MISSISSIPPI LEGISLATURE REGULAR SESSION 2020

By: Representative Currie

To: Medicaid

HOUSE BILL NO. 29

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO PROHIBIT ORGANIZATIONS PARTICIPATING IN A MANAGED CARE PROGRAM
3 OR COORDINATED CARE PROGRAM IMPLEMENTED BY THE DIVISION OF
4 MEDICAID FROM REMOVING ANY HOSPITALS LOCATED IN ALABAMA OR
5 TENNESSEE FROM THE COVERAGE PLANS OF THE ORGANIZATION UNLESS A
6 HOSPITAL REQUESTS TO BE REMOVED, OR REIMBURSING HOSPITALS IN
7 ALABAMA OR TENNESSEE FOR SERVICES PROVIDED TO MISSISSIPPI
8 RESIDENTS AT LOWER RATES OR AMOUNTS THAN ARE PAID TO HOSPITALS
9 LOCATED IN MISSISSIPPI FOR PROVIDING THE SAME SERVICES; AND FOR
10 RELATED PURPOSES.

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

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

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

21 (1) Inpatient hospital services.

22 (a) The division shall allow thirty (30) days of
23 inpatient hospital care annually for all Medicaid recipients.
24 Medicaid recipients requiring transplants shall not have those
25 days included in the transplant hospital stay count against the
26 thirty-day limit for inpatient hospital care. Precertification of
27 inpatient days must be obtained as required by the division.
28 (b) From and after July 1, 1994, the Executive
29 Director of the Division of Medicaid shall amend the Mississippi
30 Title XIX Inpatient Hospital Reimbursement Plan to remove the
31 occupancy rate penalty from the calculation of the Medicaid
32 Capital Cost Component utilized to determine total hospital costs
33 allocated to the Medicaid program.
34 (c) Hospitals may receive an additional payment
35 for the implantable programmable baclofen drug pump used to treat
36 spasticity that is implanted on an inpatient basis. The payment
37 pursuant to written invoice will be in addition to the facility's
38 per diem reimbursement and will represent a reduction of costs on
39 the facility's annual cost report, and shall not exceed Ten
40 Thousand Dollars ($10,000.00) per year per recipient.
41 (d) The division is authorized to implement an All
42 Patient Refined Diagnosis Related Groups (APR-DRG) reimbursement
43 methodology for inpatient hospital services.
44 (e) No service benefits or reimbursement
45 limitations in this section shall apply to payments under an
46 APR-DRG or Ambulatory Payment Classification (APC) model or a

47 managed care program or similar model described in subsection (H)
48 of this section unless specifically authorized by the division.
49 (2) Outpatient hospital services.
50 (a) Emergency services.
51 (b) Other outpatient hospital services. The
52 division shall allow benefits for other medically necessary
53 outpatient hospital services (such as chemotherapy, radiation,
54 surgery and therapy), including outpatient services in a clinic or
55 other facility that is not located inside the hospital, but that
56 has been designated as an outpatient facility by the hospital, and
57 that was in operation or under construction on July 1, 2009,
58 provided that the costs and charges associated with the operation
59 of the hospital clinic are included in the hospital's cost report.
60 In addition, the Medicare thirty-five-mile rule will apply to
61 those hospital clinics not located inside the hospital that are
62 constructed after July 1, 2009. Where the same services are
63 reimbursed as clinic services, the division may revise the rate or
64 methodology of outpatient reimbursement to maintain consistency,
65 efficiency, economy and quality of care.
66 (c) The division is authorized to implement an
67 Ambulatory Payment Classification (APC) methodology for outpatient
68 hospital services. The division may give rural hospitals that
69 have fifty (50) or fewer licensed beds the option to not be
70 reimbursed for outpatient hospital services using the APC
71 methodology, but reimbursement for outpatient hospital services

72 provided by those hospitals shall be based on one hundred one
73 percent (101%) of the rate established under Medicare for
74 outpatient hospital services. Those hospitals choosing to not be
75 reimbursed under the APC methodology shall remain under cost-based
76 reimbursement for a two-year period.
77 (d) No service benefits or reimbursement
78 limitations in this section shall apply to payments under an
79 APR-DRG or APC model or a managed care program or similar model
80 described in subsection (H) of this section.
81 (3) Laboratory and x-ray services.
82 (4) Nursing facility services.
83 (a) The division shall make full payment to
84 nursing facilities for each day, not exceeding forty-two (42) days
85 per year, that a patient is absent from the facility on home
86 leave. Payment may be made for the following home leave days in
87 addition to the forty-two-day limitation: Christmas, the day
88 before Christmas, the day after Christmas, Thanksgiving, the day
89 before Thanksgiving and the day after Thanksgiving.
90 (b) From and after July 1, 1997, the division
91 shall implement the integrated case-mix payment and quality
92 monitoring system, which includes the fair rental system for
93 property costs and in which recapture of depreciation is
94 eliminated. The division may reduce the payment for hospital
95 leave and therapeutic home leave days to the lower of the case-mix
96 category as computed for the resident on leave using the

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

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

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

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

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

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

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

172 determined in accordance with regulations of the division. The
173 division may reimburse eligible providers as determined by the
174 Patient Protection and Affordable Care Act for certain primary
175 care services as defined by the act at one hundred percent (100%)
176 of the rate established under Medicare. Additionally, the
177 division shall reimburse obstetricians and gynecologists for
178 certain primary care services as defined by the division at one
179 hundred percent (100%) of the rate established under Medicare.
180 (7) (a) Home health services for eligible persons, not
181 to exceed in cost the prevailing cost of nursing facility
182 services. All home health visits must be precertified as required
183 by the division.
184 (b) [Repealed]
185 (8) Emergency medical transportation services as
186 determined by the division.
187 (9) Prescription drugs and other covered drugs and
188 services as may be determined by the division.
189 The division shall establish a mandatory preferred drug list.
190 Drugs not on the mandatory preferred drug list shall be made
191 available by utilizing prior authorization procedures established
192 by the division.
193 The division may seek to establish relationships with other
194 states in order to lower acquisition costs of prescription drugs
195 to include single-source and innovator multiple-source drugs or
196 generic drugs. In addition, if allowed by federal law or

197 regulation, the division may seek to establish relationships with
198 and negotiate with other countries to facilitate the acquisition
199 of prescription drugs to include single-source and innovator
200 multiple-source drugs or generic drugs, if that will lower the
201 acquisition costs of those prescription drugs.
202 The division may allow for a combination of prescriptions for
203 single-source and innovator multiple-source drugs and generic
204 drugs to meet the needs of the beneficiaries.
205 The executive director may approve specific maintenance drugs
206 for beneficiaries with certain medical conditions, which may be
207 prescribed and dispensed in three-month supply increments.
208 Drugs prescribed for a resident of a psychiatric residential
209 treatment facility must be provided in true unit doses when
210 available. The division may require that drugs not covered by
211 Medicare Part D for a resident of a long-term care facility be
212 provided in true unit doses when available. Those drugs that were
213 originally billed to the division but are not used by a resident
214 in any of those facilities shall be returned to the billing
215 pharmacy for credit to the division, in accordance with the
216 guidelines of the State Board of Pharmacy and any requirements of
217 federal law and regulation. Drugs shall be dispensed to a
218 recipient and only one (1) dispensing fee per month may be
219 charged. The division shall develop a methodology for reimbursing
220 for restocked drugs, which shall include a restock fee as

221 determined by the division not exceeding Seven Dollars and
222 Eighty-two Cents ($7.82).

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

227 The division is authorized to develop and implement a program
228 of payment for additional pharmacist services as may be determined
229 by the division.

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

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

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

245 drugs and innovator multiple-source drugs and the costs to the
246 Medicaid program of those alternative drugs.
247 Notwithstanding any law or regulation, information obtained
248 or maintained by the division regarding the prescription drug
249 program, including trade secrets and manufacturer or labeler
250 pricing, is confidential and not subject to disclosure except to
251 other state agencies.
252 The dispensing fee for each new or refill prescription,
253 including nonlegend or over-the-counter drugs covered by the
254 division, shall be not less than Three Dollars and Ninety-one
255 Cents ($3.91), as determined by the division.
256 The division shall not reimburse for single-source or
257 innovator multiple-source drugs if there are equally effective
258 generic equivalents available and if the generic equivalents are
259 the least expensive.
260 It is the intent of the Legislature that the pharmacists
261 providers be reimbursed for the reasonable costs of filling and
262 dispensing prescriptions for Medicaid beneficiaries.
263 The division may allow certain drugs, implantable drug system
264 devices, and medical supplies, with limited distribution or
265 limited access for beneficiaries and administered in an
266 appropriate clinical setting, to be reimbursed as either a medical
267 claim or pharmacy claim, as determined by the division.
268 Notwithstanding any other provision of this article, the
269 division shall allow physician-administered drugs to be billed and

270 reimbursed as either a medical claim or pharmacy point-of-sale to
271 allow greater access to care.

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

276 (10) Dental and orthodontic services to be determined
277 by the division.

278 This dental services program under this paragraph shall be
279 known as the "James Russell Dumas Medicaid Dental Services
280 Program."

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

290 The division shall include dental services as a necessary
291 component of overall health services provided to children who are
292 eligible for services.

293 (11) Eyeglasses for all Medicaid beneficiaries who have
294 (a) had surgery on the eyeball or ocular muscle that results in a

295 vision change for which eyeglasses or a change in eyeglasses is
296 medically indicated within six (6) months of the surgery and is in
297 accordance with policies established by the division, or (b) one
298 (1) pair every five (5) years and in accordance with policies
299 established by the division. In either instance, the eyeglasses
300 must be prescribed by a physician skilled in diseases of the eye
301 or an optometrist, whichever the beneficiary may select.
302 (12) Intermediate care facility services.
303 (a) The division shall make full payment to all
304 intermediate care facilities for individuals with intellectual
305 disabilities for each day, not exceeding sixty-three (63) days per
306 year, that a patient is absent from the facility on home leave.
307 Payment may be made for the following home leave days in addition
308 to the sixty-three-day limitation: Christmas, the day before
309 Christmas, the day after Christmas, Thanksgiving, the day before
310 Thanksgiving and the day after Thanksgiving.
311 (b) All state-owned intermediate care facilities
312 for individuals with intellectual disabilities shall be reimbursed
313 on a full reasonable cost basis.
314 (c) Effective January 1, 2015, the division shall
315 update the fair rental reimbursement system for intermediate care
316 facilities for individuals with intellectual disabilities.
317 (13) Family planning services, including drugs,
318 supplies and devices, when those services are under the
319 supervision of a physician or nurse practitioner.

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

345 availability of funds specifically appropriated for that purpose
346 by the Legislature.

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

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

369 (17) Durable medical equipment services and medical
370 supplies. Precertification of durable medical equipment and
371 medical supplies must be obtained as required by the division.
372 The Division of Medicaid may require durable medical equipment
373 providers to obtain a surety bond in the amount and to the
374 specifications as established by the Balanced Budget Act of 1997.
375 (18) (a) Notwithstanding any other provision of this
376 section to the contrary, as provided in the Medicaid state plan
377 amendment or amendments as defined in Section 43-13-145(10), the
378 division shall make additional reimbursement to hospitals that
379 serve a disproportionate share of low-income patients and that
380 meet the federal requirements for those payments as provided in
381 Section 1923 of the federal Social Security Act and any applicable
382 regulations. It is the intent of the Legislature that the
383 division shall draw down all available federal funds allotted to
384 the state for disproportionate share hospitals. However, from and
385 after January 1, 1999, public hospitals participating in the
386 Medicaid disproportionate share program may be required to
387 participate in an intergovernmental transfer program as provided
388 in Section 1903 of the federal Social Security Act and any
389 applicable regulations.
390 (b) The division may establish a Medicare Upper
391 Payment Limits Program, as defined in Section 1902(a)(30) of the
392 federal Social Security Act and any applicable federal
393 regulations, for hospitals, and may establish a Medicare Upper

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

419 physicians, shall make additional reimbursement for physicians, as
420 defined in Section 1902(a)(30) of the federal Social Security Act
421 and any applicable federal regulations. Notwithstanding any other
422 provision of this article to the contrary, effective upon
423 implementation of the Mississippi Hospital Access Program (MHAP)
424 provided in subparagraph (c)(i) below, the hospital portion of the
425 inpatient Upper Payment Limits Program shall transition into and
426 be replaced by the MHAP program. However, the division is
427 authorized to develop and implement an alternative fee-for-service
428 Upper Payment Limits model in accordance with federal laws and
429 regulations if necessary to preserve supplemental funding.
430 Further, the division, in consultation with the Mississippi
431 Hospital Association and a governmental hospital located in a
432 county bordering the Gulf of Mexico and the State of Alabama shall
433 develop alternative models for distribution of medical claims and
434 supplemental payments for inpatient and outpatient hospital
435 services, and such models may include, but shall not be limited to
436 the following: increasing rates for inpatient and outpatient
437 services; creating a low-income utilization pool of funds to
438 reimburse hospitals for the costs of uncompensated care, charity
439 care and bad debts as permitted and approved pursuant to federal
440 regulations and the Centers for Medicare and Medicaid Services;
441 supplemental payments based upon Medicaid utilization, quality,
442 service lines and/or costs of providing such services to Medicaid
443 beneficiaries and to uninsured patients. The goals of such

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

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

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

490 (iii) The intent of this subparagraph (c) is
491 that effective for all inpatient hospital Medicaid services during
492 state fiscal year 2016, and so long as this provision shall remain

493 in effect hereafter, the division shall to the fullest extent
494 feasible replace the additional reimbursement for hospital
495 inpatient services under the inpatient Medicare Upper Payment
496 Limits (UPL) Program with additional reimbursement under the MHAP
497 and other payment programs for inpatient and/or outpatient
498 payments which may be developed under the authority of this
499 paragraph.

500 (iv) The division shall assess each hospital
501 as provided in Section 43-13-145(4)(a) for the purpose of
502 financing the state portion of the MHAP, supplemental payments and
503 such other purposes as specified in Section 43-13-145. The
504 assessment will remain in effect as long as the MHAP and
505 supplemental payments are in effect.

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

517 Department of Health as the agency for PHRM/ISS for the Division
518 of Medicaid shall be reimbursed on a full reasonable cost basis.
519 (b) Early intervention system services. The
520 division shall cooperate with the State Department of Health,
521 acting as lead agency, in the development and implementation of a
522 statewide system of delivery of early intervention services, under
523 Part C of the Individuals with Disabilities Education Act (IDEA).
524 The State Department of Health shall certify annually in writing
525 to the executive director of the division the dollar amount of
526 state early intervention funds available that will be utilized as
527 a certified match for Medicaid matching funds. Those funds then
528 shall be used to provide expanded targeted case management
529 services for Medicaid eligible children with special needs who are
530 eligible for the state's early intervention system.
531 Qualifications for persons providing service coordination shall be
532 determined by the State Department of Health and the Division of
533 Medicaid.
534 (20) Home- and community-based services for physically
535 disabled approved services as allowed by a waiver from the United
536 States Department of Health and Human Services for home- and
537 community-based services for physically disabled people using
538 state funds that are provided from the appropriation to the State
539 Department of Rehabilitation Services and used to match federal
540 funds under a cooperative agreement between the division and the
541 department, provided that funds for these services are

542 specifically appropriated to the Department of Rehabilitation
543 Services.
544 (21) Nurse practitioner services. Services furnished
545 by a registered nurse who is licensed and certified by the
546 Mississippi Board of Nursing as a nurse practitioner, including,
547 but not limited to, nurse anesthetists, nurse midwives, family
548 nurse practitioners, family planning nurse practitioners,
549 pediatric nurse practitioners, obstetrics-gynecology nurse
550 practitioners and neonatal nurse practitioners, under regulations
551 adopted by the division. Reimbursement for those services shall
552 not exceed ninety percent (90%) of the reimbursement rate for
553 comparable services rendered by a physician. The division may
554 provide for a reimbursement rate for nurse practitioner services
555 of up to one hundred percent (100%) of the reimbursement rate for
556 comparable services rendered by a physician for nurse practitioner
557 services that are provided after the normal working hours of the
558 nurse practitioner, as determined in accordance with regulations
559 of the division.
560 (22) Ambulatory services delivered in federally
561 qualified health centers, rural health centers and clinics of the
562 local health departments of the State Department of Health for
563 individuals eligible for Medicaid under this article based on
564 reasonable costs as determined by the division. Federally
565 qualified health centers shall be reimbursed by the Medicaid

566 prospective payment system as approved by the Centers for Medicare
567 and Medicaid Services.
568 (23) Inpatient psychiatric services. Inpatient
569 psychiatric services to be determined by the division for
570 recipients under age twenty-one (21) that are provided under the
571 direction of a physician in an inpatient program in a licensed
572 acute care psychiatric facility or in a licensed psychiatric
573 residential treatment facility, before the recipient reaches age
574 twenty-one (21) or, if the recipient was receiving the services
575 immediately before he or she reached age twenty-one (21), before
576 the earlier of the date he or she no longer requires the services
577 or the date he or she reaches age twenty-two (22), as provided by
578 federal regulations. From and after January 1, 2015, the division
579 shall update the fair rental reimbursement system for psychiatric
580 residential treatment facilities. Precertification of inpatient
581 days and residential treatment days must be obtained as required
582 by the division. From and after July 1, 2009, all state-owned and
583 state-operated facilities that provide inpatient psychiatric
584 services to persons under age twenty-one (21) who are eligible for
585 Medicaid reimbursement shall be reimbursed for those services on a
586 full reasonable cost basis.
587 (24) [Deleted]
588 (25) [Deleted]
589 (26) Hospice care. As used in this paragraph, the term
590 "hospice care" means a coordinated program of active professional

591 medical attention within the home and outpatient and inpatient
592 care that treats the terminally ill patient and family as a unit,
593 employing a medically directed interdisciplinary team. The
594 program provides relief of severe pain or other physical symptoms
595 and supportive care to meet the special needs arising out of
596 physical, psychological, spiritual, social and economic stresses
597 that are experienced during the final stages of illness and during
598 dying and bereavement and meets the Medicare requirements for
599 participation as a hospice as provided in federal regulations.
600 (27) Group health plan premiums and cost-sharing if it
601 is cost-effective as defined by the United States Secretary of
602 Health and Human Services.
603 (28) Other health insurance premiums that are
604 cost-effective as defined by the United States Secretary of Health
605 and Human Services. Medicare eligible must have Medicare Part B
606 before other insurance premiums can be paid.
607 (29) The Division of Medicaid may apply for a waiver
608 from the United States Department of Health and Human Services for
609 home- and community-based services for developmentally disabled
610 people using state funds that are provided from the appropriation
611 to the State Department of Mental Health and/or funds transferred
612 to the department by a political subdivision or instrumentality of
613 the state and used to match federal funds under a cooperative
614 agreement between the division and the department, provided that
615 funds for these services are specifically appropriated to the

616 Department of Mental Health and/or transferred to the department
617 by a political subdivision or instrumentality of the state.
618 (30) Pediatric skilled nursing services for eligible
619 persons under twenty-one (21) years of age.
620 (31) Targeted case management services for children
621 with special needs, under waivers from the United States
622 Department of Health and Human Services, using state funds that
623 are provided from the appropriation to the Mississippi Department
624 of Human Services and used to match federal funds under a
625 cooperative agreement between the division and the department.
626 (32) Care and services provided in Christian Science
627 Sanatoria listed and certified by the Commission for Accreditation
628 of Christian Science Nursing Organizations/Facilities, Inc.,
629 rendered in connection with treatment by prayer or spiritual means
630 to the extent that those services are subject to reimbursement
631 under Section 1903 of the federal Social Security Act.
632 (33) Podiatrist services.
633 (34) Assisted living services as provided through
634 home- and community-based services under Title XIX of the federal
635 Social Security Act, as amended, subject to the availability of
636 funds specifically appropriated for that purpose by the
637 Legislature.
638 (35) Services and activities authorized in Sections
639 43-27-101 and 43-27-103, using state funds that are provided from
640 the appropriation to the Mississippi Department of Human Services

641 and used to match federal funds under a cooperative agreement
642 between the division and the department.
643 (36) Nonemergency transportation services for
644 Medicaid-eligible persons, to be provided by the Division of
645 Medicaid. The division may contract with additional entities to
646 administer nonemergency transportation services as it deems
647 necessary. All providers shall have a valid driver's license,
648 valid vehicle license tags and a standard liability insurance
649 policy covering the vehicle. The division may pay providers a
650 flat fee based on mileage tiers, or in the alternative, may
651 reimburse on actual miles traveled. The division may apply to the
652 Center for Medicare and Medicaid Services (CMS) for a waiver to
653 draw federal matching funds for nonemergency transportation
654 services as a covered service instead of an administrative cost.
655 The PEER Committee shall conduct a performance evaluation of the
656 nonemergency transportation program to evaluate the administration
657 of the program and the providers of transportation services to
658 determine the most cost-effective ways of providing nonemergency
659 transportation services to the patients served under the program.
660 The performance evaluation shall be completed and provided to the
661 members of the Senate Medicaid Committee and the House Medicaid
662 Committee not later than January 1, 2019, and every two (2) years
663 thereafter.
664 (37) [Deleted]

665 (38) Chiropractic services. A chiropractor's manual
666 manipulation of the spine to correct a subluxation, if x-ray
667 demonstrates that a subluxation exists and if the subluxation has
668 resulted in a neuromusculoskeletal condition for which
669 manipulation is appropriate treatment, and related spinal x-rays
670 performed to document these conditions. Reimbursement for
671 chiropractic services shall not exceed Seven Hundred Dollars
672 ($700.00) per year per beneficiary.
673 (39) Dually eligible Medicare/Medicaid beneficiaries.
674 The division shall pay the Medicare deductible and coinsurance
675 amounts for services available under Medicare, as determined by
676 the division. From and after July 1, 2009, the division shall
677 reimburse crossover claims for inpatient hospital services and
678 crossover claims covered under Medicare Part B in the same manner
679 that was in effect on January 1, 2008, unless specifically
680 authorized by the Legislature to change this method.
681 (40) [Deleted]
682 (41) Services provided by the State Department of
683 Rehabilitation Services for the care and rehabilitation of persons
684 with spinal cord injuries or traumatic brain injuries, as allowed
685 under waivers from the United States Department of Health and
686 Human Services, using up to seventy-five percent (75%) of the
687 funds that are appropriated to the Department of Rehabilitation
688 Services from the Spinal Cord and Head Injury Trust Fund
689 established under Section 37-33-261 and used to match federal

690 funds under a cooperative agreement between the division and the
691 department.
692 (42) [Deleted]
693 (43) The division shall provide reimbursement,
694 according to a payment schedule developed by the division, for
695 smoking cessation medications for pregnant women during their
696 pregnancy and other Medicaid-eligible women who are of
697 child-bearing age.
698 (44) Nursing facility services for the severely
699 disabled.
700 (a) Severe disabilities include, but are not
701 limited to, spinal cord injuries, closed-head injuries and
702 ventilator-dependent patients.
703 (b) Those services must be provided in a long-term
704 care nursing facility dedicated to the care and treatment of
705 persons with severe disabilities.
706 (45) Physician assistant services. Services furnished
707 by a physician assistant who is licensed by the State Board of
708 Medical Licensure and is practicing with physician supervision
709 under regulations adopted by the board, under regulations adopted
710 by the division. Reimbursement for those services shall not
711 exceed ninety percent (90%) of the reimbursement rate for
712 comparable services rendered by a physician. The division may
713 provide for a reimbursement rate for physician assistant services
714 of up to one hundred percent (100%) or the reimbursement rate for

715 comparable services rendered by a physician for physician
716 assistant services that are provided after the normal working
717 hours of the physician assistant, as determined in accordance with
718 regulations of the division.

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

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

734 (b) Participation in any disease management
735 program implemented under this paragraph (47) is optional with the
736 individual. An individual must affirmatively elect to participate
737 in the disease management program in order to participate, and may
738 elect to discontinue participation in the program at any time.

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

740 (a) Pediatric long-term acute care hospital
741 services means services provided to eligible persons under
742 twenty-one (21) years of age by a freestanding Medicare-certified
743 hospital that has an average length of inpatient stay greater than
744 twenty-five (25) days and that is primarily engaged in providing
745 chronic or long-term medical care to persons under twenty-one (21)
746 years of age.
747 (b) The services under this paragraph (48) shall
748 be reimbursed as a separate category of hospital services.
749 (49) The division shall establish copayments and/or
750 coinsurance for all Medicaid services for which copayments and/or
751 coinsurance are allowable under federal law or regulation.
752 (50) Services provided by the State Department of
753 Rehabilitation Services for the care and rehabilitation of persons
754 who are deaf and blind, as allowed under waivers from the United
755 States Department of Health and Human Services to provide home-
756 and community-based services using state funds that are provided
757 from the appropriation to the State Department of Rehabilitation
758 Services or if funds are voluntarily provided by another agency.
759 (51) Upon determination of Medicaid eligibility and in
760 association with annual redetermination of Medicaid eligibility,
761 beneficiaries shall be encouraged to undertake a physical
762 examination that will establish a base-line level of health and
763 identification of a usual and customary source of care (a medical
764 home) to aid utilization of disease management tools. This

765 physical examination and utilization of these disease management
766 tools shall be consistent with current United States Preventive
767 Services Task Force or other recognized authority recommendations.
768 For persons who are determined ineligible for Medicaid, the
769 division will provide information and direction for accessing
770 medical care and services in the area of their residence.
771 (52) Notwithstanding any provisions of this article,
772 the division may pay enhanced reimbursement fees related to trauma
773 care, as determined by the division in conjunction with the State
774 Department of Health, using funds appropriated to the State
775 Department of Health for trauma care and services and used to
776 match federal funds under a cooperative agreement between the
777 division and the State Department of Health. The division, in
778 conjunction with the State Department of Health, may use grants,
779 waivers, demonstrations, or other projects as necessary in the
780 development and implementation of this reimbursement program.
781 (53) Targeted case management services for high-cost
782 beneficiaries may be developed by the division for all services
783 under this section.
784 (54) [Deleted]
785 (55) Therapy services. The plan of care for therapy
786 services may be developed to cover a period of treatment for up to
787 six (6) months, but in no event shall the plan of care exceed a
788 six-month period of treatment. The projected period of treatment
789 must be indicated on the initial plan of care and must be updated

790 with each subsequent revised plan of care. Based on medical
791 necessity, the division shall approve certification periods for
792 less than or up to six (6) months, but in no event shall the
793 certification period exceed the period of treatment indicated on
794 the plan of care. The appeal process for any reduction in therapy
795 services shall be consistent with the appeal process in federal
796 regulations.

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

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

812 (58) Treatment services for persons with opioid
813 dependency or other highly addictive substance use disorders. The
814 division is authorized to reimburse eligible providers for

815 treatment of opioid dependency and other highly addictive
816 substance use disorders, as determined by the division. Treatment
817 related to these conditions shall not count against any physician
818 visit limit imposed under this section.
819 (59) The division shall allow beneficiaries between the
820 ages of ten (10) and eighteen (18) years to receive vaccines
821 through a pharmacy venue.
822 (B) Notwithstanding any other provision of this article to
823 the contrary, the division shall reduce the rate of reimbursement
824 to providers for any service provided under this section by five
825 percent (5%) of the allowed amount for that service. However, the
826 reduction in the reimbursement rates required by this subsection
827 (B) shall not apply to inpatient hospital services, outpatient
828 hospital services, nursing facility services, intermediate care
829 facility services, psychiatric residential treatment facility
830 services, pharmacy services provided under subsection (A)(9) of
831 this section, or any service provided by the University of
832 Mississippi Medical Center or a state agency, a state facility or
833 a public agency that either provides its own state match through
834 intergovernmental transfer or certification of funds to the
835 division, or a service for which the federal government sets the
836 reimbursement methodology and rate. From and after January 1,
837 2010, the reduction in the reimbursement rates required by this
838 subsection (B) shall not apply to physicians' services. In
839 addition, the reduction in the reimbursement rates required by

840 this subsection (B) shall not apply to case management services
841 and home-delivered meals provided under the home- and
842 community-based services program for the elderly and disabled by a
843 planning and development district (PDD). Planning and development
844 districts participating in the home- and community-based services
845 program for the elderly and disabled as case management providers
846 shall be reimbursed for case management services at the maximum
847 rate approved by the Centers for Medicare and Medicaid Services
848 (CMS). The Medical Care Advisory Committee established in Section
849 43-13-107(3)(a) shall develop a study and advise the division with
850 respect to (1) determining the effect of any across-the-board five
851 percent (5%) reduction in the rate of reimbursement to providers
852 authorized under this subsection (B), and (2) comparing provider
853 reimbursement rates to those applicable in other states in order
854 to establish a fair and equitable provider reimbursement structure
855 that encourages participation in the Medicaid program, and (3)
856 comparing dental and orthodontic services reimbursement rates to
857 those applicable in other states in fee-for-service and in managed
858 care programs in order to establish a fair and equitable dental
859 provider reimbursement structure that encourages participation in
860 the Medicaid program, and (4) make a report thereon with any
861 legislative recommendations to the Chairmen of the Senate and
862 House Medicaid Committees prior to January 1, 2019.
863 (C) The division may pay to those providers who participate
864 in and accept patient referrals from the division's emergency room

865 redirection program a percentage, as determined by the division,
866 of savings achieved according to the performance measures and
867 reduction of costs required of that program. Federally qualified
868 health centers may participate in the emergency room redirection
869 program, and the division may pay those centers a percentage of
870 any savings to the Medicaid program achieved by the centers'
871 accepting patient referrals through the program, as provided in
872 this subsection (C).

873 (D) [Deleted]

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

880 (F) The executive director shall keep the Governor advised
881 on a timely basis of the funds available for expenditure and the
882 projected expenditures. Notwithstanding any other provisions of
883 this article, if current or projected expenditures of the division
884 are reasonably anticipated to exceed the amount of funds
885 appropriated to the division for any fiscal year, the Governor,
886 after consultation with the executive director, shall take all
887 appropriate measures to reduce costs, which may include, but are
888 not limited to:

889 (1) Reducing or discontinuing any or all services that
890 are deemed to be optional under Title XIX of the Social Security
891 Act;
892 (2) Reducing reimbursement rates for any or all service
893 types;
894 (3) Imposing additional assessments on health care
895 providers; or
896 (4) Any additional cost-containment measures deemed
897 appropriate by the Governor.
898 Beginning in fiscal year 2010 and in fiscal years thereafter,
899 when Medicaid expenditures are projected to exceed funds available
900 for the fiscal year, the division shall submit the expected
901 shortfall information to the PEER Committee not later than
902 December 1 of the year in which the shortfall is projected to
903 occur. PEER shall review the computations of the division and
904 report its findings to the Legislative Budget Office not later
905 than January 7 in any year.
906 (G) Notwithstanding any other provision of this article, it
907 shall be the duty of each provider participating in the Medicaid
908 program to keep and maintain books, documents and other records as
909 prescribed by the Division of Medicaid in substantiation of its
910 cost reports for a period of three (3) years after the date of
911 submission to the Division of Medicaid of an original cost report,
912 or three (3) years after the date of submission to the Division of
913 Medicaid of an amended cost report.

914 (H) (1) Notwithstanding any other provision of this
915 article, the division is authorized to implement (a) a managed
916 care program, (b) a coordinated care program, (c) a coordinated
917 care organization program, (d) a health maintenance organization
918 program, (e) a patient-centered medical home program, (f) an
919 accountable care organization program, (g) provider-sponsored
920 health plan, or (h) any combination of the above programs.
921 Managed care programs, coordinated care programs, coordinated care
922 organization programs, health maintenance organization programs,
923 patient-centered medical home programs, accountable care
924 organization programs, provider-sponsored health plans, or any
925 combination of the above programs or other similar programs
926 implemented by the division under this section shall be limited to
927 the greater of (i) forty-five percent (45%) of the total
928 enrollment of Medicaid beneficiaries, or (ii) the categories of
929 beneficiaries participating in the program as of January 1, 2014,
930 plus the categories of beneficiaries composed primarily of persons
931 younger than nineteen (19) years of age, and the division is
932 authorized to enroll categories of beneficiaries in such
933 program(s) as long as the appropriate limitations are not exceeded
934 in the aggregate. As a condition for the approval of any program
935 under this subsection (H)(1), the division shall require that no
936 program may:

937 (a) Pay providers at a rate that is less than the
938 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
939 reimbursement rate;
940 (b) Override the medical decisions of hospital
941 physicians or staff regarding patients admitted to a hospital for
942 an emergency medical condition as defined by 42 US Code Section
943 1395dd. This restriction (b) does not prohibit the retrospective
944 review of the appropriateness of the determination that an
945 emergency medical condition exists by chart review or coding
946 algorithm, nor does it prohibit prior authorization for
947 nonemergency hospital admissions;
948 (c) Pay providers at a rate that is less than the
949 normal Medicaid reimbursement rate. It is the intent of the
950 Legislature that all managed care entities described in this
951 subsection (H), in collaboration with the division, develop and
952 implement innovative payment models that incentivize improvements
953 in health care quality, outcomes, or value, as determined by the
954 division. Participation in the provider network of any managed
955 care, coordinated care, provider-sponsored health plan, or similar
956 contractor shall not be conditioned on the provider's agreement to
957 accept such alternative payment models;
958 (d) Implement a prior authorization program for
959 prescription drugs that is more stringent than the prior
960 authorization processes used by the division in its administration
961 of the Medicaid program;

962 (e) [Deleted]

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

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

972 (2) Notwithstanding any provision of this section, no
973 expansion of Medicaid managed care program contracts may be
974 implemented by the division without enabling legislation from the
975 Mississippi Legislature. There is hereby established the
976 Commission on Expanding Medicaid Managed Care to develop a
977 recommendation to the Legislature and the Division of Medicaid
978 relative to authorizing the division to expand Medicaid managed
979 care contracts to include additional categories of
980 Medicaid-eligible beneficiaries, and to study the feasibility of
981 developing an alternative managed care payment model for medically
982 complex children.

983 (a) The members of the commission shall be as
984 follows:

985 (i) The Chairmen of the Senate Medicaid
986 Committee and the Senate Appropriations Committee and a member of
987 the Senate appointed by the Lieutenant Governor;
988 (ii) The Chairmen of the House Medicaid
989 Committee and the House Appropriations Committee and a member of
990 the House of Representatives appointed by the Speaker of the
991 House;
992 (iii) The Executive Director of the Division
993 of Medicaid, Office of the Governor;
994 (iv) The Commissioner of the Mississippi
995 Department of Insurance;
996 (v) A representative of a hospital that
997 operates in Mississippi, appointed by the Speaker of the House;
998 (vi) A licensed physician appointed by the
999 Lieutenant Governor;
1000 (vii) A licensed pharmacist appointed by the
1001 Governor;
1002 (viii) A licensed mental health professional
1003 or alcohol and drug counselor appointed by the Governor;
1004 (ix) The Executive Director of the
1005 Mississippi State Medical Association (MSMA);
1006 (x) Representatives of each of the current
1007 managed care organizations operated in the state appointed by the
1008 Governor; and

1009 (xi) A representative of the long-term care
1010 industry appointed by the Governor.
1011 (b) The commission shall meet within forty-five
1012 (45) days of the effective date of this section, upon the call of
1013 the Governor, and shall evaluate the Medicaid managed care
1014 program. Specifically, the commission shall:
1015 (i) Review the program's financial metrics;
1016 (ii) Review the program's product offerings;
1017 (iii) Review the program's impact on
1018 insurance premiums for individuals and small businesses;
1019 (iv) Make recommendations for future managed
1020 care program modifications;
1021 (v) Determine whether the expansion of the
1022 Medicaid managed care program may endanger the access to care by
1023 vulnerable patients;
1024 (vi) Review the financial feasibility and
1025 health outcomes of populations health management as specifically
1026 provided in paragraph (2) above;
1027 (vii) Make recommendations regarding a pilot
1028 program to evaluate an alternative managed care payment model for
1029 medically complex children;
1030 (viii) The commission may request the
1031 assistance of the PEER Committee in making its evaluation; and

1032 (ix) The commission shall solicit information
1033 from any person or entity the commission deems relevant to its
1034 study.
1035 (c) The members of the commission shall elect a
1036 chair from among the members. The commission shall develop and
1037 report its findings and any recommendations for proposed
1038 legislation to the Governor and the Legislature on or before
1039 December 1, 2018. A quorum of the membership shall be required to
1040 approve any final report and recommendation. Members of the
1041 commission shall be reimbursed for necessary travel expense in the
1042 same manner as public employees are reimbursed for official duties
1043 and members of the Legislature shall be reimbursed in the same
1044 manner as for attending out-of-session committee meetings.
1045 (d) Upon making its report, the commission shall
1046 be dissolved.
1047 (3) Any contractors providing direct patient care under
1048 a managed care program established in this section shall provide
1049 to the Legislature and the division statistical data to be shared
1050 with provider groups in order to improve patient access,
1051 appropriate utilization, cost savings and health outcomes not
1052 later than October 1 of each year. The division and the
1053 contractors participating in the managed care program, a
1054 coordinated care program or a provider-sponsored health plan shall
1055 be subject to annual program audits performed by the Office of the
1056 State Auditor, the PEER Committee and/or an independent third

1057 party that has no existing contractual relationship with the
1058 division. Those audits shall determine among other items, the
1059 financial benefit to the State of Mississippi of the managed care
1060 program, the difference between the premiums paid to the managed
1061 care contractors and the payments made by those contractors to
1062 health care providers, compliance with performance measures
1063 required under the contracts, and whether costs have been
1064 contained due to improved health care outcomes. In addition, the
1065 audit shall review the most common claim denial codes to determine
1066 the reasons for the denials. This audit report shall be
1067 considered a public document and shall be posted in its entirety
1068 on the division's website.

1069 (4) All health maintenance organizations, coordinated
1070 care organizations, provider-sponsored health plans, or other
1071 organizations paid for services on a capitated basis by the
1072 division under any managed care program or coordinated care
1073 program implemented by the division under this section shall
1074 reimburse all providers in those organizations at rates no lower
1075 than those provided under this section for beneficiaries who are
1076 not participating in those programs.

1077 (5) No health maintenance organization, coordinated
1078 care organization, provider-sponsored health plan, or other
1079 organization paid for services on a capitated basis by the
1080 division under any managed care program or coordinated care
1081 program implemented by the division under this section shall

1082 require its providers or beneficiaries to use any pharmacy that
1083 ships, mails or delivers prescription drugs or legend drugs or
1084 devices.

1085 (6) No health maintenance organization, coordinated
1086 care organization, provider-sponsored health plan, or other
1087 organization paid for services on a capitated basis by the
1088 division under any managed care program or coordinated care
1089 program implemented by the division under this section shall
1090 require its providers to be credentialed by the organization in
1091 order to receive reimbursement from the organization, but those
1092 organizations shall recognize the credentialing of the providers
1093 by the division.

1094 (7) No health maintenance organization, coordinated
1095 care organization, provider-sponsored health plan, or other
1096 organization 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 (a)
1099 remove any hospitals located in Alabama or Tennessee from the
1100 coverage plans of the organization unless a hospital requests to
1101 be removed, or (b) reimburse hospitals in Alabama or Tennessee for
1102 services provided to Mississippi residents at lower rates or
1103 amounts than are paid to hospitals located in Mississippi for
1104 providing the same services.

1105 (I) [Deleted]

1106 (J) There shall be no cuts in inpatient and outpatient
1107 hospital payments, or allowable days or volumes, as long as the
1108 hospital assessment provided in Section 43-13-145 is in effect.
1109 This subsection (J) shall not apply to decreases in payments that
1110 are a result of: reduced hospital admissions, audits or payments
1111 under the APR-DRG or APC models, or a managed care program or
1112 similar model described in subsection (H) of this section.
1113 (K) This section shall stand repealed on July 1, 2021.
1114 **SECTION 2.** This act shall take effect and be in force from
1115 and after its passage.