

By: Senator(s) Burton

To: Medicaid; Appropriations

SENATE BILL NO. 2064

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO AUTHORIZE MEDICAID REIMBURSEMENT TO PHYSICIANS PROVIDING
3 TELEMEDICINE MEDICAL SERVICES TO STUDENTS IN A SCHOOL-BASED
4 SETTING; AND FOR RELATED PURPOSES.

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

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

8 43-13-117. (A) Medicaid as authorized by this article shall
9 include payment of part or all of the costs, at the discretion of
10 the division, with approval of the Governor and the Centers for
11 Medicare and Medicaid Services, of the following types of care and
12 services rendered to eligible applicants who have been determined
13 to be eligible for that care and services, within the limits of
14 state appropriations and federal matching funds:

15 (1) Inpatient hospital services.

16 (a) The division shall allow thirty (30) days of
17 inpatient hospital care annually for all Medicaid recipients.

18 Medicaid recipients requiring transplants shall not have those
19 days included in the transplant hospital stay count against the



20 thirty-day limit for inpatient hospital care. Precertification of
21 inpatient days must be obtained as required by the division.

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

28 (c) Hospitals may receive an additional payment
29 for the implantable programmable baclofen drug pump used to treat
30 spasticity that is implanted on an inpatient basis. The payment
31 pursuant to written invoice will be in addition to the facility's
32 per diem reimbursement and will represent a reduction of costs on
33 the facility's annual cost report, and shall not exceed Ten
34 Thousand Dollars (\$10,000.00) per year per recipient.

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

38 (e) No service benefits or reimbursement
39 limitations in this section shall apply to payments under an
40 APR-DRG or Ambulatory Payment Classification (APC) model or a
41 managed care program or similar model described in subsection (H)
42 of this section unless specifically authorized by the division.

43 (2) Outpatient hospital services.

44 (a) Emergency services.



45 (b) Other outpatient hospital services. The
46 division shall allow benefits for other medically necessary
47 outpatient hospital services (such as chemotherapy, radiation,
48 surgery and therapy), including outpatient services in a clinic or
49 other facility that is not located inside the hospital, but that
50 has been designated as an outpatient facility by the hospital, and
51 that was in operation or under construction on July 1, 2009,
52 provided that the costs and charges associated with the operation
53 of the hospital clinic are included in the hospital's cost report.
54 In addition, the Medicare thirty-five-mile rule will apply to
55 those hospital clinics not located inside the hospital that are
56 constructed after July 1, 2009. Where the same services are
57 reimbursed as clinic services, the division may revise the rate or
58 methodology of outpatient reimbursement to maintain consistency,
59 efficiency, economy and quality of care.

60 (c) The division is authorized to implement an
61 Ambulatory Payment Classification (APC) methodology for outpatient
62 hospital services. The division may give rural hospitals that
63 have fifty (50) or fewer licensed beds the option to not be
64 reimbursed for outpatient hospital services using the APC
65 methodology, but reimbursement for outpatient hospital services
66 provided by those hospitals shall be based on one hundred one
67 percent (101%) of the rate established under Medicare for
68 outpatient hospital services. Those hospitals choosing to not be



69 reimbursed under the APC methodology shall remain under cost-based
70 reimbursement for a two-year period.

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

75 (3) Laboratory and x-ray services.

76 (4) Nursing facility services.

77 (a) The division shall make full payment to
78 nursing facilities for each day, not exceeding forty-two (42) days
79 per year, that a patient is absent from the facility on home
80 leave. Payment may be made for the following home leave days in
81 addition to the forty-two-day limitation: Christmas, the day
82 before Christmas, the day after Christmas, Thanksgiving, the day
83 before Thanksgiving and the day after Thanksgiving.

84 (b) From and after July 1, 1997, the division
85 shall implement the integrated case-mix payment and quality
86 monitoring system, which includes the fair rental system for
87 property costs and in which recapture of depreciation is
88 eliminated. The division may reduce the payment for hospital
89 leave and therapeutic home leave days to the lower of the case-mix
90 category as computed for the resident on leave using the
91 assessment being utilized for payment at that point in time, or a
92 case-mix score of 1.000 for nursing facilities, and shall compute
93 case-mix scores of residents so that only services provided at the



94 nursing facility are considered in calculating a facility's per
95 diem.

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

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

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



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

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

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



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

152 (6) Physician's services. Physician visits as
153 determined by the division and in accordance with federal laws and
154 regulations. The division may develop and implement a different
155 reimbursement model or schedule for physician's services provided
156 by physicians based at an academic health care center and by
157 physicians at rural health centers that are associated with an
158 academic health care center. From and after January 1, 2010, all
159 fees for physician's services that are covered only by Medicaid
160 shall be increased to ninety percent (90%) of the rate established
161 on January 1, 2018, and as may be adjusted each July thereafter,
162 under Medicare. The division may provide for a reimbursement rate
163 for physician's services of up to one hundred percent (100%) of
164 the rate established under Medicare for physician's services that
165 are provided after the normal working hours of the physician, as
166 determined in accordance with regulations of the division. The
167 division may reimburse eligible providers as determined by the



168 Patient Protection and Affordable Care Act for certain primary
169 care services as defined by the act at one hundred percent (100%)
170 of the rate established under Medicare. Additionally, the
171 division shall reimburse obstetricians and gynecologists for
172 certain primary care services as defined by the division at one
173 hundred percent (100%) of the rate established under Medicare.

174 (7) (a) Home health services for eligible persons, not
175 to exceed in cost the prevailing cost of nursing facility
176 services. All home health visits must be precertified as required
177 by the division.

178 (b) [Repealed]

179 (8) Emergency medical transportation services as
180 determined by the division.

181 (9) Prescription drugs and other covered drugs and
182 services as may be determined by the division.

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

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



193 of prescription drugs to include single-source and innovator
194 multiple-source drugs or generic drugs, if that will lower the
195 acquisition costs of those prescription drugs.

196 The division may allow for a combination of prescriptions for
197 single-source and innovator multiple-source drugs and generic
198 drugs to meet the needs of the beneficiaries.

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

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



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

221 The division is authorized to develop and implement a program
222 of payment for additional pharmacist services as may be determined
223 by the division.

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

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

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



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

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

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

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

257 The division may allow certain drugs, implantable drug system
258 devices, and medical supplies, with limited distribution or
259 limited access for beneficiaries and administered in an
260 appropriate clinical setting, to be reimbursed as either a medical
261 claim or pharmacy claim, as determined by the division.

262 Notwithstanding any other provision of this article, the
263 division shall allow physician-administered drugs to be billed and
264 reimbursed as either a medical claim or pharmacy point-of-sale to
265 allow greater access to care.



266 It is the intent of the Legislature that the division and any
267 managed care entity described in subsection (H) of this section
268 encourage the use of Alpha-Hydroxyprogesterone Caproate (17P) to
269 prevent recurrent preterm birth.

270 (10) Dental and orthodontic services to be determined
271 by the division.

272 This dental services program under this paragraph shall be
273 known as the "James Russell Dumas Medicaid Dental Services
274 Program."

275 The Medical Care Advisory Committee, assisted by the Division
276 of Medicaid, shall annually determine the effect of this incentive
277 by evaluating the number of dentists who are Medicaid providers,
278 the number who and the degree to which they are actively billing
279 Medicaid, the geographic trends of where dentists are offering
280 what types of Medicaid services and other statistics pertinent to
281 the goals of this legislative intent. This data shall annually be
282 presented to the Chair of the Senate Medicaid Committee and the
283 Chair of the House Medicaid Committee.

284 The division shall include dental services as a necessary
285 component of overall health services provided to children who are
286 eligible for services.

287 (11) Eyeglasses for all Medicaid beneficiaries who have
288 (a) had surgery on the eyeball or ocular muscle that results in a
289 vision change for which eyeglasses or a change in eyeglasses is
290 medically indicated within six (6) months of the surgery and is in



291 accordance with policies established by the division, or (b) one
292 (1) pair every five (5) years and in accordance with policies
293 established by the division. In either instance, the eyeglasses
294 must be prescribed by a physician skilled in diseases of the eye
295 or an optometrist, whichever the beneficiary may select.

296 (12) Intermediate care facility services.

297 (a) The division shall make full payment to all
298 intermediate care facilities for individuals with intellectual
299 disabilities for each day, not exceeding sixty-three (63) days per
300 year, that a patient is absent from the facility on home leave.
301 Payment may be made for the following home leave days in addition
302 to the sixty-three-day limitation: Christmas, the day before
303 Christmas, the day after Christmas, Thanksgiving, the day before
304 Thanksgiving and the day after Thanksgiving.

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

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

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

314 (14) Clinic services. Such diagnostic, preventive,
315 therapeutic, rehabilitative or palliative services furnished to an



316 outpatient by or under the supervision of a physician or dentist
317 in a facility that is not a part of a hospital but that is
318 organized and operated to provide medical care to outpatients.
319 Clinic services shall include any services reimbursed as
320 outpatient hospital services that may be rendered in such a
321 facility, including those that become so after July 1, 1991. On
322 July 1, 1999, all fees for physicians' services reimbursed under
323 authority of this paragraph (14) shall be reimbursed at ninety
324 percent (90%) of the rate established on January 1, 1999, and as
325 may be adjusted each July thereafter, under Medicare (Title XVIII
326 of the federal Social Security Act, as amended). The division may
327 develop and implement a different reimbursement model or schedule
328 for physician's services provided by physicians based at an
329 academic health care center and by physicians at rural health
330 centers that are associated with an academic health care center.
331 The division may provide for a reimbursement rate for physician's
332 clinic services of up to one hundred percent (100%) of the rate
333 established under Medicare for physician's services that are
334 provided after the normal working hours of the physician, as
335 determined in accordance with regulations of the division.

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



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

345 (16) Mental health services. Certain services provided
346 by a psychiatrist shall be reimbursed at up to one hundred percent
347 (100%) of the Medicare rate. Approved therapeutic and case
348 management services (a) provided by an approved regional mental
349 health/intellectual disability center established under Sections
350 41-19-31 through 41-19-39, or by another community mental health
351 service provider meeting the requirements of the Department of
352 Mental Health to be an approved mental health/intellectual
353 disability center if determined necessary by the Department of
354 Mental Health, using state funds that are provided in the
355 appropriation to the division to match federal funds, or (b)
356 provided by a facility that is certified by the State Department
357 of Mental Health to provide therapeutic and case management
358 services, to be reimbursed on a fee for service basis, or (c)
359 provided in the community by a facility or program operated by the
360 Department of Mental Health. Any such services provided by a
361 facility described in subparagraph (b) must have the prior
362 approval of the division to be reimbursable under this section.

363 (17) Durable medical equipment services and medical
364 supplies. Precertification of durable medical equipment and
365 medical supplies must be obtained as required by the division.



366 The Division of Medicaid may require durable medical equipment
367 providers to obtain a surety bond in the amount and to the
368 specifications as established by the Balanced Budget Act of 1997.

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

384 (b) The division may establish a Medicare Upper
385 Payment Limits Program, as defined in Section 1902(a)(30) of the
386 federal Social Security Act and any applicable federal
387 regulations, for hospitals, and may establish a Medicare Upper
388 Payment Limits Program for nursing facilities, and may establish a
389 Medicare Upper Payment Limits Program for physicians employed or
390 contracted by public hospitals. Upon successful implementation of



391 a Medicare Upper Payment Limits Program for physicians employed by
392 public hospitals, the division may develop a plan for implementing
393 an Upper Payment Limits Program for physicians employed by other
394 classes of hospitals. The division shall assess each hospital
395 and, if the program is established for nursing facilities, shall
396 assess each nursing facility, for the sole purpose of financing
397 the state portion of the Medicare Upper Payment Limits Program.
398 The hospital assessment shall be as provided in Section
399 43-13-145(4) (a) and the nursing facility assessment, if
400 established, shall be based on Medicaid utilization or other
401 appropriate method consistent with federal regulations. The
402 assessment will remain in effect as long as the state participates
403 in the Medicare Upper Payment Limits Program. Public hospitals
404 with physicians participating in the Medicare Upper Payment Limits
405 Program shall be required to participate in an intergovernmental
406 transfer program for the purpose of financing the state portion of
407 the physician UPL payments. As provided in the Medicaid state
408 plan amendment or amendments as defined in Section 43-13-145(10),
409 the division shall make additional reimbursement to hospitals and,
410 if the program is established for nursing facilities, shall make
411 additional reimbursement to nursing facilities, for the Medicare
412 Upper Payment Limits, and, if the program is established for
413 physicians, shall make additional reimbursement for physicians, as
414 defined in Section 1902(a) (30) of the federal Social Security Act
415 and any applicable federal regulations. Notwithstanding any other



416 provision of this article to the contrary, effective upon
417 implementation of the Mississippi Hospital Access Program (MHAP)
418 provided in subparagraph (c)(i) below, the hospital portion of the
419 inpatient Upper Payment Limits Program shall transition into and
420 be replaced by the MHAP program. However, the division is
421 authorized to develop and implement an alternative fee-for-service
422 Upper Payment Limits model in accordance with federal laws and
423 regulations if necessary to preserve supplemental funding.
424 Further, the division, in consultation with the Mississippi
425 Hospital Association and a governmental hospital located in a
426 county bordering the Gulf of Mexico and the State of Alabama shall
427 develop alternative models for distribution of medical claims and
428 supplemental payments for inpatient and outpatient hospital
429 services, and such models may include, but shall not be limited to
430 the following: increasing rates for inpatient and outpatient
431 services; creating a low-income utilization pool of funds to
432 reimburse hospitals for the costs of uncompensated care, charity
433 care and bad debts as permitted and approved pursuant to federal
434 regulations and the Centers for Medicare and Medicaid Services;
435 supplemental payments based upon Medicaid utilization, quality,
436 service lines and/or costs of providing such services to Medicaid
437 beneficiaries and to uninsured patients. The goals of such
438 payment models shall be to ensure access to inpatient and
439 outpatient care and to maximize any federal funds that are
440 available to reimburse hospitals for services provided. Any such



441 documents required to achieve the goals described in this
442 paragraph shall be submitted to the Centers for Medicare and
443 Medicaid Services, with a proposed effective date of July 1, 2019,
444 to the extent possible, but in no event shall the effective date
445 of such payment models be later than July 1, 2020. The Chairmen
446 of the Senate and House Medicaid Committees shall be provided a
447 copy of the proposed payment model(s) prior to submission.
448 Effective July 1, 2018, and until such time as any payment
449 model(s) as described above become effective, the division, in
450 consultation with the Mississippi Hospital Association and a
451 governmental hospital located in a county bordering the Gulf of
452 Mexico and the State of Alabama is authorized to implement a
453 transitional program for inpatient and outpatient payments and/or
454 supplemental payments (including, but not limited to, MHAP and
455 directed payments), to redistribute available supplemental funds
456 among hospital providers, provided that when compared to a
457 hospital's prior year supplemental payments, supplemental payments
458 made pursuant to any such transitional program shall not result in
459 a decrease of more than five percent (5%) and shall not increase
460 by more than the amount needed to maximize the distribution of the
461 available funds.

462 (c) (i) Not later than December 1, 2015, the
463 division shall, subject to approval by the Centers for Medicare
464 and Medicaid Services (CMS), establish, implement and operate a
465 Mississippi Hospital Access Program (MHAP) for the purpose of



466 protecting patient access to hospital care through hospital
467 inpatient reimbursement programs provided in this section designed
468 to maintain total hospital reimbursement for inpatient services
469 rendered by in-state hospitals and the out-of-state hospital that
470 is authorized by federal law to submit intergovernmental transfers
471 (IGTs) to the State of Mississippi and is classified as Level I
472 trauma center located in a county contiguous to the state line at
473 the maximum levels permissible under applicable federal statutes
474 and regulations, at which time the current inpatient Medicare
475 Upper Payment Limits (UPL) Program for hospital inpatient services
476 shall transition to the MHAP.

477 (ii) Subject only to approval by the Centers
478 for Medicare and Medicaid Services (CMS) where required, the MHAP
479 shall provide increased inpatient capitation (PMPM) payments to
480 managed care entities contracting with the division pursuant to
481 subsection (H) of this section to support availability of hospital
482 services or such other payments permissible under federal law
483 necessary to accomplish the intent of this subsection.

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



491 and other payment programs for inpatient and/or outpatient
492 payments which may be developed under the authority of this
493 paragraph.

494 (iv) The division shall assess each hospital
495 as provided in Section 43-13-145(4) (a) for the purpose of
496 financing the state portion of the MHAP, supplemental payments and
497 such other purposes as specified in Section 43-13-145. The
498 assessment will remain in effect as long as the MHAP and
499 supplemental payments are in effect.

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

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



516 statewide system of delivery of early intervention services, under
517 Part C of the Individuals with Disabilities Education Act (IDEA).
518 The State Department of Health shall certify annually in writing
519 to the executive director of the division the dollar amount of
520 state early intervention funds available that will be utilized as
521 a certified match for Medicaid matching funds. Those funds then
522 shall be used to provide expanded targeted case management
523 services for Medicaid eligible children with special needs who are
524 eligible for the state's early intervention system.

525 Qualifications for persons providing service coordination shall be
526 determined by the State Department of Health and the Division of
527 Medicaid.

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

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



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

554 (22) Ambulatory services delivered in federally
555 qualified health centers, rural health centers and clinics of the
556 local health departments of the State Department of Health for
557 individuals eligible for Medicaid under this article based on
558 reasonable costs as determined by the division. Federally
559 qualified health centers shall be reimbursed by the Medicaid
560 prospective payment system as approved by the Centers for Medicare
561 and Medicaid Services.

562 (23) Inpatient psychiatric services. Inpatient
563 psychiatric services to be determined by the division for
564 recipients under age twenty-one (21) that are provided under the
565 direction of a physician in an inpatient program in a licensed



566 acute care psychiatric facility or in a licensed psychiatric
567 residential treatment facility, before the recipient reaches age
568 twenty-one (21) or, if the recipient was receiving the services
569 immediately before he or she reached age twenty-one (21), before
570 the earlier of the date he or she no longer requires the services
571 or the date he or she reaches age twenty-two (22), as provided by
572 federal regulations. From and after January 1, 2015, the division
573 shall update the fair rental reimbursement system for psychiatric
574 residential treatment facilities. Precertification of inpatient
575 days and residential treatment days must be obtained as required
576 by the division. From and after July 1, 2009, all state-owned and
577 state-operated facilities that provide inpatient psychiatric
578 services to persons under age twenty-one (21) who are eligible for
579 Medicaid reimbursement shall be reimbursed for those services on a
580 full reasonable cost basis.

581 (24) [Deleted]

582 (25) [Deleted]

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



591 that are experienced during the final stages of illness and during
592 dying and bereavement and meets the Medicare requirements for
593 participation as a hospice as provided in federal regulations.

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

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

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

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

614 (31) Targeted case management services for children
615 with special needs, under waivers from the United States



616 Department of Health and Human Services, using state funds that
617 are provided from the appropriation to the Mississippi Department
618 of Human Services and used to match federal funds under a
619 cooperative agreement between the division and the department.

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

626 (33) Podiatrist services.

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

632 (35) Services and activities authorized in Sections
633 43-27-101 and 43-27-103, using state funds that are provided from
634 the appropriation to the Mississippi Department of Human Services
635 and used to match federal funds under a cooperative agreement
636 between the division and the department.

637 (36) Nonemergency transportation services for
638 Medicaid-eligible persons, to be provided by the Division of
639 Medicaid. The division may contract with additional entities to
640 administer nonemergency transportation services as it deems



641 necessary. All providers shall have a valid driver's license,
642 valid vehicle license tags and a standard liability insurance
643 policy covering the vehicle. The division may pay providers a
644 flat fee based on mileage tiers, or in the alternative, may
645 reimburse on actual miles traveled. The division may apply to the
646 Center for Medicare and Medicaid Services (CMS) for a waiver to
647 draw federal matching funds for nonemergency transportation
648 services as a covered service instead of an administrative cost.
649 The PEER Committee shall conduct a performance evaluation of the
650 nonemergency transportation program to evaluate the administration
651 of the program and the providers of transportation services to
652 determine the most cost-effective ways of providing nonemergency
653 transportation services to the patients served under the program.
654 The performance evaluation shall be completed and provided to the
655 members of the Senate Medicaid Committee and the House Medicaid
656 Committee not later than January 1, 2019, and every two (2) years
657 thereafter.

658 (37) [Deleted]

659 (38) Chiropractic services. A chiropractor's manual
660 manipulation of the spine to correct a subluxation, if x-ray
661 demonstrates that a subluxation exists and if the subluxation has
662 resulted in a neuromusculoskeletal condition for which
663 manipulation is appropriate treatment, and related spinal x-rays
664 performed to document these conditions. Reimbursement for



665 chiropractic services shall not exceed Seven Hundred Dollars
666 (\$700.00) per year per beneficiary.

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

675 (40) [Deleted]

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

686 (42) [Deleted]

687 (43) The division shall provide reimbursement,
688 according to a payment schedule developed by the division, for
689 smoking cessation medications for pregnant women during their



690 pregnancy and other Medicaid-eligible women who are of
691 child-bearing age.

692 (44) Nursing facility services for the severely
693 disabled.

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

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

700 (45) Physician assistant services. Services furnished
701 by a physician assistant who is licensed by the State Board of
702 Medical Licensure and is practicing with physician supervision
703 under regulations adopted by the board, under regulations adopted
704 by the division. Reimbursement for those services shall not
705 exceed ninety percent (90%) of the reimbursement rate for
706 comparable services rendered by a physician. The division may
707 provide for a reimbursement rate for physician assistant services
708 of up to one hundred percent (100%) or the reimbursement rate for
709 comparable services rendered by a physician for physician
710 assistant services that are provided after the normal working
711 hours of the physician assistant, as determined in accordance with
712 regulations of the division.

713 (46) The division shall make application to the federal
714 Centers for Medicare and Medicaid Services (CMS) for a waiver to



715 develop and provide services for children with serious emotional
716 disturbances as defined in Section 43-14-1(1), which may include
717 home- and community-based services, case management services or
718 managed care services through mental health providers certified by
719 the Department of Mental Health. The division may implement and
720 provide services under this waived program only if funds for
721 these services are specifically appropriated for this purpose by
722 the Legislature, or if funds are voluntarily provided by affected
723 agencies.

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

728 (b) Participation in any disease management
729 program implemented under this paragraph (47) is optional with the
730 individual. An individual must affirmatively elect to participate
731 in the disease management program in order to participate, and may
732 elect to discontinue participation in the program at any time.

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

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



739 chronic or long-term medical care to persons under twenty-one (21)
740 years of age.

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

743 (49) The division shall establish copayments and/or
744 coinsurance for all Medicaid services for which copayments and/or
745 coinsurance are allowable under federal law or regulation.

746 (50) Services provided by the State Department of
747 Rehabilitation Services for the care and rehabilitation of persons
748 who are deaf and blind, as allowed under waivers from the United
749 States Department of Health and Human Services to provide home-
750 and community-based services using state funds that are provided
751 from the appropriation to the State Department of Rehabilitation
752 Services or if funds are voluntarily provided by another agency.

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



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

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

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

778 (54) [Deleted]

779 (55) Therapy services. The plan of care for therapy
780 services may be developed to cover a period of treatment for up to
781 six (6) months, but in no event shall the plan of care exceed a
782 six-month period of treatment. The projected period of treatment
783 must be indicated on the initial plan of care and must be updated
784 with each subsequent revised plan of care. Based on medical
785 necessity, the division shall approve certification periods for
786 less than or up to six (6) months, but in no event shall the



787 certification period exceed the period of treatment indicated on
788 the plan of care. The appeal process for any reduction in therapy
789 services shall be consistent with the appeal process in federal
790 regulations.

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

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

806 (58) Treatment services for persons with opioid
807 dependency or other highly addictive substance use disorders. The
808 division is authorized to reimburse eligible providers for
809 treatment of opioid dependency and other highly addictive
810 substance use disorders, as determined by the division. Treatment



811 related to these conditions shall not count against any physician
812 visit limit imposed under this section.

813 (59) The division shall allow beneficiaries between the
814 ages of ten (10) and eighteen (18) years to receive vaccines
815 through a pharmacy venue.

816 (60) (a) The division shall provide Medicaid
817 reimbursement to a physician for a telemedicine medical service
818 provided by the physician, even if the physician is not the
819 patient's primary care physician or provider, if:

820 (i) The physician is an authorized health
821 care provider under Medicaid;

822 (ii) The patient is a child who receives the
823 service in a primary or secondary school-based setting;

824 (iii) The parent or legal guardian of the
825 patient provides consent before the service is provided; and

826 (iv) A health professional is present with
827 the patient during the treatment.

828 (b) In the case of a service provided to a child
829 in a school-based setting, the notification, if any, must include
830 a summary of the service, including exam findings, prescribed or
831 administered medications, and patient instructions.

832 (c) If a patient receiving a telemedicine medical
833 service in a school-based setting does not have a primary care
834 physician or provider, the division shall require that the
835 patient's parent or legal guardian receive:



836 (i) The notification required under this
837 paragraph; and
838 (ii) A list of primary care physicians or
839 providers from which the patient may select the patient's primary
840 care physician or provider.

841 (d) If before implementing any provision of this
842 paragraph the division determines that a waiver or authorization
843 from a federal agency is necessary for implementation of that
844 provision, the division affected by the provision shall request
845 the waiver or authorization and may delay implementing that
846 provision until the waiver or authorization is granted.

847 (B) Notwithstanding any other provision of this article to
848 the contrary, the division shall reduce the rate of reimbursement
849 to providers for any service provided under this section by five
850 percent (5%) of the allowed amount for that service. However, the
851 reduction in the reimbursement rates required by this subsection
852 (B) shall not apply to inpatient hospital services, outpatient
853 hospital services, nursing facility services, intermediate care
854 facility services, psychiatric residential treatment facility
855 services, pharmacy services provided under subsection (A) (9) of
856 this section, or any service provided by the University of
857 Mississippi Medical Center or a state agency, a state facility or
858 a public agency that either provides its own state match through
859 intergovernmental transfer or certification of funds to the
860 division, or a service for which the federal government sets the



861 reimbursement methodology and rate. From and after January 1,
862 2010, the reduction in the reimbursement rates required by this
863 subsection (B) shall not apply to physicians' services. In
864 addition, the reduction in the reimbursement rates required by
865 this subsection (B) shall not apply to case management services
866 and home-delivered meals provided under the home- and
867 community-based services program for the elderly and disabled by a
868 planning and development district (PDD). Planning and development
869 districts participating in the home- and community-based services
870 program for the elderly and disabled as case management providers
871 shall be reimbursed for case management services at the maximum
872 rate approved by the Centers for Medicare and Medicaid Services
873 (CMS). The Medical Care Advisory Committee established in Section
874 43-13-107(3)(a) shall develop a study and advise the division with
875 respect to (1) determining the effect of any across-the-board five
876 percent (5%) reduction in the rate of reimbursement to providers
877 authorized under this subsection (B), and (2) comparing provider
878 reimbursement rates to those applicable in other states in order
879 to establish a fair and equitable provider reimbursement structure
880 that encourages participation in the Medicaid program, and (3)
881 comparing dental and orthodontic services reimbursement rates to
882 those applicable in other states in fee-for-service and in managed
883 care programs in order to establish a fair and equitable dental
884 provider reimbursement structure that encourages participation in
885 the Medicaid program, and (4) make a report thereon with any



886 legislative recommendations to the Chairmen of the Senate and
887 House Medicaid Committees prior to January 1, 2019.

888 (C) The division may pay to those providers who participate
889 in and accept patient referrals from the division's emergency room
890 redirection program a percentage, as determined by the division,
891 of savings achieved according to the performance measures and
892 reduction of costs required of that program. Federally qualified
893 health centers may participate in the emergency room redirection
894 program, and the division may pay those centers a percentage of
895 any savings to the Medicaid program achieved by the centers'
896 accepting patient referrals through the program, as provided in
897 this subsection (C).

898 (D) [Deleted]

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

905 (F) The executive director shall keep the Governor advised
906 on a timely basis of the funds available for expenditure and the
907 projected expenditures. Notwithstanding any other provisions of
908 this article, if current or projected expenditures of the division
909 are reasonably anticipated to exceed the amount of funds
910 appropriated to the division for any fiscal year, the Governor,



911 after consultation with the executive director, shall take all
912 appropriate measures to reduce costs, which may include, but are
913 not limited to:

914 (1) Reducing or discontinuing any or all services that
915 are deemed to be optional under Title XIX of the Social Security
916 Act;

917 (2) Reducing reimbursement rates for any or all service
918 types;

919 (3) Imposing additional assessments on health care
920 providers; or

921 (4) Any additional cost-containment measures deemed
922 appropriate by the Governor.

923 Beginning in fiscal year 2010 and in fiscal years thereafter,
924 when Medicaid expenditures are projected to exceed funds available
925 for the fiscal year, the division shall submit the expected
926 shortfall information to the PEER Committee not later than
927 December 1 of the year in which the shortfall is projected to
928 occur. PEER shall review the computations of the division and
929 report its findings to the Legislative Budget Office not later
930 than January 7 in any year.

931 (G) Notwithstanding any other provision of this article, it
932 shall be the duty of each provider participating in the Medicaid
933 program to keep and maintain books, documents and other records as
934 prescribed by the Division of Medicaid in substantiation of its
935 cost reports for a period of three (3) years after the date of



936 submission to the Division of Medicaid of an original cost report,
937 or three (3) years after the date of submission to the Division of
938 Medicaid of an amended cost report.

939 (H) (1) Notwithstanding any other provision of this
940 article, the division is authorized to implement (a) a managed
941 care program, (b) a coordinated care program, (c) a coordinated
942 care organization program, (d) a health maintenance organization
943 program, (e) a patient-centered medical home program, (f) an
944 accountable care organization program, (g) provider-sponsored
945 health plan, or (h) any combination of the above programs.
946 Managed care programs, coordinated care programs, coordinated care
947 organization programs, health maintenance organization programs,
948 patient-centered medical home programs, accountable care
949 organization programs, provider-sponsored health plans, or any
950 combination of the above programs or other similar programs
951 implemented by the division under this section shall be limited to
952 the greater of (i) forty-five percent (45%) of the total
953 enrollment of Medicaid beneficiaries, or (ii) the categories of
954 beneficiaries participating in the program as of January 1, 2014,
955 plus the categories of beneficiaries composed primarily of persons
956 younger than nineteen (19) years of age, and the division is
957 authorized to enroll categories of beneficiaries in such
958 program(s) as long as the appropriate limitations are not exceeded
959 in the aggregate. As a condition for the approval of any program



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

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

965 (b) Override the medical decisions of hospital
966 physicians or staff regarding patients admitted to a hospital for
967 an emergency medical condition as defined by 42 US Code Section
968 1395dd. This restriction (b) does not prohibit the retrospective
969 review of the appropriateness of the determination that an
970 emergency medical condition exists by chart review or coding
971 algorithm, nor does it prohibit prior authorization for
972 nonemergency hospital admissions;

973 (c) Pay providers at a rate that is less than the
974 normal Medicaid reimbursement rate. It is the intent of the
975 Legislature that all managed care entities described in this
976 subsection (H), in collaboration with the division, develop and
977 implement innovative payment models that incentivize improvements
978 in health care quality, outcomes, or value, as determined by the
979 division. Participation in the provider network of any managed
980 care, coordinated care, provider-sponsored health plan, or similar
981 contractor shall not be conditioned on the provider's agreement to
982 accept such alternative payment models;

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



985 authorization processes used by the division in its administration
986 of the Medicaid program;

987 (e) [Deleted]

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

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

997 (2) Notwithstanding any provision of this section, no
998 expansion of Medicaid managed care program contracts may be
999 implemented by the division without enabling legislation from the
1000 Mississippi Legislature. There is hereby established the
1001 Commission on Expanding Medicaid Managed Care to develop a
1002 recommendation to the Legislature and the Division of Medicaid
1003 relative to authorizing the division to expand Medicaid managed
1004 care contracts to include additional categories of
1005 Medicaid-eligible beneficiaries, and to study the feasibility of
1006 developing an alternative managed care payment model for medically
1007 complex children.

1008 (a) The members of the commission shall be as
1009 follows:



1010 (i) The Chairmen of the Senate Medicaid
1011 Committee and the Senate Appropriations Committee and a member of
1012 the Senate appointed by the Lieutenant Governor;

1013 (ii) The Chairmen of the House Medicaid
1014 Committee and the House Appropriations Committee and a member of
1015 the House of Representatives appointed by the Speaker of the
1016 House;

1017 (iii) The Executive Director of the Division
1018 of Medicaid, Office of the Governor;

1019 (iv) The Commissioner of the Mississippi
1020 Department of Insurance;

1021 (v) A representative of a hospital that
1022 operates in Mississippi, appointed by the Speaker of the House;

1023 (vi) A licensed physician appointed by the
1024 Lieutenant Governor;

1025 (vii) A licensed pharmacist appointed by the
1026 Governor;

1027 (viii) A licensed mental health professional
1028 or alcohol and drug counselor appointed by the Governor;

1029 (ix) The Executive Director of the
1030 Mississippi State Medical Association (MSMA);

1031 (x) Representatives of each of the current
1032 managed care organizations operated in the state appointed by the
1033 Governor; and



1034 (xi) A representative of the long-term care
1035 industry appointed by the Governor.

1036 (b) The commission shall meet within forty-five
1037 (45) days of the effective date of this section, upon the call of
1038 the Governor, and shall evaluate the Medicaid managed care
1039 program. Specifically, the commission shall:

1040 (i) Review the program's financial metrics;

1041 (ii) Review the program's product offerings;

1042 (iii) Review the program's impact on
1043 insurance premiums for individuals and small businesses;

1044 (iv) Make recommendations for future managed
1045 care program modifications;

1046 (v) Determine whether the expansion of the
1047 Medicaid managed care program may endanger the access to care by
1048 vulnerable patients;

1049 (vi) Review the financial feasibility and
1050 health outcomes of populations health management as specifically
1051 provided in paragraph (2) above;

1052 (vii) Make recommendations regarding a pilot
1053 program to evaluate an alternative managed care payment model for
1054 medically complex children;

1055 (viii) The commission may request the
1056 assistance of the PEER Committee in making its evaluation; and



1057 (ix) The commission shall solicit information
1058 from any person or entity the commission deems relevant to its
1059 study.

1060 (c) The members of the commission shall elect a
1061 chair from among the members. The commission shall develop and
1062 report its findings and any recommendations for proposed
1063 legislation to the Governor and the Legislature on or before
1064 December 1, 2018. A quorum of the membership shall be required to
1065 approve any final report and recommendation. Members of the
1066 commission shall be reimbursed for necessary travel expense in the
1067 same manner as public employees are reimbursed for official duties
1068 and members of the Legislature shall be reimbursed in the same
1069 manner as for attending out-of-session committee meetings.

1070 (d) Upon making its report, the commission shall
1071 be dissolved.

1072 (3) Any contractors providing direct patient care under
1073 a managed care program established in this section shall provide
1074 to the Legislature and the division statistical data to be shared
1075 with provider groups in order to improve patient access,
1076 appropriate utilization, cost savings and health outcomes not
1077 later than October 1 of each year. The division and the
1078 contractors participating in the managed care program, a
1079 coordinated care program or a provider-sponsored health plan shall
1080 be subject to annual program audits performed by the Office of the
1081 State Auditor, the PEER Committee and/or an independent third



1082 party that has no existing contractual relationship with the
1083 division. Those audits shall determine among other items, the
1084 financial benefit to the State of Mississippi of the managed care
1085 program, the difference between the premiums paid to the managed
1086 care contractors and the payments made by those contractors to
1087 health care providers, compliance with performance measures
1088 required under the contracts, and whether costs have been
1089 contained due to improved health care outcomes. In addition, the
1090 audit shall review the most common claim denial codes to determine
1091 the reasons for the denials. This audit report shall be
1092 considered a public document and shall be posted in its entirety
1093 on the division's website.

1094 (4) All health maintenance organizations, coordinated
1095 care organizations, provider-sponsored health plans, or other
1096 organizations paid for services on a capitated basis by the
1097 division under any managed care program or coordinated care
1098 program implemented by the division under this section shall
1099 reimburse all providers in those organizations at rates no lower
1100 than those provided under this section for beneficiaries who are
1101 not participating in those programs.

1102 (5) No health maintenance organization, coordinated
1103 care organization, provider-sponsored health plan, or other
1104 organization paid for services on a capitated basis by the
1105 division under any managed care program or coordinated care
1106 program implemented by the division under this section shall



1107 require its providers or beneficiaries to use any pharmacy that
1108 ships, mails or delivers prescription drugs or legend drugs or
1109 devices.

1110 (6) No health maintenance organization, coordinated
1111 care organization, provider-sponsored health plan, or other
1112 organization paid for services on a capitated basis by the
1113 division under any managed care program or coordinated care
1114 program implemented by the division under this section shall
1115 require its providers to be credentialed by the organization in
1116 order to receive reimbursement from the organization, but those
1117 organizations shall recognize the credentialing of the providers
1118 by the division.

1119 (I) [Deleted]

1120 (J) There shall be no cuts in inpatient and outpatient
1121 hospital payments, or allowable days or volumes, as long as the
1122 hospital assessment provided in Section 43-13-145 is in effect.
1123 This subsection (J) shall not apply to decreases in payments that
1124 are a result of: reduced hospital admissions, audits or payments
1125 under the APR-DRG or APC models, or a managed care program or
1126 similar model described in subsection (H) of this section.

1127 (K) This section shall stand repealed on July 1, 2021.

1128 **SECTION 2.** This act shall take effect and be in force from
1129 and after July 1, 2019.

