years who are not eligible for Medicare
286 benefits, the level of benefits to be the same level as for all
287 other active participants. For employees who retire on or after
288 July 1, 2005, and not retiring due to work-related disability
289 under the Public Employees' Retirement System, the same health
290 insurance coverage as for all other active employees and their
291 dependents shall be available to those retiring employees and all
292 dependents under age sixty-five (65) years who are not eligible
293 for Medicare benefits only if the retiring employees were
294 participants in the State and School Employees Health Insurance
295 Plan for four (4) years or more before their retirement, the level
296 of benefits to be the same level as for all other active
297 participants. This section will apply to those employees who
298 retire due to one hundred percent (100%) medical disability as
299 well as those employees electing early retirement.

300 (e) **Medical benefits for retired employees and**
301 **dependents over age sixty-five (65) years or otherwise eligible**
302 **for Medicare benefits.** For employees who retire before July 1,
303 2005, and for employees retiring due to work-related disability
304 under the Public Employees' Retirement System, the health
305 insurance coverage available to retired employees over age
306 sixty-five (65) years or otherwise eligible for Medicare benefits,
307 and all dependents over age sixty-five (65) years or otherwise
308 eligible for Medicare benefits, shall be the major medical
309 coverage. For employees retiring on or after July 1, 2005, and
310 not retiring due to work-related disability under the Public
311 Employees' Retirement System, the health insurance coverage
312 described in this paragraph (e) shall be available to those
313 retiring employees only if they were participants in the State and
314 School Employees Health Insurance Plan for four (4) years or more
315 and are over age sixty-five (65) years or otherwise eligible for
316 Medicare benefits, and to all dependents over age sixty-five (65)
317 years or otherwise eligible for Medicare benefits. Benefits shall
318 be reduced by Medicare benefits as though the Medicare benefits
319 were the base plan.
320 All covered individuals shall be assumed to have full
321 Medicare coverage, Parts A and B; and any Medicare payments under
322 both Parts A and B shall be computed to reduce benefits payable
323 under this plan.

324 (f) Lifetime maximum: The lifetime maximum amount of
325 benefits payable under the health insurance plan for each
326 participant is Two Million Dollars ($2,000,000.00).
327 (2) Nonduplication of benefits — reduction of benefits by
328 Title XIX benefits: When benefits would be payable under more
329 than one (1) group plan, benefits under those plans will be
330 coordinated to the extent that the total benefits under all plans
331 will not exceed the total expenses incurred.
332 Benefits for hospital or surgical or medical benefits shall
333 be reduced by any similar benefits payable in accordance with
334 Title XIX of the Social Security Act or under any amendments
335 thereto, or any implementing legislation.
336 Benefits for hospital or surgical or medical benefits shall
337 be reduced by any similar benefits payable by workers'
338 compensation.
339 No health care benefits under the state plan shall restrict
340 coverage for medically appropriate treatment prescribed by a
341 physician and agreed to by a fully informed insured, or if the
342 insured lacks legal capacity to consent by a person who has legal
343 authority to consent on his or her behalf, based on an insured's
344 diagnosis with a terminal condition. As used in this paragraph,
345 "terminal condition" means any aggressive malignancy, chronic
346 end-stage cardiovascular or cerebral vascular disease, or any
347 other disease, illness or condition which physician diagnoses as
348 terminal.

349 Not later than January 1, 2016, the state health plan shall
350 not require a higher co-payment, deductible or coinsurance amount
351 for patient-administered anti-cancer medications, including, but
352 not limited to, those orally administered or self-injected, than
353 it requires for anti-cancer medications that are injected or
354 intravenously administered by a health care provider, regardless
355 of the formulation or benefit category determination by the plan.
356 For the purposes of this paragraph, the term "anti-cancer
357 medications" has the meaning as defined in Section 83-9-24.
358 (3) (a) Schedule of life insurance benefits — group term:
359 The amount of term life insurance for each active employee of a
360 department, agency or institution of the state government shall
361 not be in excess of One Hundred Thousand Dollars ($100,000.00), or
362 twice the amount of the employee's annual wage to the next highest
363 One Thousand Dollars ($1,000.00), whichever may be less, but in no
364 case less than Thirty Thousand Dollars ($30,000.00), with a like
365 amount for accidental death and dismemberment on a
366 twenty-four-hour basis. The plan will further contain a premium
367 waiver provision if a covered employee becomes totally and
368 permanently disabled before age sixty-five (65) years. Employees
369 retiring after June 30, 1999, shall be eligible to continue life
370 insurance coverage in an amount of Five Thousand Dollars
371 ($5,000.00), Ten Thousand Dollars ($10,000.00) or Twenty Thousand
372 Dollars ($20,000.00) into retirement.

373 (b) Effective October 1, 1999, schedule of life
374 insurance benefits — group term: The amount of term life
375 insurance for each active employee of any school district,
376 community/junior college, public library or university-based
377 program authorized under Section 37-23-31 for deaf, aphasic and
378 emotionally disturbed children or any regular nonstudent bus
379 driver shall not be in excess of One Hundred Thousand Dollars
380 ($100,000.00), or twice the amount of the employee's annual wage
381 to the next highest One Thousand Dollars ($1,000.00), whichever
382 may be less, but in no case less than Thirty Thousand Dollars
383 ($30,000.00), with a like amount for accidental death and
384 dismemberment on a twenty-four-hour basis. The plan will further
385 contain a premium waiver provision if a covered employee of any
386 school district, community/junior college, public library or
387 university-based program authorized under Section 37-23-31 for
388 deaf, aphasic and emotionally disturbed children or any regular
389 nonstudent bus driver becomes totally and permanently disabled
390 before age sixty-five (65) years. Employees of any school
391 district, community/junior college, public library or
392 university-based program authorized under Section 37-23-31 for
393 deaf, aphasic and emotionally disturbed children or any regular
394 nonstudent bus driver retiring after September 30, 1999, shall be
395 eligible to continue life insurance coverage in an amount of Five
396 Thousand Dollars ($5,000.00), Ten Thousand Dollars ($10,000.00) or
397 Twenty Thousand Dollars ($20,000.00) into retirement.

398 (4) Any eligible employee who on March 1, 1971, was
399 participating in a group life insurance program that has
400 provisions different from those included in this article and for
401 which the State of Mississippi was paying a part of the premium
402 may, at his discretion, continue to participate in that plan. The
403 employee shall pay in full all additional costs, if any, above the
404 minimum program established by this article. Under no
405 circumstances shall any individual who begins employment with the
406 state after March 1, 1971, be eligible for the provisions of this
407 subsection.
408 (5) The board may offer medical savings accounts as defined
409 in Section 71-9-3 as a plan option.
410 (6) Any premium differentials, differences in coverages,
411 discounts determined by risk or by any other factors shall be
412 uniformly applied to all active employees participating in the
413 insurance plan. It is the intent of the Legislature that the
414 state contribution to the plan be the same for each employee
415 throughout the state.
416 (7) On October 1, 1999, any school district,
417 community/junior college district or public library may elect to
418 remain with an existing policy or policies of group life insurance
419 with an insurance company approved by the State and School
420 Employees Health Insurance Management Board, in lieu of
421 participation in the State and School Life Insurance Plan. On or
422 after July 1, 2004, until October 1, 2004, any school district,

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

441 (a) The insurance company offering the group life
442 insurance plan shall be rated "A-" or better by A.M. Best state
443 insurance rating service and be licensed as an admitted carrier in
444 the State of Mississippi by the Mississippi Department of
445 Insurance.

446 (b) The insurance company group life insurance plan
447 shall provide the same life insurance, accidental death and

448 dismemberment insurance and waiver of premium benefits as provided
449 in the State and School Life Insurance Plan.
450 (c) The insurance company group life insurance plan
451 shall be fully insured, and no form of self-funding life insurance
452 by the company shall be approved.
453 (d) The insurance company group life insurance plan
454 shall have one (1) composite rate per One Thousand Dollars
455 ($1,000.00) of coverage for active employees regardless of age and
456 one (1) composite rate per One Thousand Dollars ($1,000.00) of
457 coverage for all retirees regardless of age or type of retiree.
458 (e) The insurance company and its group life insurance
459 plan shall comply with any administrative requirements of the
460 State and School Employees Health Insurance Management Board. If
461 any insurance company providing group life insurance benefits to
462 employees under this subsection (7) fails to comply with any
463 requirements specified in this subsection or any administrative
464 requirements of the board, the state shall discontinue providing
465 funding for the cost of that insurance.
466 **SECTION 3.** The following shall be codified as Section
467 43-13-117.3, Mississippi Code of 1972:
468 <u>43-13-117.3.</u> (1) The division and its contracted health
469 insurers, health plans, health maintenance organizations,
470 coordinated care organizations, behavioral health management firms
471 and third-party administrators under contract to a Medicaid
472 managed care organization or coordinated care organization shall

473 provide coverage for the following services and contraceptive
474 methods:
475 (a) Food and Drug Administration ("FDA") approved
476 contraceptive drugs, devices and other products; however, coverage
477 shall not be required for male condoms or FDA-approved oral
478 contraceptive drugs that do not have a therapeutic equivalent, and
479 provided that:
480 (i) If the FDA has approved one or more
481 therapeutic equivalents of a contraceptive drug, device or
482 product, the division shall not be required to include all such
483 therapeutically equivalent versions in its formulary as long as at
484 least one (1) is included and covered without cost-sharing and in
485 accordance with this section; and
486 (ii) If there is a therapeutic equivalent of a
487 drug, device or other product for a FDA-approved contraceptive
488 method, the division may provide coverage for more than one (1)
489 drug, device or other product and may impose cost-sharing
490 requirements as long as at least one (1) drug, device or other
491 product for that method is available without cost-sharing;
492 however, if an individual's attending provider recommends a
493 particular FDA-approved contraceptive based on a medical
494 determination with respect to that individual, regardless of
495 whether the contraceptive has a therapeutic equivalent, the
496 division shall provide coverage, subject to the division's

497 utilization management procedures, for the prescribed
498 contraceptive drug, device or product without cost-sharing;
499 (b) FDA-approved emergency contraception available
500 over-the-counter, whether or not with a prescription;
501 (c) Prescription contraceptives intended to last: (i)
502 for not more than a three-month period for the first time the
503 prescription contraceptive is dispensed to the covered person; and
504 (ii) for not more than a twelve-month period for any later
505 dispensing of the same prescription, which may be dispensed all at
506 once or over the course of the twelve-month period, regardless of
507 whether the covered person was enrolled with the division at the
508 time the prescription contraceptive was first dispensed; however,
509 the insured may not fill more than one (1) twelve-month
510 prescription in a single dispensing per plan year;
511 (d) Voluntary female sterilization procedures;
512 (e) Patient education and counseling on contraception;
513 and
514 (f) Follow-up services related to the drugs, devices,
515 products and procedures covered under this subsection including,
516 but not limited to, management of side effects, counseling for
517 continued adherence and device insertion and removal.
518 (2) (a) The coverage provided under this section shall not
519 be subject to any deductible, coinsurance, copayment or any other
520 cost-sharing requirement, except as provided for in paragraph
521 (a)(i) and (ii) of subsection (1) of this section or as otherwise

522 required under federal law. Coverage offered under this section
523 shall not impose unreasonable restrictions or delays in the
524 coverage; however, reasonable medical management techniques may be
525 applied to coverage within a method category, as defined by the
526 FDA, but not across types of methods.

527 (b) Benefits for an enrollee under this section shall
528 be the same for the enrollee's covered spouse and covered
529 dependents.

530 (3) Nothing in this section shall be construed to exclude
531 coverage for contraceptive drugs, devices, products and procedures
532 prescribed by a provider for reasons other than contraceptive
533 purposes, including, but not limited to, decreasing the risk of
534 ovarian cancer, eliminating symptoms of menopause or providing
535 contraception that is necessary to preserve the life or health of
536 an enrollee or the enrollee's covered spouse or covered
537 dependents.

538 (4) Nothing in this section shall be construed to deny or
539 restrict the division's authority to ensure its contracted health
540 insurers, health plans, health maintenance organizations,
541 coordinated care organizations, behavioral health management firms
542 and third-party administrators under contract to a Medicaid
543 managed care organization or coordinated care organization are in
544 compliance with this section.

545 (5) Nothing in this section shall be construed to require
546 the division to cover experimental or investigational treatments.

547 (6) For the purposes of this section, the following words
548 shall have the meanings as defined in this subsection unless the
549 context clearly requires otherwise:
550 (a) "Provider" means an individual or facility
551 licensed, certified or otherwise authorized or permitted by law to
552 administer health care in the ordinary course of business or
553 professional practice acting within the scope of their license.
554 (b) "Therapeutic equivalent" means a contraceptive
555 drug, device or product that is: (i) approved as safe and
556 effective; (ii) pharmaceutically equivalent to another
557 contraceptive drug, device or product in that it contains an
558 identical amount of the same active drug ingredient in the same
559 dosage form and route of administration and meets compendial or
560 other applicable standards of strength, quality, purity and
561 identity; and (iii) assigned the same therapeutic equivalence code
562 as another contraceptive drug, device or product by the FDA.
563 **SECTION 4.** Section 43-13-117, Mississippi Code of 1972, is
564 amended as follows:
565 43-13-117. (A) Medicaid as authorized by this article shall
566 include payment of part or all of the costs, at the discretion of
567 the division, with approval of the Governor, of the following
568 types of care and services rendered to eligible applicants who
569 have been determined to be eligible for that care and services,
570 within the limits of state appropriations and federal matching
571 funds:

572 (1) Inpatient hospital services.

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

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

585 (c) Hospitals will receive an additional payment
586 for the implantable programmable baclofen drug pump used to treat
587 spasticity that is implanted on an inpatient basis. The payment
588 pursuant to written invoice will be in addition to the facility's
589 per diem reimbursement and will represent a reduction of costs on
590 the facility's annual cost report, and shall not exceed Ten
591 Thousand Dollars ($10,000.00) per year per recipient.

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

595 (e) No service benefits or reimbursement
596 limitations in this section shall apply to payments under an

597 APR-DRG or Ambulatory Payment Classification (APC) model or a
598 managed care program or similar model described in subsection (H)
599 of this section.

600 (2) Outpatient hospital services.

601 (a) Emergency services.

602 (b) Other outpatient hospital services. The
603 division shall allow benefits for other medically necessary
604 outpatient hospital services (such as chemotherapy, radiation,
605 surgery and therapy), including outpatient services in a clinic or
606 other facility that is not located inside the hospital, but that
607 has been designated as an outpatient facility by the hospital, and
608 that was in operation or under construction on July 1, 2009,
609 provided that the costs and charges associated with the operation
610 of the hospital clinic are included in the hospital's cost report.
611 In addition, the Medicare thirty-five-mile rule will apply to
612 those hospital clinics not located inside the hospital that are
613 constructed after July 1, 2009. Where the same services are
614 reimbursed as clinic services, the division may revise the rate or
615 methodology of outpatient reimbursement to maintain consistency,
616 efficiency, economy and quality of care.

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

620 (d) No service benefits or reimbursement
621 limitations in this section shall apply to payments under an

622 APR-DRG or APC model or a managed care program or similar model
623 described in subsection (H) of this section.

624 (3) Laboratory and x-ray services.

625 (4) Nursing facility services.

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

633 (b) From and after July 1, 1997, the division
634 shall implement the integrated case-mix payment and quality
635 monitoring system, which includes the fair rental system for
636 property costs and in which recapture of depreciation is
637 eliminated. The division may reduce the payment for hospital
638 leave and therapeutic home leave days to the lower of the case-mix
639 category as computed for the resident on leave using the
640 assessment being utilized for payment at that point in time, or a
641 case-mix score of 1.000 for nursing facilities, and shall compute
642 case-mix scores of residents so that only services provided at the
643 nursing facility are considered in calculating a facility's per
644 diem.

645 (c) From and after July 1, 1997, all state-owned
646 nursing facilities shall be reimbursed on a full reasonable cost
647 basis.
648 (d) On or after January 1, 2015, the division
649 shall update the case-mix payment system resource utilization
650 grouper and classifications and fair rental reimbursement system.
651 The division shall develop and implement a payment add-on to
652 reimburse nursing facilities for ventilator dependent resident
653 services.
654 (e) The division shall develop and implement, not
655 later than January 1, 2001, a case-mix payment add-on determined
656 by time studies and other valid statistical data that will
657 reimburse a nursing facility for the additional cost of caring for
658 a resident who has a diagnosis of Alzheimer's or other related
659 dementia and exhibits symptoms that require special care. Any
660 such case-mix add-on payment shall be supported by a determination
661 of additional cost. The division shall also develop and implement
662 as part of the fair rental reimbursement system for nursing
663 facility beds, an Alzheimer's resident bed depreciation enhanced
664 reimbursement system that will provide an incentive to encourage
665 nursing facilities to convert or construct beds for residents with
666 Alzheimer's or other related dementia.
667 (f) The division shall develop and implement an
668 assessment process for long-term care services. The division may

669 provide the assessment and related functions directly or through
670 contract with the area agencies on aging.

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

675 (5) Periodic screening and diagnostic services for
676 individuals under age twenty-one (21) years as are needed to
677 identify physical and mental defects and to provide health care
678 treatment and other measures designed to correct or ameliorate
679 defects and physical and mental illness and conditions discovered
680 by the screening services, regardless of whether these services
681 are included in the state plan. The division may include in its
682 periodic screening and diagnostic program those discretionary
683 services authorized under the federal regulations adopted to
684 implement Title XIX of the federal Social Security Act, as
685 amended. The division, in obtaining physical therapy services,
686 occupational therapy services, and services for individuals with
687 speech, hearing and language disorders, may enter into a
688 cooperative agreement with the State Department of Education for
689 the provision of those services to handicapped students by public
690 school districts using state funds that are provided from the
691 appropriation to the Department of Education to obtain federal
692 matching funds through the division. The division, in obtaining
693 medical and mental health assessments, treatment, care and

694 services for children who are in, or at risk of being put in, the
695 custody of the Mississippi Department of Human Services may enter
696 into a cooperative agreement with the Mississippi Department of
697 Human Services for the provision of those services using state
698 funds that are provided from the appropriation to the Department
699 of Human Services to obtain federal matching funds through the
700 division.

701 (6) Physician's services. The division shall allow
702 twelve (12) physician visits annually. The division may develop
703 and implement a different reimbursement model or schedule for
704 physician's services provided by physicians based at an academic
705 health care center and by physicians at rural health centers that
706 are associated with an academic health care center. From and
707 after January 1, 2010, all fees for physician's services that are
708 covered only by Medicaid shall be increased to ninety percent
709 (90%) of the rate established on January 1, 2010, and as may be
710 adjusted each July thereafter, under Medicare. The division may
711 provide for a reimbursement rate for physician's services of up to
712 one hundred percent (100%) of the rate established under Medicare
713 for physician's services that are provided after the normal
714 working hours of the physician, as determined in accordance with
715 regulations of the division. The division may reimburse eligible
716 providers as determined by the Patient Protection and Affordable
717 Care Act for certain primary care services as defined by the act

718 at one hundred percent (100%) of the rate established under
719 Medicare.
720 (7) (a) Home health services for eligible persons, not
721 to exceed in cost the prevailing cost of nursing facility
722 services, not to exceed twenty-five (25) visits per year. All
723 home health visits must be precertified as required by the
724 division.
725 (b) [Repealed]
726 (8) Emergency medical transportation services. On
727 January 1, 1994, emergency medical transportation services shall
728 be reimbursed at seventy percent (70%) of the rate established
729 under Medicare (Title XVIII of the federal Social Security Act, as
730 amended). "Emergency medical transportation services" shall mean,
731 but shall not be limited to, the following services by a properly
732 permitted ambulance operated by a properly licensed provider in
733 accordance with the Emergency Medical Services Act of 1974
734 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
735 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
736 (vi) disposable supplies, (vii) similar services.
737 (9) (a) Legend and other drugs as may be determined by
738 the division.
739 The division shall establish a mandatory preferred drug list.
740 Drugs not on the mandatory preferred drug list shall be made
741 available by utilizing prior authorization procedures established
742 by the division.

743 The division may seek to establish relationships with other
744 states in order to lower acquisition costs of prescription drugs
745 to include single source and innovator multiple source drugs or
746 generic drugs. In addition, if allowed by federal law or
747 regulation, the division may seek to establish relationships with
748 and negotiate with other countries to facilitate the acquisition
749 of prescription drugs to include single source and innovator
750 multiple source drugs or generic drugs, if that will lower the
751 acquisition costs of those prescription drugs.
752 The division shall allow for a combination of prescriptions
753 for single source and innovator multiple source drugs and generic
754 drugs to meet the needs of the beneficiaries, not to exceed five
755 (5) prescriptions per month for each noninstitutionalized Medicaid
756 beneficiary, with not more than two (2) of those prescriptions
757 being for single source or innovator multiple source drugs unless
758 the single source or innovator multiple source drug is less
759 expensive than the generic equivalent.
760 The executive director may approve specific maintenance drugs
761 for beneficiaries with certain medical conditions, which may be
762 prescribed and dispensed in three-month supply increments.
763 Drugs prescribed for a resident of a psychiatric residential
764 treatment facility must be provided in true unit doses when
765 available. The division may require that drugs not covered by
766 Medicare Part D for a resident of a long-term care facility be
767 provided in true unit doses when available. Those drugs that were

768 originally billed to the division but are not used by a resident
769 in any of those facilities shall be returned to the billing
770 pharmacy for credit to the division, in accordance with the
771 guidelines of the State Board of Pharmacy and any requirements of
772 federal law and regulation. Drugs shall be dispensed to a
773 recipient and only one (1) dispensing fee per month may be
774 charged. The division shall develop a methodology for reimbursing
775 for restocked drugs, which shall include a restock fee as
776 determined by the division not exceeding Seven Dollars and
777 Eighty-two Cents ($7.82).

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

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

786 The division shall develop and implement a program of payment
787 for additional pharmacist services, with payment to be based on
788 demonstrated savings, but in no case shall the total payment
789 exceed twice the amount of the dispensing fee.

790 All claims for drugs for dually eligible Medicare/Medicaid
791 beneficiaries that are paid for by Medicare must be submitted to

792 Medicare for payment before they may be processed by the
793 division's online payment system.
794 The division shall develop a pharmacy policy in which drugs
795 in tamper-resistant packaging that are prescribed for a resident
796 of a nursing facility but are not dispensed to the resident shall
797 be returned to the pharmacy and not billed to Medicaid, in
798 accordance with guidelines of the State Board of Pharmacy.
799 The division shall develop and implement a method or methods
800 by which the division will provide on a regular basis to Medicaid
801 providers who are authorized to prescribe drugs, information about
802 the costs to the Medicaid program of single source drugs and
803 innovator multiple source drugs, and information about other drugs
804 that may be prescribed as alternatives to those single source
805 drugs and innovator multiple source drugs and the costs to the
806 Medicaid program of those alternative drugs.
807 Notwithstanding any law or regulation, information obtained
808 or maintained by the division regarding the prescription drug
809 program, including trade secrets and manufacturer or labeler
810 pricing, is confidential and not subject to disclosure except to
811 other state agencies.
812 (b) Payment by the division for covered
813 multisource drugs shall be limited to the lower of the upper
814 limits established and published by the Centers for Medicare and
815 Medicaid Services (CMS) plus a dispensing fee, or the estimated
816 acquisition cost (EAC) as determined by the division, plus a

817 dispensing fee, or the providers' usual and customary charge to
818 the general public.

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

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

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

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

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

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

842 jaw or any structure contiguous to the jaw or the reduction of any
843 fracture of the jaw or any facial bone; and emergency dental
844 extractions and treatment related thereto. On July 1, 2007, fees
845 for dental care and surgery under authority of this paragraph (10)
846 shall be reimbursed as provided in subparagraph (b). It is the
847 intent of the Legislature that this rate revision for dental
848 services will be an incentive designed to increase the number of
849 dentists who actively provide Medicaid services. This dental
850 services rate revision shall be known as the "James Russell Dumas
851 Medicaid Dental Incentive Program."

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

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

867 and dental fees shall be adjusted to reflect the percentile
868 determined by the division.
869 (c) For fiscal year 2008, the amount of state
870 funds appropriated for reimbursement for dental care and surgery
871 shall be increased by ten percent (10%) of the amount of state
872 fund expenditures for that purpose for fiscal year 2007. For each
873 of fiscal years 2009 and 2010, the amount of state funds
874 appropriated for reimbursement for dental care and surgery shall
875 be increased by ten percent (10%) of the amount of state fund
876 expenditures for that purpose for the preceding fiscal year.
877 (d) The division shall establish an annual benefit
878 limit of Two Thousand Five Hundred Dollars ($2,500.00) in dental
879 expenditures per Medicaid-eligible recipient; however, a recipient
880 may exceed the annual limit on dental expenditures provided in
881 this paragraph with prior approval of the division.
882 (e) The division shall include dental services as
883 a necessary component of overall health services provided to
884 children who are eligible for services.
885 (f) This paragraph (10) shall stand repealed on
886 July 1, 2016.
887 (11) Eyeglasses for all Medicaid beneficiaries who have
888 (a) had surgery on the eyeball or ocular muscle that results in a
889 vision change for which eyeglasses or a change in eyeglasses is
890 medically indicated within six (6) months of the surgery and is in
891 accordance with policies established by the division, or (b) one

892 (1) pair every five (5) years and in accordance with policies
893 established by the division. In either instance, the eyeglasses
894 must be prescribed by a physician skilled in diseases of the eye
895 or an optometrist, whichever the beneficiary may select.
896 (12) Intermediate care facility services.
897 (a) The division shall make full payment to all
898 intermediate care facilities for individuals with intellectual
899 disabilities for each day, not exceeding eighty-four (84) days per
900 year, that a patient is absent from the facility on home leave.
901 Payment may be made for the following home leave days in addition
902 to the eighty-four-day limitation: Christmas, the day before
903 Christmas, the day after Christmas, Thanksgiving, the day before
904 Thanksgiving and the day after Thanksgiving.
905 (b) All state-owned intermediate care facilities
906 for individuals with intellectual disabilities shall be reimbursed
907 on a full reasonable cost basis.
908 (c) Effective January 1, 2015, the division shall
909 update the fair rental reimbursement system for intermediate care
910 facilities for individuals with intellectual disabilities.
911 (13) Family planning services, including drugs,
912 supplies and devices, when those services are under the
913 supervision of a physician or nurse practitioner. The division
914 shall also cover the services and contraceptive methods provided
915 for in Section 43-13-117.3.

916 (14) Clinic services. Such diagnostic, preventive,
917 therapeutic, rehabilitative or palliative services furnished to an
918 outpatient by or under the supervision of a physician or dentist
919 in a facility that is not a part of a hospital but that is
920 organized and operated to provide medical care to outpatients.
921 Clinic services shall include any services reimbursed as
922 outpatient hospital services that may be rendered in such a
923 facility, including those that become so after July 1, 1991. On
924 July 1, 1999, all fees for physicians' services reimbursed under
925 authority of this paragraph (14) shall be reimbursed at ninety
926 percent (90%) of the rate established on January 1, 1999, and as
927 may be adjusted each July thereafter, under Medicare (Title XVIII
928 of the federal Social Security Act, as amended). The division may
929 develop and implement a different reimbursement model or schedule
930 for physician's services provided by physicians based at an
931 academic health care center and by physicians at rural health
932 centers that are associated with an academic health care center.
933 The division may provide for a reimbursement rate for physician's
934 clinic services of up to one hundred percent (100%) of the rate
935 established under Medicare for physician's services that are
936 provided after the normal working hours of the physician, as
937 determined in accordance with regulations of the division.
938 (15) Home- and community-based services for the elderly
939 and disabled, as provided under Title XIX of the federal Social
940 Security Act, as amended, under waivers, subject to the

941 availability of funds specifically appropriated for that purpose
942 by the Legislature.
943 The Division of Medicaid is directed to apply for a waiver
944 amendment to increase payments for all adult day care facilities
945 based on acuity of individual patients, with a maximum of
946 Seventy-five Dollars ($75.00) per day for the most acute patients.
947 (16) Mental health services. Approved therapeutic and
948 case management services (a) provided by an approved regional
949 mental health/intellectual disability center established under
950 Sections 41-19-31 through 41-19-39, or by another community mental
951 health service provider meeting the requirements of the Department
952 of Mental Health to be an approved mental health/intellectual
953 disability center if determined necessary by the Department of
954 Mental Health, using state funds that are provided in the
955 appropriation to the division to match federal funds, or (b)
956 provided by a facility that is certified by the State Department
957 of Mental Health to provide therapeutic and case management
958 services, to be reimbursed on a fee for service basis, or (c)
959 provided in the community by a facility or program operated by the
960 Department of Mental Health. Any such services provided by a
961 facility described in subparagraph (b) must have the prior
962 approval of the division to be reimbursable under this
963 section. *** * ***
964 (17) Durable medical equipment services and medical
965 supplies. Precertification of durable medical equipment and

966 medical supplies must be obtained as required by the division.
967 The Division of Medicaid may require durable medical equipment
968 providers to obtain a surety bond in the amount and to the
969 specifications as established by the Balanced Budget Act of 1997.
970 (18) (a) Notwithstanding any other provision of this
971 section to the contrary, as provided in the Medicaid state plan
972 amendment or amendments as defined in Section 43-13-145(10), the
973 division shall make additional reimbursement to hospitals that
974 serve a disproportionate share of low-income patients and that
975 meet the federal requirements for those payments as provided in
976 Section 1923 of the federal Social Security Act and any applicable
977 regulations. It is the intent of the Legislature that the
978 division shall draw down all available federal funds allotted to
979 the state for disproportionate share hospitals. However, from and
980 after January 1, 1999, public hospitals participating in the
981 Medicaid disproportionate share program may be required to
982 participate in an intergovernmental transfer program as provided
983 in Section 1903 of the federal Social Security Act and any
984 applicable regulations.
985 (b) The division shall establish a Medicare Upper
986 Payment Limits Program, as defined in Section 1902(a)(30) of the
987 federal Social Security Act and any applicable federal
988 regulations, for hospitals, and may establish a Medicare Upper
989 Payment Limits Program for nursing facilities, and may establish a
990 Medicare Upper Payment Limits Program for physicians employed or

991 contracted by public hospitals. Upon successful implementation of
992 a Medicare Upper Payment Limits Program for physicians employed by
993 public hospitals, the division may develop a plan for implementing
994 an Upper Payment Limits Program for physicians employed by other
995 classes of hospitals. The division shall assess each hospital
996 and, if the program is established for nursing facilities, shall
997 assess each nursing facility, for the sole purpose of financing
998 the state portion of the Medicare Upper Payment Limits Program.
999 The hospital assessment shall be as provided in Section
1000 43-13-145(4)(a) and the nursing facility assessment, if
1001 established, shall be based on Medicaid utilization or other
1002 appropriate method consistent with federal regulations. The
1003 assessment will remain in effect as long as the state participates
1004 in the Medicare Upper Payment Limits Program. Public hospitals
1005 with physicians participating in the Medicare Upper Payment Limits
1006 Program shall be required to participate in an intergovernmental
1007 transfer program. As provided in the Medicaid state plan
1008 amendment or amendments as defined in Section 43-13-145(10), the
1009 division shall make additional reimbursement to hospitals and, if
1010 the program is established for nursing facilities, shall make
1011 additional reimbursement to nursing facilities, for the Medicare
1012 Upper Payment Limits, and, if the program is established for
1013 physicians, shall make additional reimbursement for physicians, as
1014 defined in Section 1902(a)(30) of the federal Social Security Act
1015 and any applicable federal regulations. Effective upon

1016 implementation of the Mississippi Hospital Access Program (MHAP)
1017 provided in subparagraph (c)(i) below, the hospital portion of the
1018 inpatient Upper Payment Limits Program shall transition into and
1019 be replaced by the MHAP program.

1020 (c) (i) Not later than December 1, 2015, the
1021 division shall, subject to approval by the Centers for Medicare
1022 and Medicaid Services (CMS), establish, implement and operate a
1023 Mississippi Hospital Access Program (MHAP) for the purpose of
1024 protecting patient access to hospital care through hospital
1025 inpatient reimbursement programs provided in this section designed
1026 to maintain total hospital reimbursement for inpatient services
1027 rendered by in-state hospitals and the out-of-state hospital that
1028 is authorized by federal law to submit intergovernmental transfers
1029 (IGTs) to the State of Mississippi and is classified as Level I
1030 trauma center located in a county contiguous to the state line at
1031 the maximum levels permissible under applicable federal statutes
1032 and regulations, at which time the current inpatient Medicare
1033 Upper Payment Limits (UPL) Program for hospital inpatient services
1034 shall transition to the MHAP.

1035 (ii) Subject only to approval by the Centers
1036 for Medicare and Medicaid Services (CMS) where required, the MHAP
1037 shall provide increased inpatient capitation (PMPM) payments to
1038 managed care entities contracting with the division pursuant to
1039 subsection (H) of this section to support availability of hospital
1040 services or such other payments permissible under federal law

1041 necessary to accomplish the intent of this subsection. For
1042 inpatient services rendered after July 1, 2015, but prior to the
1043 effective date of CMS approval and full implementation of this
1044 program, the division may pay lump-sum enhanced, transition
1045 payments, prorated inpatient UPL payments based upon fiscal year
1046 2015 June distribution levels, enhanced hospital access (PMPM)
1047 payments or such other methodologies as are approved by CMS such
1048 that the level of additional reimbursement required by this
1049 section is paid for all Medicaid hospital inpatient services
1050 delivered in fiscal year 2016.

1051 (iii) The intent of this subparagraph (c) is
1052 that effective for all inpatient hospital Medicaid services during
1053 state fiscal year 2016, and so long as this provision shall remain
1054 in effect hereafter, the division shall to the fullest extent
1055 feasible replace the additional reimbursement for hospital
1056 inpatient services under the inpatient Medicare Upper Payment
1057 Limits (UPL) Program with additional reimbursement under the MHAP.

1058 (iv) The division shall assess each hospital
1059 as provided in Section 43-13-145(4)(a) for the purpose of
1060 financing the state portion of the MHAP and such other purposes as
1061 specified in Section 43-13-145. The assessment will remain in
1062 effect as long as the MHAP is in effect.

1063 (v) In the event that the MHAP program under
1064 this subparagraph (c) is not approved by CMS, the inpatient UPL
1065 program under subparagraph (b) shall immediately become restored

1066 in the manner required to provide the maximum permissible level of
1067 UPL payments to hospital providers for all inpatient services
1068 rendered from and after July 1, 2015.

1069 (19) (a) Perinatal risk management services. The
1070 division shall promulgate regulations to be effective from and
1071 after October 1, 1988, to establish a comprehensive perinatal
1072 system for risk assessment of all pregnant and infant Medicaid
1073 recipients and for management, education and follow-up for those
1074 who are determined to be at risk. Services to be performed
1075 include case management, nutrition assessment/counseling,
1076 psychosocial assessment/counseling and health education. The
1077 division shall contract with the State Department of Health to
1078 provide the services within this paragraph (Perinatal High Risk
1079 Management/Infant Services System (PHRM/ISS)). The State
1080 Department of Health as the agency for PHRM/ISS for the Division
1081 of Medicaid shall be reimbursed on a full reasonable cost basis.

1082 (b) Early intervention system services. The
1083 division shall cooperate with the State Department of Health,
1084 acting as lead agency, in the development and implementation of a
1085 statewide system of delivery of early intervention services, under
1086 Part C of the Individuals with Disabilities Education Act (IDEA).
1087 The State Department of Health shall certify annually in writing
1088 to the executive director of the division the dollar amount of
1089 state early intervention funds available that will be utilized as
1090 a certified match for Medicaid matching funds. Those funds then

1091 shall be used to provide expanded targeted case management
1092 services for Medicaid eligible children with special needs who are
1093 eligible for the state's early intervention system.
1094 Qualifications for persons providing service coordination shall be
1095 determined by the State Department of Health and the Division of
1096 Medicaid.

1097 (20) Home- and community-based services for physically
1098 disabled approved services as allowed by a waiver from the United
1099 States Department of Health and Human Services for home- and
1100 community-based services for physically disabled people using
1101 state funds that are provided from the appropriation to the State
1102 Department of Rehabilitation Services and used to match federal
1103 funds under a cooperative agreement between the division and the
1104 department, provided that funds for these services are
1105 specifically appropriated to the Department of Rehabilitation
1106 Services.

1107 (21) Nurse practitioner services. Services furnished
1108 by a registered nurse who is licensed and certified by the
1109 Mississippi Board of Nursing as a nurse practitioner, including,
1110 but not limited to, nurse anesthetists, nurse midwives, family
1111 nurse practitioners, family planning nurse practitioners,
1112 pediatric nurse practitioners, obstetrics-gynecology nurse
1113 practitioners and neonatal nurse practitioners, under regulations
1114 adopted by the division. Reimbursement for those services shall
1115 not exceed ninety percent (90%) of the reimbursement rate for

1116 comparable services rendered by a physician. The division may
1117 provide for a reimbursement rate for nurse practitioner services
1118 of up to one hundred percent (100%) of the reimbursement rate for
1119 comparable services rendered by a physician for nurse practitioner
1120 services that are provided after the normal working hours of the
1121 nurse practitioner, as determined in accordance with regulations
1122 of the division.

1123 (22) Ambulatory services delivered in federally
1124 qualified health centers, rural health centers and clinics of the
1125 local health departments of the State Department of Health for
1126 individuals eligible for Medicaid under this article based on
1127 reasonable costs as determined by the division.

1128 (23) Inpatient psychiatric services. Inpatient
1129 psychiatric services to be determined by the division for
1130 recipients under age twenty-one (21) that are provided under the
1131 direction of a physician in an inpatient program in a licensed
1132 acute care psychiatric facility or in a licensed psychiatric
1133 residential treatment facility, before the recipient reaches age
1134 twenty-one (21) or, if the recipient was receiving the services
1135 immediately before he or she reached age twenty-one (21), before
1136 the earlier of the date he or she no longer requires the services
1137 or the date he or she reaches age twenty-two (22), as provided by
1138 federal regulations. From and after January 1, 2015, the division
1139 shall update the fair rental reimbursement system for psychiatric
1140 residential treatment facilities. Precertification of inpatient

1141 days and residential treatment days must be obtained as required
1142 by the division. From and after July 1, 2009, all state-owned and
1143 state-operated facilities that provide inpatient psychiatric
1144 services to persons under age twenty-one (21) who are eligible for
1145 Medicaid reimbursement shall be reimbursed for those services on a
1146 full reasonable cost basis.

1147 (24) [Deleted]

1148 (25) [Deleted]

1149 (26) Hospice care. As used in this paragraph, the term
1150 "hospice care" means a coordinated program of active professional
1151 medical attention within the home and outpatient and inpatient
1152 care that treats the terminally ill patient and family as a unit,
1153 employing a medically directed interdisciplinary team. The
1154 program provides relief of severe pain or other physical symptoms
1155 and supportive care to meet the special needs arising out of
1156 physical, psychological, spiritual, social and economic stresses
1157 that are experienced during the final stages of illness and during
1158 dying and bereavement and meets the Medicare requirements for
1159 participation as a hospice as provided in federal regulations.

1160 (27) Group health plan premiums and cost-sharing if it
1161 is cost-effective as defined by the United States Secretary of
1162 Health and Human Services.

1163 (28) Other health insurance premiums that are
1164 cost-effective as defined by the United States Secretary of Health

1165 and Human Services. Medicare eligible must have Medicare Part B
1166 before other insurance premiums can be paid.
1167 (29) The Division of Medicaid may apply for a waiver
1168 from the United States Department of Health and Human Services for
1169 home- and community-based services for developmentally disabled
1170 people using state funds that are provided from the appropriation
1171 to the State Department of Mental Health and/or funds transferred
1172 to the department by a political subdivision or instrumentality of
1173 the state and used to match federal funds under a cooperative
1174 agreement between the division and the department, provided that
1175 funds for these services are specifically appropriated to the
1176 Department of Mental Health and/or transferred to the department
1177 by a political subdivision or instrumentality of the state.
1178 (30) Pediatric skilled nursing services for eligible
1179 persons under twenty-one (21) years of age.
1180 (31) Targeted case management services for children
1181 with special needs, under waivers from the United States
1182 Department of Health and Human Services, using state funds that
1183 are provided from the appropriation to the Mississippi Department
1184 of Human Services and used to match federal funds under a
1185 cooperative agreement between the division and the department.
1186 (32) Care and services provided in Christian Science
1187 Sanatoria listed and certified by the Commission for Accreditation
1188 of Christian Science Nursing Organizations/Facilities, Inc.,
1189 rendered in connection with treatment by prayer or spiritual means

1190 to the extent that those services are subject to reimbursement
1191 under Section 1903 of the federal Social Security Act.
1192 (33) Podiatrist services.
1193 (34) Assisted living services as provided through
1194 home- and community-based services under Title XIX of the federal
1195 Social Security Act, as amended, subject to the availability of
1196 funds specifically appropriated for that purpose by the
1197 Legislature.
1198 (35) Services and activities authorized in Sections
1199 43-27-101 and 43-27-103, using state funds that are provided from
1200 the appropriation to the Mississippi Department of Human Services
1201 and used to match federal funds under a cooperative agreement
1202 between the division and the department.
1203 (36) Nonemergency transportation services for
1204 Medicaid-eligible persons, to be provided by the Division of
1205 Medicaid. The division may contract with additional entities to
1206 administer nonemergency transportation services as it deems
1207 necessary. All providers shall have a valid driver's license,
1208 vehicle inspection sticker, valid vehicle license tags and a
1209 standard liability insurance policy covering the vehicle. The
1210 division may pay providers a flat fee based on mileage tiers, or
1211 in the alternative, may reimburse on actual miles traveled. The
1212 division may apply to the Center for Medicare and Medicaid
1213 Services (CMS) for a waiver to draw federal matching funds for
1214 nonemergency transportation services as a covered service instead

1215 of an administrative cost. The PEER Committee shall conduct a
1216 performance evaluation of the nonemergency transportation program
1217 to evaluate the administration of the program and the providers of
1218 transportation services to determine the most cost-effective ways
1219 of providing nonemergency transportation services to the patients
1220 served under the program. The performance evaluation shall be
1221 completed and provided to the members of the Senate Public Health
1222 and Welfare Committee and the House Medicaid Committee not later
1223 than January 15, 2008.

1224 (37) [Deleted]

1225 (38) Chiropractic services. A chiropractor's manual
1226 manipulation of the spine to correct a subluxation, if x-ray
1227 demonstrates that a subluxation exists and if the subluxation has
1228 resulted in a neuromusculoskeletal condition for which
1229 manipulation is appropriate treatment, and related spinal x-rays
1230 performed to document these conditions. Reimbursement for
1231 chiropractic services shall not exceed Seven Hundred Dollars
1232 ($700.00) per year per beneficiary.

1233 (39) Dually eligible Medicare/Medicaid beneficiaries.
1234 The division shall pay the Medicare deductible and coinsurance
1235 amounts for services available under Medicare, as determined by
1236 the division. From and after July 1, 2009, the division shall
1237 reimburse crossover claims for inpatient hospital services and
1238 crossover claims covered under Medicare Part B in the same manner

1239 that was in effect on January 1, 2008, unless specifically
1240 authorized by the Legislature to change this method.
1241 (40) [Deleted]
1242 (41) Services provided by the State Department of
1243 Rehabilitation Services for the care and rehabilitation of persons
1244 with spinal cord injuries or traumatic brain injuries, as allowed
1245 under waivers from the United States Department of Health and
1246 Human Services, using up to seventy-five percent (75%) of the
1247 funds that are appropriated to the Department of Rehabilitation
1248 Services from the Spinal Cord and Head Injury Trust Fund
1249 established under Section 37-33-261 and used to match federal
1250 funds under a cooperative agreement between the division and the
1251 department.
1252 (42) Notwithstanding any other provision in this
1253 article to the contrary, the division may develop a population
1254 health management program for women and children health services
1255 through the age of one (1) year. This program is primarily for
1256 obstetrical care associated with low birth weight and preterm
1257 babies. The division may apply to the federal Centers for
1258 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
1259 any other waivers that may enhance the program. In order to
1260 effect cost savings, the division may develop a revised payment
1261 methodology that may include at-risk capitated payments, and may
1262 require member participation in accordance with the terms and
1263 conditions of an approved federal waiver.

1264 (43) The division shall provide reimbursement,
1265 according to a payment schedule developed by the division, for
1266 smoking cessation medications for pregnant women during their
1267 pregnancy and other Medicaid-eligible women who are of
1268 child-bearing age.
1269 (44) Nursing facility services for the severely
1270 disabled.
1271 (a) Severe disabilities include, but are not
1272 limited to, spinal cord injuries, closed-head injuries and
1273 ventilator dependent patients.
1274 (b) Those services must be provided in a long-term
1275 care nursing facility dedicated to the care and treatment of
1276 persons with severe disabilities.
1277 (45) Physician assistant services. Services furnished
1278 by a physician assistant who is licensed by the State Board of
1279 Medical Licensure and is practicing with physician supervision
1280 under regulations adopted by the board, under regulations adopted
1281 by the division. Reimbursement for those services shall not
1282 exceed ninety percent (90%) of the reimbursement rate for
1283 comparable services rendered by a physician. The division may
1284 provide for a reimbursement rate for physician assistant services
1285 of up to one hundred percent (100%) or the reimbursement rate for
1286 comparable services rendered by a physician for physician
1287 assistant services that are provided after the normal working

1288 hours of the physician assistant, as determined in accordance with
1289 regulations of the division.
1290 (46) The division shall make application to the federal
1291 Centers for Medicare and Medicaid Services (CMS) for a waiver to
1292 develop and provide services for children with serious emotional
1293 disturbances as defined in Section 43-14-1(1), which may include
1294 home- and community-based services, case management services or
1295 managed care services through mental health providers certified by
1296 the Department of Mental Health. The division may implement and
1297 provide services under this waivered program only if funds for
1298 these services are specifically appropriated for this purpose by
1299 the Legislature, or if funds are voluntarily provided by affected
1300 agencies.
1301 (47) (a) Notwithstanding any other provision in this
1302 article to the contrary, the division may develop and implement
1303 disease management programs for individuals with high-cost chronic
1304 diseases and conditions, including the use of grants, waivers,
1305 demonstrations or other projects as necessary.
1306 (b) Participation in any disease management
1307 program implemented under this paragraph (47) is optional with the
1308 individual. An individual must affirmatively elect to participate
1309 in the disease management program in order to participate, and may
1310 elect to discontinue participation in the program at any time.
1311 (48) Pediatric long-term acute care hospital services.

1312 (a) Pediatric long-term acute care hospital
1313 services means services provided to eligible persons under
1314 twenty-one (21) years of age by a freestanding Medicare-certified
1315 hospital that has an average length of inpatient stay greater than
1316 twenty-five (25) days and that is primarily engaged in providing
1317 chronic or long-term medical care to persons under twenty-one (21)
1318 years of age.
1319 (b) The services under this paragraph (48) shall
1320 be reimbursed as a separate category of hospital services.
1321 (49) The division shall establish copayments and/or
1322 coinsurance for all Medicaid services for which copayments and/or
1323 coinsurance are allowable under federal law or regulation, and
1324 shall set the amount of the copayment and/or coinsurance for each
1325 of those services at the maximum amount allowable under federal
1326 law or regulation.
1327 (50) Services provided by the State Department of
1328 Rehabilitation Services for the care and rehabilitation of persons
1329 who are deaf and blind, as allowed under waivers from the United
1330 States Department of Health and Human Services to provide
1331 home- and community-based services using state funds that are
1332 provided from the appropriation to the State Department of
1333 Rehabilitation Services or if funds are voluntarily provided by
1334 another agency.
1335 (51) Upon determination of Medicaid eligibility and in
1336 association with annual redetermination of Medicaid eligibility,

1337 beneficiaries shall be encouraged to undertake a physical
1338 examination that will establish a base-line level of health and
1339 identification of a usual and customary source of care (a medical
1340 home) to aid utilization of disease management tools. This
1341 physical examination and utilization of these disease management
1342 tools shall be consistent with current United States Preventive
1343 Services Task Force or other recognized authority recommendations.
1344 For persons who are determined ineligible for Medicaid, the
1345 division will provide information and direction for accessing
1346 medical care and services in the area of their residence.
1347 (52) Notwithstanding any provisions of this article,
1348 the division may pay enhanced reimbursement fees related to trauma
1349 care, as determined by the division in conjunction with the State
1350 Department of Health, using funds appropriated to the State
1351 Department of Health for trauma care and services and used to
1352 match federal funds under a cooperative agreement between the
1353 division and the State Department of Health. The division, in
1354 conjunction with the State Department of Health, may use grants,
1355 waivers, demonstrations, or other projects as necessary in the
1356 development and implementation of this reimbursement program.
1357 (53) Targeted case management services for high-cost
1358 beneficiaries shall be developed by the division for all services
1359 under this section.
1360 (54) Adult foster care services pilot program. Social
1361 and protective services on a pilot program basis in an approved

1362 foster care facility for vulnerable adults who would otherwise
1363 need care in a long-term care facility, to be implemented in an
1364 area of the state with the greatest need for such program, under
1365 the Medicaid Waivers for the Elderly and Disabled program or an
1366 assisted living waiver. The division may use grants, waivers,
1367 demonstrations or other projects as necessary in the development
1368 and implementation of this adult foster care services pilot
1369 program.

1370 (55) Therapy services. The plan of care for therapy
1371 services may be developed to cover a period of treatment for up to
1372 six (6) months, but in no event shall the plan of care exceed a
1373 six-month period of treatment. The projected period of treatment
1374 must be indicated on the initial plan of care and must be updated
1375 with each subsequent revised plan of care. Based on medical
1376 necessity, the division shall approve certification periods for
1377 less than or up to six (6) months, but in no event shall the
1378 certification period exceed the period of treatment indicated on
1379 the plan of care. The appeal process for any reduction in therapy
1380 services shall be consistent with the appeal process in federal
1381 regulations.

1382 (56) Prescribed pediatric extended care centers
1383 services for medically dependent or technologically dependent
1384 children with complex medical conditions that require continual
1385 care as prescribed by the child's attending physician, as
1386 determined by the division.

1387 (57) No Medicaid benefit shall restrict coverage for
1388 medically appropriate treatment prescribed by a physician and
1389 agreed to by a fully informed individual, or if the individual
1390 lacks legal capacity to consent by a person who has legal
1391 authority to consent on his or her behalf, based on an
1392 individual's diagnosis with a terminal condition. As used in this
1393 paragraph (57), "terminal condition" means any aggressive
1394 malignancy, chronic end-stage cardiovascular or cerebral vascular
1395 disease, or any other disease, illness or condition which a
1396 physician diagnoses as terminal.
1397 (B) Notwithstanding any other provision of this article to
1398 the contrary, the division shall reduce the rate of reimbursement
1399 to providers for any service provided under this section by five
1400 percent (5%) of the allowed amount for that service. However, the
1401 reduction in the reimbursement rates required by this subsection
1402 (B) shall not apply to inpatient hospital services, nursing
1403 facility services, intermediate care facility services,
1404 psychiatric residential treatment facility services, pharmacy
1405 services provided under subsection (A)(9) of this section, or any
1406 service provided by the University of Mississippi Medical Center
1407 or a state agency, a state facility or a public agency that either
1408 provides its own state match through intergovernmental transfer or
1409 certification of funds to the division, or a service for which the
1410 federal government sets the reimbursement methodology and rate.
1411 From and after January 1, 2010, the reduction in the reimbursement

1412 rates required by this subsection (B) shall not apply to
1413 physicians' services. In addition, the reduction in the
1414 reimbursement rates required by this subsection (B) shall not
1415 apply to case management services and home-delivered meals
1416 provided under the home- and community-based services program for
1417 the elderly and disabled by a planning and development district
1418 (PDD). Planning and development districts participating in the
1419 home- and community-based services program for the elderly and
1420 disabled as case management providers shall be reimbursed for case
1421 management services at the maximum rate approved by the Centers
1422 for Medicare and Medicaid Services (CMS).

1423 (C) The division may pay to those providers who participate
1424 in and accept patient referrals from the division's emergency room
1425 redirection program a percentage, as determined by the division,
1426 of savings achieved according to the performance measures and
1427 reduction of costs required of that program. Federally qualified
1428 health centers may participate in the emergency room redirection
1429 program, and the division may pay those centers a percentage of
1430 any savings to the Medicaid program achieved by the centers'
1431 accepting patient referrals through the program, as provided in
1432 this subsection (C).

1433 (D) Notwithstanding any provision of this article, except as
1434 authorized in the following subsection and in Section 43-13-139,
1435 neither *** * *** <u>(1)</u> the limitations on quantity or frequency of use
1436 of or the fees or charges for any of the care or services

1437 available to recipients under this section, nor *** * *** (2) the
1438 payments, payment methodology as provided below in this subsection
1439 (D), or rates of reimbursement to providers rendering care or
1440 services authorized under this section to recipients, may be
1441 increased, decreased or otherwise changed from the levels in
1442 effect on July 1, 1999, unless they are authorized by an amendment
1443 to this section by the Legislature. However, the restriction in
1444 this subsection shall not prevent the division from changing the
1445 payments, payment methodology as provided below in this subsection
1446 (D), or rates of reimbursement to providers without an amendment
1447 to this section whenever those changes are required by federal law
1448 or regulation, or whenever those changes are necessary to correct
1449 administrative errors or omissions in calculating those payments
1450 or rates of reimbursement. The prohibition on any changes in
1451 payment methodology provided in this subsection (D) shall apply
1452 only to payment methodologies used for determining the rates of
1453 reimbursement for inpatient hospital services, outpatient hospital
1454 services, nursing facility services, and/or pharmacy services,
1455 except as required by federal law, and the federally mandated
1456 rebasing of rates as required by the Centers for Medicare and
1457 Medicaid Services (CMS) shall not be considered payment
1458 methodology for purposes of this subsection (D). No service
1459 benefits or reimbursement limitations in this section shall apply
1460 to payments under an APR-DRG or APC model or a managed care

1461 program or similar model described in subsection (H) of this
1462 section.
1463 (E) Notwithstanding any provision of this article, no new
1464 groups or categories of recipients and new types of care and
1465 services may be added without enabling legislation from the
1466 Mississippi Legislature, except that the division may authorize
1467 those changes without enabling legislation when the addition of
1468 recipients or services is ordered by a court of proper authority.
1469 (F) The executive director shall keep the Governor advised
1470 on a timely basis of the funds available for expenditure and the
1471 projected expenditures. If current or projected expenditures of
1472 the division are reasonably anticipated to exceed the amount of
1473 funds appropriated to the division for any fiscal year, the
1474 Governor, after consultation with the executive director, shall
1475 discontinue any or all of the payment of the types of care and
1476 services as provided in this section that are deemed to be
1477 optional services under Title XIX of the federal Social Security
1478 Act, as amended, and when necessary, shall institute any other
1479 cost containment measures on any program or programs authorized
1480 under the article to the extent allowed under the federal law
1481 governing that program or programs. However, the Governor shall
1482 not be authorized to discontinue or eliminate any service under
1483 this section that is mandatory under federal law, or to
1484 discontinue or eliminate, or adjust income limits or resource
1485 limits for, any eligibility category or group under Section

1486 43-13-115. Beginning in fiscal year 2010 and in fiscal years
1487 thereafter, when Medicaid expenditures are projected to exceed
1488 funds available for any quarter in the fiscal year, the division
1489 shall submit the expected shortfall information to the PEER
1490 Committee, which shall review the computations of the division and
1491 report its findings to the Legislative Budget Office within thirty
1492 (30) days of such notification by the division, and not later than
1493 January 7 in any year. If expenditure reductions or cost
1494 containments are implemented, the Governor may implement a maximum
1495 amount of state share expenditure reductions to providers, of
1496 which hospitals will be responsible for twenty-five percent (25%)
1497 of provider reductions as follows: in fiscal year 2010, the
1498 maximum amount shall be Twenty-four Million Dollars
1499 ($24,000,000.00); in fiscal year 2011, the maximum amount shall be
1500 Thirty-two Million Dollars ($32,000,000.00); and in fiscal year
1501 2012 and thereafter, the maximum amount shall be Forty Million
1502 Dollars ($40,000,000.00). However, instead of implementing cuts,
1503 the hospital share shall be in the form of an additional
1504 assessment not to exceed Ten Million Dollars ($10,000,000.00) as
1505 provided in Section 43-13-145(4)(a)(ii). If Medicaid expenditures
1506 are projected to exceed the amount of funds appropriated to the
1507 division in any fiscal year in excess of the expenditure
1508 reductions to providers, then funds shall be transferred by the
1509 State Fiscal Officer from the Health Care Trust Fund into the
1510 Health Care Expendable Fund and to the Governor's Office, Division

1511 of Medicaid, from the Health Care Expendable Fund, in the amount
1512 and at such time as requested by the Governor to reconcile the
1513 deficit. If the cost containment measures described above have
1514 been implemented and there are insufficient funds in the Health
1515 Care Trust Fund to reconcile any remaining deficit in any fiscal
1516 year, the Governor shall institute any other additional cost
1517 containment measures on any program or programs authorized under
1518 this article to the extent allowed under federal law. Hospitals
1519 shall be responsible for twenty-five percent (25%) of any
1520 additional imposed provider cuts. However, instead of
1521 implementing hospital expenditure reductions, the hospital
1522 reductions shall be in the form of an additional assessment not to
1523 exceed twenty-five percent (25%) of provider expenditure
1524 reductions as provided in Section 43-13-145(4)(a)(ii). It is the
1525 intent of the Legislature that the expenditures of the division
1526 during any fiscal year shall not exceed the amounts appropriated
1527 to the division for that fiscal year.
1528 (G) Notwithstanding any other provision of this article, it
1529 shall be the duty of each nursing facility, intermediate care
1530 facility for individuals with intellectual disabilities,
1531 psychiatric residential treatment facility, and nursing facility
1532 for the severely disabled that is participating in the Medicaid
1533 program to keep and maintain books, documents and other records as
1534 prescribed by the Division of Medicaid in substantiation of its
1535 cost reports for a period of three (3) years after the date of

1536 submission to the Division of Medicaid of an original cost report,
1537 or three (3) years after the date of submission to the Division of
1538 Medicaid of an amended cost report.

1539 (H) (1) Notwithstanding any other provision of this
1540 article, the division is authorized to implement (a) a managed
1541 care program, (b) a coordinated care program, (c) a coordinated
1542 care organization program, (d) a health maintenance organization
1543 program, (e) a patient-centered medical home program, (f) an
1544 accountable care organization program, (g) provider-sponsored
1545 health plan, or (h) any combination of the above programs.
1546 Managed care programs, coordinated care programs, coordinated care
1547 organization programs, health maintenance organization programs,
1548 patient-centered medical home programs, accountable care
1549 organization programs, provider-sponsored health plans, or any
1550 combination of the above programs or other similar programs
1551 implemented by the division under this section shall be limited to
1552 the greater of (i) forty-five percent (45%) of the total
1553 enrollment of Medicaid beneficiaries, or (ii) the categories of
1554 beneficiaries participating in the program as of January 1, 2014,
1555 plus the categories of beneficiaries composed primarily of persons
1556 younger than nineteen (19) years of age, and the division is
1557 authorized to enroll categories of beneficiaries in such
1558 program(s) as long as the appropriate limitations are not exceeded
1559 in the aggregate. As a condition for the approval of any program

1560 under this subsection (H)(1), the division shall require that no
1561 program may:

1562 (a) Pay providers at a rate that is less than the
1563 Medicaid All-Patient Refined-Diagnosis Related Groups (APR-DRG)
1564 reimbursement rate;

1565 (b) Override the medical decisions of hospital
1566 physicians or staff regarding patients admitted to a hospital for
1567 an emergency medical condition as defined by 42 US Code Section
1568 1395dd. This restriction (b) does not prohibit the retrospective
1569 review of the appropriateness of the determination that an
1570 emergency medical condition exists by chart review or coding
1571 algorithm, nor does it prohibit prior authorization for
1572 nonemergency hospital admissions;

1573 (c) Pay providers at a rate that is less than the
1574 normal Medicaid reimbursement rate; however, the division may
1575 approve use of innovative payment models that recognize
1576 alternative payment models, including quality and value-based
1577 payments, provided both parties mutually agree and the Division of
1578 Medicaid approves of said models. Participation in the provider
1579 network of any managed care, coordinated care, provider-sponsored
1580 health plan, or similar contractor shall not be conditioned on the
1581 provider's agreement to accept such alternative payment models;

1582 (d) Implement a prior authorization program for
1583 prescription drugs that is more stringent than the prior

1584 authorization processes used by the division in its administration
1585 of the Medicaid program;
1586 (e) Implement a policy that does not comply with
1587 the prescription drugs payment requirements established in
1588 subsection (A)(9) of this section;
1589 (f) Implement a preferred drug list that is more
1590 stringent than the mandatory preferred drug list established by
1591 the division under subsection (A)(9) of this section;
1592 (g) Implement a policy which denies beneficiaries
1593 with hemophilia access to the federally funded hemophilia
1594 treatment centers as part of the Medicaid Managed Care network of
1595 providers. All Medicaid beneficiaries with hemophilia shall
1596 receive unrestricted access to anti-hemophilia factor products
1597 through noncapitated reimbursement programs.
1598 (2) Any contractors providing direct patient care under
1599 a managed care program established in this section shall provide
1600 to the Legislature and the division statistical data to be shared
1601 with provider groups in order to improve patient access,
1602 appropriate utilization, cost savings and health outcomes.
1603 (3) All health maintenance organizations, coordinated
1604 care organizations, provider-sponsored health plans, or other
1605 organizations paid for services on a capitated basis by the
1606 division under any managed care program or coordinated care
1607 program implemented by the division under this section shall
1608 reimburse all providers in those organizations at rates no lower

1609 than those provided under this section for beneficiaries who are
1610 not participating in those programs.

1611 (4) No health maintenance organization, coordinated
1612 care organization, provider-sponsored health plan, or other
1613 organization paid for services on a capitated basis by the
1614 division under any managed care program or coordinated care
1615 program implemented by the division under this section shall
1616 require its providers or beneficiaries to use any pharmacy that
1617 ships, mails or delivers prescription drugs or legend drugs or
1618 devices.

1619 (I) [Deleted]

1620 (J) There shall be no cuts in inpatient and outpatient
1621 hospital payments, or allowable days or volumes, as long as the
1622 hospital assessment provided in Section 43-13-145 is in effect.
1623 This subsection (J) shall not apply to decreases in payments that
1624 are a result of: reduced hospital admissions, audits or payments
1625 under the APR-DRG or APC models, or a managed care program or
1626 similar model described in subsection (H) of this section.

1627 (K) This section shall stand repealed on *** July 1, 2020.

1628 **SECTION 5.** This act shall take effect and be in force from
1629 and after June 30, 2018.