MISSISSIPPI LEGISLATURE REGULAR SESSION 2020

By: Representative Currie

To: Medicaid

HOUSE BILL NO. 32

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO REQUIRE EACH ORGANIZATION PARTICIPATING IN A MANAGED CARE
3 PROGRAM OR COORDINATED CARE PROGRAM IMPLEMENTED BY THE DIVISION OF
4 MEDICAID TO PROVIDE TO EACH HEALTH CARE PROVIDER FOR WHOM THE
5 ORGANIZATION HAS DENIED THE COVERAGE OF A PROCEDURE THAT WAS
6 ORDERED OR REQUESTED BY THE HEALTH CARE PROVIDER FOR A PATIENT, A
7 LETTER THAT PROVIDES A DETAILED EXPLANATION OF THE REASONS FOR THE
8 DENIAL OF COVERAGE OF THE PROCEDURE AND THE NAME AND THE
9 CREDENTIALS OF THE PERSON WHO DENIED THE COVERAGE; TO PROVIDE THAT
10 THE LETTER SHALL BE SENT TO THE HEALTH CARE PROVIDER IN BOTH
11 PHYSICAL AND ELECTRONIC FORMAT AND SHALL BE SIGNED BY THE PERSON
12 WHO DENIED THE COVERAGE; AND FOR RELATED PURPOSES.

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

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

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

23 (1) Inpatient hospital services.

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

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

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

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

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

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

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

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

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

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

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

199 regulation, the division may seek to establish relationships with
200 and negotiate with other countries to facilitate the acquisition
201 of prescription drugs to include single-source and innovator
202 multiple-source drugs or generic drugs, if that will lower the
203 acquisition costs of those prescription drugs.

204 The division may allow for a combination of prescriptions for
205 single-source and innovator multiple-source drugs and generic
206 drugs to meet the needs of the beneficiaries.

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

210 Drugs prescribed for a resident of a psychiatric residential
211 treatment facility must be provided in true unit doses when
212 available. The division may require that drugs not covered by
213 Medicare Part D for a resident of a long-term care facility be
214 provided in true unit doses when available. Those drugs that were
215 originally billed to the division but are not used by a resident
216 in any of those facilities shall be returned to the billing
217 pharmacy for credit to the division, in accordance with the
218 guidelines of the State Board of Pharmacy and any requirements of
219 federal law and regulation. Drugs shall be dispensed to a
220 recipient and only one (1) dispensing fee per month may be
221 charged. The division shall develop a methodology for reimbursing
222 for restocked drugs, which shall include a restock fee as

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

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

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

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

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

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

247 drugs and innovator multiple-source drugs and the costs to the
248 Medicaid program of those alternative drugs.

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

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

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

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

265 The division may allow certain drugs, implantable drug system
266 devices, and medical supplies, with limited distribution or
267 limited access for beneficiaries and administered in an
268 appropriate clinical setting, to be reimbursed as either a medical
269 claim or pharmacy claim, as determined by the division.

270 Notwithstanding any other provision of this article, the
271 division shall allow physician-administered drugs to be billed and

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

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

278 (10) Dental and orthodontic services to be determined
279 by the division.

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

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

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

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

297 vision change for which eyeglasses or a change in eyeglasses is
298 medically indicated within six (6) months of the surgery and is in
299 accordance with policies established by the division, or (b) one
300 (1) pair every five (5) years and in accordance with policies
301 established by the division. In either instance, the eyeglasses
302 must be prescribed by a physician skilled in diseases of the eye
303 or an optometrist, whichever the beneficiary may select.

304 (12) Intermediate care facility services.

305 (a) The division shall make full payment to all
306 intermediate care facilities for individuals with intellectual
307 disabilities for each day, not exceeding sixty-three (63) days per
308 year, that a patient is absent from the facility on home leave.
309 Payment may be made for the following home leave days in addition
310 to the sixty-three-day limitation: Christmas, the day before
311 Christmas, the day after Christmas, Thanksgiving, the day before
312 Thanksgiving and the day after Thanksgiving.

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

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

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

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

347 availability of funds specifically appropriated for that purpose
348 by the Legislature.

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

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

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

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

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

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

470 (c) (i) Not later than December 1, 2015, the
471 division shall, subject to approval by the Centers for Medicare
472 and Medicaid Services (CMS), establish, implement and operate a
473 Mississippi Hospital Access Program (MHAP) for the purpose of
474 protecting patient access to hospital care through hospital
475 inpatient reimbursement programs provided in this section designed
476 to maintain total hospital reimbursement for inpatient services
477 rendered by in-state hospitals and the out-of-state hospital that
478 is authorized by federal law to submit intergovernmental transfers
479 (IGTs) to the State of Mississippi and is classified as Level I
480 trauma center located in a county contiguous to the state line at
481 the maximum levels permissible under applicable federal statutes
482 and regulations, at which time the current inpatient Medicare
483 Upper Payment Limits (UPL) Program for hospital inpatient services
484 shall transition to the MHAP.
485 (ii) Subject only to approval by the Centers
486 for Medicare and Medicaid Services (CMS) where required, the MHAP
487 shall provide increased inpatient capitation (PMPM) payments to
488 managed care entities contracting with the division pursuant to
489 subsection (H) of this section to support availability of hospital
490 services or such other payments permissible under federal law
491 necessary to accomplish the intent of this subsection.
492 (iii) The intent of this subparagraph (c) is
493 that effective for all inpatient hospital Medicaid services during
494 state fiscal year 2016, and so long as this provision shall remain

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

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

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

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

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

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

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

618 Department of Mental Health and/or transferred to the department
619 by a political subdivision or instrumentality of the state.
620 (30) Pediatric skilled nursing services for eligible
621 persons under twenty-one (21) years of age.
622 (31) Targeted case management services for children
623 with special needs, under waivers from the United States
624 Department of Health and Human Services, using state funds that
625 are provided from the appropriation to the Mississippi Department
626 of Human Services and used to match federal funds under a
627 cooperative agreement between the division and the department.
628 (32) Care and services provided in Christian Science
629 Sanatoria listed and certified by the Commission for Accreditation
630 of Christian Science Nursing Organizations/Facilities, Inc.,
631 rendered in connection with treatment by prayer or spiritual means
632 to the extent that those services are subject to reimbursement
633 under Section 1903 of the federal Social Security Act.
634 (33) Podiatrist services.
635 (34) Assisted living services as provided through
636 home- and community-based services under Title XIX of the federal
637 Social Security Act, as amended, subject to the availability of
638 funds specifically appropriated for that purpose by the
639 Legislature.
640 (35) Services and activities authorized in Sections
641 43-27-101 and 43-27-103, using state funds that are provided from
642 the appropriation to the Mississippi Department of Human Services

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

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

692 funds under a cooperative agreement between the division and the
693 department.

694 (42) [Deleted]

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

700 (44) Nursing facility services for the severely
701 disabled.

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

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

708 (45) Physician assistant services. Services furnished
709 by a physician assistant who is licensed by the State Board of
710 Medical Licensure and is practicing with physician supervision
711 under regulations adopted by the board, under regulations adopted
712 by the division. Reimbursement for those services shall not
713 exceed ninety percent (90%) of the reimbursement rate for
714 comparable services rendered by a physician. The division may
715 provide for a reimbursement rate for physician assistant services
716 of up to one hundred percent (100%) or the reimbursement rate for

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

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

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

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

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

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

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

792 with each subsequent revised plan of care. Based on medical
793 necessity, the division shall approve certification periods for
794 less than or up to six (6) months, but in no event shall the
795 certification period exceed the period of treatment indicated on
796 the plan of care. The appeal process for any reduction in therapy
797 services shall be consistent with the appeal process in federal
798 regulations.
799 (56) Prescribed pediatric extended care centers
800 services for medically dependent or technologically dependent
801 children with complex medical conditions that require continual
802 care as prescribed by the child's attending physician, as
803 determined by the division.
804 (57) No Medicaid benefit shall restrict coverage for
805 medically appropriate treatment prescribed by a physician and
806 agreed to by a fully informed individual, or if the individual
807 lacks legal capacity to consent by a person who has legal
808 authority to consent on his or her behalf, based on an
809 individual's diagnosis with a terminal condition. As used in this
810 paragraph (57), "terminal condition" means any aggressive
811 malignancy, chronic end-stage cardiovascular or cerebral vascular
812 disease, or any other disease, illness or condition which a
813 physician diagnoses as terminal.
814 (58) Treatment services for persons with opioid
815 dependency or other highly addictive substance use disorders. The
816 division is authorized to reimburse eligible providers for

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

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

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

875 (D) [Deleted]

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

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

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

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

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

964 (e) [Deleted]

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

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

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

985 (a) The members of the commission shall be as
986 follows:

987 (i) The Chairmen of the Senate Medicaid
988 Committee and the Senate Appropriations Committee and a member of
989 the Senate appointed by the Lieutenant Governor;
990 (ii) The Chairmen of the House Medicaid
991 Committee and the House Appropriations Committee and a member of
992 the House of Representatives appointed by the Speaker of the
993 House;
994 (iii) The Executive Director of the Division
995 of Medicaid, Office of the Governor;
996 (iv) The Commissioner of the Mississippi
997 Department of Insurance;
998 (v) A representative of a hospital that
999 operates in Mississippi, appointed by the Speaker of the House;
1000 (vi) A licensed physician appointed by the
1001 Lieutenant Governor;
1002 (vii) A licensed pharmacist appointed by the
1003 Governor;
1004 (viii) A licensed mental health professional
1005 or alcohol and drug counselor appointed by the Governor;
1006 (ix) The Executive Director of the
1007 Mississippi State Medical Association (MSMA);
1008 (x) Representatives of each of the current
1009 managed care organizations operated in the state appointed by the
1010 Governor; and

1011 (xi) A representative of the long-term care
1012 industry appointed by the Governor.
1013 (b) The commission shall meet within forty-five
1014 (45) days of the effective date of this section, upon the call of
1015 the Governor, and shall evaluate the Medicaid managed care
1016 program. Specifically, the commission shall:
1017 (i) Review the program's financial metrics;
1018 (ii) Review the program's product offerings;
1019 (iii) Review the program's impact on
1020 insurance premiums for individuals and small businesses;
1021 (iv) Make recommendations for future managed
1022 care program modifications;
1023 (v) Determine whether the expansion of the
1024 Medicaid managed care program may endanger the access to care by
1025 vulnerable patients;
1026 (vi) Review the financial feasibility and
1027 health outcomes of populations health management as specifically
1028 provided in paragraph (2) above;
1029 (vii) Make recommendations regarding a pilot
1030 program to evaluate an alternative managed care payment model for
1031 medically complex children;
1032 (viii) The commission may request the
1033 assistance of the PEER Committee in making its evaluation; and

1034 (ix) The commission shall solicit information
1035 from any person or entity the commission deems relevant to its
1036 study.
1037 (c) The members of the commission shall elect a
1038 chair from among the members. The commission shall develop and
1039 report its findings and any recommendations for proposed
1040 legislation to the Governor and the Legislature on or before
1041 December 1, 2018. A quorum of the membership shall be required to
1042 approve any final report and recommendation. Members of the
1043 commission shall be reimbursed for necessary travel expense in the
1044 same manner as public employees are reimbursed for official duties
1045 and members of the Legislature shall be reimbursed in the same
1046 manner as for attending out-of-session committee meetings.
1047 (d) Upon making its report, the commission shall
1048 be dissolved.
1049 (3) Any contractors providing direct patient care under
1050 a managed care program established in this section shall provide
1051 to the Legislature and the division statistical data to be shared
1052 with provider groups in order to improve patient access,
1053 appropriate utilization, cost savings and health outcomes not
1054 later than October 1 of each year. The division and the
1055 contractors participating in the managed care program, a
1056 coordinated care program or a provider-sponsored health plan shall
1057 be subject to annual program audits performed by the Office of the
1058 State Auditor, the PEER Committee and/or an independent third

1059 party that has no existing contractual relationship with the
1060 division. Those audits shall determine among other items, the
1061 financial benefit to the State of Mississippi of the managed care
1062 program, the difference between the premiums paid to the managed
1063 care contractors and the payments made by those contractors to
1064 health care providers, compliance with performance measures
1065 required under the contracts, and whether costs have been
1066 contained due to improved health care outcomes. In addition, the
1067 audit shall review the most common claim denial codes to determine
1068 the reasons for the denials. This audit report shall be
1069 considered a public document and shall be posted in its entirety
1070 on the division's website.

1071 (4) All health maintenance organizations, coordinated
1072 care organizations, provider-sponsored health plans, or other
1073 organizations paid for services on a capitated basis by the
1074 division under any managed care program or coordinated care
1075 program implemented by the division under this section shall
1076 reimburse all providers in those organizations at rates no lower
1077 than those provided under this section for beneficiaries who are
1078 not participating in those programs.

1079 (5) No health maintenance organization, coordinated
1080 care organization, provider-sponsored health plan, or other
1081 organization paid for services on a capitated basis by the
1082 division under any managed care program or coordinated care
1083 program implemented by the division under this section shall

1084 require its providers or beneficiaries to use any pharmacy that
1085 ships, mails or delivers prescription drugs or legend drugs or
1086 devices.

1087 (6) No health maintenance organization, coordinated
1088 care organization, provider-sponsored health plan, or other
1089 organization paid for services on a capitated basis by the
1090 division under any managed care program or coordinated care
1091 program implemented by the division under this section shall
1092 require its providers to be credentialed by the organization in
1093 order to receive reimbursement from the organization, but those
1094 organizations shall recognize the credentialing of the providers
1095 by the division.

1096 (7) Each health maintenance organization, coordinated
1097 care organization, provider-sponsored health plan, and other
1098 organization paid for services on a capitated basis by the
1099 division under any managed care program or coordinated care
1100 program implemented by the division under this section shall
1101 provide to each physician or other health care provider for whom
1102 the organization has denied the coverage of a procedure that was
1103 ordered or requested by the health care provider for or on behalf
1104 of a patient, a letter that provides a detailed explanation of the
1105 reasons for the denial of coverage of the procedure and the name
1106 and the credentials of the person who denied the coverage. The
1107 letter shall be sent to the health care provider in both physical

1108 and electronic format and shall be signed by the person who denied

1109 the coverage.

1110 (I) [Deleted]

1111 (J) There shall be no cuts in inpatient and outpatient

1112 hospital payments, or allowable days or volumes, as long as the

1113 hospital assessment provided in Section 43-13-145 is in effect.

1114 This subsection (J) shall not apply to decreases in payments that

1115 are a result of: reduced hospital admissions, audits or payments

1116 under the APR-DRG or APC models, or a managed care program or

1117 similar model described in subsection (H) of this section.

1118 (K) This section shall stand repealed on July 1, 2021.

1119 **SECTION 2.** This act shall take effect and be in force from

1120 and after July 1, 2020.