MISSISSIPPI LEGISLATURE REGULAR SESSION 2020

By: Representative Blackmon

To: Medicaid; Appropriations

HOUSE BILL NO. 540

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE MEDICAID COVERAGE FOR SERVICES FURNISHED UNDER A
3 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) PROGRAM TO
4 PACE PROGRAM ELIGIBLE INDIVIDUALS WHO ARE ELIGIBLE FOR MEDICAID
5 AND WHO ARE ENROLLED IN A PACE PROGRAM UNDER A PACE PROGRAM
6 AGREEMENT; AND FOR RELATED PURPOSES.

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

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

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

17 (1) Inpatient hospital services.

18 (a) The division shall allow thirty (30) days of
19 inpatient hospital care annually for all Medicaid recipients.
20 Medicaid recipients requiring transplants shall not have those

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

46 (a) Emergency services.
47 (b) Other outpatient hospital services. The
48 division shall allow benefits for other medically necessary
49 outpatient hospital services (such as chemotherapy, radiation,
50 surgery and therapy), including outpatient services in a clinic or
51 other facility that is not located inside the hospital, but that
52 has been designated as an outpatient facility by the hospital, and
53 that was in operation or under construction on July 1, 2009,
54 provided that the costs and charges associated with the operation
55 of the hospital clinic are included in the hospital's cost report.
56 In addition, the Medicare thirty-five-mile rule will apply to
57 those hospital clinics not located inside the hospital that are
58 constructed after July 1, 2009. Where the same services are
59 reimbursed as clinic services, the division may revise the rate or
60 methodology of outpatient reimbursement to maintain consistency,
61 efficiency, economy and quality of care.
62 (c) The division is authorized to implement an
63 Ambulatory Payment Classification (APC) methodology for outpatient
64 hospital services. The division may give rural hospitals that
65 have fifty (50) or fewer licensed beds the option to not be
66 reimbursed for outpatient hospital services using the APC
67 methodology, but reimbursement for outpatient hospital services
68 provided by those hospitals shall be based on one hundred one
69 percent (101%) of the rate established under Medicare for
70 outpatient hospital services. Those hospitals choosing to not be

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

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

77 (3) Laboratory and x-ray services.

78 (4) Nursing facility services.

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

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

96 nursing facility are considered in calculating a facility's per
97 diem.
98 (c) From and after July 1, 1997, all state-owned
99 nursing facilities shall be reimbursed on a full reasonable cost
100 basis.
101 (d) On or after January 1, 2015, the division
102 shall update the case-mix payment system resource utilization
103 grouper and classifications and fair rental reimbursement system.
104 The division shall develop and implement a payment add-on to
105 reimburse nursing facilities for ventilator-dependent resident
106 services.
107 (e) The division shall develop and implement, not
108 later than January 1, 2001, a case-mix payment add-on determined
109 by time studies and other valid statistical data that will
110 reimburse a nursing facility for the additional cost of caring for
111 a resident who has a diagnosis of Alzheimer's or other related
112 dementia and exhibits symptoms that require special care. Any
113 such case-mix add-on payment shall be supported by a determination
114 of additional cost. The division shall also develop and implement
115 as part of the fair rental reimbursement system for nursing
116 facility beds, an Alzheimer's resident bed depreciation enhanced
117 reimbursement system that will provide an incentive to encourage
118 nursing facilities to convert or construct beds for residents with
119 Alzheimer's or other related dementia.

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

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

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

145 matching funds through the division. The division, in obtaining
146 medical and mental health assessments, treatment, care and
147 services for children who are in, or at risk of being put in, the
148 custody of the Mississippi Department of Human Services may enter
149 into a cooperative agreement with the Mississippi Department of
150 Human Services for the provision of those services using state
151 funds that are provided from the appropriation to the Department
152 of Human Services to obtain federal matching funds through the
153 division.
154 (6) Physician's services. Physician visits as
155 determined by the division and in accordance with federal laws and
156 regulations. The division may develop and implement a different
157 reimbursement model or schedule for physician's services provided
158 by physicians based at an academic health care center and by
159 physicians at rural health centers that are associated with an
160 academic health care center. From and after January 1, 2010, all
161 fees for physician's services that are covered only by Medicaid
162 shall be increased to ninety percent (90%) of the rate established
163 on January 1, 2018, and as may be adjusted each July thereafter,
164 under Medicare. The division may provide for a reimbursement rate
165 for physician's services of up to one hundred percent (100%) of
166 the rate established under Medicare for physician's services that
167 are provided after the normal working hours of the physician, as
168 determined in accordance with regulations of the division. The
169 division may reimburse eligible providers as determined by the

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

195 of prescription drugs to include single-source and innovator
196 multiple-source drugs or generic drugs, if that will lower the
197 acquisition costs of those prescription drugs.
198 The division may allow for a combination of prescriptions for
199 single-source and innovator multiple-source drugs and generic
200 drugs to meet the needs of the beneficiaries.
201 The executive director may approve specific maintenance drugs
202 for beneficiaries with certain medical conditions, which may be
203 prescribed and dispensed in three-month supply increments.
204 Drugs prescribed for a resident of a psychiatric residential
205 treatment facility must be provided in true unit doses when
206 available. The division may require that drugs not covered by
207 Medicare Part D for a resident of a long-term care facility be
208 provided in true unit doses when available. Those drugs that were
209 originally billed to the division but are not used by a resident
210 in any of those facilities shall be returned to the billing
211 pharmacy for credit to the division, in accordance with the
212 guidelines of the State Board of Pharmacy and any requirements of
213 federal law and regulation. Drugs shall be dispensed to a
214 recipient and only one (1) dispensing fee per month may be
215 charged. The division shall develop a methodology for reimbursing
216 for restocked drugs, which shall include a restock fee as
217 determined by the division not exceeding Seven Dollars and
218 Eighty-two Cents ($7.82).

219 Except for those specific maintenance drugs approved by the
220 executive director, the division shall not reimburse for any
221 portion of a prescription that exceeds a thirty-one-day supply of
222 the drug based on the daily dosage.
223 The division is authorized to develop and implement a program
224 of payment for additional pharmacist services as may be determined
225 by the division.
226 All claims for drugs for dually eligible Medicare/Medicaid
227 beneficiaries that are paid for by Medicare must be submitted to
228 Medicare for payment before they may be processed by the
229 division's online payment system.
230 The division shall develop a pharmacy policy in which drugs
231 in tamper-resistant packaging that are prescribed for a resident
232 of a nursing facility but are not dispensed to the resident shall
233 be returned to the pharmacy and not billed to Medicaid, in
234 accordance with guidelines of the State Board of Pharmacy.
235 The division shall develop and implement a method or methods
236 by which the division will provide on a regular basis to Medicaid
237 providers who are authorized to prescribe drugs, information about
238 the costs to the Medicaid program of single-source drugs and
239 innovator multiple-source drugs, and information about other drugs
240 that may be prescribed as alternatives to those single-source
241 drugs and innovator multiple-source drugs and the costs to the
242 Medicaid program of those alternative drugs.

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

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

272 (10) Dental and orthodontic services to be determined
273 by the division.

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

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

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

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

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

298 (12) Intermediate care facility services.

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

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

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

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

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

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

343 The Division of Medicaid is directed to apply for a waiver
344 amendment to increase payments for all adult day care facilities
345 based on acuity of individual patients, with a maximum of
346 Seventy-five Dollars ($75.00) per day for the most acute patients.
347 (16) Mental health services. Certain services provided
348 by a psychiatrist shall be reimbursed at up to one hundred percent
349 (100%) of the Medicare rate. Approved therapeutic and case
350 management services (a) provided by an approved regional mental
351 health/intellectual disability center established under Sections
352 41-19-31 through 41-19-39, or by another community mental health
353 service provider meeting the requirements of the Department of
354 Mental Health to be an approved mental health/intellectual
355 disability center if determined necessary by the Department of
356 Mental Health, using state funds that are provided in the
357 appropriation to the division to match federal funds, or (b)
358 provided by a facility that is certified by the State Department
359 of Mental Health to provide therapeutic and case management
360 services, to be reimbursed on a fee for service basis, or (c)
361 provided in the community by a facility or program operated by the
362 Department of Mental Health. Any such services provided by a
363 facility described in subparagraph (b) must have the prior
364 approval of the division to be reimbursable under this section.
365 (17) Durable medical equipment services and medical
366 supplies. Precertification of durable medical equipment and
367 medical supplies must be obtained as required by the division.

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

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

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

443 documents required to achieve the goals described in this
444 paragraph shall be submitted to the Centers for Medicare and
445 Medicaid Services, with a proposed effective date of July 1, 2019,
446 to the extent possible, but in no event shall the effective date
447 of such payment models be later than July 1, 2020. The Chairmen
448 of the Senate and House Medicaid Committees shall be provided a
449 copy of the proposed payment model(s) prior to submission.
450 Effective July 1, 2018, and until such time as any payment
451 model(s) as described above become effective, the division, in
452 consultation with the Mississippi Hospital Association and a
453 governmental hospital located in a county bordering the Gulf of
454 Mexico and the State of Alabama is authorized to implement a
455 transitional program for inpatient and outpatient payments and/or
456 supplemental payments (including, but not limited to, MHAP and
457 directed payments), to redistribute available supplemental funds
458 among hospital providers, provided that when compared to a
459 hospital's prior year supplemental payments, supplemental payments
460 made pursuant to any such transitional program shall not result in
461 a decrease of more than five percent (5%) and shall not increase
462 by more than the amount needed to maximize the distribution of the
463 available funds.
464 (c) (i) Not later than December 1, 2015, the
465 division shall, subject to approval by the Centers for Medicare
466 and Medicaid Services (CMS), establish, implement and operate a
467 Mississippi Hospital Access Program (MHAP) for the purpose of

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

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

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

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

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

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

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

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

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

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

543 but not limited to, nurse anesthetists, nurse midwives, family
544 nurse practitioners, family planning nurse practitioners,
545 pediatric nurse practitioners, obstetrics-gynecology nurse
546 practitioners and neonatal nurse practitioners, under regulations
547 adopted by the division. Reimbursement for those services shall
548 not exceed ninety percent (90%) of the reimbursement rate for
549 comparable services rendered by a physician. The division may
550 provide for a reimbursement rate for nurse practitioner services
551 of up to one hundred percent (100%) of the reimbursement rate for
552 comparable services rendered by a physician for nurse practitioner
553 services that are provided after the normal working hours of the
554 nurse practitioner, as determined in accordance with regulations
555 of the division.
556 (22) Ambulatory services delivered in federally
557 qualified health centers, rural health centers and clinics of the
558 local health departments of the State Department of Health for
559 individuals eligible for Medicaid under this article based on
560 reasonable costs as determined by the division. Federally
561 qualified health centers shall be reimbursed by the Medicaid
562 prospective payment system as approved by the Centers for Medicare
563 and Medicaid Services.
564 (23) Inpatient psychiatric services. Inpatient
565 psychiatric services to be determined by the division for
566 recipients under age twenty-one (21) that are provided under the
567 direction of a physician in an inpatient program in a licensed

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

583 (24) [Deleted]

584 (25) [Deleted]

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

593 that are experienced during the final stages of illness and during
594 dying and bereavement and meets the Medicare requirements for
595 participation as a hospice as provided in federal regulations.
596 (27) Group health plan premiums and cost-sharing if it
597 is cost-effective as defined by the United States Secretary of
598 Health and Human Services.
599 (28) Other health insurance premiums that are
600 cost-effective as defined by the United States Secretary of Health
601 and Human Services. Medicare eligible must have Medicare Part B
602 before other insurance premiums can be paid.
603 (29) The Division of Medicaid may apply for a waiver
604 from the United States Department of Health and Human Services for
605 home- and community-based services for developmentally disabled
606 people using state funds that are provided from the appropriation
607 to the State Department of Mental Health and/or funds transferred
608 to the department by a political subdivision or instrumentality of
609 the state and used to match federal funds under a cooperative
610 agreement between the division and the department, provided that
611 funds for these services are specifically appropriated to the
612 Department of Mental Health and/or transferred to the department
613 by a political subdivision or instrumentality of the state.
614 (30) Pediatric skilled nursing services for eligible
615 persons under twenty-one (21) years of age.
616 (31) Targeted case management services for children
617 with special needs, under waivers from the United States

618 Department of Health and Human Services, using state funds that
619 are provided from the appropriation to the Mississippi Department
620 of Human Services and used to match federal funds under a
621 cooperative agreement between the division and the department.
622 (32) Care and services provided in Christian Science
623 Sanatoria listed and certified by the Commission for Accreditation
624 of Christian Science Nursing Organizations/Facilities, Inc.,
625 rendered in connection with treatment by prayer or spiritual means
626 to the extent that those services are subject to reimbursement
627 under Section 1903 of the federal Social Security Act.
628 (33) Podiatrist services.
629 (34) Assisted living services as provided through
630 home- and community-based services under Title XIX of the federal
631 Social Security Act, as amended, subject to the availability of
632 funds specifically appropriated for that purpose by the
633 Legislature.
634 (35) Services and activities authorized in Sections
635 43-27-101 and 43-27-103, using state funds that are provided from
636 the appropriation to the Mississippi Department of Human Services
637 and used to match federal funds under a cooperative agreement
638 between the division and the department.
639 (36) Nonemergency transportation services for
640 Medicaid-eligible persons, to be provided by the Division of
641 Medicaid. The division may contract with additional entities to
642 administer nonemergency transportation services as it deems

643 necessary. All providers shall have a valid driver's license,
644 valid vehicle license tags and a standard liability insurance
645 policy covering the vehicle. The division may pay providers a
646 flat fee based on mileage tiers, or in the alternative, may
647 reimburse on actual miles traveled. The division may apply to the
648 Center for Medicare and Medicaid Services (CMS) for a waiver to
649 draw federal matching funds for nonemergency transportation
650 services as a covered service instead of an administrative cost.
651 The PEER Committee shall conduct a performance evaluation of the
652 nonemergency transportation program to evaluate the administration
653 of the program and the providers of transportation services to
654 determine the most cost-effective ways of providing nonemergency
655 transportation services to the patients served under the program.
656 The performance evaluation shall be completed and provided to the
657 members of the Senate Medicaid Committee and the House Medicaid
658 Committee not later than January 1, 2019, and every two (2) years
659 thereafter.
660 (37) [Deleted]
661 (38) Chiropractic services. A chiropractor's manual
662 manipulation of the spine to correct a subluxation, if x-ray
663 demonstrates that a subluxation exists and if the subluxation has
664 resulted in a neuromusculoskeletal condition for which
665 manipulation is appropriate treatment, and related spinal x-rays
666 performed to document these conditions. Reimbursement for

667 chiropractic services shall not exceed Seven Hundred Dollars
668 ($700.00) per year per beneficiary.
669 (39) Dually eligible Medicare/Medicaid beneficiaries.
670 The division shall pay the Medicare deductible and coinsurance
671 amounts for services available under Medicare, as determined by
672 the division. From and after July 1, 2009, the division shall
673 reimburse crossover claims for inpatient hospital services and
674 crossover claims covered under Medicare Part B in the same manner
675 that was in effect on January 1, 2008, unless specifically
676 authorized by the Legislature to change this method.
677 (40) [Deleted]
678 (41) Services provided by the State Department of
679 Rehabilitation Services for the care and rehabilitation of persons
680 with spinal cord injuries or traumatic brain injuries, as allowed
681 under waivers from the United States Department of Health and
682 Human Services, using up to seventy-five percent (75%) of the
683 funds that are appropriated to the Department of Rehabilitation
684 Services from the Spinal Cord and Head Injury Trust Fund
685 established under Section 37-33-261 and used to match federal
686 funds under a cooperative agreement between the division and the
687 department.
688 (42) [Deleted]
689 (43) The division shall provide reimbursement,
690 according to a payment schedule developed by the division, for
691 smoking cessation medications for pregnant women during their

692 pregnancy and other Medicaid-eligible women who are of
693 child-bearing age.
694 (44) Nursing facility services for the severely
695 disabled.
696 (a) Severe disabilities include, but are not
697 limited to, spinal cord injuries, closed-head injuries and
698 ventilator-dependent patients.
699 (b) Those services must be provided in a long-term
700 care nursing facility dedicated to the care and treatment of
701 persons with severe disabilities.
702 (45) Physician assistant services. Services furnished
703 by a physician assistant who is licensed by the State Board of
704 Medical Licensure and is practicing with physician supervision
705 under regulations adopted by the board, under regulations adopted
706 by the division. Reimbursement for those services shall not
707 exceed ninety percent (90%) of the reimbursement rate for
708 comparable services rendered by a physician. The division may
709 provide for a reimbursement rate for physician assistant services
710 of up to one hundred percent (100%) or the reimbursement rate for
711 comparable services rendered by a physician for physician
712 assistant services that are provided after the normal working
713 hours of the physician assistant, as determined in accordance with
714 regulations of the division.
715 (46) The division shall make application to the federal
716 Centers for Medicare and Medicaid Services (CMS) for a waiver to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

813 related to these conditions shall not count against any physician
814 visit limit imposed under this section.
815 (59) The division shall allow beneficiaries between the
816 ages of ten (10) and eighteen (18) years to receive vaccines
817 through a pharmacy venue.
818 (60) Services furnished under a program of
819 all-inclusive care for the elderly (PACE) program under 42 USC
820 Section 1396u-4 to PACE program eligible individuals who are
821 eligible for Medicaid and who are enrolled in a PACE program under
822 a PACE program agreement.
823 (B) Notwithstanding any other provision of this article to
824 the contrary, the division shall reduce the rate of reimbursement
825 to providers for any service provided under this section by five
826 percent (5%) of the allowed amount for that service. However, the
827 reduction in the reimbursement rates required by this subsection
828 (B) shall not apply to inpatient hospital services, outpatient
829 hospital services, nursing facility services, intermediate care
830 facility services, psychiatric residential treatment facility
831 services, pharmacy services provided under subsection (A)(9) of
832 this section, or any service provided by the University of
833 Mississippi Medical Center or a state agency, a state facility or
834 a public agency that either provides its own state match through
835 intergovernmental transfer or certification of funds to the
836 division, or a service for which the federal government sets the
837 reimbursement methodology and rate. From and after January 1,

838 2010, the reduction in the reimbursement rates required by this
839 subsection (B) shall not apply to physicians' services. In
840 addition, the reduction in the reimbursement rates required by
841 this subsection (B) shall not apply to case management services
842 and home-delivered meals provided under the home- and
843 community-based services program for the elderly and disabled by a
844 planning and development district (PDD). Planning and development
845 districts participating in the home- and community-based services
846 program for the elderly and disabled as case management providers
847 shall be reimbursed for case management services at the maximum
848 rate approved by the Centers for Medicare and Medicaid Services
849 (CMS). The Medical Care Advisory Committee established in Section
850 43-13-107(3)(a) shall develop a study and advise the division with
851 respect to (1) determining the effect of any across-the-board five
852 percent (5%) reduction in the rate of reimbursement to providers
853 authorized under this subsection (B), and (2) comparing provider
854 reimbursement rates to those applicable in other states in order
855 to establish a fair and equitable provider reimbursement structure
856 that encourages participation in the Medicaid program, and (3)
857 comparing dental and orthodontic services reimbursement rates to
858 those applicable in other states in fee-for-service and in managed
859 care programs in order to establish a fair and equitable dental
860 provider reimbursement structure that encourages participation in
861 the Medicaid program, and (4) make a report thereon with any

862 legislative recommendations to the Chairmen of the Senate and
863 House Medicaid Committees prior to January 1, 2019.
864 (C) The division may pay to those providers who participate
865 in and accept patient referrals from the division's emergency room
866 redirection program a percentage, as determined by the division,
867 of savings achieved according to the performance measures and
868 reduction of costs required of that program. Federally qualified
869 health centers may participate in the emergency room redirection
870 program, and the division may pay those centers a percentage of
871 any savings to the Medicaid program achieved by the centers'
872 accepting patient referrals through the program, as provided in
873 this subsection (C).
874 (D) [Deleted]
875 (E) Notwithstanding any provision of this article, no new
876 groups or categories of recipients and new types of care and
877 services may be added without enabling legislation from the
878 Mississippi Legislature, except that the division may authorize
879 those changes without enabling legislation when the addition of
880 recipients or services is ordered by a court of proper authority.
881 (F) The executive director shall keep the Governor advised
882 on a timely basis of the funds available for expenditure and the
883 projected expenditures. Notwithstanding any other provisions of
884 this article, if current or projected expenditures of the division
885 are reasonably anticipated to exceed the amount of funds
886 appropriated to the division for any fiscal year, the Governor,

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

912 submission to the Division of Medicaid of an original cost report,
913 or three (3) years after the date of submission to the Division of
914 Medicaid of an amended cost report.

915 (H) (1) Notwithstanding any other provision of this
916 article, the division is authorized to implement (a) a managed
917 care program, (b) a coordinated care program, (c) a coordinated
918 care organization program, (d) a health maintenance organization
919 program, (e) a patient-centered medical home program, (f) an
920 accountable care organization program, (g) provider-sponsored
921 health plan, or (h) any combination of the above programs.
922 Managed care programs, coordinated care programs, coordinated care
923 organization programs, health maintenance organization programs,
924 patient-centered medical home programs, accountable care
925 organization programs, provider-sponsored health plans, or any
926 combination of the above programs or other similar programs
927 implemented by the division under this section shall be limited to
928 the greater of (i) forty-five percent (45%) of the total
929 enrollment of Medicaid beneficiaries, or (ii) the categories of
930 beneficiaries participating in the program as of January 1, 2014,
931 plus the categories of beneficiaries composed primarily of persons
932 younger than nineteen (19) years of age, and the division is
933 authorized to enroll categories of beneficiaries in such
934 program(s) as long as the appropriate limitations are not exceeded
935 in the aggregate. As a condition for the approval of any program

936 under this subsection (H)(1), the division shall require that no
937 program may:
938 (a) Pay providers at a rate that is less than the
939 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
940 reimbursement rate;
941 (b) Override the medical decisions of hospital
942 physicians or staff regarding patients admitted to a hospital for
943 an emergency medical condition as defined by 42 US Code Section
944 1395dd. This restriction (b) does not prohibit the retrospective
945 review of the appropriateness of the determination that an
946 emergency medical condition exists by chart review or coding
947 algorithm, nor does it prohibit prior authorization for
948 nonemergency hospital admissions;
949 (c) Pay providers at a rate that is less than the
950 normal Medicaid reimbursement rate. It is the intent of the
951 Legislature that all managed care entities described in this
952 subsection (H), in collaboration with the division, develop and
953 implement innovative payment models that incentivize improvements
954 in health care quality, outcomes, or value, as determined by the
955 division. Participation in the provider network of any managed
956 care, coordinated care, provider-sponsored health plan, or similar
957 contractor shall not be conditioned on the provider's agreement to
958 accept such alternative payment models;
959 (d) Implement a prior authorization program for
960 prescription drugs that is more stringent than the prior

961 authorization processes used by the division in its administration
962 of the Medicaid program;
963 (e) [Deleted]
964 (f) Implement a preferred drug list that is more
965 stringent than the mandatory preferred drug list established by
966 the division under subsection (A)(9) of this section;
967 (g) Implement a policy which denies beneficiaries
968 with hemophilia access to the federally funded hemophilia
969 treatment centers as part of the Medicaid Managed Care network of
970 providers. All Medicaid beneficiaries with hemophilia shall
971 receive unrestricted access to anti-hemophilia factor products
972 through noncapitated reimbursement programs.
973 (2) Notwithstanding any provision of this section, no
974 expansion of Medicaid managed care program contracts may be
975 implemented by the division without enabling legislation from the
976 Mississippi Legislature. There is hereby established the
977 Commission on Expanding Medicaid Managed Care to develop a
978 recommendation to the Legislature and the Division of Medicaid
979 relative to authorizing the division to expand Medicaid managed
980 care contracts to include additional categories of
981 Medicaid-eligible beneficiaries, and to study the feasibility of
982 developing an alternative managed care payment model for medically
983 complex children.
984 (a) The members of the commission shall be as
985 follows:

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

1010 (xi) A representative of the long-term care
1011 industry appointed by the Governor.
1012 (b) The commission shall meet within forty-five
1013 (45) days of the effective date of this section, upon the call of
1014 the Governor, and shall evaluate the Medicaid managed care
1015 program. Specifically, the commission shall:
1016 (i) Review the program's financial metrics;
1017 (ii) Review the program's product offerings;
1018 (iii) Review the program's impact on
1019 insurance premiums for individuals and small businesses;
1020 (iv) Make recommendations for future managed
1021 care program modifications;
1022 (v) Determine whether the expansion of the
1023 Medicaid managed care program may endanger the access to care by
1024 vulnerable patients;
1025 (vi) Review the financial feasibility and
1026 health outcomes of populations health management as specifically
1027 provided in paragraph (2) above;
1028 (vii) Make recommendations regarding a pilot
1029 program to evaluate an alternative managed care payment model for
1030 medically complex children;
1031 (viii) The commission may request the
1032 assistance of the PEER Committee in making its evaluation; and

1033 (ix) The commission shall solicit information
1034 from any person or entity the commission deems relevant to its
1035 study.

1036 (c) The members of the commission shall elect a
1037 chair from among the members. The commission shall develop and
1038 report its findings and any recommendations for proposed
1039 legislation to the Governor and the Legislature on or before
1040 December 1, 2018. A quorum of the membership shall be required to
1041 approve any final report and recommendation. Members of the
1042 commission shall be reimbursed for necessary travel expense in the
1043 same manner as public employees are reimbursed for official duties
1044 and members of the Legislature shall be reimbursed in the same
1045 manner as for attending out-of-session committee meetings.

1046 (d) Upon making its report, the commission shall
1047 be dissolved.

1048 (3) Any contractors providing direct patient care under
1049 a managed care program established in this section shall provide
1050 to the Legislature and the division statistical data to be shared
1051 with provider groups in order to improve patient access,
1052 appropriate utilization, cost savings and health outcomes not
1053 later than October 1 of each year. The division and the
1054 contractors participating in the managed care program, a
1055 coordinated care program or a provider-sponsored health plan shall
1056 be subject to annual program audits performed by the Office of the
1057 State Auditor, the PEER Committee and/or an independent third

1058 party that has no existing contractual relationship with the
1059 division. Those audits shall determine among other items, the
1060 financial benefit to the State of Mississippi of the managed care
1061 program, the difference between the premiums paid to the managed
1062 care contractors and the payments made by those contractors to
1063 health care providers, compliance with performance measures
1064 required under the contracts, and whether costs have been
1065 contained due to improved health care outcomes. In addition, the
1066 audit shall review the most common claim denial codes to determine
1067 the reasons for the denials. This audit report shall be
1068 considered a public document and shall be posted in its entirety
1069 on the division's website.

1070 (4) All health maintenance organizations, coordinated
1071 care organizations, provider-sponsored health plans, or other
1072 organizations paid for services on a capitated basis by the
1073 division under any managed care program or coordinated care
1074 program implemented by the division under this section shall
1075 reimburse all providers in those organizations at rates no lower
1076 than those provided under this section for beneficiaries who are
1077 not participating in those programs.

1078 (5) No health maintenance organization, coordinated
1079 care organization, provider-sponsored health plan, or other
1080 organization paid for services on a capitated basis by the
1081 division under any managed care program or coordinated care
1082 program implemented by the division under this section shall

1083 require its providers or beneficiaries to use any pharmacy that
1084 ships, mails or delivers prescription drugs or legend drugs or
1085 devices.

1086 (6) No health maintenance organization, coordinated
1087 care organization, provider-sponsored health plan, or other
1088 organization paid for services on a capitated basis by the
1089 division under any managed care program or coordinated care
1090 program implemented by the division under this section shall
1091 require its providers to be credentialed by the organization in
1092 order to receive reimbursement from the organization, but those
1093 organizations shall recognize the credentialing of the providers
1094 by the division.

1095 (I) [Deleted]

1096 (J) There shall be no cuts in inpatient and outpatient
1097 hospital payments, or allowable days or volumes, as long as the
1098 hospital assessment provided in Section 43-13-145 is in effect.
1099 This subsection (J) shall not apply to decreases in payments that
1100 are a result of: reduced hospital admissions, audits or payments
1101 under the APR-DRG or APC models, or a managed care program or
1102 similar model described in subsection (H) of this section.

1103 (K) This section shall stand repealed on July 1, 2021.

1104 **SECTION 2.** This act shall take effect and be in force from
1105 and after July 1, 2020.