MISSISSIPPI LEGISLATURE REGULAR SESSION 2022

By: Representative Hines To: Medicaid; Appropriations

HOUSE BILL NO. 317

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO REQUIRE MANAGED CARE ORGANIZATIONS UNDER ANY MANAGED CARE
3 PROGRAM IMPLEMENTED BY THE DIVISION OF MEDICAID TO USE A CLEAR SET
4 OF LEVEL OF CARE GUIDELINES IN THE DETERMINATION OF MEDICAL
5 NECESSITY AND IN ALL UTILIZATION MANAGEMENT PRACTICES THAT ARE
6 CONSISTENT WITH WIDELY ACCEPTED PROFESSIONAL STANDARDS OF CARE; TO
7 PROHIBIT THOSE ORGANIZATIONS FROM USING ANY ADDITIONAL CRITERIA
8 THAT WOULD RESULT IN DENIAL OF CARE THAT WOULD BE DETERMINED
9 APPROPRIATE AND, THEREFORE, MEDICALLY NECESSARY BY THE GUIDELINES
10 AND CERTAIN SPECIFIED PRINCIPLES; AND FOR RELATED PURPOSES.

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

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

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

21 (1) Inpatient hospital services.

22 (a) The division is authorized to implement an All
23 Patient Refined Diagnosis Related Groups (APR-DRG) reimbursement
24 methodology for inpatient hospital services.
25 (b) No service benefits or reimbursement
26 limitations in this subsection (A)(1) shall apply to payments
27 under an APR-DRG or Ambulatory Payment Classification (APC) model
28 or a managed care program or similar model described in subsection
29 (H) of this section unless specifically authorized by the
30 division.
31 (2) Outpatient hospital services.
32 (a) Emergency services.
33 (b) Other outpatient hospital services. The
34 division shall allow benefits for other medically necessary
35 outpatient hospital services (such as chemotherapy, radiation,
36 surgery and therapy), including outpatient services in a clinic or
37 other facility that is not located inside the hospital, but that
38 has been designated as an outpatient facility by the hospital, and
39 that was in operation or under construction on July 1, 2009,
40 provided that the costs and charges associated with the operation
41 of the hospital clinic are included in the hospital's cost report.
42 In addition, the Medicare thirty-five-mile rule will apply to
43 those hospital clinics not located inside the hospital that are
44 constructed after July 1, 2009. Where the same services are
45 reimbursed as clinic services, the division may revise the rate or

46 methodology of outpatient reimbursement to maintain consistency,
47 efficiency, economy and quality of care.
48 (c) The division is authorized to implement an
49 Ambulatory Payment Classification (APC) methodology for outpatient
50 hospital services. The division shall give rural hospitals that
51 have fifty (50) or fewer licensed beds the option to not be
52 reimbursed for outpatient hospital services using the APC
53 methodology, but reimbursement for outpatient hospital services
54 provided by those hospitals shall be based on one hundred one
55 percent (101%) of the rate established under Medicare for
56 outpatient hospital services. Those hospitals choosing to not be
57 reimbursed under the APC methodology shall remain under cost-based
58 reimbursement for a two-year period.
59 (d) No service benefits or reimbursement
60 limitations in this subsection (A)(2) shall apply to payments
61 under an APR-DRG or APC model or a managed care program or similar
62 model described in subsection (H) of this section unless
63 specifically authorized by the division.
64 (3) Laboratory and x-ray services.
65 (4) Nursing facility services.
66 (a) The division shall make full payment to
67 nursing facilities for each day, not exceeding forty-two (42) days
68 per year, that a patient is absent from the facility on home
69 leave. Payment may be made for the following home leave days in
70 addition to the forty-two-day limitation: Christmas, the day

71 before Christmas, the day after Christmas, Thanksgiving, the day
72 before Thanksgiving and the day after Thanksgiving.

73 (b) From and after July 1, 1997, the division
74 shall implement the integrated case-mix payment and quality
75 monitoring system, which includes the fair rental system for
76 property costs and in which recapture of depreciation is
77 eliminated. The division may reduce the payment for hospital
78 leave and therapeutic home leave days to the lower of the case-mix
79 category as computed for the resident on leave using the
80 assessment being utilized for payment at that point in time, or a
81 case-mix score of 1.000 for nursing facilities, and shall compute
82 case-mix scores of residents so that only services provided at the
83 nursing facility are considered in calculating a facility's per
84 diem.

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

88 (d) On or after January 1, 2015, the division
89 shall update the case-mix payment system resource utilization
90 grouper and classifications and fair rental reimbursement system.
91 The division shall develop and implement a payment add-on to
92 reimburse nursing facilities for ventilator-dependent resident
93 services.

94 (e) The division shall develop and implement, not
95 later than January 1, 2001, a case-mix payment add-on determined

96 by time studies and other valid statistical data that will
97 reimburse a nursing facility for the additional cost of caring for
98 a resident who has a diagnosis of Alzheimer's or other related
99 dementia and exhibits symptoms that require special care. Any
100 such case-mix add-on payment shall be supported by a determination
101 of additional cost. The division shall also develop and implement
102 as part of the fair rental reimbursement system for nursing
103 facility beds, an Alzheimer's resident bed depreciation enhanced
104 reimbursement system that will provide an incentive to encourage
105 nursing facilities to convert or construct beds for residents with
106 Alzheimer's or other related dementia.

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

111 The division shall apply for necessary federal waivers to
112 assure that additional services providing alternatives to nursing
113 facility care are made available to applicants for nursing
114 facility care.

115 (5) Periodic screening and diagnostic services for
116 individuals under age twenty-one (21) years as are needed to
117 identify physical and mental defects and to provide health care
118 treatment and other measures designed to correct or ameliorate
119 defects and physical and mental illness and conditions discovered
120 by the screening services, regardless of whether these services

121 are included in the state plan. The division may include in its
122 periodic screening and diagnostic program those discretionary
123 services authorized under the federal regulations adopted to
124 implement Title XIX of the federal Social Security Act, as
125 amended. The division, in obtaining physical therapy services,
126 occupational therapy services, and services for individuals with
127 speech, hearing and language disorders, may enter into a
128 cooperative agreement with the State Department of Education for
129 the provision of those services to handicapped students by public
130 school districts using state funds that are provided from the
131 appropriation to the Department of Education to obtain federal
132 matching funds through the division. The division, in obtaining
133 medical and mental health assessments, treatment, care and
134 services for children who are in, or at risk of being put in, the
135 custody of the Mississippi Department of Human Services may enter
136 into a cooperative agreement with the Mississippi Department of
137 Human Services for the provision of those services using state
138 funds that are provided from the appropriation to the Department
139 of Human Services to obtain federal matching funds through the
140 division.
141 (6) Physician services. Fees for physician's services
142 that are covered only by Medicaid shall be reimbursed at ninety
143 percent (90%) of the rate established on January 1, 2018, and as
144 may be adjusted each July thereafter, under Medicare. The
145 division may provide for a reimbursement rate for physician's

146 services of up to one hundred percent (100%) of the rate
147 established under Medicare for physician's services that are
148 provided after the normal working hours of the physician, as
149 determined in accordance with regulations of the division. The
150 division may reimburse eligible providers, as determined by the
151 division, for certain primary care services at one hundred percent
152 (100%) of the rate established under Medicare. The division shall
153 reimburse obstetricians and gynecologists for certain primary care
154 services as defined by the division at one hundred percent (100%)
155 of the rate established under Medicare.

156 (7) (a) Home health services for eligible persons, not
157 to exceed in cost the prevailing cost of nursing facility
158 services. All home health visits must be precertified as required
159 by the division. In addition to physicians, certified registered
160 nurse practitioners, physician assistants and clinical nurse
161 specialists are authorized to prescribe or order home health
162 services and plans of care, sign home health plans of care,
163 certify and recertify eligibility for home health services and
164 conduct the required initial face-to-face visit with the recipient
165 of the services.

166 (b) [Repealed]

167 (8) Emergency medical transportation services as
168 determined by the division.

169 (9) Prescription drugs and other covered drugs and
170 services as determined by the division.

171 The division shall establish a mandatory preferred drug list.
172 Drugs not on the mandatory preferred drug list shall be made
173 available by utilizing prior authorization procedures established
174 by the division.
175 The division may seek to establish relationships with other
176 states in order to lower acquisition costs of prescription drugs
177 to include single-source and innovator multiple-source drugs or
178 generic drugs. In addition, if allowed by federal law or
179 regulation, the division may seek to establish relationships with
180 and negotiate with other countries to facilitate the acquisition
181 of prescription drugs to include single-source and innovator
182 multiple-source drugs or generic drugs, if that will lower the
183 acquisition costs of those prescription drugs.
184 The division may allow for a combination of prescriptions for
185 single-source and innovator multiple-source drugs and generic
186 drugs to meet the needs of the beneficiaries.
187 The executive director may approve specific maintenance drugs
188 for beneficiaries with certain medical conditions, which may be
189 prescribed and dispensed in three-month supply increments.
190 Drugs prescribed for a resident of a psychiatric residential
191 treatment facility must be provided in true unit doses when
192 available. The division may require that drugs not covered by
193 Medicare Part D for a resident of a long-term care facility be
194 provided in true unit doses when available. Those drugs that were
195 originally billed to the division but are not used by a resident

196 in any of those facilities shall be returned to the billing
197 pharmacy for credit to the division, in accordance with the
198 guidelines of the State Board of Pharmacy and any requirements of
199 federal law and regulation. Drugs shall be dispensed to a
200 recipient and only one (1) dispensing fee per month may be
201 charged. The division shall develop a methodology for reimbursing
202 for restocked drugs, which shall include a restock fee as
203 determined by the division not exceeding Seven Dollars and
204 Eighty-two Cents ($7.82).

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

209 The division is authorized to develop and implement a program
210 of payment for additional pharmacist services as determined by the
211 division.

212 All claims for drugs for dually eligible Medicare/Medicaid
213 beneficiaries that are paid for by Medicare must be submitted to
214 Medicare for payment before they may be processed by the
215 division's online payment system.

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

221 The division shall develop and implement a method or methods
222 by which the division will provide on a regular basis to Medicaid
223 providers who are authorized to prescribe drugs, information about
224 the costs to the Medicaid program of single-source drugs and
225 innovator multiple-source drugs, and information about other drugs
226 that may be prescribed as alternatives to those single-source
227 drugs and innovator multiple-source drugs and the costs to the
228 Medicaid program of those alternative drugs.
229 Notwithstanding any law or regulation, information obtained
230 or maintained by the division regarding the prescription drug
231 program, including trade secrets and manufacturer or labeler
232 pricing, is confidential and not subject to disclosure except to
233 other state agencies.
234 The dispensing fee for each new or refill prescription,
235 including nonlegend or over-the-counter drugs covered by the
236 division, shall be not less than Three Dollars and Ninety-one
237 Cents ($3.91), as determined by the division.
238 The division shall not reimburse for single-source or
239 innovator multiple-source drugs if there are equally effective
240 generic equivalents available and if the generic equivalents are
241 the least expensive.
242 It is the intent of the Legislature that the pharmacists
243 providers be reimbursed for the reasonable costs of filling and
244 dispensing prescriptions for Medicaid beneficiaries.

245 The division shall allow certain drugs, including
246 physician-administered drugs, and implantable drug system devices,
247 and medical supplies, with limited distribution or limited access
248 for beneficiaries and administered in an appropriate clinical
249 setting, to be reimbursed as either a medical claim or pharmacy
250 claim, as determined by the division.

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

255 (10) Dental and orthodontic services to be determined
256 by the division.

257 The division shall increase the amount of the reimbursement
258 rate for diagnostic and preventative dental services for each of
259 the fiscal years 2022, 2023 and 2024 by five percent (5%) above
260 the amount of the reimbursement rate for the previous fiscal year.
261 It is the intent of the Legislature that the reimbursement rate
262 revision for preventative dental services will be an incentive to
263 increase the number of dentists who actively provide Medicaid
264 services. This dental services reimbursement rate revision shall
265 be known as the "James Russell Dumas Medicaid Dental Services
266 Incentive Program."

267 The Medical Care Advisory Committee, assisted by the Division
268 of Medicaid, shall annually determine the effect of this incentive
269 by evaluating the number of dentists who are Medicaid providers,

270 the number who and the degree to which they are actively billing
271 Medicaid, the geographic trends of where dentists are offering
272 what types of Medicaid services and other statistics pertinent to
273 the goals of this legislative intent. This data shall annually be
274 presented to the Chair of the Senate Medicaid Committee and the
275 Chair of the House Medicaid Committee.

276 The division shall include dental services as a necessary
277 component of overall health services provided to children who are
278 eligible for services.

279 (11) Eyeglasses for all Medicaid beneficiaries who have
280 (a) had surgery on the eyeball or ocular muscle that results in a
281 vision change for which eyeglasses or a change in eyeglasses is
282 medically indicated within six (6) months of the surgery and is in
283 accordance with policies established by the division, or (b) one
284 (1) pair every five (5) years and in accordance with policies
285 established by the division. In either instance, the eyeglasses
286 must be prescribed by a physician skilled in diseases of the eye
287 or an optometrist, whichever the beneficiary may select.

288 (12) Intermediate care facility services.

289 (a) The division shall make full payment to all
290 intermediate care facilities for individuals with intellectual
291 disabilities for each day, not exceeding sixty-three (63) days per
292 year, that a patient is absent from the facility on home leave.
293 Payment may be made for the following home leave days in addition
294 to the sixty-three-day limitation: Christmas, the day before

295 Christmas, the day after Christmas, Thanksgiving, the day before
296 Thanksgiving and the day after Thanksgiving.
297 (b) All state-owned intermediate care facilities
298 for individuals with intellectual disabilities shall be reimbursed
299 on a full reasonable cost basis.
300 (c) Effective January 1, 2015, the division shall
301 update the fair rental reimbursement system for intermediate care
302 facilities for individuals with intellectual disabilities.
303 (13) Family planning services, including drugs,
304 supplies and devices, when those services are under the
305 supervision of a physician or nurse practitioner.
306 (14) Clinic services. Preventive, diagnostic,
307 therapeutic, rehabilitative or palliative services that are
308 furnished by a facility that is not part of a hospital but is
309 organized and operated to provide medical care to outpatients.
310 Clinic services include, but are not limited to:
311 (a) Services provided by ambulatory surgical
312 centers (ACSs) as defined in Section 41-75-1(a); and
313 (b) Dialysis center services.
314 (15) Home- and community-based services for the elderly
315 and disabled, as provided under Title XIX of the federal Social
316 Security Act, as amended, under waivers, subject to the
317 availability of funds specifically appropriated for that purpose
318 by the Legislature.

319 (16) Mental health services. Certain services provided
320 by a psychiatrist shall be reimbursed at up to one hundred percent
321 (100%) of the Medicare rate. Approved therapeutic and case
322 management services (a) provided by an approved regional mental
323 health/intellectual disability center established under Sections
324 41-19-31 through 41-19-39, or by another community mental health
325 service provider meeting the requirements of the Department of
326 Mental Health to be an approved mental health/intellectual
327 disability center if determined necessary by the Department of
328 Mental Health, using state funds that are provided in the
329 appropriation to the division to match federal funds, or (b)
330 provided by a facility that is certified by the State Department
331 of Mental Health to provide therapeutic and case management
332 services, to be reimbursed on a fee for service basis, or (c)
333 provided in the community by a facility or program operated by the
334 Department of Mental Health. Any such services provided by a
335 facility described in subparagraph (b) must have the prior
336 approval of the division to be reimbursable under this section.
337 (17) Durable medical equipment services and medical
338 supplies. Precertification of durable medical equipment and
339 medical supplies must be obtained as required by the division.
340 The Division of Medicaid may require durable medical equipment
341 providers to obtain a surety bond in the amount and to the
342 specifications as established by the Balanced Budget Act of 1997.

343 (18) (a) Notwithstanding any other provision of this
344 section to the contrary, as provided in the Medicaid state plan
345 amendment or amendments as defined in Section 43-13-145(10), the
346 division shall make additional reimbursement to hospitals that
347 serve a disproportionate share of low-income patients and that
348 meet the federal requirements for those payments as provided in
349 Section 1923 of the federal Social Security Act and any applicable
350 regulations. It is the intent of the Legislature that the
351 division shall draw down all available federal funds allotted to
352 the state for disproportionate share hospitals. However, from and
353 after January 1, 1999, public hospitals participating in the
354 Medicaid disproportionate share program may be required to
355 participate in an intergovernmental transfer program as provided
356 in Section 1903 of the federal Social Security Act and any
357 applicable regulations.
358 (b) (i) The division may establish a Medicare
359 Upper Payment Limits Program, as defined in Section 1902(a)(30) of
360 the federal Social Security Act and any applicable federal
361 regulations, or an allowable delivery system or provider payment
362 initiative authorized under 42 CFR 438.6(c), for hospitals,
363 nursing facilities, physicians employed or contracted by
364 hospitals, and emergency ambulance transportation providers.
365 (ii) The division shall assess each hospital,
366 nursing facility, and emergency ambulance transportation provider
367 for the sole purpose of financing the state portion of the

368 Medicare Upper Payment Limits Program or other program(s)
369 authorized under this subsection (A)(18)(b). The hospital
370 assessment shall be as provided in Section 43-13-145(4)(a), and
371 the nursing facility and the emergency ambulance transportation
372 assessments, if established, shall be based on Medicaid
373 utilization or other appropriate method, as determined by the
374 division, consistent with federal regulations. The assessments
375 will remain in effect as long as the state participates in the
376 Medicare Upper Payment Limits Program or other program(s)
377 authorized under this subsection (A)(18)(b). In addition to the
378 hospital assessment provided in Section 43-13-145(4)(a), hospitals
379 with physicians participating in the Medicare Upper Payment Limits
380 Program or other program(s) authorized under this subsection
381 (A)(18)(b) shall be required to participate in an
382 intergovernmental transfer or assessment, as determined by the
383 division, for the purpose of financing the state portion of the
384 physician UPL payments or other payment(s) authorized under this
385 subsection (A)(18)(b).
386 (iii) Subject to approval by the Centers for
387 Medicare and Medicaid Services (CMS) and the provisions of this
388 subsection (A)(18)(b), the division shall make additional
389 reimbursement to hospitals, nursing facilities, and emergency
390 ambulance transportation providers for the Medicare Upper Payment
391 Limits Program or other program(s) authorized under this
392 subsection (A)(18)(b), and, if the program is established for

393 physicians, shall make additional reimbursement for physicians, as
394 defined in Section 1902(a)(30) of the federal Social Security Act
395 and any applicable federal regulations, provided the assessment in
396 this subsection (A)(18)(b) is in effect.

397 (iv) Notwithstanding any other provision of
398 this article to the contrary, effective upon implementation of the
399 Mississippi Hospital Access Program (MHAP) provided in
400 subparagraph (c)(i) below, the hospital portion of the inpatient
401 Upper Payment Limits Program shall transition into and be replaced
402 by the MHAP program. However, the division is authorized to
403 develop and implement an alternative fee-for-service Upper Payment
404 Limits model in accordance with federal laws and regulations if
405 necessary to preserve supplemental funding. Further, the
406 division, in consultation with the hospital industry shall develop
407 alternative models for distribution of medical claims and
408 supplemental payments for inpatient and outpatient hospital
409 services, and such models may include, but shall not be limited to
410 the following: increasing rates for inpatient and outpatient
411 services; creating a low-income utilization pool of funds to
412 reimburse hospitals for the costs of uncompensated care, charity
413 care and bad debts as permitted and approved pursuant to federal
414 regulations and the Centers for Medicare and Medicaid Services;
415 supplemental payments based upon Medicaid utilization, quality,
416 service lines and/or costs of providing such services to Medicaid
417 beneficiaries and to uninsured patients. The goals of such

418 payment models shall be to ensure access to inpatient and
419 outpatient care and to maximize any federal funds that are
420 available to reimburse hospitals for services provided. Any such
421 documents required to achieve the goals described in this
422 paragraph shall be submitted to the Centers for Medicare and
423 Medicaid Services, with a proposed effective date of July 1, 2019,
424 to the extent possible, but in no event shall the effective date
425 of such payment models be later than July 1, 2020. The Chairmen
426 of the Senate and House Medicaid Committees shall be provided a
427 copy of the proposed payment model(s) prior to submission.
428 Effective July 1, 2018, and until such time as any payment
429 model(s) as described above become effective, the division, in
430 consultation with the hospital industry, is authorized to
431 implement a transitional program for inpatient and outpatient
432 payments and/or supplemental payments (including, but not limited
433 to, MHAP and directed payments), to redistribute available
434 supplemental funds among hospital providers, provided that when
435 compared to a hospital's prior year supplemental payments,
436 supplemental payments made pursuant to any such transitional
437 program shall not result in a decrease of more than five percent
438 (5%) and shall not increase by more than the amount needed to
439 maximize the distribution of the available funds.
440 (c) (i) Not later than December l, 2015, the
441 division shall, subject to approval by the Centers for Medicare
442 and Medicaid Services (CMS), establish, implement and operate a

443 Mississippi Hospital Access Program (MHAP) for the purpose of
444 protecting patient access to hospital care through hospital
445 inpatient reimbursement programs provided in this section designed
446 to maintain total hospital reimbursement for inpatient services
447 rendered by in-state hospitals and the out-of-state hospital that
448 is authorized by federal law to submit intergovernmental transfers
449 (IGTs) to the State of Mississippi and is classified as Level I
450 trauma center located in a county contiguous to the state line at
451 the maximum levels permissible under applicable federal statutes
452 and regulations, at which time the current inpatient Medicare
453 Upper Payment Limits (UPL) Program for hospital inpatient services
454 shall transition to the MHAP.

455 (ii) Subject to approval by the Centers for
456 Medicare and Medicaid Services (CMS), the MHAP shall provide
457 increased inpatient capitation (PMPM) payments to managed care
458 entities contracting with the division pursuant to subsection (H)
459 of this section to support availability of hospital services or
460 such other payments permissible under federal law necessary to
461 accomplish the intent of this subsection.

462 (iii) The intent of this subparagraph (c) is
463 that effective for all inpatient hospital Medicaid services during
464 state fiscal year 2016, and so long as this provision shall remain
465 in effect hereafter, the division shall to the fullest extent
466 feasible replace the additional reimbursement for hospital
467 inpatient services under the inpatient Medicare Upper Payment

468 Limits (UPL) Program with additional reimbursement under the MHAP
469 and other payment programs for inpatient and/or outpatient
470 payments which may be developed under the authority of this
471 paragraph.

472 (iv) The division shall assess each hospital
473 as provided in Section 43-13-145(4)(a) for the purpose of
474 financing the state portion of the MHAP, supplemental payments and
475 such other purposes as specified in Section 43-13-145. The
476 assessment will remain in effect as long as the MHAP and
477 supplemental payments are in effect.

478 (19) (a) Perinatal risk management services. The
479 division shall promulgate regulations to be effective from and
480 after October 1, 1988, to establish a comprehensive perinatal
481 system for risk assessment of all pregnant and infant Medicaid
482 recipients and for management, education and follow-up for those
483 who are determined to be at risk. Services to be performed
484 include case management, nutrition assessment/counseling,
485 psychosocial assessment/counseling and health education. The
486 division shall contract with the State Department of Health to
487 provide services within this paragraph (Perinatal High Risk
488 Management/Infant Services System (PHRM/ISS)). The State
489 Department of Health shall be reimbursed on a full reasonable cost
490 basis for services provided under this subparagraph (a).

491 (b) Early intervention system services. The
492 division shall cooperate with the State Department of Health,

493 acting as lead agency, in the development and implementation of a
494 statewide system of delivery of early intervention services, under
495 Part C of the Individuals with Disabilities Education Act (IDEA).
496 The State Department of Health shall certify annually in writing
497 to the executive director of the division the dollar amount of
498 state early intervention funds available that will be utilized as
499 a certified match for Medicaid matching funds. Those funds then
500 shall be used to provide expanded targeted case management
501 services for Medicaid eligible children with special needs who are
502 eligible for the state's early intervention system.
503 Qualifications for persons providing service coordination shall be
504 determined by the State Department of Health and the Division of
505 Medicaid.
506 (20) Home- and community-based services for physically
507 disabled approved services as allowed by a waiver from the United
508 States Department of Health and Human Services for home- and
509 community-based services for physically disabled people using
510 state funds that are provided from the appropriation to the State
511 Department of Rehabilitation Services and used to match federal
512 funds under a cooperative agreement between the division and the
513 department, provided that funds for these services are
514 specifically appropriated to the Department of Rehabilitation
515 Services.
516 (21) Nurse practitioner services. Services furnished
517 by a registered nurse who is licensed and certified by the

518 Mississippi Board of Nursing as a nurse practitioner, including,
519 but not limited to, nurse anesthetists, nurse midwives, family
520 nurse practitioners, family planning nurse practitioners,
521 pediatric nurse practitioners, obstetrics-gynecology nurse
522 practitioners and neonatal nurse practitioners, under regulations
523 adopted by the division. Reimbursement for those services shall
524 not exceed ninety percent (90%) of the reimbursement rate for
525 comparable services rendered by a physician. The division may
526 provide for a reimbursement rate for nurse practitioner services
527 of up to one hundred percent (100%) of the reimbursement rate for
528 comparable services rendered by a physician for nurse practitioner
529 services that are provided after the normal working hours of the
530 nurse practitioner, as determined in accordance with regulations
531 of the division.
532 (22) Ambulatory services delivered in federally
533 qualified health centers, rural health centers and clinics of the
534 local health departments of the State Department of Health for
535 individuals eligible for Medicaid under this article based on
536 reasonable costs as determined by the division. Federally
537 qualified health centers shall be reimbursed by the Medicaid
538 prospective payment system as approved by the Centers for Medicare
539 and Medicaid Services. The division shall recognize federally
540 qualified health centers (FQHCs), rural health clinics (RHCs)) and
541 community mental health centers (CMHCs) as both an originating and
542 distant site provider for the purposes of telehealth

543 reimbursement. The division is further authorized and directed to
544 reimburse FQHCs, RHCs and CMHCs for both distant site and
545 originating site services when such services are appropriately
546 provided by the same organization.

547 (23) Inpatient psychiatric services.

548 (a) Inpatient psychiatric services to be
549 determined by the division for recipients under age twenty-one
550 (21) that are provided under the direction of a physician in an
551 inpatient program in a licensed acute care psychiatric facility or
552 in a licensed psychiatric residential treatment facility, before
553 the recipient reaches age twenty-one (21) or, if the recipient was
554 receiving the services immediately before he or she reached age
555 twenty-one (21), before the earlier of the date he or she no
556 longer requires the services or the date he or she reaches age
557 twenty-two (22), as provided by federal regulations. From and
558 after January 1, 2015, the division shall update the fair rental
559 reimbursement system for psychiatric residential treatment
560 facilities. Precertification of inpatient days and residential
561 treatment days must be obtained as required by the division. From
562 and after July 1, 2009, all state-owned and state-operated
563 facilities that provide inpatient psychiatric services to persons
564 under age twenty-one (21) who are eligible for Medicaid
565 reimbursement shall be reimbursed for those services on a full
566 reasonable cost basis.

567 (b) The division may reimburse for services
568 provided by a licensed freestanding psychiatric hospital to
569 Medicaid recipients over the age of twenty-one (21) in a method
570 and manner consistent with the provisions of Section 43-13-117.5.
571 (24) [Deleted]
572 (25) [Deleted]
573 (26) Hospice care. As used in this paragraph, the term
574 "hospice care" means a coordinated program of active professional
575 medical attention within the home and outpatient and inpatient
576 care that treats the terminally ill patient and family as a unit,
577 employing a medically directed interdisciplinary team. The
578 program provides relief of severe pain or other physical symptoms
579 and supportive care to meet the special needs arising out of
580 physical, psychological, spiritual, social and economic stresses
581 that are experienced during the final stages of illness and during
582 dying and bereavement and meets the Medicare requirements for
583 participation as a hospice as provided in federal regulations.
584 (27) Group health plan premiums and cost-sharing if it
585 is cost-effective as defined by the United States Secretary of
586 Health and Human Services.
587 (28) Other health insurance premiums that are
588 cost-effective as defined by the United States Secretary of Health
589 and Human Services. Medicare eligible must have Medicare Part B
590 before other insurance premiums can be paid.

591 (29) The Division of Medicaid may apply for a waiver
592 from the United States Department of Health and Human Services for
593 home- and community-based services for developmentally disabled
594 people using state funds that are provided from the appropriation
595 to the State Department of Mental Health and/or funds transferred
596 to the department by a political subdivision or instrumentality of
597 the state and used to match federal funds under a cooperative
598 agreement between the division and the department, provided that
599 funds for these services are specifically appropriated to the
600 Department of Mental Health and/or transferred to the department
601 by a political subdivision or instrumentality of the state.
602 (30) Pediatric skilled nursing services as determined
603 by the division and in a manner consistent with regulations
604 promulgated by the Mississippi State Department of Health.
605 (31) Targeted case management services for children
606 with special needs, under waivers from the United States
607 Department of Health and Human Services, using state funds that
608 are provided from the appropriation to the Mississippi Department
609 of Human Services and used to match federal funds under a
610 cooperative agreement between the division and the department.
611 (32) Care and services provided in Christian Science
612 Sanatoria listed and certified by the Commission for Accreditation
613 of Christian Science Nursing Organizations/Facilities, Inc.,
614 rendered in connection with treatment by prayer or spiritual means

615 to the extent that those services are subject to reimbursement
616 under Section 1903 of the federal Social Security Act.
617 (33) Podiatrist services.
618 (34) Assisted living services as provided through
619 home- and community-based services under Title XIX of the federal
620 Social Security Act, as amended, subject to the availability of
621 funds specifically appropriated for that purpose by the
622 Legislature.
623 (35) Services and activities authorized in Sections
624 43-27-101 and 43-27-103, using state funds that are provided from
625 the appropriation to the Mississippi Department of Human Services
626 and used to match federal funds under a cooperative agreement
627 between the division and the department.
628 (36) Nonemergency transportation services for
629 Medicaid-eligible persons as determined by the division. The PEER
630 Committee shall conduct a performance evaluation of the
631 nonemergency transportation program to evaluate the administration
632 of the program and the providers of transportation services to
633 determine the most cost-effective ways of providing nonemergency
634 transportation services to the patients served under the program.
635 The performance evaluation shall be completed and provided to the
636 members of the Senate Medicaid Committee and the House Medicaid
637 Committee not later than January 1, 2019, and every two (2) years
638 thereafter.
639 (37) [Deleted]

640 (38) Chiropractic services. A chiropractor's manual
641 manipulation of the spine to correct a subluxation, if x-ray
642 demonstrates that a subluxation exists and if the subluxation has
643 resulted in a neuromusculoskeletal condition for which
644 manipulation is appropriate treatment, and related spinal x-rays
645 performed to document these conditions. Reimbursement for
646 chiropractic services shall not exceed Seven Hundred Dollars
647 ($700.00) per year per beneficiary.
648 (39) Dually eligible Medicare/Medicaid beneficiaries.
649 The division shall pay the Medicare deductible and coinsurance
650 amounts for services available under Medicare, as determined by
651 the division. From and after July 1, 2009, the division shall
652 reimburse crossover claims for inpatient hospital services and
653 crossover claims covered under Medicare Part B in the same manner
654 that was in effect on January 1, 2008, unless specifically
655 authorized by the Legislature to change this method.
656 (40) [Deleted]
657 (41) Services provided by the State Department of
658 Rehabilitation Services for the care and rehabilitation of persons
659 with spinal cord injuries or traumatic brain injuries, as allowed
660 under waivers from the United States Department of Health and
661 Human Services, using up to seventy-five percent (75%) of the
662 funds that are appropriated to the Department of Rehabilitation
663 Services from the Spinal Cord and Head Injury Trust Fund
664 established under Section 37-33-261 and used to match federal

665 funds under a cooperative agreement between the division and the
666 department.
667 (42) [Deleted]
668 (43) The division shall provide reimbursement,
669 according to a payment schedule developed by the division, for
670 smoking cessation medications for pregnant women during their
671 pregnancy and other Medicaid-eligible women who are of
672 child-bearing age.
673 (44) Nursing facility services for the severely
674 disabled.
675 (a) Severe disabilities include, but are not
676 limited to, spinal cord injuries, closed-head injuries and
677 ventilator-dependent patients.
678 (b) Those services must be provided in a long-term
679 care nursing facility dedicated to the care and treatment of
680 persons with severe disabilities.
681 (45) Physician assistant services. Services furnished
682 by a physician assistant who is licensed by the State Board of
683 Medical Licensure and is practicing with physician supervision
684 under regulations adopted by the board, under regulations adopted
685 by the division. Reimbursement for those services shall not
686 exceed ninety percent (90%) of the reimbursement rate for
687 comparable services rendered by a physician. The division may
688 provide for a reimbursement rate for physician assistant services
689 of up to one hundred percent (100%) or the reimbursement rate for

690 comparable services rendered by a physician for physician
691 assistant services that are provided after the normal working
692 hours of the physician assistant, as determined in accordance with
693 regulations of the division.

694 (46) The division shall make application to the federal
695 Centers for Medicare and Medicaid Services (CMS) for a waiver to
696 develop and provide services for children with serious emotional
697 disturbances as defined in Section 43-14-1(1), which may include
698 home- and community-based services, case management services or
699 managed care services through mental health providers certified by
700 the Department of Mental Health. The division may implement and
701 provide services under this waivered program only if funds for
702 these services are specifically appropriated for this purpose by
703 the Legislature, or if funds are voluntarily provided by affected
704 agencies.

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

709 (b) Participation in any disease management
710 program implemented under this paragraph (47) is optional with the
711 individual. An individual must affirmatively elect to participate
712 in the disease management program in order to participate, and may
713 elect to discontinue participation in the program at any time.

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

715 (a) Pediatric long-term acute care hospital
716 services means services provided to eligible persons under
717 twenty-one (21) years of age by a freestanding Medicare-certified
718 hospital that has an average length of inpatient stay greater than
719 twenty-five (25) days and that is primarily engaged in providing
720 chronic or long-term medical care to persons under twenty-one (21)
721 years of age.

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

724 (49) The division may establish copayments and/or
725 coinsurance for any Medicaid services for which copayments and/or
726 coinsurance are allowable under federal law or regulation.

727 (50) Services provided by the State Department of
728 Rehabilitation Services for the care and rehabilitation of persons
729 who are deaf and blind, as allowed under waivers from the United
730 States Department of Health and Human Services to provide home-
731 and community-based services using state funds that are provided
732 from the appropriation to the State Department of Rehabilitation
733 Services or if funds are voluntarily provided by another agency.

734 (51) Upon determination of Medicaid eligibility and in
735 association with annual redetermination of Medicaid eligibility,
736 beneficiaries shall be encouraged to undertake a physical
737 examination that will establish a base-line level of health and
738 identification of a usual and customary source of care (a medical
739 home) to aid utilization of disease management tools. This

740 physical examination and utilization of these disease management
741 tools shall be consistent with current United States Preventive
742 Services Task Force or other recognized authority recommendations.
743 For persons who are determined ineligible for Medicaid, the
744 division will provide information and direction for accessing
745 medical care and services in the area of their residence.
746 (52) Notwithstanding any provisions of this article,
747 the division may pay enhanced reimbursement fees related to trauma
748 care, as determined by the division in conjunction with the State
749 Department of Health, using funds appropriated to the State
750 Department of Health for trauma care and services and used to
751 match federal funds under a cooperative agreement between the
752 division and the State Department of Health. The division, in
753 conjunction with the State Department of Health, may use grants,
754 waivers, demonstrations, enhanced reimbursements, Upper Payment
755 Limits Programs, supplemental payments, or other projects as
756 necessary in the development and implementation of this
757 reimbursement program.
758 (53) Targeted case management services for high-cost
759 beneficiaries may be developed by the division for all services
760 under this section.
761 (54) [Deleted]
762 (55) Therapy services. The plan of care for therapy
763 services may be developed to cover a period of treatment for up to
764 six (6) months, but in no event shall the plan of care exceed a

765 six-month period of treatment. The projected period of treatment
766 must be indicated on the initial plan of care and must be updated
767 with each subsequent revised plan of care. Based on medical
768 necessity, the division shall approve certification periods for
769 less than or up to six (6) months, but in no event shall the
770 certification period exceed the period of treatment indicated on
771 the plan of care. The appeal process for any reduction in therapy
772 services shall be consistent with the appeal process in federal
773 regulations.
774 (56) Prescribed pediatric extended care centers
775 services for medically dependent or technologically dependent
776 children with complex medical conditions that require continual
777 care as prescribed by the child's attending physician, as
778 determined by the division.
779 (57) No Medicaid benefit shall restrict coverage for
780 medically appropriate treatment prescribed by a physician and
781 agreed to by a fully informed individual, or if the individual
782 lacks legal capacity to consent by a person who has legal
783 authority to consent on his or her behalf, based on an
784 individual's diagnosis with a terminal condition. As used in this
785 paragraph (57), "terminal condition" means any aggressive
786 malignancy, chronic end-stage cardiovascular or cerebral vascular
787 disease, or any other disease, illness or condition which a
788 physician diagnoses as terminal.

789 (58) Treatment services for persons with opioid
790 dependency or other highly addictive substance use disorders. The
791 division is authorized to reimburse eligible providers for
792 treatment of opioid dependency and other highly addictive
793 substance use disorders, as determined by the division. Treatment
794 related to these conditions shall not count against any physician
795 visit limit imposed under this section.
796 (59) The division shall allow beneficiaries between the
797 ages of ten (10) and eighteen (18) years to receive vaccines
798 through a pharmacy venue. The division and the State Department
799 of Health shall coordinate and notify OB-GYN providers that the
800 Vaccines for Children program is available to providers free of
801 charge.
802 (B) [Deleted]
803 (C) The division may pay to those providers who participate
804 in and accept patient referrals from the division's emergency room
805 redirection program a percentage, as determined by the division,
806 of savings achieved according to the performance measures and
807 reduction of costs required of that program. Federally qualified
808 health centers may participate in the emergency room redirection
809 program, and the division may pay those centers a percentage of
810 any savings to the Medicaid program achieved by the centers'
811 accepting patient referrals through the program, as provided in
812 this subsection (C).

813 (D) (1) Notwithstanding any provision of this article,
814 except as authorized in subsection (E) of this section and in
815 Section 43-13-139, (a) the limitations on the quantity or
816 frequency of use of, or the fees or charges for, any of the care
817 or services available to recipients under this section; and (b)
818 the payments or rates of reimbursement to providers rendering care
819 or services authorized under this section to recipients shall not
820 be increased, decreased or otherwise changed from the levels in
821 effect on July 1, 2021, unless they are authorized by an amendment
822 to this section by the Legislature.

823 (2) When any of the changes described in paragraph (1)
824 of this subsection are authorized by an amendment to this section
825 by the Legislature that is effective after July 1, 2021, the
826 changes made in the later amendment shall not be further changed
827 from the levels in effect on the effective date of the later
828 amendment unless those changes are authorized by another amendment
829 to this section by the Legislature.

830 (E) Notwithstanding any provision of this article, no new
831 groups or categories of recipients and new types of care and
832 services may be added without enabling legislation from the
833 Mississippi Legislature, except that the division may authorize
834 those changes without enabling legislation when the addition of
835 recipients or services is ordered by a court of proper authority.

836 (F) The executive director shall keep the Governor advised
837 on a timely basis of the funds available for expenditure and the

838 projected expenditures. Notwithstanding any other provisions of
839 this article, if current or projected expenditures of the division
840 are reasonably anticipated to exceed the amount of funds
841 appropriated to the division for any fiscal year, the Governor,
842 after consultation with the executive director, shall take all
843 appropriate measures to reduce costs, which may include, but are
844 not limited to:

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

848 (2) Reducing reimbursement rates for any or all service
849 types;

850 (3) Imposing additional assessments on health care
851 providers; or

852 (4) Any additional cost-containment measures deemed
853 appropriate by the Governor.

854 To the extent allowed under federal law, any reduction to
855 services or reimbursement rates under this subsection (F) shall be
856 accompanied by a reduction, to the fullest allowable amount, to
857 the profit margin and administrative fee portions of capitated
858 payments to organizations described in paragraph (1) of subsection
859 (H).

860 Beginning in fiscal year 2010 and in fiscal years thereafter,
861 when Medicaid expenditures are projected to exceed funds available
862 for the fiscal year, the division shall submit the expected

863 shortfall information to the PEER Committee not later than
864 December 1 of the year in which the shortfall is projected to
865 occur. PEER shall review the computations of the division and
866 report its findings to the Legislative Budget Office not later
867 than January 7 in any year.

868 (G) Notwithstanding any other provision of this article, it
869 shall be the duty of each provider participating in the Medicaid
870 program to keep and maintain books, documents and other records as
871 prescribed by the Division of Medicaid in accordance with federal
872 laws and regulations.

873 (H) (1) Notwithstanding any other provision of this
874 article, the division is authorized to implement (a) a managed
875 care program, (b) a coordinated care program, (c) a coordinated
876 care organization program, (d) a health maintenance organization
877 program, (e) a patient-centered medical home program, (f) an
878 accountable care organization program, (g) provider-sponsored
879 health plan, or (h) any combination of the above programs. As a
880 condition for the approval of any program under this subsection
881 (H)(1), the division shall require that no managed care program,
882 coordinated care program, coordinated care organization program,
883 health maintenance organization program, or provider-sponsored
884 health plan may:

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

888 (b) Override the medical decisions of hospital
889 physicians or staff regarding patients admitted to a hospital for
890 an emergency medical condition as defined by 42 US Code Section
891 1395dd. This restriction (b) does not prohibit the retrospective
892 review of the appropriateness of the determination that an
893 emergency medical condition exists by chart review or coding
894 algorithm, nor does it prohibit prior authorization for
895 nonemergency hospital admissions;
896 (c) Pay providers at a rate that is less than the
897 normal Medicaid reimbursement rate. It is the intent of the
898 Legislature that all managed care entities described in this
899 subsection (H), in collaboration with the division, develop and
900 implement innovative payment models that incentivize improvements
901 in health care quality, outcomes, or value, as determined by the
902 division. Participation in the provider network of any managed
903 care, coordinated care, provider-sponsored health plan, or similar
904 contractor shall not be conditioned on the provider's agreement to
905 accept such alternative payment models;
906 (d) Implement a prior authorization and
907 utilization review program for medical services, transportation
908 services and prescription drugs that is more stringent than the
909 prior authorization processes used by the division in its
910 administration of the Medicaid program. Not later than December
911 2, 2021, the contractors that are receiving capitated payments
912 under a managed care delivery system established under this

913 subsection (H) shall submit a report to the Chairmen of the House
914 and Senate Medicaid Committees on the status of the prior
915 authorization and utilization review program for medical services,
916 transportation services and prescription drugs that is required to
917 be implemented under this subparagraph (d);

918 (e) [Deleted]

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

922 (g) Implement a policy which denies beneficiaries
923 with hemophilia access to the federally funded hemophilia
924 treatment centers as part of the Medicaid Managed Care network of
925 providers.

926 Each health maintenance organization, coordinated care
927 organization, provider-sponsored health plan, or other
928 organization paid for services on a capitated basis by the
929 division under any managed care program or coordinated care
930 program implemented by the division under this section shall use a
931 clear set of level of care guidelines in the determination of
932 medical necessity and in all utilization management practices,
933 including the prior authorization process, concurrent reviews,
934 retrospective reviews and payments, that are consistent with
935 widely accepted professional standards of care. Organizations
936 participating in a managed care program or coordinated care
937 program implemented by the division may not use any additional

938 criteria that would result in denial of care that would be
939 determined appropriate and, therefore, medically necessary under
940 those levels of care guidelines.

941 (2) Notwithstanding any provision of this section, the
942 recipients eligible for enrollment into a Medicaid Managed Care
943 Program authorized under this subsection (H) may include only
944 those categories of recipients eligible for participation in the
945 Medicaid Managed Care Program as of January 1, 2021, the
946 Children's Health Insurance Program (CHIP), and the CMS-approved
947 Section 1115 demonstration waivers in operation as of January 1,
948 2021. No expansion of Medicaid Managed Care Program contracts may
949 be implemented by the division without enabling legislation from
950 the Mississippi Legislature.

951 (3) (a) Any contractors receiving capitated payments
952 under a managed care delivery system established in this section
953 shall provide to the Legislature and the division statistical data
954 to be shared with provider groups in order to improve patient
955 access, appropriate utilization, cost savings and health outcomes
956 not later than October 1 of each year. Additionally, each
957 contractor shall disclose to the Chairmen of the Senate and House
958 Medicaid Committees the administrative expenses costs for the
959 prior calendar year, and the number of full-equivalent employees
960 located in the State of Mississippi dedicated to the Medicaid and
961 CHIP lines of business as of June 30 of the current year.

962 (b) The division and the contractors participating
963 in the managed care program, a coordinated care program or a
964 provider-sponsored health plan shall be subject to annual program
965 reviews or audits performed by the Office of the State Auditor,
966 the PEER Committee, the Department of Insurance and/or independent
967 third parties.

968 (c) Those reviews shall include, but not be
969 limited to, at least two (2) of the following items:

970 (i) The financial benefit to the State of
971 Mississippi of the managed care program,

972 (ii) The difference between the premiums paid
973 to the managed care contractors and the payments made by those
974 contractors to health care providers,

975 (iii) Compliance with performance measures
976 required under the contracts,

977 (iv) Administrative expense allocation
978 methodologies,

979 (v) Whether nonprovider payments assigned as
980 medical expenses are appropriate,

981 (vi) Capitated arrangements with related
982 party subcontractors,

983 (vii) Reasonableness of corporate
984 allocations,

985 (viii) Value-added benefits and the extent to
986 which they are used,

987 (ix) The effectiveness of subcontractor
988 oversight, including subcontractor review,
989 (x) Whether health care outcomes have been
990 improved, and
991 (xi) The most common claim denial codes to
992 determine the reasons for the denials.
993 The audit reports shall be considered public documents and
994 shall be posted in their entirety on the division's website.
995 (4) All health maintenance organizations, coordinated
996 care organizations, provider-sponsored health plans, or other
997 organizations paid for services on a capitated basis by the
998 division under any managed care program or coordinated care
999 program implemented by the division under this section shall
1000 reimburse all providers in those organizations at rates no lower
1001 than those provided under this section for beneficiaries who are
1002 not participating in those programs.
1003 (5) No health maintenance organization, coordinated
1004 care organization, provider-sponsored health plan, or other
1005 organization paid for services on a capitated basis by the
1006 division under any managed care program or coordinated care
1007 program implemented by the division under this section shall
1008 require its providers or beneficiaries to use any pharmacy that
1009 ships, mails or delivers prescription drugs or legend drugs or
1010 devices.

1011 (6) (a) Not later than December 1, 2021, the
1012 contractors who are receiving capitated payments under a managed
1013 care delivery system established under this subsection (H) shall
1014 develop and implement a uniform credentialing process for
1015 providers. Under that uniform credentialing process, a provider
1016 who meets the criteria for credentialing will be credentialed with
1017 all of those contractors and no such provider will have to be
1018 separately credentialed by any individual contractor in order to
1019 receive reimbursement from the contractor. Not later than
1020 December 2, 2021, those contractors shall submit a report to the
1021 Chairmen of the House and Senate Medicaid Committees on the status
1022 of the uniform credentialing process for providers that is
1023 required under this subparagraph (a).
1024 (b) If those contractors have not implemented a
1025 uniform credentialing process as described in subparagraph (a) by
1026 December 1, 2021, the division shall develop and implement, not
1027 later than July 1, 2022, a single, consolidated credentialing
1028 process by which all providers will be credentialed. Under the
1029 division's single, consolidated credentialing process, no such
1030 contractor shall require its providers to be separately
1031 credentialed by the contractor in order to receive reimbursement
1032 from the contractor, but those contractors shall recognize the
1033 credentialing of the providers by the division's credentialing
1034 process.

1035 (c) The division shall require a uniform provider
1036 credentialing application that shall be used in the credentialing
1037 process that is established under subparagraph (a) or (b). If the
1038 contractor or division, as applicable, has not approved or denied
1039 the provider credentialing application within sixty (60) days of
1040 receipt of the completed application that includes all required
1041 information necessary for credentialing, then the contractor or
1042 division, upon receipt of a written request from the applicant and
1043 within five (5) business days of its receipt, shall issue a
1044 temporary provider credential/enrollment to the applicant if the
1045 applicant has a valid Mississippi professional or occupational
1046 license to provide the health care services to which the
1047 credential/enrollment would apply. The contractor or the division
1048 shall not issue a temporary credential/enrollment if the applicant
1049 has reported on the application a history of medical or other
1050 professional or occupational malpractice claims, a history of
1051 substance abuse or mental health issues, a criminal record, or a
1052 history of medical or other licensing board, state or federal
1053 disciplinary action, including any suspension from participation
1054 in a federal or state program. The temporary
1055 credential/enrollment shall be effective upon issuance and shall
1056 remain in effect until the provider's credentialing/enrollment
1057 application is approved or denied by the contractor or division.
1058 The contractor or division shall render a final decision regarding
1059 credentialing/enrollment of the provider within sixty (60) days

1060 from the date that the temporary provider credential/enrollment is
1061 issued to the applicant.
1062 (d) If the contractor or division does not render
1063 a final decision regarding credentialing/enrollment of the
1064 provider within the time required in subparagraph (c), the
1065 provider shall be deemed to be credentialed by and enrolled with
1066 all of the contractors and eligible to receive reimbursement from
1067 the contractors.
1068 (7) (a) Each contractor that is receiving capitated
1069 payments under a managed care delivery system established under
1070 this subsection (H) shall provide to each provider for whom the
1071 contractor has denied the coverage of a procedure that was ordered
1072 or requested by the provider for or on behalf of a patient, a
1073 letter that provides a detailed explanation of the reasons for the
1074 denial of coverage of the procedure and the name and the
1075 credentials of the person who denied the coverage. The letter
1076 shall be sent to the provider in electronic format.
1077 (b) After a contractor that is receiving capitated
1078 payments under a managed care delivery system established under
1079 this subsection (H) has denied coverage for a claim submitted by a
1080 provider, the contractor shall issue to the provider within sixty
1081 (60) days a final ruling of denial of the claim that allows the
1082 provider to have a state fair hearing and/or agency appeal with
1083 the division. If a contractor does not issue a final ruling of
1084 denial within sixty (60) days as required by this subparagraph

1085 (b), the provider's claim shall be deemed to be automatically
1086 approved and the contractor shall pay the amount of the claim to
1087 the provider.

1088 (c) After a contractor has issued a final ruling
1089 of denial of a claim submitted by a provider, the division shall
1090 conduct a state fair hearing and/or agency appeal on the matter of
1091 the disputed claim between the contractor and the provider within
1092 sixty (60) days, and shall render a decision on the matter within
1093 thirty (30) days after the date of the hearing and/or appeal.

1094 (8) It is the intention of the Legislature that the
1095 division evaluate the feasibility of using a single vendor to
1096 administer pharmacy benefits provided under a managed care
1097 delivery system established under this subsection (H). Providers
1098 of pharmacy benefits shall cooperate with the division in any
1099 transition to a carve-out of pharmacy benefits under managed care.

1100 (9) It is the intention of the Legislature that the
1101 division evaluate the feasibility of using a single vendor to
1102 administer dental benefits provided under a managed care delivery
1103 system established in this subsection (H). Providers of dental
1104 benefits shall cooperate with the division in any transition to a
1105 carve-out of dental benefits under managed care.

1106 (10) It is the intent of the Legislature that any
1107 contractor receiving capitated payments under a managed care
1108 delivery system established in this section shall implement

1109 innovative programs to improve the health and well-being of
1110 members diagnosed with prediabetes and diabetes.
1111 (11) It is the intent of the Legislature that any
1112 contractors receiving capitated payments under a managed care
1113 delivery system established under this subsection (H) shall work
1114 with providers of Medicaid services to improve the utilization of
1115 long-acting reversible contraceptives (LARCs). Not later than
1116 December 1, 2021, any contractors receiving capitated payments
1117 under a managed care delivery system established under this
1118 subsection (H) shall provide to the Chairmen of the House and
1119 Senate Medicaid Committees and House and Senate Public Health
1120 Committees a report of LARC utilization for State Fiscal Years
1121 2018 through 2020 as well as any programs, initiatives, or efforts
1122 made by the contractors and providers to increase LARC
1123 utilization. This report shall be updated annually to include
1124 information for subsequent state fiscal years.
1125 (12) The division is authorized to make not more than
1126 one (1) emergency extension of the contracts that are in effect on
1127 July 1, 2021, with contractors who are receiving capitated
1128 payments under a managed care delivery system established under
1129 this subsection (H), as provided in this paragraph (12). The
1130 maximum period of any such extension shall be one (1) year, and
1131 under any such extensions, the contractors shall be subject to all
1132 of the provisions of this subsection (H). The extended contracts

1133 shall be revised to incorporate any provisions of this subsection
1134 (H).
1135 (13) (a) Each health maintenance organization,
1136 coordinated care organization, provider-sponsored health plan, or
1137 other organization paid for services on a capitated basis by the
1138 division under any managed care program or coordinated care
1139 program implemented by the division under this section shall use a
1140 clear set of level of care guidelines in the determination of
1141 medical necessity and in all utilization management practices,
1142 including the prior authorization process, concurrent reviews,
1143 retrospective reviews and payments, that are consistent with
1144 widely accepted professional standards of care (including the
1145 Level of Care Utilization System [LOCUS], Child and Adolescent
1146 Level of Care Utilization System [CALOCUS] and the American
1147 Society of Addiction Medicine [ASAM], Child and Adolescent Service
1148 Intensity Instrument [CASSI]). Organizations participating in a
1149 managed care program or coordinated care program implemented by
1150 the division may not use any additional criteria that would result
1151 in denial of care that would be determined appropriate and,
1152 therefore, medically necessary by the guidelines and the
1153 principles in subparagraph (b).
1154 (b) The standards of care must incorporate the
1155 following eight (8) principles:

1156 (i) Effective treatment requires treatment of
1157 the individual's underlying condition and is not limited to
1158 alleviation of the individual's current symptoms.
1159 (ii) Effective treatment requires treatment
1160 of co-occurring mental health and substance use disorders and/or
1161 medical conditions in a coordinated manner that considers the
1162 interactions of the disorders when determining the appropriate
1163 level of care.
1164 (iii) Patients should receive treatment for
1165 mental health and substance use disorders at the least intensive
1166 and restrictive level of care that is safe and effective.
1167 (iv) When there is ambiguity as to the
1168 appropriate level of care, the practitioner and insurer should err
1169 on the side of caution by placing the patient in a higher level of
1170 care that is currently available.
1171 (v) Effective treatment of mental health and
1172 substance use disorders includes services needed to maintain
1173 functioning or prevent deterioration.
1174 (vi) The appropriate duration of treatment
1175 for mental health and substance use disorders is based on the
1176 individual needs of the patient; there is no specific limit on the
1177 duration of such treatment.
1178 (vii) The unique needs of children and
1179 adolescents must be taken into account when making decisions

1180 regarding the level of care involving their treatment for mental

1181 health or substance use disorders.

1182 (viii) The determination of the appropriate

1183 level of care for patients with mental health or substance use

1184 disorders should be made on the basis of a multidimensional

1185 assessment that takes into account a wide variety of information

1186 about the patient.

1187 (I) [Deleted]

1188 (J) There shall be no cuts in inpatient and outpatient

1189 hospital payments, or allowable days or volumes, as long as the

1190 hospital assessment provided in Section 43-13-145 is in effect.

1191 This subsection (J) shall not apply to decreases in payments that

1192 are a result of: reduced hospital admissions, audits or payments

1193 under the APR-DRG or APC models, or a managed care program or

1194 similar model described in subsection (H) of this section.

1195 (K) In the negotiation and execution of such contracts

1196 involving services performed by actuarial firms, the Executive

1197 Director of the Division of Medicaid may negotiate a limitation on

1198 liability to the state of prospective contractors.

1199 (L) This section shall stand repealed on July 1, 2024.

1200 **SECTION 2.** This act shall take effect and be in force from

1201 and after July 1, 2022.