REPORT OF CONFERENCE COMMITTEE

MR. PRESIDENT AND MR. SPEAKER:

We, the undersigned conferees, have had under consideration the amendments to the following entitled BILL:

S. B. No. 2836: Mississippi Medicaid program; revise services, provider reimbursement rates and extend repealer.

We, therefore, respectfully submit the following report and recommendation:

1. That the House recede from its Amendment No. 1.

2. That the Senate and House adopt the following amendment:

Amend by striking all after the enacting clause and inserting in lieu thereof the following:

66 **SECTION 1.** Section 43-13-117, Mississippi Code of 1972, is
67 amended as follows:
68 43-13-117. (A) Medicaid as authorized by this article shall
69 include payment of part or all of the costs, at the discretion of
70 the division, with approval of the Governor and the Centers for
71 Medicare and Medicaid Services, of the following types of care and
72 services rendered to eligible applicants who have been determined
73 to be eligible for that care and services, within the limits of
74 state appropriations and federal matching funds:
75 (1) Inpatient hospital services.
76 (a) The division shall allow thirty (30) days of
77 inpatient hospital care annually for all Medicaid recipients.
78 Medicaid recipients requiring transplants shall not have those
79 days included in the transplant hospital stay count against the

80 thirty-day limit for inpatient hospital care. Precertification of
81 inpatient days must be obtained as required by the division.
82 (b) From and after July 1, 1994, the Executive
83 Director of the Division of Medicaid shall amend the Mississippi
84 Title XIX Inpatient Hospital Reimbursement Plan to remove the
85 occupancy rate penalty from the calculation of the Medicaid
86 Capital Cost Component utilized to determine total hospital costs
87 allocated to the Medicaid program.
88 (c) Hospitals *** * *** <u>may</u> receive an additional
89 payment for the implantable programmable baclofen drug pump used
90 to treat spasticity that is implanted on an inpatient basis. The
91 payment pursuant to written invoice will be in addition to the
92 facility's per diem reimbursement and will represent a reduction
93 of costs on the facility's annual cost report, and shall not
94 exceed Ten Thousand Dollars ($10,000.00) per year per recipient.
95 (d) The division is authorized to implement an
96 All-Patient Refined-Diagnosis Related Groups (APR-DRG)
97 reimbursement methodology for inpatient hospital services.
98 (e) No service benefits or reimbursement
99 limitations in this section shall apply to payments under an
100 APR-DRG or Ambulatory Payment Classification (APC) model or a
101 managed care program or similar model described in subsection (H)
102 of this section <u>unless specifically authorized by the division</u>.
103 (2) Outpatient hospital services.
104 (a) Emergency services.

105 (b) Other outpatient hospital services. The
106 division shall allow benefits for other medically necessary
107 outpatient hospital services (such as chemotherapy, radiation,
108 surgery and therapy), including outpatient services in a clinic or
109 other facility that is not located inside the hospital, but that
110 has been designated as an outpatient facility by the hospital, and
111 that was in operation or under construction on July 1, 2009,
112 provided that the costs and charges associated with the operation
113 of the hospital clinic are included in the hospital's cost report.
114 In addition, the Medicare thirty-five-mile rule will apply to
115 those hospital clinics not located inside the hospital that are
116 constructed after July 1, 2009. Where the same services are
117 reimbursed as clinic services, the division may revise the rate or
118 methodology of outpatient reimbursement to maintain consistency,
119 efficiency, economy and quality of care.

120 (c) The division is authorized to implement an
121 Ambulatory Payment Classification (APC) methodology for outpatient
122 hospital services. <u>The division may give rural hospitals that</u>
123 <u>have fifty (50) or fewer licensed beds the option to not be</u>
124 <u>reimbursed for outpatient hospital services using the APC</u>
125 <u>methodology, but reimbursement for outpatient hospital services</u>
126 <u>provided by those hospitals shall be based on one hundred one</u>
127 <u>percent (101%) of the rate established under Medicare for</u>
128 <u>outpatient hospital services. Those hospitals choosing to not be</u>

129 reimbursed under the APC methodology shall remain under cost-based
130 reimbursement for a two-year period.
131 (d) No service benefits or reimbursement
132 limitations in this section shall apply to payments under an
133 APR-DRG or APC model or a managed care program or similar model
134 described in subsection (H) of this section.
135 (3) Laboratory and x-ray services.
136 (4) Nursing facility services.
137 (a) The division shall make full payment to
138 nursing facilities for each day, not exceeding * * * forty-two
139 (42) days per year, that a patient is absent from the facility on
140 home leave. Payment may be made for the following home leave days
141 in addition to the * * * forty-two-day limitation: Christmas, the
142 day before Christmas, the day after Christmas, Thanksgiving, the
143 day before Thanksgiving and the day after Thanksgiving.
144 (b) From and after July 1, 1997, the division
145 shall implement the integrated case-mix payment and quality
146 monitoring system, which includes the fair rental system for
147 property costs and in which recapture of depreciation is
148 eliminated. The division may reduce the payment for hospital
149 leave and therapeutic home leave days to the lower of the case-mix
150 category as computed for the resident on leave using the
151 assessment being utilized for payment at that point in time, or a
152 case-mix score of 1.000 for nursing facilities, and shall compute
153 case-mix scores of residents so that only services provided at the

154 nursing facility are considered in calculating a facility's per
155 diem.

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

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

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

178 (f) The division shall develop and implement an
179 assessment process for long-term care services. The division may
180 provide the assessment and related functions directly or through
181 contract with the area agencies on aging.
182 The division shall apply for necessary federal waivers to
183 assure that additional services providing alternatives to nursing
184 facility care are made available to applicants for nursing
185 facility care.
186 (5) Periodic screening and diagnostic services for
187 individuals under age twenty-one (21) years as are needed to
188 identify physical and mental defects and to provide health care
189 treatment and other measures designed to correct or ameliorate
190 defects and physical and mental illness and conditions discovered
191 by the screening services, regardless of whether these services
192 are included in the state plan. The division may include in its
193 periodic screening and diagnostic program those discretionary
194 services authorized under the federal regulations adopted to
195 implement Title XIX of the federal Social Security Act, as
196 amended. The division, in obtaining physical therapy services,
197 occupational therapy services, and services for individuals with
198 speech, hearing and language disorders, may enter into a
199 cooperative agreement with the State Department of Education for
200 the provision of those services to handicapped students by public
201 school districts using state funds that are provided from the
202 appropriation to the Department of Education to obtain federal

203 matching funds through the division. The division, in obtaining
204 medical and mental health assessments, treatment, care and
205 services for children who are in, or at risk of being put in, the
206 custody of the Mississippi Department of Human Services may enter
207 into a cooperative agreement with the Mississippi Department of
208 Human Services for the provision of those services using state
209 funds that are provided from the appropriation to the Department
210 of Human Services to obtain federal matching funds through the
211 division.
212 (6) Physician's services. * * * Physician visits as
213 determined by the division and in accordance with federal laws and
214 regulations. The division may develop and implement a different
215 reimbursement model or schedule for physician's services provided
216 by physicians based at an academic health care center and by
217 physicians at rural health centers that are associated with an
218 academic health care center. From and after January 1, 2010, all
219 fees for physician's services that are covered only by Medicaid
220 shall be increased to ninety percent (90%) of the rate established
221 on January 1, * * * 2018, and as may be adjusted each July
222 thereafter, under Medicare. The division may provide for a
223 reimbursement rate for physician's services of up to one hundred
224 percent (100%) of the rate established under Medicare for
225 physician's services that are provided after the normal working
226 hours of the physician, as determined in accordance with
227 regulations of the division. The division may reimburse eligible

228 providers as determined by the Patient Protection and Affordable
229 Care Act for certain primary care services as defined by the act
230 at one hundred percent (100%) of the rate established under
231 Medicare. Additionally, the division shall reimburse
232 obstetricians and gynecologists for certain primary care services
233 as defined by the division at one hundred percent (100%) of the
234 rate established under Medicare.
235 (7) (a) Home health services for eligible persons, not
236 to exceed in cost the prevailing cost of nursing facility
237 services *** * ***. All home health visits must be precertified as
238 required by the division.
239 (b) [Repealed]
240 (8) Emergency medical transportation services as
241 determined by the division. *** * ***
242 (9) *** * *** Prescription drugs and other covered drugs
243 and services as may be determined by the division.
244 The division shall establish a mandatory preferred drug list.
245 Drugs not on the mandatory preferred drug list shall be made
246 available by utilizing prior authorization procedures established
247 by the division.
248 The division may seek to establish relationships with other
249 states in order to lower acquisition costs of prescription drugs
250 to include single source and innovator multiple source drugs or
251 generic drugs. In addition, if allowed by federal law or
252 regulation, the division may seek to establish relationships with

253 and negotiate with other countries to facilitate the acquisition
254 of prescription drugs to include single source and innovator
255 multiple source drugs or generic drugs, if that will lower the
256 acquisition costs of those prescription drugs.

257 The division *** * *** <u>may</u> allow for a combination of
258 prescriptions for single source and innovator multiple source
259 drugs and generic drugs to meet the needs of the
260 beneficiaries *** * ***.

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

264 Drugs prescribed for a resident of a psychiatric residential
265 treatment facility must be provided in true unit doses when
266 available. The division may require that drugs not covered by
267 Medicare Part D for a resident of a long-term care facility be
268 provided in true unit doses when available. Those drugs that were
269 originally billed to the division but are not used by a resident
270 in any of those facilities shall be returned to the billing
271 pharmacy for credit to the division, in accordance with the
272 guidelines of the State Board of Pharmacy and any requirements of
273 federal law and regulation. Drugs shall be dispensed to a
274 recipient and only one (1) dispensing fee per month may be
275 charged. The division shall develop a methodology for reimbursing
276 for restocked drugs, which shall include a restock fee as

277 determined by the division not exceeding Seven Dollars and
278 Eighty-two Cents ($7.82).
279 *** * ***
280 Except for those specific maintenance drugs approved by the
281 executive director, the division shall not reimburse for any
282 portion of a prescription that exceeds a thirty-one-day supply of
283 the drug based on the daily dosage.
284 The division *** * *** is authorized to develop and implement a
285 program of payment for additional pharmacist services *** * *** as may
286 be determined by the division.
287 All claims for drugs for dually eligible Medicare/Medicaid
288 beneficiaries that are paid for by Medicare must be submitted to
289 Medicare for payment before they may be processed by the
290 division's online payment system.
291 The division shall develop a pharmacy policy in which drugs
292 in tamper-resistant packaging that are prescribed for a resident
293 of a nursing facility but are not dispensed to the resident shall
294 be returned to the pharmacy and not billed to Medicaid, in
295 accordance with guidelines of the State Board of Pharmacy.
296 The division shall develop and implement a method or methods
297 by which the division will provide on a regular basis to Medicaid
298 providers who are authorized to prescribe drugs, information about
299 the costs to the Medicaid program of single source drugs and
300 innovator multiple source drugs, and information about other drugs
301 that may be prescribed as alternatives to those single source

302 drugs and innovator multiple source drugs and the costs to the
303 Medicaid program of those alternative drugs.

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

309 *** * ***

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

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

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

321 <u>The division may allow certain drugs, implantable drug system</u>
322 <u>devices, and medical supplies, with limited distribution or</u>
323 <u>limited access for beneficiaries and administered in an</u>
324 <u>appropriate clinical setting, to be reimbursed as either a medical</u>
325 <u>claim or pharmacy claim, as determined by the division.</u>

326 Notwithstanding any other provision of this article, the
327 division shall allow physician-administered drugs to be billed and
328 reimbursed as either a medical claim or pharmacy point-of-sale to
329 allow greater access to care.
330 It is the intent of the Legislature that the division and any
331 managed care entity described in subsection (H) of this section
332 encourage the use of Alpha-Hydroxyprogesterone Caproate (17P) to
333 prevent recurrent preterm birth.
334 (10) * * * Dental and orthodontic services to be
335 determined by the division.
336 This dental services * * * program under this paragraph shall
337 be known as the "James Russell Dumas Medicaid Dental * * *
338 Services Program."
339 The * * * Medical Care Advisory Committee, assisted by the
340 Division of Medicaid, shall annually determine the effect of this
341 incentive by evaluating the number of dentists who are Medicaid
342 providers, the number who and the degree to which they are
343 actively billing Medicaid, the geographic trends of where dentists
344 are offering what types of Medicaid services and other statistics
345 pertinent to the goals of this legislative intent. This data
346 shall annually be presented to the Chair of the Senate * * *
347 Medicaid Committee and the Chair of the House Medicaid Committee.
348 * * *

349 *** * *** The division shall include dental services as a
350 necessary component of overall health services provided to
351 children who are eligible for services.
352 *** * ***
353 (11) Eyeglasses for all Medicaid beneficiaries who have
354 (a) had surgery on the eyeball or ocular muscle that results in a
355 vision change for which eyeglasses or a change in eyeglasses is
356 medically indicated within six (6) months of the surgery and is in
357 accordance with policies established by the division, or (b) one
358 (1) pair every five (5) years and in accordance with policies
359 established by the division. In either instance, the eyeglasses
360 must be prescribed by a physician skilled in diseases of the eye
361 or an optometrist, whichever the beneficiary may select.
362 (12) Intermediate care facility services.
363 (a) The division shall make full payment to all
364 intermediate care facilities for individuals with intellectual
365 disabilities for each day, not exceeding *** * *** <u>sixty-three (63)</u>
366 days per year, that a patient is absent from the facility on home
367 leave. Payment may be made for the following home leave days in
368 addition to the *** * *** <u>sixty-three-day</u> limitation: Christmas, the
369 day before Christmas, the day after Christmas, Thanksgiving, the
370 day before Thanksgiving and the day after Thanksgiving.
371 (b) All state-owned intermediate care facilities
372 for individuals with intellectual disabilities shall be reimbursed
373 on a full reasonable cost basis.

374 (c) Effective January 1, 2015, the division shall
375 update the fair rental reimbursement system for intermediate care
376 facilities for individuals with intellectual disabilities.
377 (13) Family planning services, including drugs,
378 supplies and devices, when those services are under the
379 supervision of a physician or nurse practitioner.
380 (14) Clinic services. Such diagnostic, preventive,
381 therapeutic, rehabilitative or palliative services furnished to an
382 outpatient by or under the supervision of a physician or dentist
383 in a facility that is not a part of a hospital but that is
384 organized and operated to provide medical care to outpatients.
385 Clinic services shall include any services reimbursed as
386 outpatient hospital services that may be rendered in such a
387 facility, including those that become so after July 1, 1991. On
388 July 1, 1999, all fees for physicians' services reimbursed under
389 authority of this paragraph (14) shall be reimbursed at ninety
390 percent (90%) of the rate established on January 1, 1999, and as
391 may be adjusted each July thereafter, under Medicare (Title XVIII
392 of the federal Social Security Act, as amended). The division may
393 develop and implement a different reimbursement model or schedule
394 for physician's services provided by physicians based at an
395 academic health care center and by physicians at rural health
396 centers that are associated with an academic health care center.
397 The division may provide for a reimbursement rate for physician's
398 clinic services of up to one hundred percent (100%) of the rate

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

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

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

411 (16) Mental health services. Certain services provided
412 by a psychiatrist shall be reimbursed at up to one hundred percent
413 (100%) of the Medicare rate. Approved therapeutic and case
414 management services (a) provided by an approved regional mental
415 health/intellectual disability center established under Sections
416 41-19-31 through 41-19-39, or by another community mental health
417 service provider meeting the requirements of the Department of
418 Mental Health to be an approved mental health/intellectual
419 disability center if determined necessary by the Department of
420 Mental Health, using state funds that are provided in the
421 appropriation to the division to match federal funds, or (b)
422 provided by a facility that is certified by the State Department
423 of Mental Health to provide therapeutic and case management

424 services, to be reimbursed on a fee for service basis, or (c)
425 provided in the community by a facility or program operated by the
426 Department of Mental Health. Any such services provided by a
427 facility described in subparagraph (b) must have the prior
428 approval of the division to be reimbursable under this
429 section. *** * ***

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

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

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

474 the physician UPL payments. As provided in the Medicaid state
475 plan amendment or amendments as defined in Section 43-13-145(10),
476 the division shall make additional reimbursement to hospitals and,
477 if the program is established for nursing facilities, shall make
478 additional reimbursement to nursing facilities, for the Medicare
479 Upper Payment Limits, and, if the program is established for
480 physicians, shall make additional reimbursement for physicians, as
481 defined in Section 1902(a)(30) of the federal Social Security Act
482 and any applicable federal regulations. Notwithstanding any other
483 provision of this article to the contrary, effective upon
484 implementation of the Mississippi Hospital Access Program (MHAP)
485 provided in subparagraph (c)(i) below, the hospital portion of the
486 inpatient Upper Payment Limits Program shall transition into and
487 be replaced by the MHAP program. However, the division is
488 authorized to develop and implement an alternative fee for service
489 Upper Payment Limits model in accordance with federal laws and
490 regulations if necessary to preserve supplemental funding.
491 Further, the division, in consultation with the Mississippi
492 Hospital Association and a governmental hospital located in a
493 county bordering the Gulf of Mexico and the State of Alabama shall
494 develop alternative models for distribution of medical claims and
495 supplemental payments for inpatient and outpatient hospital
496 services, and such models may include, but shall not be limited to
497 the following: increasing rates for inpatient and outpatient
498 services; creating a low income utilization pool of funds to

499 reimburse hospitals for the costs of uncompensated care, charity
500 care and bad debts as permitted and approved pursuant to federal
501 regulations and the Centers for Medicare and Medicaid Services;
502 supplemental payments based upon Medicaid utilization, quality,
503 service lines and/or costs of providing such services to Medicaid
504 beneficiaries and to uninsured patients. The goals of such
505 payment models shall be to ensure access to inpatient and
506 outpatient care and to maximize any federal funds that are
507 available to reimburse hospitals for services provided. Any such
508 documents required to achieve the goals described in this
509 paragraph shall be submitted to the Centers for Medicare and
510 Medicaid Services, with a proposed effective date of July 1, 2019,
511 to the extent possible, but in no event shall the effective date
512 of such payment models be later than July 1, 2020. The Chairmen
513 of the Senate and House Medicaid Committees shall be provided a
514 copy of the proposed payment model(s) prior to submission.
515 Effective July 1, 2018, and until such time as any payment
516 model(s) as described above become effective, the division, in
517 consultation with the Mississippi Hospital Association and a
518 governmental hospital located in a county bordering the Gulf of
519 Mexico and the State of Alabama is authorized to implement a
520 transitional program for inpatient and outpatient payments and/or
521 supplemental payments (including but not limited to MHAP and
522 directed payments), to redistribute available supplemental funds
523 among hospital providers, provided that when compared to a

524 hospital's prior year supplemental payments, supplemental payments
525 made pursuant to any such transitional program shall not result in
526 a decrease of more than five percent (5%) and shall not increase
527 by more than the amount needed to maximize the distribution of the
528 available funds.

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

544 (ii) Subject only to approval by the Centers
545 for Medicare and Medicaid Services (CMS) where required, the MHAP
546 shall provide increased inpatient capitation (PMPM) payments to
547 managed care entities contracting with the division pursuant to
548 subsection (H) of this section to support availability of hospital

549 services or such other payments permissible under federal law
550 necessary to accomplish the intent of this subsection. * * *
551 (iii) The intent of this subparagraph (c) is
552 that effective for all inpatient hospital Medicaid services during
553 state fiscal year 2016, and so long as this provision shall remain
554 in effect hereafter, the division shall to the fullest extent
555 feasible replace the additional reimbursement for hospital
556 inpatient services under the inpatient Medicare Upper Payment
557 Limits (UPL) Program with additional reimbursement under the MHAP
558 and other payment programs for inpatient and/or outpatient
559 payments which may be developed under the authority of this
560 paragraph.
561 (iv) The division shall assess each hospital
562 as provided in Section 43-13-145(4)(a) for the purpose of
563 financing the state portion of the MHAP, supplemental payments and
564 such other purposes as specified in Section 43-13-145. The
565 assessment will remain in effect as long as the MHAP * * * and
566 supplemental payments are in effect.
567 * * *
568 (19) (a) Perinatal risk management services. The
569 division shall promulgate regulations to be effective from and
570 after October 1, 1988, to establish a comprehensive perinatal
571 system for risk assessment of all pregnant and infant Medicaid
572 recipients and for management, education and follow-up for those
573 who are determined to be at risk. Services to be performed

574 include case management, nutrition assessment/counseling,
575 psychosocial assessment/counseling and health education. The
576 division shall contract with the State Department of Health to
577 provide the services within this paragraph (Perinatal High Risk
578 Management/Infant Services System (PHRM/ISS)). The State
579 Department of Health as the agency for PHRM/ISS for the Division
580 of Medicaid shall be reimbursed on a full reasonable cost basis.
581 (b) Early intervention system services. The
582 division shall cooperate with the State Department of Health,
583 acting as lead agency, in the development and implementation of a
584 statewide system of delivery of early intervention services, under
585 Part C of the Individuals with Disabilities Education Act (IDEA).
586 The State Department of Health shall certify annually in writing
587 to the executive director of the division the dollar amount of
588 state early intervention funds available that will be utilized as
589 a certified match for Medicaid matching funds. Those funds then
590 shall be used to provide expanded targeted case management
591 services for Medicaid eligible children with special needs who are
592 eligible for the state's early intervention system.
593 Qualifications for persons providing service coordination shall be
594 determined by the State Department of Health and the Division of
595 Medicaid.
596 (20) Home- and community-based services for physically
597 disabled approved services as allowed by a waiver from the United
598 States Department of Health and Human Services for home- and

599 community-based services for physically disabled people using
600 state funds that are provided from the appropriation to the State
601 Department of Rehabilitation Services and used to match federal
602 funds under a cooperative agreement between the division and the
603 department, provided that funds for these services are
604 specifically appropriated to the Department of Rehabilitation
605 Services.

606 (21) Nurse practitioner services. Services furnished
607 by a registered nurse who is licensed and certified by the
608 Mississippi Board of Nursing as a nurse practitioner, including,
609 but not limited to, nurse anesthetists, nurse midwives, family
610 nurse practitioners, family planning nurse practitioners,
611 pediatric nurse practitioners, obstetrics-gynecology nurse
612 practitioners and neonatal nurse practitioners, under regulations
613 adopted by the division. Reimbursement for those services shall
614 not exceed ninety percent (90%) of the reimbursement rate for
615 comparable services rendered by a physician. The division may
616 provide for a reimbursement rate for nurse practitioner services
617 of up to one hundred percent (100%) of the reimbursement rate for
618 comparable services rendered by a physician for nurse practitioner
619 services that are provided after the normal working hours of the
620 nurse practitioner, as determined in accordance with regulations
621 of the division.

622 (22) Ambulatory services delivered in federally
623 qualified health centers, rural health centers and clinics of the

624 local health departments of the State Department of Health for
625 individuals eligible for Medicaid under this article based on
626 reasonable costs as determined by the division. <u>Federally</u>
627 <u>qualified health centers shall be reimbursed by the Medicaid</u>
628 <u>prospective payment system as approved by the Centers for Medicare</u>
629 <u>and Medicaid Services.</u>
630 (23) Inpatient psychiatric services. Inpatient
631 psychiatric services to be determined by the division for
632 recipients under age twenty-one (21) that are provided under the
633 direction of a physician in an inpatient program in a licensed
634 acute care psychiatric facility or in a licensed psychiatric
635 residential treatment facility, before the recipient reaches age
636 twenty-one (21) or, if the recipient was receiving the services
637 immediately before he or she reached age twenty-one (21), before
638 the earlier of the date he or she no longer requires the services
639 or the date he or she reaches age twenty-two (22), as provided by
640 federal regulations. From and after January 1, 2015, the division
641 shall update the fair rental reimbursement system for psychiatric
642 residential treatment facilities. Precertification of inpatient
643 days and residential treatment days must be obtained as required
644 by the division. From and after July 1, 2009, all state-owned and
645 state-operated facilities that provide inpatient psychiatric
646 services to persons under age twenty-one (21) who are eligible for
647 Medicaid reimbursement shall be reimbursed for those services on a
648 full reasonable cost basis.

649 (24) [Deleted]

650 (25) [Deleted]

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

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

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

669 (29) The Division of Medicaid may apply for a waiver
670 from the United States Department of Health and Human Services for
671 home- and community-based services for developmentally disabled
672 people using state funds that are provided from the appropriation
673 to the State Department of Mental Health and/or funds transferred

674 to the department by a political subdivision or instrumentality of
675 the state and used to match federal funds under a cooperative
676 agreement between the division and the department, provided that
677 funds for these services are specifically appropriated to the
678 Department of Mental Health and/or transferred to the department
679 by a political subdivision or instrumentality of the state.
680 (30) Pediatric skilled nursing services for eligible
681 persons under twenty-one (21) years of age.
682 (31) Targeted case management services for children
683 with special needs, under waivers from the United States
684 Department of Health and Human Services, using state funds that
685 are provided from the appropriation to the Mississippi Department
686 of Human Services and used to match federal funds under a
687 cooperative agreement between the division and the department.
688 (32) Care and services provided in Christian Science
689 Sanatoria listed and certified by the Commission for Accreditation
690 of Christian Science Nursing Organizations/Facilities, Inc.,
691 rendered in connection with treatment by prayer or spiritual means
692 to the extent that those services are subject to reimbursement
693 under Section 1903 of the federal Social Security Act.
694 (33) Podiatrist services.
695 (34) Assisted living services as provided through
696 home- and community-based services under Title XIX of the federal
697 Social Security Act, as amended, subject to the availability of

698 funds specifically appropriated for that purpose by the
699 Legislature.
700 (35) Services and activities authorized in Sections
701 43-27-101 and 43-27-103, using state funds that are provided from
702 the appropriation to the Mississippi Department of Human Services
703 and used to match federal funds under a cooperative agreement
704 between the division and the department.
705 (36) Nonemergency transportation services for
706 Medicaid-eligible persons, to be provided by the Division of
707 Medicaid. The division may contract with additional entities to
708 administer nonemergency transportation services as it deems
709 necessary. All providers shall have a valid driver's
710 license, *** * *** valid vehicle license tags and a standard liability
711 insurance policy covering the vehicle. The division may pay
712 providers a flat fee based on mileage tiers, or in the
713 alternative, may reimburse on actual miles traveled. The division
714 may apply to the Center for Medicare and Medicaid Services (CMS)
715 for a waiver to draw federal matching funds for nonemergency
716 transportation services as a covered service instead of an
717 administrative cost. The PEER Committee shall conduct a
718 performance evaluation of the nonemergency transportation program
719 to evaluate the administration of the program and the providers of
720 transportation services to determine the most cost-effective ways
721 of providing nonemergency transportation services to the patients
722 served under the program. The performance evaluation shall be

723 completed and provided to the members of the Senate *** * *** <u>Medicaid</u>
724 Committee and the House Medicaid Committee not later than
725 January *** * *** <u>1, 2019, and every two (2) years thereafter</u>.
726 (37) [Deleted]
727 (38) Chiropractic services. A chiropractor's manual
728 manipulation of the spine to correct a subluxation, if x-ray
729 demonstrates that a subluxation exists and if the subluxation has
730 resulted in a neuromusculoskeletal condition for which
731 manipulation is appropriate treatment, and related spinal x-rays
732 performed to document these conditions. Reimbursement for
733 chiropractic services shall not exceed Seven Hundred Dollars
734 ($700.00) per year per beneficiary.
735 (39) Dually eligible Medicare/Medicaid beneficiaries.
736 The division shall pay the Medicare deductible and coinsurance
737 amounts for services available under Medicare, as determined by
738 the division. From and after July 1, 2009, the division shall
739 reimburse crossover claims for inpatient hospital services and
740 crossover claims covered under Medicare Part B in the same manner
741 that was in effect on January 1, 2008, unless specifically
742 authorized by the Legislature to change this method.
743 (40) [Deleted]
744 (41) Services provided by the State Department of
745 Rehabilitation Services for the care and rehabilitation of persons
746 with spinal cord injuries or traumatic brain injuries, as allowed
747 under waivers from the United States Department of Health and

748 Human Services, using up to seventy-five percent (75%) of the
749 funds that are appropriated to the Department of Rehabilitation
750 Services from the Spinal Cord and Head Injury Trust Fund
751 established under Section 37-33-261 and used to match federal
752 funds under a cooperative agreement between the division and the
753 department.

754 (42) *** * *** [Deleted]

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

760 (44) Nursing facility services for the severely
761 disabled.

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

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

768 (45) Physician assistant services. Services furnished
769 by a physician assistant who is licensed by the State Board of
770 Medical Licensure and is practicing with physician supervision
771 under regulations adopted by the board, under regulations adopted
772 by the division. Reimbursement for those services shall not

773 exceed ninety percent (90%) of the reimbursement rate for
774 comparable services rendered by a physician. The division may
775 provide for a reimbursement rate for physician assistant services
776 of up to one hundred percent (100%) or the reimbursement rate for
777 comparable services rendered by a physician for physician
778 assistant services that are provided after the normal working
779 hours of the physician assistant, as determined in accordance with
780 regulations of the division.

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

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

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

798 individual. An individual must affirmatively elect to participate
799 in the disease management program in order to participate, and may
800 elect to discontinue participation in the program at any time.
801 (48) Pediatric long-term acute care hospital services.
802 (a) Pediatric long-term acute care hospital
803 services means services provided to eligible persons under
804 twenty-one (21) years of age by a freestanding Medicare-certified
805 hospital that has an average length of inpatient stay greater than
806 twenty-five (25) days and that is primarily engaged in providing
807 chronic or long-term medical care to persons under twenty-one (21)
808 years of age.
809 (b) The services under this paragraph (48) shall
810 be reimbursed as a separate category of hospital services.
811 (49) The division shall establish copayments and/or
812 coinsurance for all Medicaid services for which copayments and/or
813 coinsurance are allowable under federal law or regulation *** * ***.
814 (50) Services provided by the State Department of
815 Rehabilitation Services for the care and rehabilitation of persons
816 who are deaf and blind, as allowed under waivers from the United
817 States Department of Health and Human Services to provide home-
818 and community-based services using state funds that are provided
819 from the appropriation to the State Department of Rehabilitation
820 Services or if funds are voluntarily provided by another agency.
821 (51) Upon determination of Medicaid eligibility and in
822 association with annual redetermination of Medicaid eligibility,

823 beneficiaries shall be encouraged to undertake a physical
824 examination that will establish a base-line level of health and
825 identification of a usual and customary source of care (a medical
826 home) to aid utilization of disease management tools. This
827 physical examination and utilization of these disease management
828 tools shall be consistent with current United States Preventive
829 Services Task Force or other recognized authority recommendations.
830 For persons who are determined ineligible for Medicaid, the
831 division will provide information and direction for accessing
832 medical care and services in the area of their residence.
833 (52) Notwithstanding any provisions of this article,
834 the division may pay enhanced reimbursement fees related to trauma
835 care, as determined by the division in conjunction with the State
836 Department of Health, using funds appropriated to the State
837 Department of Health for trauma care and services and used to
838 match federal funds under a cooperative agreement between the
839 division and the State Department of Health. The division, in
840 conjunction with the State Department of Health, may use grants,
841 waivers, demonstrations, or other projects as necessary in the
842 development and implementation of this reimbursement program.
843 (53) Targeted case management services for high-cost
844 beneficiaries *** * *** may be developed by the division for all
845 services under this section.
846 (54) *** * *** [Deleted]

847 (55) Therapy services. The plan of care for therapy
848 services may be developed to cover a period of treatment for up to
849 six (6) months, but in no event shall the plan of care exceed a
850 six-month period of treatment. The projected period of treatment
851 must be indicated on the initial plan of care and must be updated
852 with each subsequent revised plan of care. Based on medical
853 necessity, the division shall approve certification periods for
854 less than or up to six (6) months, but in no event shall the
855 certification period exceed the period of treatment indicated on
856 the plan of care. The appeal process for any reduction in therapy
857 services shall be consistent with the appeal process in federal
858 regulations.
859 (56) Prescribed pediatric extended care centers
860 services for medically dependent or technologically dependent
861 children with complex medical conditions that require continual
862 care as prescribed by the child's attending physician, as
863 determined by the division.
864 (57) No Medicaid benefit shall restrict coverage for
865 medically appropriate treatment prescribed by a physician and
866 agreed to by a fully informed individual, or if the individual
867 lacks legal capacity to consent by a person who has legal
868 authority to consent on his or her behalf, based on an
869 individual's diagnosis with a terminal condition. As used in this
870 paragraph (57), "terminal condition" means any aggressive
871 malignancy, chronic end-stage cardiovascular or cerebral vascular

872 disease, or any other disease, illness or condition which a
873 physician diagnoses as terminal.
874 (58) Treatment services for persons with opioid
875 dependency. The division is authorized to reimburse eligible
876 providers for treatment of opioid dependency, as determined by the
877 division. Treatment related to these conditions shall not count
878 against any physician visit limit imposed under this section.
879 (59) The division shall allow beneficiaries between the
880 ages of ten (10) and eighteen (18) years to receive vaccines
881 through a pharmacy venue.
882 (B) Notwithstanding any other provision of this article to
883 the contrary, the division shall reduce the rate of reimbursement
884 to providers for any service provided under this section by five
885 percent (5%) of the allowed amount for that service. However, the
886 reduction in the reimbursement rates required by this subsection
887 (B) shall not apply to inpatient hospital services, outpatient
888 hospital services, nursing facility services, intermediate care
889 facility services, psychiatric residential treatment facility
890 services, pharmacy services provided under subsection (A)(9) of
891 this section, or any service provided by the University of
892 Mississippi Medical Center or a state agency, a state facility or
893 a public agency that either provides its own state match through
894 intergovernmental transfer or certification of funds to the
895 division, or a service for which the federal government sets the
896 reimbursement methodology and rate. From and after January 1,

897 2010, the reduction in the reimbursement rates required by this
898 subsection (B) shall not apply to physicians' services. In
899 addition, the reduction in the reimbursement rates required by
900 this subsection (B) shall not apply to case management services
901 and home-delivered meals provided under the home- and
902 community-based services program for the elderly and disabled by a
903 planning and development district (PDD). Planning and development
904 districts participating in the home- and community-based services
905 program for the elderly and disabled as case management providers
906 shall be reimbursed for case management services at the maximum
907 rate approved by the Centers for Medicare and Medicaid Services
908 (CMS). <u>The Medical Care Advisory Committee established in Section</u>
909 <u>43-13-107(3)(a) shall develop a study and advise the division with</u>
910 <u>respect to (1) determining the effect of any across-the-board five</u>
911 <u>percent (5%) reduction in the rate of reimbursement to providers</u>
912 <u>authorized under this subsection (B), and (2) comparing provider</u>
913 <u>reimbursement rates to those applicable in other states in order</u>
914 <u>to establish a fair and equitable provider reimbursement structure</u>
915 <u>that encourages participation in the Medicaid program, and (3)</u>
916 <u>comparing dental and orthodontic services reimbursement rates to</u>
917 <u>those applicable in other states in fee-for-service and in managed</u>
918 <u>care programs in order to establish a fair and equitable dental</u>
919 <u>provider reimbursement structure that encourages participation in</u>
920 <u>the Medicaid program, and (4) make a report thereon with any</u>

921 legislative recommendations to the Chairmen of the Senate and
922 House Medicaid Committees prior to January 1, 2019.
923 (C) The division may pay to those providers who participate
924 in and accept patient referrals from the division's emergency room
925 redirection program a percentage, as determined by the division,
926 of savings achieved according to the performance measures and
927 reduction of costs required of that program. Federally qualified
928 health centers may participate in the emergency room redirection
929 program, and the division may pay those centers a percentage of
930 any savings to the Medicaid program achieved by the centers'
931 accepting patient referrals through the program, as provided in
932 this subsection (C).
933 (D) * * * [Deleted]
934 (E) Notwithstanding any provision of this article, no new
935 groups or categories of recipients and new types of care and
936 services may be added without enabling legislation from the
937 Mississippi Legislature, except that the division may authorize
938 those changes without enabling legislation when the addition of
939 recipients or services is ordered by a court of proper authority.
940 (F) The executive director shall keep the Governor advised
941 on a timely basis of the funds available for expenditure and the
942 projected expenditures. Notwithstanding any other provisions of
943 this article, if current or projected expenditures of the division
944 are reasonably anticipated to exceed the amount of funds
945 appropriated to the division for any fiscal year, the Governor,

946 after consultation with the executive director, shall * * * take
947 all appropriate measures to reduce costs, which may include, but
948 are not limited to:
949 (1) Reducing or discontinuing any or all services that
950 are deemed to be optional under Title XIX of the Social Security
951 Act;
952 (2) Reducing reimbursement rates for any or all service
953 types;
954 (3) Imposing additional assessments on health care
955 providers; or
956 (4) Any additional cost-containment measures deemed
957 appropriate by the Governor.
958 Beginning in fiscal year 2010 and in fiscal years thereafter,
959 when Medicaid expenditures are projected to exceed funds available
960 for * * * the fiscal year, the division shall submit the expected
961 shortfall information to the PEER Committee * * * not later than
962 December 1 of the year in which the shortfall is projected to
963 occur. PEER shall review the computations of the division and
964 report its findings to the Legislative Budget Office * * * not
965 later than January 7 in any year. * * *
966 (G) Notwithstanding any other provision of this article, it
967 shall be the duty of each * * * provider participating in the
968 Medicaid program to keep and maintain books, documents and other
969 records as prescribed by the Division of Medicaid in
970 substantiation of its cost reports for a period of three (3) years

971 after the date of submission to the Division of Medicaid of an
972 original cost report, or three (3) years after the date of
973 submission to the Division of Medicaid of an amended cost report.
974 (H) (1) Notwithstanding any other provision of this
975 article, the division is authorized to implement (a) a managed
976 care program, (b) a coordinated care program, (c) a coordinated
977 care organization program, (d) a health maintenance organization
978 program, (e) a patient-centered medical home program, (f) an
979 accountable care organization program, (g) provider-sponsored
980 health plan, or (h) any combination of the above programs.
981 Managed care programs, coordinated care programs, coordinated care
982 organization programs, health maintenance organization programs,
983 patient-centered medical home programs, accountable care
984 organization programs, provider-sponsored health plans, or any
985 combination of the above programs or other similar programs
986 implemented by the division under this section shall be limited to
987 the greater of (i) forty-five percent (45%) of the total
988 enrollment of Medicaid beneficiaries, or (ii) the categories of
989 beneficiaries participating in the program as of January 1, 2014,
990 plus the categories of beneficiaries composed primarily of persons
991 younger than nineteen (19) years of age, and the division is
992 authorized to enroll categories of beneficiaries in such
993 program(s) as long as the appropriate limitations are not exceeded
994 in the aggregate. As a condition for the approval of any program

995 under this subsection (H)(1), the division shall require that no
996 program may:
997 (a) Pay providers at a rate that is less than the
998 Medicaid All-Patient Refined-Diagnosis Related Groups (APR-DRG)
999 reimbursement rate;
1000 (b) Override the medical decisions of hospital
1001 physicians or staff regarding patients admitted to a hospital for
1002 an emergency medical condition as defined by 42 US Code Section
1003 1395dd. This restriction (b) does not prohibit the retrospective
1004 review of the appropriateness of the determination that an
1005 emergency medical condition exists by chart review or coding
1006 algorithm, nor does it prohibit prior authorization for
1007 nonemergency hospital admissions;
1008 (c) Pay providers at a rate that is less than the
1009 normal Medicaid reimbursement rate *** * ***. <u>It is the intent of the</u>
1010 <u>Legislature that all managed care entities described in this</u>
1011 <u>subsection (H), in collaboration with the division, develop and</u>
1012 <u>implement innovative payment models that incentivize improvements</u>
1013 <u>in health care quality, outcomes, or value, as determined by the</u>
1014 <u>division.</u> Participation in the provider network of any managed
1015 care, coordinated care, provider-sponsored health plan, or similar
1016 contractor shall not be conditioned on the provider's agreement to
1017 accept such alternative payment models;
1018 (d) Implement a prior authorization program for
1019 prescription drugs that is more stringent than the prior

1020 authorization processes used by the division in its administration
1021 of the Medicaid program;
1022 (e) * * * [Deleted]
1023 (f) Implement a preferred drug list that is more
1024 stringent than the mandatory preferred drug list established by
1025 the division under subsection (A)(9) of this section;
1026 (g) Implement a policy which denies beneficiaries
1027 with hemophilia access to the federally funded hemophilia
1028 treatment centers as part of the Medicaid Managed Care network of
1029 providers. All Medicaid beneficiaries with hemophilia shall
1030 receive unrestricted access to anti-hemophilia factor products
1031 through noncapitated reimbursement programs.
1032 (2) Notwithstanding any provision of this section, no
1033 expansion of Medicaid managed care program contracts may be
1034 implemented by the division without enabling legislation from the
1035 Mississippi Legislature. There is hereby established the
1036 Commission on Expanding Medicaid Managed Care to develop a
1037 recommendation to the Legislature and the Division of Medicaid
1038 relative to authorizing the division to expand Medicaid managed
1039 care contracts to include additional categories of
1040 Medicaid-eligible beneficiaries, and to study the feasibility of
1041 developing an alternative managed care payment model for medically
1042 complex children.
1043 (a) The members of the commission shall be as
1044 follows:

1045 (i) The Chairmen of the Senate Medicaid
1046 Committee and the Senate Appropriations Committee and a member of
1047 the Senate appointed by the Lieutenant Governor;
1048 (ii) The Chairmen of the House Medicaid
1049 Committee and the House Appropriations Committee and a member of
1050 the House of Representatives appointed by the Speaker of the
1051 House;
1052 (iii) The Executive Director of the Division
1053 of Medicaid, Office of the Governor;
1054 (iv) The Commissioner of the Mississippi
1055 Department of Insurance;
1056 (v) A representative of a hospital that
1057 operates in Mississippi, appointed by the Speaker of the House;
1058 (vi) A licensed physician appointed by the
1059 Lieutenant Governor;
1060 (vii) A licensed pharmacist appointed by the
1061 Governor;
1062 (viii) A licensed mental health professional
1063 or alcohol and drug counselor appointed by the Governor;
1064 (ix) The Executive Director of the
1065 Mississippi State Medical Association (MSMA);
1066 (x) Representatives of each of the current
1067 managed care organizations operated in the state appointed by the
1068 Governor; and

1069 (xi) A representative of the long-term care
1070 industry appointed by the Governor.
1071 (b) The commission shall meet within forty-five
1072 (45) days of the effective date of this section, upon the call of
1073 the Governor, and shall evaluate the Medicaid managed care
1074 program. Specifically the commission shall:
1075 (i) Review the program's financial metrics;
1076 (ii) Review the program's product offerings;
1077 (iii) Review the program's impact on
1078 insurance premiums for individuals and small businesses;
1079 (iv) Make recommendations for future managed
1080 care program modifications;
1081 (v) Determine whether the expansion of the
1082 Medicaid managed care program may endanger the access to care by
1083 vulnerable patients;
1084 (vi) Review the financial feasibility and
1085 health outcomes of populations health management as specifically
1086 provided in paragraph (2) above;
1087 (vii) Make recommendations regarding a pilot
1088 program to evaluate an alternative managed care payment model for
1089 medically complex children;
1090 (viii) The commission may request the
1091 assistance of the PEER Committee in making its evaluation; and

1092 (ix) The commission shall solicit information
1093 from any person or entity the commission deems relevant to its
1094 study.
1095 (c) The members of the commission shall elect a
1096 chair from among the members. The commission shall develop and
1097 report its findings and any recommendations for proposed
1098 legislation to the Governor and the Legislature on or before
1099 December 1, 2018. A quorum of the membership shall be required to
1100 approve any final report and recommendation. Members of the
1101 commission shall be reimbursed for necessary travel expense in the
1102 same manner as public employees are reimbursed for official duties
1103 and members of the Legislature shall be reimbursed in the same
1104 manner as for attending out of session committee meetings.
1105 (d) Upon making its report, the commission shall
1106 be dissolved.
1107 (* * *3) Any contractors providing direct patient care
1108 under a managed care program established in this section shall
1109 provide to the Legislature and the division statistical data to be
1110 shared with provider groups in order to improve patient access,
1111 appropriate utilization, cost savings and health outcomes not
1112 later than October 1 of each year. The division and the
1113 contractors participating in the managed care program, a
1114 coordinated care program or a provider-sponsored health plan shall
1115 be subject to annual program audits performed by the Office of the
1116 State Auditor, the PEER Committee and/or an independent third

1117 party that has no existing contractual relationship with the
1118 division. Those audits shall determine among other items, the
1119 financial benefit to the State of Mississippi of the managed care
1120 program, the difference between the premiums paid to the managed
1121 care contractors and the payments made by those contractors to
1122 health care providers, compliance with performance measures
1123 required under the contracts, and whether costs have been
1124 contained due to improved health care outcomes. In addition, the
1125 audit shall review the most common claim denial codes to determine
1126 the reasons for the denials. This audit report shall be
1127 considered a public document and shall be posted in its entirety
1128 on the division's website.

1129 (* * *4) All health maintenance organizations,
1130 coordinated care organizations, provider-sponsored health plans,
1131 or other organizations paid for services on a capitated basis by
1132 the division under any managed care program or coordinated care
1133 program implemented by the division under this section shall
1134 reimburse all providers in those organizations at rates no lower
1135 than those provided under this section for beneficiaries who are
1136 not participating in those programs.

1137 (* * *5) No health maintenance organization,
1138 coordinated care organization, provider-sponsored health plan, or
1139 other organization paid for services on a capitated basis by the
1140 division under any managed care program or coordinated care
1141 program implemented by the division under this section shall

1142 require its providers or beneficiaries to use any pharmacy that
1143 ships, mails or delivers prescription drugs or legend drugs or
1144 devices.

1145 (6) No health maintenance organization, coordinated
1146 care organization, provider-sponsored health plan, or other
1147 organization paid for services on a capitated basis by the
1148 division under any managed care program or coordinated care
1149 program implemented by the division under this section shall
1150 require its providers to be credentialed by the organization in
1151 order to receive reimbursement from the organization, but those
1152 organizations shall recognize the credentialing of the providers
1153 by the division.

1154 (I) [Deleted]

1155 (J) There shall be no cuts in inpatient and outpatient
1156 hospital payments, or allowable days or volumes, as long as the
1157 hospital assessment provided in Section 43-13-145 is in effect.
1158 This subsection (J) shall not apply to decreases in payments that
1159 are a result of: reduced hospital admissions, audits or payments
1160 under the APR-DRG or APC models, or a managed care program or
1161 similar model described in subsection (H) of this section.

1162 (K) This section shall stand repealed on *** July 1, 2021.

1163 **SECTION 2.** Section 43-13-145, Mississippi Code of 1972, as
1164 amended by Senate Bill No. 2912, 2018 Regular Session, is amended
1165 as follows:

1166 43-13-145. (1) (a) Upon each nursing facility licensed by
1167 the State of Mississippi, there is levied an assessment in an
1168 amount set by the division, equal to the maximum rate allowed by
1169 federal law or regulation, for each licensed and occupied bed of
1170 the facility.

1171 (b) A nursing facility is exempt from the assessment
1172 levied under this subsection if the facility is operated under the
1173 direction and control of:

1174 (i) The United States Veterans Administration or
1175 other agency or department of the United States government;

1176 (ii) The State Veterans Affairs Board; or

1177 (iii) The University of Mississippi Medical
1178 Center.

1179 (2) (a) Upon each intermediate care facility for
1180 individuals with intellectual disabilities licensed by the State
1181 of Mississippi, there is levied an assessment in an amount set by
1182 the division, equal to the maximum rate allowed by federal law or
1183 regulation, for each licensed and occupied bed of the facility.

1184 (b) An intermediate care facility for individuals with
1185 intellectual disabilities is exempt from the assessment levied
1186 under this subsection if the facility is operated under the
1187 direction and control of:

1188 (i) The United States Veterans Administration or
1189 other agency or department of the United States government;

1190 (ii) The State Veterans Affairs Board; or

1191 (iii) The University of Mississippi Medical
1192 Center.
1193 (3) (a) Upon each psychiatric residential treatment
1194 facility licensed by the State of Mississippi, there is levied an
1195 assessment in an amount set by the division, equal to the maximum
1196 rate allowed by federal law or regulation, for each licensed and
1197 occupied bed of the facility.
1198 (b) A psychiatric residential treatment facility is
1199 exempt from the assessment levied under this subsection if the
1200 facility is operated under the direction and control of:
1201 (i) The United States Veterans Administration or
1202 other agency or department of the United States government;
1203 (ii) The University of Mississippi Medical Center;
1204 or
1205 (iii) A state agency or a state facility that
1206 either provides its own state match through intergovernmental
1207 transfer or certification of funds to the division.
1208 (4) Hospital assessment.
1209 (a) (i) Subject to and upon fulfillment of the
1210 requirements and conditions of paragraph (f) below, and
1211 notwithstanding any other provisions of this section, effective
1212 for state fiscal years 2016 through fiscal year 2021, an annual
1213 assessment on each hospital licensed in the state is imposed on
1214 each non-Medicare hospital inpatient day as defined below at a
1215 rate that is determined by dividing the sum prescribed in this

1216 subparagraph (i), plus the nonfederal share necessary to maximize
1217 the Disproportionate Share Hospital (DSH) and *** Medicare Upper
1218 Payment Limits (UPL) Program payments and *** hospital access
1219 payments and such other supplemental payments as may be developed
1220 pursuant to Section 43-13-117(A)(18), by the total number of
1221 non-Medicare hospital inpatient days as defined below for all
1222 licensed Mississippi hospitals, except as provided in paragraph
1223 (d) below. If the state matching funds percentage for the
1224 Mississippi Medicaid program is sixteen percent (16%) or less, the
1225 sum used in the formula under this subparagraph (i) shall be
1226 Seventy-four Million Dollars ($74,000,000.00). If the state
1227 matching funds percentage for the Mississippi Medicaid program is
1228 twenty-four percent (24%) or higher, the sum used in the formula
1229 under this subparagraph (i) shall be One Hundred Four Million
1230 Dollars ($104,000,000.00). If the state matching funds percentage
1231 for the Mississippi Medicaid program is between sixteen percent
1232 (16%) and twenty-four percent (24%), the sum used in the formula
1233 under this subparagraph (i) shall be a pro rata amount determined
1234 as follows: the current state matching funds percentage rate
1235 minus sixteen percent (16%) divided by eight percent (8%)
1236 multiplied by Thirty Million Dollars ($30,000,000.00) and add that
1237 amount to Seventy-four Million Dollars ($74,000,000.00). However,
1238 no assessment in a quarter under this subparagraph (i) may exceed
1239 the assessment in the previous quarter by more than Three Million
1240 Seven Hundred Fifty Thousand Dollars ($3,750,000.00) (which would

1241 be Fifteen Million Dollars ($15,000,000.00) on an annualized
1242 basis). The division shall publish the state matching funds
1243 percentage rate applicable to the Mississippi Medicaid program on
1244 the tenth day of the first month of each quarter and the
1245 assessment determined under the formula prescribed above shall be
1246 applicable in the quarter following any adjustment in that state
1247 matching funds percentage rate. The division shall notify each
1248 hospital licensed in the state as to any projected increases or
1249 decreases in the assessment determined under this subparagraph
1250 (i). However, if the Centers for Medicare and Medicaid Services
1251 (CMS) does not approve the provision in Section 43-13-117(39)
1252 requiring the division to reimburse crossover claims for inpatient
1253 hospital services and crossover claims covered under Medicare Part
1254 B for dually eligible beneficiaries in the same manner that was in
1255 effect on January 1, 2008, the sum that otherwise would have been
1256 used in the formula under this subparagraph (i) shall be reduced
1257 by Seven Million Dollars ($7,000,000.00).
1258 (ii) In addition to the assessment provided under
1259 subparagraph (i), effective for state fiscal years 2016 through
1260 fiscal year 2021, an additional annual assessment on each hospital
1261 licensed in the state is imposed on each non-Medicare hospital
1262 inpatient day as defined below at a rate that is determined by
1263 dividing twenty-five percent (25%) of any provider reductions in
1264 the Medicaid program as authorized in Section 43-13-117(F) for
1265 that fiscal year up to the following maximum amount, plus the

1266 nonfederal share necessary to maximize the Disproportionate Share
1267 Hospital (DSH) and inpatient Medicare Upper Payment Limits (UPL)
1268 Program payments and inpatient hospital access payments, by the
1269 total number of non-Medicare hospital inpatient days as defined
1270 below for all licensed Mississippi hospitals: in fiscal year
1271 2010, the maximum amount shall be Twenty-four Million Dollars
1272 ($24,000,000.00); in fiscal year 2011, the maximum amount shall be
1273 Thirty-two Million Dollars ($32,000,000.00); and in fiscal year
1274 2012 and thereafter, the maximum amount shall be Forty Million
1275 Dollars ($40,000,000.00). Any such deficit in the Medicaid
1276 program shall be reviewed by the PEER Committee as provided in
1277 Section 43-13-117(F).

1278 (iii) In addition to the assessments provided in
1279 subparagraphs (i) and (ii), effective for state fiscal years 2016
1280 through fiscal year 2021, an additional annual assessment on each
1281 hospital licensed in the state is imposed pursuant to the
1282 provisions of Section 43-13-117(F) if the cost containment
1283 measures described therein have been implemented and there are
1284 insufficient funds in the Health Care Trust Fund to reconcile any
1285 remaining deficit in any fiscal year. If the Governor institutes
1286 any other additional cost containment measures on any program or
1287 programs authorized under the Medicaid program pursuant to Section
1288 43-13-117(F), hospitals shall be responsible for twenty-five
1289 percent (25%) of any such additional imposed provider cuts, which
1290 shall be in the form of an additional assessment not to exceed the

1291 twenty-five percent (25%) of provider expenditure reductions.
1292 Such additional assessment shall be imposed on each non-Medicare
1293 hospital inpatient day in the same manner as assessments are
1294 imposed under subparagraphs (i) and (ii).
1295 (b) Payment and definitions.
1296 (i) The hospital assessment as described in this
1297 subsection (4) shall be assessed and collected monthly no later
1298 than the fifteenth calendar day of each month; provided, however,
1299 that the first three (3) monthly payments shall be assessed but
1300 not be collected until collection is satisfied for the third
1301 monthly (September) payment and the second three (3) monthly
1302 payments shall be assessed but not be collected until collection
1303 is satisfied for the sixth monthly (December) payment and provided
1304 that the portion of the assessment related to the DSH payments
1305 shall be paid in three (3) one-third (1/3) installments due no
1306 later than the fifteenth calendar day of the payment month of the
1307 DSH payments required by Section 43-13-117(A)(18), which shall be
1308 paid during the second, third and fourth quarters of the state
1309 fiscal year, and provided that the assessment related to any
1310 *** * *** UPL payment(s) shall be paid no later than the fifteenth
1311 calendar day of the payment month of the UPL payment(s) and
1312 provided assessments related to *** * *** hospital access payments
1313 will be collected beginning the initial month that the division
1314 funds MHAP.

1315 (ii) Definitions. For purposes of this subsection
1316 (4):
1317 1. "Non-Medicare hospital inpatient day"
1318 means total hospital inpatient days including subcomponent days
1319 less Medicare inpatient days including subcomponent days from the
1320 hospital's *** * *** <u>most recent</u> Medicare cost report <u>for the second</u>
1321 <u>calendar year preceding the beginning of the state fiscal year,</u> on
1322 file with CMS <u>per the CMS HCRIS database, or cost report submitted</u>
1323 <u>to the Division if the HCRIS database is not available to the</u>
1324 <u>Division, as of June 1 of each year</u>.
1325 a. Total hospital inpatient days shall
1326 be the sum of Worksheet S-3, Part 1, column 8 row 14, column 8 row
1327 16, and column 8 row 17, excluding column 8 rows 5 and 6.
1328 b. Hospital Medicare inpatient days
1329 shall be the sum of Worksheet S-3, Part 1, column 6 row 14, column
1330 6 row 16.00, and column 6 row 17, excluding column 6 rows 5 and 6.
1331 c. Inpatient days shall not include
1332 residential treatment or long-term care days.
1333 2. "Subcomponent inpatient day" means the
1334 number of days of care charged to a beneficiary for inpatient
1335 hospital rehabilitation and psychiatric care services in units of
1336 full days. A day begins at midnight and ends twenty-four (24)
1337 hours later. A part of a day, including the day of admission and
1338 day on which a patient returns from leave of absence, counts as a
1339 full day. However, the day of discharge, death, or a day on which

1340 a patient begins a leave of absence is not counted as a day unless
1341 discharge or death occur on the day of admission. If admission
1342 and discharge or death occur on the same day, the day is
1343 considered a day of admission and counts as one (1) subcomponent
1344 inpatient day.
1345 (c) The assessment provided in this subsection is
1346 intended to satisfy and not be in addition to the assessment and
1347 intergovernmental transfers provided in Section 43-13-117(A)(18).
1348 Nothing in this section shall be construed to authorize any state
1349 agency, division or department, or county, municipality or other
1350 local governmental unit to license for revenue, levy or impose any
1351 other tax, fee or assessment upon hospitals in this state not
1352 authorized by a specific statute.
1353 (d) Hospitals operated by the United States Department
1354 of Veterans Affairs and state-operated facilities that provide
1355 only inpatient and outpatient psychiatric services shall not be
1356 subject to the hospital assessment provided in this subsection.
1357 (e) Multihospital systems, closure, merger<u>, change of</u>
1358 <u>ownership</u> and new hospitals.
1359 (i) If a hospital conducts, operates or maintains
1360 more than one (1) hospital licensed by the State Department of
1361 Health, the provider shall pay the hospital assessment for each
1362 hospital separately.
1363 (ii) Notwithstanding any other provision in this
1364 section, if a hospital subject to this assessment operates or

1365 conducts business only for a portion of a fiscal year, the
1366 assessment for the state fiscal year shall be adjusted by
1367 multiplying the assessment by a fraction, the numerator of which
1368 is the number of days in the year during which the hospital
1369 operates, and the denominator of which is three hundred sixty-five
1370 (365). Immediately upon ceasing to operate, the hospital shall
1371 pay the assessment for the year as so adjusted (to the extent not
1372 previously paid).

1373 (iii) The division shall determine the tax for new
1374 hospitals and hospitals that undergo a change of ownership in
1375 accordance with this section, using the best available
1376 information, as determined by the division.

1377 (f) Applicability.

1378 The hospital assessment imposed by this subsection shall not
1379 take effect and/or shall cease to be imposed if:

1380 (i) The assessment is determined to be an
1381 impermissible tax under Title XIX of the Social Security Act; or

1382 (ii) CMS revokes its approval of the division's
1383 2009 Medicaid State Plan Amendment for the methodology for DSH
1384 payments to hospitals under Section 43-13-117(A)(18).

1385 This subsection (4) is repealed on July 1, 2021.

1386 (5) Each health care facility that is subject to the
1387 provisions of this section shall keep and preserve such suitable
1388 books and records as may be necessary to determine the amount of
1389 assessment for which it is liable under this section. The books

1390 and records shall be kept and preserved for a period of not less
1391 than five (5) years, during which time those books and records
1392 shall be open for examination during business hours by the
1393 division, the Department of Revenue, the Office of the Attorney
1394 General and the State Department of Health.

1395 (6) Except as provided in subsection (4) of this section,
1396 the assessment levied under this section shall be collected by the
1397 division each month *** * ***.

1398 (7) All assessments collected under this section shall be
1399 deposited in the Medical Care Fund created by Section 43-13-143.

1400 (8) The assessment levied under this section shall be in
1401 addition to any other assessments, taxes or fees levied by law,
1402 and the assessment shall constitute a debt due the State of
1403 Mississippi from the time the assessment is due until it is paid.

1404 (9) (a) If a health care facility that is liable for
1405 payment of an assessment levied by the division does not pay the
1406 assessment when it is due, the division shall give written notice
1407 to the health care facility by certified or registered mail
1408 demanding payment of the assessment within ten (10) days from the
1409 date of delivery of the notice. If the health care facility fails
1410 or refuses to pay the assessment after receiving the notice and
1411 demand from the division, the division shall withhold from any
1412 Medicaid reimbursement payments that are due to the health care
1413 facility the amount of the unpaid assessment and a penalty of ten
1414 percent (10%) of the amount of the assessment, plus the legal rate

1415 of interest until the assessment is paid in full. If the health
1416 care facility does not participate in the Medicaid program, the
1417 division shall turn over to the Office of the Attorney General the
1418 collection of the unpaid assessment by civil action. In any such
1419 civil action, the Office of the Attorney General shall collect the
1420 amount of the unpaid assessment and a penalty of ten percent (10%)
1421 of the amount of the assessment, plus the legal rate of interest
1422 until the assessment is paid in full.

1423 (b) As an additional or alternative method for
1424 collecting unpaid assessments levied by the division, if a health
1425 care facility fails or refuses to pay the assessment after
1426 receiving notice and demand from the division, the division may
1427 file a notice of a tax lien with the chancery clerk of the county
1428 in which the health care facility is located, for the amount of
1429 the unpaid assessment and a penalty of ten percent (10%) of the
1430 amount of the assessment, plus the legal rate of interest until
1431 the assessment is paid in full. Immediately upon receipt of
1432 notice of the tax lien for the assessment, the chancery clerk
1433 shall forward the notice to the circuit clerk who shall enter the
1434 notice of the tax lien as a judgment upon the judgment roll and
1435 show in the appropriate columns the name of the health care
1436 facility as judgment debtor, the name of the division as judgment
1437 creditor, the amount of the unpaid assessment, and the date and
1438 time of enrollment. The judgment shall be valid as against
1439 mortgagees, pledgees, entrusters, purchasers, judgment creditors

1440 and other persons from the time of filing with the clerk. The
1441 amount of the judgment shall be a debt due the State of
1442 Mississippi and remain a lien upon the tangible property of the
1443 health care facility until the judgment is satisfied. The
1444 judgment shall be the equivalent of any enrolled judgment of a
1445 court of record and shall serve as authority for the issuance of
1446 writs of execution, writs of attachment or other remedial writs.
1447 (10) (a) * * * To further the provisions of Section
1448 43-13-117(A)(18), the Division of Medicaid shall submit to the
1449 Centers for Medicare and Medicaid Services (CMS) * * * any
1450 documents regarding the hospital assessment established under
1451 subsection (4) of this section. In addition to defining the
1452 assessment established in subsection (4) of this section if
1453 necessary, the * * * documents shall * * * describe any * * *
1454 supplement payment programs and/or payment methodologies as
1455 authorized in Section 43-13-117(A)(18) if necessary. * * *
1456 (* * *b) All hospitals satisfying the minimum federal
1457 DSH eligibility requirements (Section 1923(d) of the Social
1458 Security Act) * * * may, subject to OBRA 1993 payment limitations,
1459 receive * * * a DSH payment. This * * * DSH payment shall expend
1460 the balance of the federal DSH allotment and associated state
1461 share not utilized in DSH payments to state-owned institutions for
1462 treatment of mental diseases. The payment to each hospital shall
1463 be calculated by applying a uniform percentage to the uninsured
1464 costs of each eligible hospital, excluding state-owned

1465 institutions for treatment of mental diseases; however, that
1466 percentage for a state-owned teaching hospital located in Hinds
1467 County shall be multiplied by a factor of two (2).
1468 * * *
1469 (* * *11) The division shall implement DSH and * * *
1470 supplemental payment calculation methodologies that result in the
1471 maximization of available federal funds.
1472 (* * *12) The DSH * * * payments shall be paid on or before
1473 December 31, March 31, and June 30 of each fiscal year, in
1474 increments of one-third (1/3) of the total calculated DSH * * *
1475 amounts. Supplemental payments developed pursuant to Section
1476 43-13-117(A)(18) shall be paid monthly.
1477 (* * *13) The hospital assessment as described in
1478 subsection (4) above shall be assessed and collected monthly no
1479 later than the fifteenth calendar day of each month; provided,
1480 however, that the first three (3) monthly payments shall be
1481 assessed but not be collected until collection is satisfied for
1482 the third monthly (September) payment and the second three (3)
1483 monthly payments shall be assessed but not be collected until
1484 collection is satisfied for the sixth monthly (December) payment
1485 and provided that the portion of the assessment related to the DSH
1486 payments shall be paid in three (3) one-third (1/3) installments
1487 due no later than the fifteenth calendar day of the payment month
1488 of the DSH payments required by Section 43-13-117(A)(18), which
1489 shall be paid during the second, third and fourth quarters of the

1490 state fiscal year, and provided that the assessment related to
1491 any * * * supplemental payment * * * programs developed pursuant
1492 to Section 43-13-117(A)(18) shall be paid no later than the
1493 fifteenth calendar day of the payment month of the * * *
1494 payment(s) * * *.
1495 (* * *14) If for any reason any part of the plan for * * *
1496 annual DSH and * * * supplemental payment programs to hospitals
1497 provided under subsection (10) of this section and/or developed
1498 pursuant to Section 43-13-117(A)(18) is not approved by CMS, the
1499 remainder of the plan shall remain in full force and effect.
1500 (* * *15) Nothing in this section shall prevent the
1501 Division of Medicaid from facilitating participation in Medicaid
1502 supplemental hospital payment programs by a hospital located in a
1503 county contiguous to the State of Mississippi that is also
1504 authorized by federal law to submit intergovernmental transfers
1505 (IGTs) to the State of Mississippi to fund the state share of the
1506 hospital's supplemental and/or MHAP payments.
1507 (* * *16) Subsections (10) through (* * *15) of this
1508 section shall stand repealed on July 1, * * * 2024.
1509 **SECTION 3.** This act shall take effect and be in force from
1510 and after July 1, 2018.

Further, amend by striking the title in its entirety and inserting in lieu thereof the following:

1 AN ACT RELATING TO THE MISSISSIPPI MEDICAID PROGRAM; TO AMEND
2 SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO EXTEND THE DATE OF

3 THE REPEALER ON THE COMPREHENSIVE LIST OF THE TYPES OF CARE AND
4 SERVICES COVERED BY MEDICAID; TO PROVIDE THAT RURAL HOSPITALS THAT
5 HAVE FIFTY OR FEWER LICENSED BEDS SHALL BE GIVEN THE OPTION TO BE
6 REIMBURSED UNDER MEDICAID FOR OUTPATIENT HOSPITAL SERVICES BASED
7 ON 101% OF THE MEDICARE RATE FOR THOSE SERVICES INSTEAD OF USING
8 THE AMBULATORY PAYMENT CLASSIFICATION (APC) METHODOLOGY; TO REDUCE
9 THE ANNUAL NUMBER OF HOME LEAVE DAYS FOR PATIENTS IN NURSING
10 FACILITIES AND INTERMEDIATE CARE FACILITIES; TO DELETE THE ANNUAL
11 LIMIT ON PHYSICIAN VISITS; TO AUTHORIZE THE DIVISION TO REIMBURSE
12 OBSTETRICIANS AND GYNECOLOGISTS FOR CERTAIN PRIMARY CARE SERVICES
13 AS DEFINED BY THE DIVISION AT 100% OF THE RATE ESTABLISHED UNDER
14 MEDICARE; TO DELETE THE ANNUAL LIMITS ON HOME HEALTH SERVICES
15 VISITS; TO DELETE THE RESTRICTION ON THE REIMBURSEMENT RATE FOR
16 EMERGENCY MEDICAL TRANSPORTATION SERVICES; TO DELETE THE MONTHLY
17 PRESCRIPTION LIMIT FOR MEDICAID BENEFICIARIES; TO DIRECT THE
18 DIVISION TO ALLOW PHYSICIAN-ADMINISTERED DRUGS TO BE BILLED AND
19 REIMBURSED AS EITHER A MEDICAL CLAIM OR PHARMACY POINT-OF-SALE TO
20 ALLOW GREATER ACCESS TO CARE; TO AUTHORIZE THE DIVISION TO
21 ENCOURAGE THE USE OF CERTAIN PRETERM BIRTH SERVICES (17P); TO
22 PROVIDE THAT THE COVERAGE OF DENTAL AND ORTHODONTIC SERVICES WILL
23 BE DETERMINED BY THE DIVISION; TO PROVIDE THAT CERTAIN SERVICES
24 PROVIDED BY A PSYCHIATRIST MAY BE REIMBURSED AT UP TO 100% OF THE
25 MEDICARE RATE; TO REVISE CERTAIN PROVISIONS OF THE MEDICARE UPPER
26 PAYMENT LIMITS (UPL) PROGRAM AND THE MISSISSIPPI HOSPITAL ACCESS
27 PROGRAM (MHAP); TO PROVIDE THAT FEDERALLY QUALIFIED HEALTH CENTERS
28 PROVIDING AMBULATORY SERVICES SHALL BE REIMBURSED BY THE MEDICAID
29 PROSPECTIVE PAYMENT SYSTEM AS APPROVED BY THE CENTERS FOR MEDICARE
30 AND MEDICAID SERVICES; TO AUTHORIZE INSTEAD OF REQUIRE THAT
31 TARGETED CASE MANAGEMENT SERVICES FOR HIGH-COST BENEFICIARIES BE
32 DEVELOPED FOR ALL SERVICES COVERED BY THIS SECTION; TO AUTHORIZE
33 MEDICAID REIMBURSEMENT FOR TREATMENT FOR OPIOID DEPENDENCY; TO
34 DIRECT THE DIVISION TO ALLOW BENEFICIARIES BETWEEN THE AGES OF TEN
35 AND EIGHTEEN YEARS TO RECEIVE VACCINES THROUGH A PHARMACY VENUE;
36 TO INCLUDE OUTPATIENT HOSPITAL SERVICES IN THE LIST OF SERVICES
37 THAT ARE EXEMPT FROM THE FIVE PERCENT REDUCTION IN THE PROVIDER
38 REIMBURSEMENT RATE; TO DIRECT THE MEDICAL CARE ADVISORY COMMITTEE
39 TO DEVELOP RECOMMENDATIONS TO THE LEGISLATURE RELATING TO THE
40 AUTHORITY OF THE DIVISION TO REDUCE THE RATE OF PROVIDER
41 REIMBURSEMENT BY FIVE PERCENT; TO DELETE THE PROHIBITION ON THE
42 DIVISION FROM MAKING CERTAIN CHANGES TO THE SERVICES AUTHORIZED
43 UNDER THIS SECTION WITHOUT AN AMENDMENT TO THIS SECTION BY THE
44 LEGISLATURE; TO REVISE THE ACTIONS THAT THE DIVISION MAY TAKE TO
45 REDUCE COSTS IF CURRENT OR PROJECTED EXPENDITURES OF THE DIVISION
46 ARE REASONABLY ANTICIPATED BY THE DIVISION TO EXCEED THE AMOUNT OF
47 FUNDS APPROPRIATED TO THE DIVISION FOR ANY FISCAL YEAR; TO
48 PROHIBIT THE DIVISION FROM IMPLEMENTING THE EXPANSION OF MEDICAID
49 MANAGED CARE CONTRACTS WITHOUT ENABLING LEGISLATION; TO ESTABLISH
50 A COMMISSION ON EXPANDING MEDICAID MANAGED CARE TO DEVELOP
51 RECOMMENDATIONS TO THE GOVERNOR AND THE LEGISLATURE; TO PROVIDE
52 THAT THE DIVISION AND THE CONTRACTORS PARTICIPATING IN THE MANAGED

53 CARE PROGRAM, A COORDINATED CARE PROGRAM OR A PROVIDER-SPONSORED
54 HEALTH PLAN SHALL BE SUBJECT TO ANNUAL PROGRAM AUDITS PERFORMED BY
55 THE OFFICE OF THE STATE AUDITOR, THE PEER COMMITTEE AND/OR AN
56 INDEPENDENT THIRD PARTY; TO PROHIBIT MANAGED CARE ORGANIZATIONS
57 FROM REQUIRING THEIR PROVIDERS TO BE CREDENTIALED BY THE
58 ORGANIZATION IN ORDER TO RECEIVE REIMBURSEMENT; TO AMEND SECTION
59 43-13-145, MISSISSIPPI CODE OF 1972, AS AMENDED BY SENATE BILL NO.
60 2912, 2018 REGULAR SESSION, TO EXTEND THE AUTOMATIC REPEALER ON
61 THE SECTION THAT PROVIDES FOR CERTAIN PROVIDER ASSESSMENTS UNDER
62 THE MISSISSIPPI MEDICAID PROGRAM; TO REVISE CERTAIN PROVISIONS
63 RELATING TO THE CALCULATION OF THE ASSESSMENTS; AND FOR RELATED
64 PURPOSES.

CONFEREES FOR THE SENATE	CONFEREES FOR THE HOUSE
X (SIGNED) Brice Wiggins	X (SIGNED) Chris Brown
X (SIGNED) Terry C. Burton	X (SIGNED) Jason White
X (SIGNED) Eugene S. Clarke	X (SIGNED) Joey Hood