MISSISSIPPI LEGISLATURE REGULAR SESSION 2022

By: Representative Hood To: Medicaid

HOUSE BILL NO. 657
(As Sent to Governor)

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO DELETE THE PROVISION THAT PROHIBITS THE DIVISION OF MEDICAID'S
3 RATES OF REIMBURSEMENT, SERVICES, CHARGES AND FEES FROM BEING
4 INCREASED, DECREASED OR OTHERWISE CHANGED UNLESS THEY ARE
5 AUTHORIZED BY AN AMENDMENT TO THIS SECTION BY THE LEGISLATURE; TO
6 ESTABLISH A PROCEDURE FOR THE MEDICAID COMMITTEES OF THE HOUSE AND
7 SENATE TO REVIEW PROPOSED CHANGES IN PROVIDER RATES OF
8 REIMBURSEMENT OR PAYMENT METHODOLOGIES BY THE DIVISION OF MEDICAID
9 BEFORE THE CHANGES WILL TAKE EFFECT; TO REQUIRE THE DIVISION TO
10 INCREASE THE AMOUNT OF THE REIMBURSEMENT RATE FOR RESTORATIVE
11 DENTAL SERVICES FOR FISCAL YEARS 2023, 2024 AND 2025 BY 5% ABOVE
12 THE AMOUNT OF THE REIMBURSEMENT RATE FOR THE PREVIOUS FISCAL YEAR;
13 TO SET REQUIREMENTS FOR THE REIMBURSEMENT OF DURABLE MEDICAL
14 EQUIPMENT, INCLUDING NONINVASIVE VENTILATORS OR VENTILATION
15 TREATMENTS PROPERLY ORDERED AND BEING USED IN AN APPROPRIATE CARE
16 SETTING; TO REQUIRE REIMBURSEMENT TO DURABLE MEDICAL EQUIPMENT
17 SUPPLIERS FOR HOME USE OF NONINVASIVE AND INVASIVE VENTILATORS TO
18 BE ON A CONTINUOUS MONTHLY PAYMENT BASIS FOR THE DURATION OF
19 MEDICAL NEED THROUGHOUT A PATIENT'S VALID PRESCRIPTION PERIOD; TO
20 REQUIRE THE DIVISION TO ESTABLISH A MEDICARE UPPER PAYMENT LIMITS
21 PROGRAM OR ANOTHER ALLOWABLE DELIVERY SYSTEM AUTHORIZED BY FEDERAL
22 LAW FOR EMERGENCY AMBULANCE TRANSPORTATION PROVIDERS; TO PROVIDE
23 FOR THE FORMULA THAT THE DIVISION SHALL USE FOR CALCULATING
24 AMBULANCE SERVICE ACCESS PAYMENT AMOUNTS; TO PROVIDE THAT THE
25 DIVISION SHALL REIMBURSE FOR OUTPATIENT HOSPITAL SERVICES PROVIDED
26 TO ELIGIBLE MEDICAID BENEFICIARIES UNDER THE AGE OF 21 BY BORDER
27 CITY UNIVERSITY-AFFILIATED PEDIATRIC TEACHING HOSPITALS; TO
28 REQUIRE THE DIVISION TO EVALUATE THE FEASIBILITY OF USING A SINGLE
29 VENDOR TO ADMINISTER DENTAL BENEFITS PROVIDED UNDER A MANAGED CARE
30 DELIVERY SYSTEM; TO PROVIDE THAT PLANNING AND DEVELOPMENT
31 DISTRICTS PARTICIPATING IN THE HOME- AND COMMUNITY-BASED SERVICES
32 PROGRAM FOR THE ELDERLY AND DISABLED AS CASE MANAGEMENT PROVIDERS
33 SHALL BE REIMBURSED FOR CASE MANAGEMENT SERVICES AT THE MAXIMUM
34 RATE APPROVED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES;

35 TO REQUIRE THE DIVISION TO REIMBURSE FOR SERVICES PROVIDED TO
36 ELIGIBLE MEDICAID BENEFICIARIES BY A LICENSED BIRTHING CENTER IN A
37 METHOD AND MANNER TO BE DETERMINED BY THE DIVISION IN ACCORDANCE
38 WITH FEDERAL LAWS AND FEDERAL REGULATIONS; TO REQUIRE THE DIVISION
39 TO SEEK ANY NECESSARY WAIVERS, MAKE ANY REQUIRED AMENDMENTS TO ITS
40 STATE PLAN OR REVISE ANY MANAGED CARE CONTRACTS AUTHORIZED UNDER
41 THIS SECTION AS NECESSARY TO PROVIDE SUCH BIRTHING CENTER
42 SERVICES; TO AMEND SECTION 43-13-121, MISSISSIPPI CODE OF 1972, TO
43 ESTABLISH A PROCEDURE FOR THE MEDICAID COMMITTEES OF THE HOUSE AND
44 SENATE TO REVIEW PROPOSED STATE PLAN AMENDMENTS OF THE DIVISION OF
45 MEDICAID BEFORE THE PROPOSED STATE PLAN AMENDMENTS ARE FILED WITH
46 THE CENTERS FOR MEDICARE AND MEDICAID SERVICES; TO PROVIDE THAT
47 THE MEDICAID COMMITTEES HAVE NO AUTHORITY UNDER THE PRECEDING
48 PROVISIONS TO VETO OR REVISE ANY PROPOSED ACTIONS BY THE DIVISION
49 OF MEDICAID, BUT ARE LIMITED TO REVIEWING, MAKING OBJECTIONS TO
50 AND MAKING RECOMMENDATIONS FOR SUGGESTED CHANGES TO PROPOSED
51 ACTIONS BY THE DIVISION; TO AMEND SECTION 43-13-139, MISSISSIPPI
52 CODE OF 1972, TO PROVIDE THAT IF ANY STATE PLAN AMENDMENT
53 SUBMITTED TO COMPLY WITH THE PROVISIONS OF SECTION 43-13-117 IS
54 DISAPPROVED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN
55 SERVICES, THE DIVISION MAY OPERATE UNDER THE STATE PLAN AS
56 PREVIOUSLY APPROVED BY THE UNITED STATES DEPARTMENT OF HEALTH AND
57 HUMAN SERVICES IN ORDER TO PRESERVE FEDERAL MATCHING FUNDS; TO
58 REQUIRE THE DIVISION TO PROVIDE NOTICE OF THE DISAPPROVAL TO THE
59 CHAIRMEN OF THE HOUSE AND SENATE MEDICAID COMMITTEES; TO AMEND
60 SECTIONS 41-71-1 AND 41-71-13, MISSISSIPPI CODE OF 1972, TO
61 AUTHORIZE NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS AND CLINICAL
62 NURSE SPECIALISTS TO PRESCRIBE OR ORDER HOME HEALTH SERVICES AND
63 PLANS OF CARE, CERTIFY AND RECERTIFY ELIGIBILITY FOR HOME HEALTH
64 SERVICES AND CONDUCT THE REQUIRED INITIAL FACE-TO-FACE VISIT WITH
65 THE RECIPIENT OF THE SERVICES; TO PROVIDE THAT THE AMENDMENTS IN
66 THE ACT ARE RETROACTIVE TO MAY 8, 2020; AND FOR RELATED PURPOSES.

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

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

70 **[Through June 30, 2022, this section shall read as follows:]**

71 43-13-117. (A) Medicaid as authorized by this article shall
72 include payment of part or all of the costs, at the discretion of
73 the division, with approval of the Governor and the Centers for
74 Medicare and Medicaid Services, of the following types of care and
75 services rendered to eligible applicants who have been determined

76 to be eligible for that care and services, within the limits of
77 state appropriations and federal matching funds:
78 (1) Inpatient hospital services.
79 (a) The division is authorized to implement an All
80 Patient Refined Diagnosis Related Groups (APR-DRG) reimbursement
81 methodology for inpatient hospital services.
82 (b) No service benefits or reimbursement
83 limitations in this subsection (A)(1) shall apply to payments
84 under an APR-DRG or Ambulatory Payment Classification (APC) model
85 or a managed care program or similar model described in subsection
86 (H) of this section unless specifically authorized by the
87 division.
88 (2) Outpatient hospital services.
89 (a) Emergency services.
90 (b) Other outpatient hospital services. The
91 division shall allow benefits for other medically necessary
92 outpatient hospital services (such as chemotherapy, radiation,
93 surgery and therapy), including outpatient services in a clinic or
94 other facility that is not located inside the hospital, but that
95 has been designated as an outpatient facility by the hospital, and
96 that was in operation or under construction on July 1, 2009,
97 provided that the costs and charges associated with the operation
98 of the hospital clinic are included in the hospital's cost report.
99 In addition, the Medicare thirty-five-mile rule will apply to
100 those hospital clinics not located inside the hospital that are

101 constructed after July 1, 2009. Where the same services are
102 reimbursed as clinic services, the division may revise the rate or
103 methodology of outpatient reimbursement to maintain consistency,
104 efficiency, economy and quality of care.
105 (c) The division is authorized to implement an
106 Ambulatory Payment Classification (APC) methodology for outpatient
107 hospital services. The division shall give rural hospitals that
108 have fifty (50) or fewer licensed beds the option to not be
109 reimbursed for outpatient hospital services using the APC
110 methodology, but reimbursement for outpatient hospital services
111 provided by those hospitals shall be based on one hundred one
112 percent (101%) of the rate established under Medicare for
113 outpatient hospital services. Those hospitals choosing to not be
114 reimbursed under the APC methodology shall remain under cost-based
115 reimbursement for a two-year period.
116 (d) No service benefits or reimbursement
117 limitations in this subsection (A)(2) shall apply to payments
118 under an APR-DRG or APC model or a managed care program or similar
119 model described in subsection (H) of this section unless
120 specifically authorized by the division.
121 (3) Laboratory and x-ray services.
122 (4) Nursing facility services.
123 (a) The division shall make full payment to
124 nursing facilities for each day, not exceeding forty-two (42) days
125 per year, that a patient is absent from the facility on home

126 leave. Payment may be made for the following home leave days in
127 addition to the forty-two-day limitation: Christmas, the day
128 before Christmas, the day after Christmas, Thanksgiving, the day
129 before Thanksgiving and the day after Thanksgiving.
130 (b) From and after July 1, 1997, the division
131 shall implement the integrated case-mix payment and quality
132 monitoring system, which includes the fair rental system for
133 property costs and in which recapture of depreciation is
134 eliminated. The division may reduce the payment for hospital
135 leave and therapeutic home leave days to the lower of the case-mix
136 category as computed for the resident on leave using the
137 assessment being utilized for payment at that point in time, or a
138 case-mix score of 1.000 for nursing facilities, and shall compute
139 case-mix scores of residents so that only services provided at the
140 nursing facility are considered in calculating a facility's per
141 diem.
142 (c) From and after July 1, 1997, all state-owned
143 nursing facilities shall be reimbursed on a full reasonable cost
144 basis.
145 (d) On or after January 1, 2015, the division
146 shall update the case-mix payment system resource utilization
147 grouper and classifications and fair rental reimbursement system.
148 The division shall develop and implement a payment add-on to
149 reimburse nursing facilities for ventilator-dependent resident
150 services.

151 (e) The division shall develop and implement, not
152 later than January 1, 2001, a case-mix payment add-on determined
153 by time studies and other valid statistical data that will
154 reimburse a nursing facility for the additional cost of caring for
155 a resident who has a diagnosis of Alzheimer's or other related
156 dementia and exhibits symptoms that require special care. Any
157 such case-mix add-on payment shall be supported by a determination
158 of additional cost. The division shall also develop and implement
159 as part of the fair rental reimbursement system for nursing
160 facility beds, an Alzheimer's resident bed depreciation enhanced
161 reimbursement system that will provide an incentive to encourage
162 nursing facilities to convert or construct beds for residents with
163 Alzheimer's or other related dementia.
164 (f) The division shall develop and implement an
165 assessment process for long-term care services. The division may
166 provide the assessment and related functions directly or through
167 contract with the area agencies on aging.
168 The division shall apply for necessary federal waivers to
169 assure that additional services providing alternatives to nursing
170 facility care are made available to applicants for nursing
171 facility care.
172 (5) Periodic screening and diagnostic services for
173 individuals under age twenty-one (21) years as are needed to
174 identify physical and mental defects and to provide health care
175 treatment and other measures designed to correct or ameliorate

176 defects and physical and mental illness and conditions discovered
177 by the screening services, regardless of whether these services
178 are included in the state plan. The division may include in its
179 periodic screening and diagnostic program those discretionary
180 services authorized under the federal regulations adopted to
181 implement Title XIX of the federal Social Security Act, as
182 amended. The division, in obtaining physical therapy services,
183 occupational therapy services, and services for individuals with
184 speech, hearing and language disorders, may enter into a
185 cooperative agreement with the State Department of Education for
186 the provision of those services to handicapped students by public
187 school districts using state funds that are provided from the
188 appropriation to the Department of Education to obtain federal
189 matching funds through the division. The division, in obtaining
190 medical and mental health assessments, treatment, care and
191 services for children who are in, or at risk of being put in, the
192 custody of the Mississippi Department of Human Services may enter
193 into a cooperative agreement with the Mississippi Department of
194 Human Services for the provision of those services using state
195 funds that are provided from the appropriation to the Department
196 of Human Services to obtain federal matching funds through the
197 division.
198 (6) Physician services. Fees for physician's services
199 that are covered only by Medicaid shall be reimbursed at ninety
200 percent (90%) of the rate established on January 1, 2018, and as

201 may be adjusted each July thereafter, under Medicare. The
202 division may provide for a reimbursement rate for physician's
203 services of up to one hundred percent (100%) of the rate
204 established under Medicare for physician's services that are
205 provided after the normal working hours of the physician, as
206 determined in accordance with regulations of the division. The
207 division may reimburse eligible providers, as determined by the
208 division, for certain primary care services at one hundred percent
209 (100%) of the rate established under Medicare. The division shall
210 reimburse obstetricians and gynecologists for certain primary care
211 services as defined by the division at one hundred percent (100%)
212 of the rate established under Medicare.
213 (7) (a) Home health services for eligible persons, not
214 to exceed in cost the prevailing cost of nursing facility
215 services. All home health visits must be precertified as required
216 by the division. In addition to physicians, certified registered
217 nurse practitioners, physician assistants and clinical nurse
218 specialists are authorized to prescribe or order home health
219 services and plans of care, sign home health plans of care,
220 certify and recertify eligibility for home health services and
221 conduct the required initial face-to-face visit with the recipient
222 of the services.
223 (b) [Repealed]
224 (8) Emergency medical transportation services as
225 determined by the division.

226 (9) Prescription drugs and other covered drugs and
227 services as determined by the division.
228 The division shall establish a mandatory preferred drug list.
229 Drugs not on the mandatory preferred drug list shall be made
230 available by utilizing prior authorization procedures established
231 by the division.
232 The division may seek to establish relationships with other
233 states in order to lower acquisition costs of prescription drugs
234 to include single-source and innovator multiple-source drugs or
235 generic drugs. In addition, if allowed by federal law or
236 regulation, the division may seek to establish relationships with
237 and negotiate with other countries to facilitate the acquisition
238 of prescription drugs to include single-source and innovator
239 multiple-source drugs or generic drugs, if that will lower the
240 acquisition costs of those prescription drugs.
241 The division may allow for a combination of prescriptions for
242 single-source and innovator multiple-source drugs and generic
243 drugs to meet the needs of the beneficiaries.
244 The executive director may approve specific maintenance drugs
245 for beneficiaries with certain medical conditions, which may be
246 prescribed and dispensed in three-month supply increments.
247 Drugs prescribed for a resident of a psychiatric residential
248 treatment facility must be provided in true unit doses when
249 available. The division may require that drugs not covered by
250 Medicare Part D for a resident of a long-term care facility be

251 provided in true unit doses when available. Those drugs that were
252 originally billed to the division but are not used by a resident
253 in any of those facilities shall be returned to the billing
254 pharmacy for credit to the division, in accordance with the
255 guidelines of the State Board of Pharmacy and any requirements of
256 federal law and regulation. Drugs shall be dispensed to a
257 recipient and only one (1) dispensing fee per month may be
258 charged. The division shall develop a methodology for reimbursing
259 for restocked drugs, which shall include a restock fee as
260 determined by the division not exceeding Seven Dollars and
261 Eighty-two Cents ($7.82).

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

266 The division is authorized to develop and implement a program
267 of payment for additional pharmacist services as determined by the
268 division.

269 All claims for drugs for dually eligible Medicare/Medicaid
270 beneficiaries that are paid for by Medicare must be submitted to
271 Medicare for payment before they may be processed by the
272 division's online payment system.

273 The division shall develop a pharmacy policy in which drugs
274 in tamper-resistant packaging that are prescribed for a resident
275 of a nursing facility but are not dispensed to the resident shall

276 be returned to the pharmacy and not billed to Medicaid, in
277 accordance with guidelines of the State Board of Pharmacy.
278 The division shall develop and implement a method or methods
279 by which the division will provide on a regular basis to Medicaid
280 providers who are authorized to prescribe drugs, information about
281 the costs to the Medicaid program of single-source drugs and
282 innovator multiple-source drugs, and information about other drugs
283 that may be prescribed as alternatives to those single-source
284 drugs and innovator multiple-source drugs and the costs to the
285 Medicaid program of those alternative drugs.
286 Notwithstanding any law or regulation, information obtained
287 or maintained by the division regarding the prescription drug
288 program, including trade secrets and manufacturer or labeler
289 pricing, is confidential and not subject to disclosure except to
290 other state agencies.
291 The dispensing fee for each new or refill prescription,
292 including nonlegend or over-the-counter drugs covered by the
293 division, shall be not less than Three Dollars and Ninety-one
294 Cents ($3.91), as determined by the division.
295 The division shall not reimburse for single-source or
296 innovator multiple-source drugs if there are equally effective
297 generic equivalents available and if the generic equivalents are
298 the least expensive.

299 It is the intent of the Legislature that the pharmacists
300 providers be reimbursed for the reasonable costs of filling and
301 dispensing prescriptions for Medicaid beneficiaries.
302 The division shall allow certain drugs, including
303 physician-administered drugs, and implantable drug system devices,
304 and medical supplies, with limited distribution or limited access
305 for beneficiaries and administered in an appropriate clinical
306 setting, to be reimbursed as either a medical claim or pharmacy
307 claim, as determined by the division.
308 It is the intent of the Legislature that the division and any
309 managed care entity described in subsection (H) of this section
310 encourage the use of Alpha-Hydroxyprogesterone Caproate (17P) to
311 prevent recurrent preterm birth.
312 (10) Dental and orthodontic services to be determined
313 by the division.
314 The division shall increase the amount of the reimbursement
315 rate for diagnostic and preventative dental services for each of
316 the fiscal years 2022, 2023 and 2024 by five percent (5%) above
317 the amount of the reimbursement rate for the previous fiscal year.
318 It is the intent of the Legislature that the reimbursement rate
319 revision for preventative dental services will be an incentive to
320 increase the number of dentists who actively provide Medicaid
321 services. This dental services reimbursement rate revision shall
322 be known as the "James Russell Dumas Medicaid Dental Services
323 Incentive Program."

324 The Medical Care Advisory Committee, assisted by the Division
325 of Medicaid, shall annually determine the effect of this incentive
326 by evaluating the number of dentists who are Medicaid providers,
327 the number who and the degree to which they are actively billing
328 Medicaid, the geographic trends of where dentists are offering
329 what types of Medicaid services and other statistics pertinent to
330 the goals of this legislative intent. This data shall annually be
331 presented to the Chair of the Senate Medicaid Committee and the
332 Chair of the House Medicaid Committee.

333 The division shall include dental services as a necessary
334 component of overall health services provided to children who are
335 eligible for services.

336 (11) Eyeglasses for all Medicaid beneficiaries who have
337 (a) had surgery on the eyeball or ocular muscle that results in a
338 vision change for which eyeglasses or a change in eyeglasses is
339 medically indicated within six (6) months of the surgery and is in
340 accordance with policies established by the division, or (b) one
341 (1) pair every five (5) years and in accordance with policies
342 established by the division. In either instance, the eyeglasses
343 must be prescribed by a physician skilled in diseases of the eye
344 or an optometrist, whichever the beneficiary may select.

345 (12) Intermediate care facility services.

346 (a) The division shall make full payment to all
347 intermediate care facilities for individuals with intellectual
348 disabilities for each day, not exceeding sixty-three (63) days per

349 year, that a patient is absent from the facility on home leave.
350 Payment may be made for the following home leave days in addition
351 to the sixty-three-day limitation: Christmas, the day before
352 Christmas, the day after Christmas, Thanksgiving, the day before
353 Thanksgiving and the day after Thanksgiving.
354 (b) All state-owned intermediate care facilities
355 for individuals with intellectual disabilities shall be reimbursed
356 on a full reasonable cost basis.
357 (c) Effective January 1, 2015, the division shall
358 update the fair rental reimbursement system for intermediate care
359 facilities for individuals with intellectual disabilities.
360 (13) Family planning services, including drugs,
361 supplies and devices, when those services are under the
362 supervision of a physician or nurse practitioner.
363 (14) Clinic services. Preventive, diagnostic,
364 therapeutic, rehabilitative or palliative services that are
365 furnished by a facility that is not part of a hospital but is
366 organized and operated to provide medical care to outpatients.
367 Clinic services include, but are not limited to:
368 (a) Services provided by ambulatory surgical
369 centers (ACSs) as defined in Section 41-75-1(a); and
370 (b) Dialysis center services.
371 (15) Home- and community-based services for the elderly
372 and disabled, as provided under Title XIX of the federal Social
373 Security Act, as amended, under waivers, subject to the

374 availability of funds specifically appropriated for that purpose
375 by the Legislature.
376 (16) Mental health services. Certain services provided
377 by a psychiatrist shall be reimbursed at up to one hundred percent
378 (100%) of the Medicare rate. Approved therapeutic and case
379 management services (a) provided by an approved regional mental
380 health/intellectual disability center established under Sections
381 41-19-31 through 41-19-39, or by another community mental health
382 service provider meeting the requirements of the Department of
383 Mental Health to be an approved mental health/intellectual
384 disability center if determined necessary by the Department of
385 Mental Health, using state funds that are provided in the
386 appropriation to the division to match federal funds, or (b)
387 provided by a facility that is certified by the State Department
388 of Mental Health to provide therapeutic and case management
389 services, to be reimbursed on a fee for service basis, or (c)
390 provided in the community by a facility or program operated by the
391 Department of Mental Health. Any such services provided by a
392 facility described in subparagraph (b) must have the prior
393 approval of the division to be reimbursable under this section.
394 (17) Durable medical equipment services and medical
395 supplies. Precertification of durable medical equipment and
396 medical supplies must be obtained as required by the division.
397 The Division of Medicaid may require durable medical equipment

398 providers to obtain a surety bond in the amount and to the
399 specifications as established by the Balanced Budget Act of 1997.
400 (18) (a) Notwithstanding any other provision of this
401 section to the contrary, as provided in the Medicaid state plan
402 amendment or amendments as defined in Section 43-13-145(10), the
403 division shall make additional reimbursement to hospitals that
404 serve a disproportionate share of low-income patients and that
405 meet the federal requirements for those payments as provided in
406 Section 1923 of the federal Social Security Act and any applicable
407 regulations. It is the intent of the Legislature that the
408 division shall draw down all available federal funds allotted to
409 the state for disproportionate share hospitals. However, from and
410 after January 1, 1999, public hospitals participating in the
411 Medicaid disproportionate share program may be required to
412 participate in an intergovernmental transfer program as provided
413 in Section 1903 of the federal Social Security Act and any
414 applicable regulations.
415 (b) (i) The division may establish a Medicare
416 Upper Payment Limits Program, as defined in Section 1902(a)(30) of
417 the federal Social Security Act and any applicable federal
418 regulations, or an allowable delivery system or provider payment
419 initiative authorized under 42 CFR 438.6(c), for hospitals,
420 nursing facilities, physicians employed or contracted by
421 hospitals, and emergency ambulance transportation providers.

422 (ii) The division shall assess each hospital,
423 nursing facility, and emergency ambulance transportation provider
424 for the sole purpose of financing the state portion of the
425 Medicare Upper Payment Limits Program or other program(s)
426 authorized under this subsection (A)(18)(b). The hospital
427 assessment shall be as provided in Section 43-13-145(4)(a), and
428 the nursing facility and the emergency ambulance transportation
429 assessments, if established, shall be based on Medicaid
430 utilization or other appropriate method, as determined by the
431 division, consistent with federal regulations. The assessments
432 will remain in effect as long as the state participates in the
433 Medicare Upper Payment Limits Program or other program(s)
434 authorized under this subsection (A)(18)(b). In addition to the
435 hospital assessment provided in Section 43-13-145(4)(a), hospitals
436 with physicians participating in the Medicare Upper Payment Limits
437 Program or other program(s) authorized under this subsection
438 (A)(18)(b) shall be required to participate in an
439 intergovernmental transfer or assessment, as determined by the
440 division, for the purpose of financing the state portion of the
441 physician UPL payments or other payment(s) authorized under this
442 subsection (A)(18)(b).
443 (iii) Subject to approval by the Centers for
444 Medicare and Medicaid Services (CMS) and the provisions of this
445 subsection (A)(18)(b), the division shall make additional
446 reimbursement to hospitals, nursing facilities, and emergency

447 ambulance transportation providers for the Medicare Upper Payment
448 Limits Program or other program(s) authorized under this
449 subsection (A)(18)(b), and, if the program is established for
450 physicians, shall make additional reimbursement for physicians, as
451 defined in Section 1902(a)(30) of the federal Social Security Act
452 and any applicable federal regulations, provided the assessment in
453 this subsection (A)(18)(b) is in effect.

454 (iv) Notwithstanding any other provision of
455 this article to the contrary, effective upon implementation of the
456 Mississippi Hospital Access Program (MHAP) provided in
457 subparagraph (c)(i) below, the hospital portion of the inpatient
458 Upper Payment Limits Program shall transition into and be replaced
459 by the MHAP program. However, the division is authorized to
460 develop and implement an alternative fee-for-service Upper Payment
461 Limits model in accordance with federal laws and regulations if
462 necessary to preserve supplemental funding. Further, the
463 division, in consultation with the hospital industry shall develop
464 alternative models for distribution of medical claims and
465 supplemental payments for inpatient and outpatient hospital
466 services, and such models may include, but shall not be limited to
467 the following: increasing rates for inpatient and outpatient
468 services; creating a low-income utilization pool of funds to
469 reimburse hospitals for the costs of uncompensated care, charity
470 care and bad debts as permitted and approved pursuant to federal
471 regulations and the Centers for Medicare and Medicaid Services;

472 supplemental payments based upon Medicaid utilization, quality,
473 service lines and/or costs of providing such services to Medicaid
474 beneficiaries and to uninsured patients. The goals of such
475 payment models shall be to ensure access to inpatient and
476 outpatient care and to maximize any federal funds that are
477 available to reimburse hospitals for services provided. Any such
478 documents required to achieve the goals described in this
479 paragraph shall be submitted to the Centers for Medicare and
480 Medicaid Services, with a proposed effective date of July 1, 2019,
481 to the extent possible, but in no event shall the effective date
482 of such payment models be later than July 1, 2020. The Chairmen
483 of the Senate and House Medicaid Committees shall be provided a
484 copy of the proposed payment model(s) prior to submission.
485 Effective July 1, 2018, and until such time as any payment
486 model(s) as described above become effective, the division, in
487 consultation with the hospital industry, is authorized to
488 implement a transitional program for inpatient and outpatient
489 payments and/or supplemental payments (including, but not limited
490 to, MHAP and directed payments), to redistribute available
491 supplemental funds among hospital providers, provided that when
492 compared to a hospital's prior year supplemental payments,
493 supplemental payments made pursuant to any such transitional
494 program shall not result in a decrease of more than five percent
495 (5%) and shall not increase by more than the amount needed to
496 maximize the distribution of the available funds.

497 (c) (i) Not later than December 1, 2015, the
498 division shall, subject to approval by the Centers for Medicare
499 and Medicaid Services (CMS), establish, implement and operate a
500 Mississippi Hospital Access Program (MHAP) for the purpose of
501 protecting patient access to hospital care through hospital
502 inpatient reimbursement programs provided in this section designed
503 to maintain total hospital reimbursement for inpatient services
504 rendered by in-state hospitals and the out-of-state hospital that
505 is authorized by federal law to submit intergovernmental transfers
506 (IGTs) to the State of Mississippi and is classified as Level I
507 trauma center located in a county contiguous to the state line at
508 the maximum levels permissible under applicable federal statutes
509 and regulations, at which time the current inpatient Medicare
510 Upper Payment Limits (UPL) Program for hospital inpatient services
511 shall transition to the MHAP.

512 (ii) Subject to approval by the Centers for
513 Medicare and Medicaid Services (CMS), the MHAP shall provide
514 increased inpatient capitation (PMPM) payments to managed care
515 entities contracting with the division pursuant to subsection (H)
516 of this section to support availability of hospital services or
517 such other payments permissible under federal law necessary to
518 accomplish the intent of this subsection.

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

522 in effect hereafter, the division shall to the fullest extent
523 feasible replace the additional reimbursement for hospital
524 inpatient services under the inpatient Medicare Upper Payment
525 Limits (UPL) Program with additional reimbursement under the MHAP
526 and other payment programs for inpatient and/or outpatient
527 payments which may be developed under the authority of this
528 paragraph.

529 (iv) The division shall assess each hospital
530 as provided in Section 43-13-145(4)(a) for the purpose of
531 financing the state portion of the MHAP, supplemental payments and
532 such other purposes as specified in Section 43-13-145. The
533 assessment will remain in effect as long as the MHAP and
534 supplemental payments are in effect.

535 (19) (a) Perinatal risk management services. The
536 division shall promulgate regulations to be effective from and
537 after October 1, 1988, to establish a comprehensive perinatal
538 system for risk assessment of all pregnant and infant Medicaid
539 recipients and for management, education and follow-up for those
540 who are determined to be at risk. Services to be performed
541 include case management, nutrition assessment/counseling,
542 psychosocial assessment/counseling and health education. The
543 division shall contract with the State Department of Health to
544 provide services within this paragraph (Perinatal High Risk
545 Management/Infant Services System (PHRM/ISS)). The State

546 Department of Health shall be reimbursed on a full reasonable cost
547 basis for services provided under this subparagraph (a).
548 (b) Early intervention system services. The
549 division shall cooperate with the State Department of Health,
550 acting as lead agency, in the development and implementation of a
551 statewide system of delivery of early intervention services, under
552 Part C of the Individuals with Disabilities Education Act (IDEA).
553 The State Department of Health shall certify annually in writing
554 to the executive director of the division the dollar amount of
555 state early intervention funds available that will be utilized as
556 a certified match for Medicaid matching funds. Those funds then
557 shall be used to provide expanded targeted case management
558 services for Medicaid eligible children with special needs who are
559 eligible for the state's early intervention system.
560 Qualifications for persons providing service coordination shall be
561 determined by the State Department of Health and the Division of
562 Medicaid.
563 (20) Home- and community-based services for physically
564 disabled approved services as allowed by a waiver from the United
565 States Department of Health and Human Services for home- and
566 community-based services for physically disabled people using
567 state funds that are provided from the appropriation to the State
568 Department of Rehabilitation Services and used to match federal
569 funds under a cooperative agreement between the division and the
570 department, provided that funds for these services are

571 specifically appropriated to the Department of Rehabilitation
572 Services.
573 (21) Nurse practitioner services. Services furnished
574 by a registered nurse who is licensed and certified by the
575 Mississippi Board of Nursing as a nurse practitioner, including,
576 but not limited to, nurse anesthetists, nurse midwives, family
577 nurse practitioners, family planning nurse practitioners,
578 pediatric nurse practitioners, obstetrics-gynecology nurse
579 practitioners and neonatal nurse practitioners, under regulations
580 adopted by the division. Reimbursement for those services shall
581 not exceed ninety percent (90%) of the reimbursement rate for
582 comparable services rendered by a physician. The division may
583 provide for a reimbursement rate for nurse practitioner services
584 of up to one hundred percent (100%) of the reimbursement rate for
585 comparable services rendered by a physician for nurse practitioner
586 services that are provided after the normal working hours of the
587 nurse practitioner, as determined in accordance with regulations
588 of the division.
589 (22) Ambulatory services delivered in federally
590 qualified health centers, rural health centers and clinics of the
591 local health departments of the State Department of Health for
592 individuals eligible for Medicaid under this article based on
593 reasonable costs as determined by the division. Federally
594 qualified health centers shall be reimbursed by the Medicaid
595 prospective payment system as approved by the Centers for Medicare

596 and Medicaid Services. The division shall recognize federally
597 qualified health centers (FQHCs), rural health clinics (RHCs) and
598 community mental health centers (CMHCs) as both an originating and
599 distant site provider for the purposes of telehealth
600 reimbursement. The division is further authorized and directed to
601 reimburse FQHCs, RHCs and CMHCs for both distant site and
602 originating site services when such services are appropriately
603 provided by the same organization.
604 (23) Inpatient psychiatric services.
605 (a) Inpatient psychiatric services to be
606 determined by the division for recipients under age twenty-one
607 (21) that are provided under the direction of a physician in an
608 inpatient program in a licensed acute care psychiatric facility or
609 in a licensed psychiatric residential treatment facility, before
610 the recipient reaches age twenty-one (21) or, if the recipient was
611 receiving the services immediately before he or she reached age
612 twenty-one (21), before the earlier of the date he or she no
613 longer requires the services or the date he or she reaches age
614 twenty-two (22), as provided by federal regulations. From and
615 after January 1, 2015, the division shall update the fair rental
616 reimbursement system for psychiatric residential treatment
617 facilities. Precertification of inpatient days and residential
618 treatment days must be obtained as required by the division. From
619 and after July 1, 2009, all state-owned and state-operated
620 facilities that provide inpatient psychiatric services to persons

621 under age twenty-one (21) who are eligible for Medicaid
622 reimbursement shall be reimbursed for those services on a full
623 reasonable cost basis.
624 (b) The division may reimburse for services
625 provided by a licensed freestanding psychiatric hospital to
626 Medicaid recipients over the age of twenty-one (21) in a method
627 and manner consistent with the provisions of Section 43-13-117.5.
628 (24) [Deleted]
629 (25) [Deleted]
630 (26) Hospice care. As used in this paragraph, the term
631 "hospice care" means a coordinated program of active professional
632 medical attention within the home and outpatient and inpatient
633 care that treats the terminally ill patient and family as a unit,
634 employing a medically directed interdisciplinary team. The
635 program provides relief of severe pain or other physical symptoms
636 and supportive care to meet the special needs arising out of
637 physical, psychological, spiritual, social and economic stresses
638 that are experienced during the final stages of illness and during
639 dying and bereavement and meets the Medicare requirements for
640 participation as a hospice as provided in federal regulations.
641 (27) Group health plan premiums and cost-sharing if it
642 is cost-effective as defined by the United States Secretary of
643 Health and Human Services.
644 (28) Other health insurance premiums that are
645 cost-effective as defined by the United States Secretary of Health

646 and Human Services. Medicare eligible must have Medicare Part B
647 before other insurance premiums can be paid.
648 (29) The Division of Medicaid may apply for a waiver
649 from the United States Department of Health and Human Services for
650 home- and community-based services for developmentally disabled
651 people using state funds that are provided from the appropriation
652 to the State Department of Mental Health and/or funds transferred
653 to the department by a political subdivision or instrumentality of
654 the state and used to match federal funds under a cooperative
655 agreement between the division and the department, provided that
656 funds for these services are specifically appropriated to the
657 Department of Mental Health and/or transferred to the department
658 by a political subdivision or instrumentality of the state.
659 (30) Pediatric skilled nursing services as determined
660 by the division and in a manner consistent with regulations
661 promulgated by the Mississippi State Department of Health.
662 (31) Targeted case management services for children
663 with special needs, under waivers from the United States
664 Department of Health and Human Services, using state funds that
665 are provided from the appropriation to the Mississippi Department
666 of Human Services and used to match federal funds under a
667 cooperative agreement between the division and the department.
668 (32) Care and services provided in Christian Science
669 Sanatoria listed and certified by the Commission for Accreditation
670 of Christian Science Nursing Organizations/Facilities, Inc.,

671 rendered in connection with treatment by prayer or spiritual means
672 to the extent that those services are subject to reimbursement
673 under Section 1903 of the federal Social Security Act.

674 (33) Podiatrist services.

675 (34) Assisted living services as provided through
676 home- and community-based services under Title XIX of the federal
677 Social Security Act, as amended, subject to the availability of
678 funds specifically appropriated for that purpose by the
679 Legislature.

680 (35) Services and activities authorized in Sections
681 43-27-101 and 43-27-103, using state funds that are provided from
682 the appropriation to the Mississippi Department of Human Services
683 and used to match federal funds under a cooperative agreement
684 between the division and the department.

685 (36) Nonemergency transportation services for
686 Medicaid-eligible persons as determined by the division. The PEER
687 Committee shall conduct a performance evaluation of the
688 nonemergency transportation program to evaluate the administration
689 of the program and the providers of transportation services to
690 determine the most cost-effective ways of providing nonemergency
691 transportation services to the patients served under the program.
692 The performance evaluation shall be completed and provided to the
693 members of the Senate Medicaid Committee and the House Medicaid
694 Committee not later than January 1, 2019, and every two (2) years
695 thereafter.

696 (37) [Deleted]

697 (38) Chiropractic services. A chiropractor's manual
698 manipulation of the spine to correct a subluxation, if x-ray
699 demonstrates that a subluxation exists and if the subluxation has
700 resulted in a neuromusculoskeletal condition for which
701 manipulation is appropriate treatment, and related spinal x-rays
702 performed to document these conditions. Reimbursement for
703 chiropractic services shall not exceed Seven Hundred Dollars
704 ($700.00) per year per beneficiary.

705 (39) Dually eligible Medicare/Medicaid beneficiaries.
706 The division shall pay the Medicare deductible and coinsurance
707 amounts for services available under Medicare, as determined by
708 the division. From and after July 1, 2009, the division shall
709 reimburse crossover claims for inpatient hospital services and
710 crossover claims covered under Medicare Part B in the same manner
711 that was in effect on January 1, 2008, unless specifically
712 authorized by the Legislature to change this method.

713 (40) [Deleted]

714 (41) Services provided by the State Department of
715 Rehabilitation Services for the care and rehabilitation of persons
716 with spinal cord injuries or traumatic brain injuries, as allowed
717 under waivers from the United States Department of Health and
718 Human Services, using up to seventy-five percent (75%) of the
719 funds that are appropriated to the Department of Rehabilitation
720 Services from the Spinal Cord and Head Injury Trust Fund

721 established under Section 37-33-261 and used to match federal
722 funds under a cooperative agreement between the division and the
723 department.

724 (42) [Deleted]

725 (43) The division shall provide reimbursement,
726 according to a payment schedule developed by the division, for
727 smoking cessation medications for pregnant women during their
728 pregnancy and other Medicaid-eligible women who are of
729 child-bearing age.

730 (44) Nursing facility services for the severely
731 disabled.

732 (a) Severe disabilities include, but are not
733 limited to, spinal cord injuries, closed-head injuries and
734 ventilator-dependent patients.

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

738 (45) Physician assistant services. Services furnished
739 by a physician assistant who is licensed by the State Board of
740 Medical Licensure and is practicing with physician supervision
741 under regulations adopted by the board, under regulations adopted
742 by the division. Reimbursement for those services shall not
743 exceed ninety percent (90%) of the reimbursement rate for
744 comparable services rendered by a physician. The division may
745 provide for a reimbursement rate for physician assistant services

746 of up to one hundred percent (100%) or the reimbursement rate for
747 comparable services rendered by a physician for physician
748 assistant services that are provided after the normal working
749 hours of the physician assistant, as determined in accordance with
750 regulations of the division.

751 (46) The division shall make application to the federal
752 Centers for Medicare and Medicaid Services (CMS) for a waiver to
753 develop and provide services for children with serious emotional
754 disturbances as defined in Section 43-14-1(1), which may include
755 home- and community-based services, case management services or
756 managed care services through mental health providers certified by
757 the Department of Mental Health. The division may implement and
758 provide services under this waivered program only if funds for
759 these services are specifically appropriated for this purpose by
760 the Legislature, or if funds are voluntarily provided by affected
761 agencies.

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

766 (b) Participation in any disease management
767 program implemented under this paragraph (47) is optional with the
768 individual. An individual must affirmatively elect to participate
769 in the disease management program in order to participate, and may
770 elect to discontinue participation in the program at any time.

771 (48) Pediatric long-term acute care hospital services.
772 (a) Pediatric long-term acute care hospital
773 services means services provided to eligible persons under
774 twenty-one (21) years of age by a freestanding Medicare-certified
775 hospital that has an average length of inpatient stay greater than
776 twenty-five (25) days and that is primarily engaged in providing
777 chronic or long-term medical care to persons under twenty-one (21)
778 years of age.
779 (b) The services under this paragraph (48) shall
780 be reimbursed as a separate category of hospital services.
781 (49) The division may establish copayments and/or
782 coinsurance for any Medicaid services for which copayments and/or
783 coinsurance are allowable under federal law or regulation.
784 (50) Services provided by the State Department of
785 Rehabilitation Services for the care and rehabilitation of persons
786 who are deaf and blind, as allowed under waivers from the United
787 States Department of Health and Human Services to provide home-
788 and community-based services using state funds that are provided
789 from the appropriation to the State Department of Rehabilitation
790 Services or if funds are voluntarily provided by another agency.
791 (51) Upon determination of Medicaid eligibility and in
792 association with annual redetermination of Medicaid eligibility,
793 beneficiaries shall be encouraged to undertake a physical
794 examination that will establish a base-line level of health and
795 identification of a usual and customary source of care (a medical

796 home) to aid utilization of disease management tools. This
797 physical examination and utilization of these disease management
798 tools shall be consistent with current United States Preventive
799 Services Task Force or other recognized authority recommendations.
800 For persons who are determined ineligible for Medicaid, the
801 division will provide information and direction for accessing
802 medical care and services in the area of their residence.
803 (52) Notwithstanding any provisions of this article,
804 the division may pay enhanced reimbursement fees related to trauma
805 care, as determined by the division in conjunction with the State
806 Department of Health, using funds appropriated to the State
807 Department of Health for trauma care and services and used to
808 match federal funds under a cooperative agreement between the
809 division and the State Department of Health. The division, in
810 conjunction with the State Department of Health, may use grants,
811 waivers, demonstrations, enhanced reimbursements, Upper Payment
812 Limits Programs, supplemental payments, or other projects as
813 necessary in the development and implementation of this
814 reimbursement program.
815 (53) Targeted case management services for high-cost
816 beneficiaries may be developed by the division for all services
817 under this section.
818 (54) [Deleted]
819 (55) Therapy services. The plan of care for therapy
820 services may be developed to cover a period of treatment for up to

821 six (6) months, but in no event shall the plan of care exceed a
822 six-month period of treatment. The projected period of treatment
823 must be indicated on the initial plan of care and must be updated
824 with each subsequent revised plan of care. Based on medical
825 necessity, the division shall approve certification periods for
826 less than or up to six (6) months, but in no event shall the
827 certification period exceed the period of treatment indicated on
828 the plan of care. The appeal process for any reduction in therapy
829 services shall be consistent with the appeal process in federal
830 regulations.

831 (56) Prescribed pediatric extended care centers
832 services for medically dependent or technologically dependent
833 children with complex medical conditions that require continual
834 care as prescribed by the child's attending physician, as
835 determined by the division.

836 (57) No Medicaid benefit shall restrict coverage for
837 medically appropriate treatment prescribed by a physician and
838 agreed to by a fully informed individual, or if the individual
839 lacks legal capacity to consent by a person who has legal
840 authority to consent on his or her behalf, based on an
841 individual's diagnosis with a terminal condition. As used in this
842 paragraph (57), "terminal condition" means any aggressive
843 malignancy, chronic end-stage cardiovascular or cerebral vascular
844 disease, or any other disease, illness or condition which a
845 physician diagnoses as terminal.

846 (58) Treatment services for persons with opioid
847 dependency or other highly addictive substance use disorders. The
848 division is authorized to reimburse eligible providers for
849 treatment of opioid dependency and other highly addictive
850 substance use disorders, as determined by the division. Treatment
851 related to these conditions shall not count against any physician
852 visit limit imposed under this section.
853 (59) The division shall allow beneficiaries between the
854 ages of ten (10) and eighteen (18) years to receive vaccines
855 through a pharmacy venue. The division and the State Department
856 of Health shall coordinate and notify OB-GYN providers that the
857 Vaccines for Children program is available to providers free of
858 charge.
859 (B) [Deleted]
860 (C) The division may pay to those providers who participate
861 in and accept patient referrals from the division's emergency room
862 redirection program a percentage, as determined by the division,
863 of savings achieved according to the performance measures and
864 reduction of costs required of that program. Federally qualified
865 health centers may participate in the emergency room redirection
866 program, and the division may pay those centers a percentage of
867 any savings to the Medicaid program achieved by the centers'
868 accepting patient referrals through the program, as provided in
869 this subsection (C).

870 (D) (1) * * * As used in this subsection (D), the following
871 terms shall be defined as provided in this paragraph, except as
872 otherwise provided in this subsection:
873 (a) "Committees" means the Medicaid Committees of
874 the House of Representatives and the Senate, and "committee" means
875 either one of those committees.
876 (b) "Rate change" means an increase, decrease or
877 other change in the payments or rates of reimbursement, or a
878 change in any payment methodology that results in an increase,
879 decrease or other change in the payments or rates of
880 reimbursement, to any Medicaid provider that renders any services
881 authorized to be provided to Medicaid recipients under this
882 article.
883 (2) * * * Whenever the Division of Medicaid proposes a
884 rate change, the division shall give notice to the chairmen of the
885 committees at least thirty (30) calendar days before the proposed
886 rate change is scheduled to take effect. The division shall
887 furnish the chairmen with a concise summary of each proposed rate
888 change along with the notice, and shall furnish the chairmen with
889 a copy of any proposed rate change upon request. The division
890 also shall provide a summary and copy of any proposed rate change
891 to any other member of the Legislature upon request.
892 (3) If the chairman of either committee or both
893 chairmen jointly object to the proposed rate change or any part
894 thereof, the chairman or chairmen shall notify the division and

895 provide the reasons for their objection in writing not later than
896 seven (7) calendar days after receipt of the notice from the
897 division. The chairman or chairmen may make written
898 recommendations to the division for changes to be made to a
899 proposed rate change.
900 (4) (a) The chairman of either committee or both
901 chairmen jointly may hold a committee meeting to review a proposed
902 rate change. If either chairman or both chairmen decide to hold a
903 meeting, they shall notify the division of their intention in
904 writing within seven (7) calendar days after receipt of the notice
905 from the division, and shall set the date and time for the meeting
906 in their notice to the division, which shall not be later than
907 fourteen (14) calendar days after receipt of the notice from the
908 division.
909 (b) After the committee meeting, the committee or
910 committees may object to the proposed rate change or any part
911 thereof. The committee or committees shall notify the division
912 and the reasons for their objection in writing not later than
913 seven (7) calendar days after the meeting. The committee or
914 committees may make written recommendations to the division for
915 changes to be made to a proposed rate change.
916 (5) If both chairmen notify the division in writing
917 within seven (7) calendar days after receipt of the notice from
918 the division that they do not object to the proposed rate change
919 and will not be holding a meeting to review the proposed rate

920 change, the proposed rate change will take effect on the original
921 date as scheduled by the division or on such other date as
922 specified by the division.
923 (6) (a) If there are any objections to a proposed rate
924 change or any part thereof from either or both of the chairmen or
925 the committees, the division may withdraw the proposed rate
926 change, make any of the recommended changes to the proposed rate
927 change, or not make any changes to the proposed rate change.
928 (b) If the division does not make any changes to
929 the proposed rate change, it shall notify the chairmen of that
930 fact in writing, and the proposed rate change shall take effect on
931 the original date as scheduled by the division or on such other
932 date as specified by the division.
933 (c) If the division makes any changes to the
934 proposed rate change, the division shall notify the chairmen of
935 its actions in writing, and the revised proposed rate change shall
936 take effect on the date as specified by the division.
937 (7) Nothing in this subsection (D) shall be construed
938 as giving the chairmen or the committees any authority to veto,
939 nullify or revise any rate change proposed by the division. The
940 authority of the chairmen or the committees under this subsection
941 shall be limited to reviewing, making objections to and making
942 recommendations for changes to rate changes proposed by the
943 division.

944 (E) Notwithstanding any provision of this article, no new
945 groups or categories of recipients and new types of care and
946 services may be added without enabling legislation from the
947 Mississippi Legislature, except that the division may authorize
948 those changes without enabling legislation when the addition of
949 recipients or services is ordered by a court of proper authority.
950 (F) The executive director shall keep the Governor advised
951 on a timely basis of the funds available for expenditure and the
952 projected expenditures. Notwithstanding any other provisions of
953 this article, if current or projected expenditures of the division
954 are reasonably anticipated to exceed the amount of funds
955 appropriated to the division for any fiscal year, the Governor,
956 after consultation with the executive director, shall take all
957 appropriate measures to reduce costs, which may include, but are
958 not limited to:
959 (1) Reducing or discontinuing any or all services that
960 are deemed to be optional under Title XIX of the Social Security
961 Act;
962 (2) Reducing reimbursement rates for any or all service
963 types;
964 (3) Imposing additional assessments on health care
965 providers; or
966 (4) Any additional cost-containment measures deemed
967 appropriate by the Governor.

968 To the extent allowed under federal law, any reduction to
969 services or reimbursement rates under this subsection (F) shall be
970 accompanied by a reduction, to the fullest allowable amount, to
971 the profit margin and administrative fee portions of capitated
972 payments to organizations described in paragraph (1) of subsection
973 (H).

974 Beginning in fiscal year 2010 and in fiscal years thereafter,
975 when Medicaid expenditures are projected to exceed funds available
976 for the fiscal year, the division shall submit the expected
977 shortfall information to the PEER Committee not later than
978 December 1 of the year in which the shortfall is projected to
979 occur. PEER shall review the computations of the division and
980 report its findings to the Legislative Budget Office not later
981 than January 7 in any year.

982 (G) Notwithstanding any other provision of this article, it
983 shall be the duty of each provider participating in the Medicaid
984 program to keep and maintain books, documents and other records as
985 prescribed by the Division of Medicaid in accordance with federal
986 laws and regulations.

987 (H) (1) Notwithstanding any other provision of this
988 article, the division is authorized to implement (a) a managed
989 care program, (b) a coordinated care program, (c) a coordinated
990 care organization program, (d) a health maintenance organization
991 program, (e) a patient-centered medical home program, (f) an
992 accountable care organization program, (g) provider-sponsored

993 health plan, or (h) any combination of the above programs. As a
994 condition for the approval of any program under this subsection
995 (H)(1), the division shall require that no managed care program,
996 coordinated care program, coordinated care organization program,
997 health maintenance organization program, or provider-sponsored
998 health plan may:
999 (a) Pay providers at a rate that is less than the
1000 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
1001 reimbursement rate;
1002 (b) Override the medical decisions of hospital
1003 physicians or staff regarding patients admitted to a hospital for
1004 an emergency medical condition as defined by 42 US Code Section
1005 1395dd. This restriction (b) does not prohibit the retrospective
1006 review of the appropriateness of the determination that an
1007 emergency medical condition exists by chart review or coding
1008 algorithm, nor does it prohibit prior authorization for
1009 nonemergency hospital admissions;
1010 (c) Pay providers at a rate that is less than the
1011 normal Medicaid reimbursement rate. It is the intent of the
1012 Legislature that all managed care entities described in this
1013 subsection (H), in collaboration with the division, develop and
1014 implement innovative payment models that incentivize improvements
1015 in health care quality, outcomes, or value, as determined by the
1016 division. Participation in the provider network of any managed
1017 care, coordinated care, provider-sponsored health plan, or similar

1018 contractor shall not be conditioned on the provider's agreement to
1019 accept such alternative payment models;
1020 (d) Implement a prior authorization and
1021 utilization review program for medical services, transportation
1022 services and prescription drugs that is more stringent than the
1023 prior authorization processes used by the division in its
1024 administration of the Medicaid program. Not later than December
1025 2, 2021, the contractors that are receiving capitated payments
1026 under a managed care delivery system established under this
1027 subsection (H) shall submit a report to the Chairmen of the House
1028 and Senate Medicaid Committees on the status of the prior
1029 authorization and utilization review program for medical services,
1030 transportation services and prescription drugs that is required to
1031 be implemented under this subparagraph (d);
1032 (e) [Deleted]
1033 (f) Implement a preferred drug list that is more
1034 stringent than the mandatory preferred drug list established by
1035 the division under subsection (A)(9) of this section;
1036 (g) Implement a policy which denies beneficiaries
1037 with hemophilia access to the federally funded hemophilia
1038 treatment centers as part of the Medicaid Managed Care network of
1039 providers.
1040 Each health maintenance organization, coordinated care
1041 organization, provider-sponsored health plan, or other
1042 organization paid for services on a capitated basis by the

1043 division under any managed care program or coordinated care
1044 program implemented by the division under this section shall use a
1045 clear set of level of care guidelines in the determination of
1046 medical necessity and in all utilization management practices,
1047 including the prior authorization process, concurrent reviews,
1048 retrospective reviews and payments, that are consistent with
1049 widely accepted professional standards of care. Organizations
1050 participating in a managed care program or coordinated care
1051 program implemented by the division may not use any additional
1052 criteria that would result in denial of care that would be
1053 determined appropriate and, therefore, medically necessary under
1054 those levels of care guidelines.

1055 (2) Notwithstanding any provision of this section, the
1056 recipients eligible for enrollment into a Medicaid Managed Care
1057 Program authorized under this subsection (H) may include only
1058 those categories of recipients eligible for participation in the
1059 Medicaid Managed Care Program as of January 1, 2021, the
1060 Children's Health Insurance Program (CHIP), and the CMS-approved
1061 Section 1115 demonstration waivers in operation as of January 1,
1062 2021. No expansion of Medicaid Managed Care Program contracts may
1063 be implemented by the division without enabling legislation from
1064 the Mississippi Legislature.

1065 (3) (a) Any contractors receiving capitated payments
1066 under a managed care delivery system established in this section
1067 shall provide to the Legislature and the division statistical data

1068 to be shared with provider groups in order to improve patient
1069 access, appropriate utilization, cost savings and health outcomes
1070 not later than October 1 of each year. Additionally, each
1071 contractor shall disclose to the Chairmen of the Senate and House
1072 Medicaid Committees the administrative expenses costs for the
1073 prior calendar year, and the number of full-equivalent employees
1074 located in the State of Mississippi dedicated to the Medicaid and
1075 CHIP lines of business as of June 30 of the current year.
1076 (b) The division and the contractors participating
1077 in the managed care program, a coordinated care program or a
1078 provider-sponsored health plan shall be subject to annual program
1079 reviews or audits performed by the Office of the State Auditor,
1080 the PEER Committee, the Department of Insurance and/or independent
1081 third parties.
1082 (c) Those reviews shall include, but not be
1083 limited to, at least two (2) of the following items:
1084 (i) The financial benefit to the State of
1085 Mississippi of the managed care program,
1086 (ii) The difference between the premiums paid
1087 to the managed care contractors and the payments made by those
1088 contractors to health care providers,
1089 (iii) Compliance with performance measures
1090 required under the contracts,
1091 (iv) Administrative expense allocation
1092 methodologies,

1093 (v) Whether nonprovider payments assigned as
1094 medical expenses are appropriate,
1095 (vi) Capitated arrangements with related
1096 party subcontractors,
1097 (vii) Reasonableness of corporate
1098 allocations,
1099 (viii) Value-added benefits and the extent to
1100 which they are used,
1101 (ix) The effectiveness of subcontractor
1102 oversight, including subcontractor review,
1103 (x) Whether health care outcomes have been
1104 improved, and
1105 (xi) The most common claim denial codes to
1106 determine the reasons for the denials.
1107 The audit reports shall be considered public documents and
1108 shall be posted in their entirety on the division's website.
1109 (4) All health maintenance organizations, coordinated
1110 care organizations, provider-sponsored health plans, or other
1111 organizations paid for services on a capitated basis by the
1112 division under any managed care program or coordinated care
1113 program implemented by the division under this section shall
1114 reimburse all providers in those organizations at rates no lower
1115 than those provided under this section for beneficiaries who are
1116 not participating in those programs.

1117 (5) No health maintenance organization, coordinated
1118 care organization, provider-sponsored health plan, or other
1119 organization paid for services on a capitated basis by the
1120 division under any managed care program or coordinated care
1121 program implemented by the division under this section shall
1122 require its providers or beneficiaries to use any pharmacy that
1123 ships, mails or delivers prescription drugs or legend drugs or
1124 devices.
1125 (6) (a) Not later than December 1, 2021, the
1126 contractors who are receiving capitated payments under a managed
1127 care delivery system established under this subsection (H) shall
1128 develop and implement a uniform credentialing process for
1129 providers. Under that uniform credentialing process, a provider
1130 who meets the criteria for credentialing will be credentialed with
1131 all of those contractors and no such provider will have to be
1132 separately credentialed by any individual contractor in order to
1133 receive reimbursement from the contractor. Not later than
1134 December 2, 2021, those contractors shall submit a report to the
1135 Chairmen of the House and Senate Medicaid Committees on the status
1136 of the uniform credentialing process for providers that is
1137 required under this subparagraph (a).
1138 (b) If those contractors have not implemented a
1139 uniform credentialing process as described in subparagraph (a) by
1140 December 1, 2021, the division shall develop and implement, not
1141 later than July 1, 2022, a single, consolidated credentialing

1142 process by which all providers will be credentialed. Under the
1143 division's single, consolidated credentialing process, no such
1144 contractor shall require its providers to be separately
1145 credentialed by the contractor in order to receive reimbursement
1146 from the contractor, but those contractors shall recognize the
1147 credentialing of the providers by the division's credentialing
1148 process.

1149 (c) The division shall require a uniform provider
1150 credentialing application that shall be used in the credentialing
1151 process that is established under subparagraph (a) or (b). If the
1152 contractor or division, as applicable, has not approved or denied
1153 the provider credentialing application within sixty (60) days of
1154 receipt of the completed application that includes all required
1155 information necessary for credentialing, then the contractor or
1156 division, upon receipt of a written request from the applicant and
1157 within five (5) business days of its receipt, shall issue a
1158 temporary provider credential/enrollment to the applicant if the
1159 applicant has a valid Mississippi professional or occupational
1160 license to provide the health care services to which the
1161 credential/enrollment would apply. The contractor or the division
1162 shall not issue a temporary credential/enrollment if the applicant
1163 has reported on the application a history of medical or other
1164 professional or occupational malpractice claims, a history of
1165 substance abuse or mental health issues, a criminal record, or a
1166 history of medical or other licensing board, state or federal

1167 disciplinary action, including any suspension from participation
1168 in a federal or state program. The temporary
1169 credential/enrollment shall be effective upon issuance and shall
1170 remain in effect until the provider's credentialing/enrollment
1171 application is approved or denied by the contractor or division.
1172 The contractor or division shall render a final decision regarding
1173 credentialing/enrollment of the provider within sixty (60) days
1174 from the date that the temporary provider credential/enrollment is
1175 issued to the applicant.
1176 (d) If the contractor or division does not render
1177 a final decision regarding credentialing/enrollment of the
1178 provider within the time required in subparagraph (c), the
1179 provider shall be deemed to be credentialed by and enrolled with
1180 all of the contractors and eligible to receive reimbursement from
1181 the contractors.
1182 (7) (a) Each contractor that is receiving capitated
1183 payments under a managed care delivery system established under
1184 this subsection (H) shall provide to each provider for whom the
1185 contractor has denied the coverage of a procedure that was ordered
1186 or requested by the provider for or on behalf of a patient, a
1187 letter that provides a detailed explanation of the reasons for the
1188 denial of coverage of the procedure and the name and the
1189 credentials of the person who denied the coverage. The letter
1190 shall be sent to the provider in electronic format.

1191 (b) After a contractor that is receiving capitated
1192 payments under a managed care delivery system established under
1193 this subsection (H) has denied coverage for a claim submitted by a
1194 provider, the contractor shall issue to the provider within sixty
1195 (60) days a final ruling of denial of the claim that allows the
1196 provider to have a state fair hearing and/or agency appeal with
1197 the division. If a contractor does not issue a final ruling of
1198 denial within sixty (60) days as required by this subparagraph
1199 (b), the provider's claim shall be deemed to be automatically
1200 approved and the contractor shall pay the amount of the claim to
1201 the provider.
1202 (c) After a contractor has issued a final ruling
1203 of denial of a claim submitted by a provider, the division shall
1204 conduct a state fair hearing and/or agency appeal on the matter of
1205 the disputed claim between the contractor and the provider within
1206 sixty (60) days, and shall render a decision on the matter within
1207 thirty (30) days after the date of the hearing and/or appeal.
1208 (8) It is the intention of the Legislature that the
1209 division evaluate the feasibility of using a single vendor to
1210 administer pharmacy benefits provided under a managed care
1211 delivery system established under this subsection (H). Providers
1212 of pharmacy benefits shall cooperate with the division in any
1213 transition to a carve-out of pharmacy benefits under managed care.
1214 (9) It is the intention of the Legislature that the
1215 division evaluate the feasibility of using a single vendor to

1216 administer dental benefits provided under a managed care delivery
1217 system established in this subsection (H). Providers of dental
1218 benefits shall cooperate with the division in any transition to a
1219 carve-out of dental benefits under managed care.
1220 (10) It is the intent of the Legislature that any
1221 contractor receiving capitated payments under a managed care
1222 delivery system established in this section shall implement
1223 innovative programs to improve the health and well-being of
1224 members diagnosed with prediabetes and diabetes.
1225 (11) It is the intent of the Legislature that any
1226 contractors receiving capitated payments under a managed care
1227 delivery system established under this subsection (H) shall work
1228 with providers of Medicaid services to improve the utilization of
1229 long-acting reversible contraceptives (LARCs). Not later than
1230 December 1, 2021, any contractors receiving capitated payments
1231 under a managed care delivery system established under this
1232 subsection (H) shall provide to the Chairmen of the House and
1233 Senate Medicaid Committees and House and Senate Public Health
1234 Committees a report of LARC utilization for State Fiscal Years
1235 2018 through 2020 as well as any programs, initiatives, or efforts
1236 made by the contractors and providers to increase LARC
1237 utilization. This report shall be updated annually to include
1238 information for subsequent state fiscal years.
1239 (12) The division is authorized to make not more than
1240 one (1) emergency extension of the contracts that are in effect on

1241 July 1, 2021, with contractors who are receiving capitated
1242 payments under a managed care delivery system established under
1243 this subsection (H), as provided in this paragraph (12). The
1244 maximum period of any such extension shall be one (1) year, and
1245 under any such extensions, the contractors shall be subject to all
1246 of the provisions of this subsection (H). The extended contracts
1247 shall be revised to incorporate any provisions of this subsection
1248 (H).

1249 (I) [Deleted]

1250 (J) There shall be no cuts in inpatient and outpatient
1251 hospital payments, or allowable days or volumes, as long as the
1252 hospital assessment provided in Section 43-13-145 is in effect.
1253 This subsection (J) shall not apply to decreases in payments that
1254 are a result of: reduced hospital admissions, audits or payments
1255 under the APR-DRG or APC models, or a managed care program or
1256 similar model described in subsection (H) of this section.

1257 (K) In the negotiation and execution of such contracts
1258 involving services performed by actuarial firms, the Executive
1259 Director of the Division of Medicaid may negotiate a limitation on
1260 liability to the state of prospective contractors.

1261 (L) This section shall stand repealed on July 1, 2024.

1262 **[From and after July 1, 2022, this section shall read as**
1263 **follows:]**

1264 43-13-117. (A) Medicaid as authorized by this article shall
1265 include payment of part or all of the costs, at the discretion of

1266 the division, with approval of the Governor and the Centers for
1267 Medicare and Medicaid Services, of the following types of care and
1268 services rendered to eligible applicants who have been determined
1269 to be eligible for that care and services, within the limits of
1270 state appropriations and federal matching funds:

1271 (1) Inpatient hospital services.

1272 (a) The division is authorized to implement an All
1273 Patient Refined Diagnosis Related Groups (APR-DRG) reimbursement
1274 methodology for inpatient hospital services.

1275 (b) No service benefits or reimbursement
1276 limitations in this subsection (A)(1) shall apply to payments
1277 under an APR-DRG or Ambulatory Payment Classification (APC) model
1278 or a managed care program or similar model described in subsection
1279 (H) of this section unless specifically authorized by the
1280 division.

1281 (2) Outpatient hospital services.

1282 (a) Emergency services.

1283 (b) Other outpatient hospital services. The
1284 division shall allow benefits for other medically necessary
1285 outpatient hospital services (such as chemotherapy, radiation,
1286 surgery and therapy), including outpatient services in a clinic or
1287 other facility that is not located inside the hospital, but that
1288 has been designated as an outpatient facility by the hospital, and
1289 that was in operation or under construction on July 1, 2009,
1290 provided that the costs and charges associated with the operation

1291 of the hospital clinic are included in the hospital's cost report.
1292 In addition, the Medicare thirty-five-mile rule will apply to
1293 those hospital clinics not located inside the hospital that are
1294 constructed after July 1, 2009. Where the same services are
1295 reimbursed as clinic services, the division may revise the rate or
1296 methodology of outpatient reimbursement to maintain consistency,
1297 efficiency, economy and quality of care.

1298 (c) The division is authorized to implement an
1299 Ambulatory Payment Classification (APC) methodology for outpatient
1300 hospital services. The division shall give rural hospitals that
1301 have fifty (50) or fewer licensed beds the option to not be
1302 reimbursed for outpatient hospital services using the APC
1303 methodology, but reimbursement for outpatient hospital services
1304 provided by those hospitals shall be based on one hundred one
1305 percent (101%) of the rate established under Medicare for
1306 outpatient hospital services. Those hospitals choosing to not be
1307 reimbursed under the APC methodology shall remain under cost-based
1308 reimbursement for a two-year period.

1309 (d) No service benefits or reimbursement
1310 limitations in this subsection (A)(2) shall apply to payments
1311 under an APR-DRG or APC model or a managed care program or similar
1312 model described in subsection (H) of this section unless
1313 specifically authorized by the division.

1314 (3) Laboratory and x-ray services.

1315 (4) Nursing facility services.

1316 (a) The division shall make full payment to
1317 nursing facilities for each day, not exceeding forty-two (42) days
1318 per year, that a patient is absent from the facility on home
1319 leave. Payment may be made for the following home leave days in
1320 addition to the forty-two-day limitation: Christmas, the day
1321 before Christmas, the day after Christmas, Thanksgiving, the day
1322 before Thanksgiving and the day after Thanksgiving.
1323 (b) From and after July 1, 1997, the division
1324 shall implement the integrated case-mix payment and quality
1325 monitoring system, which includes the fair rental system for
1326 property costs and in which recapture of depreciation is
1327 eliminated. The division may reduce the payment for hospital
1328 leave and therapeutic home leave days to the lower of the case-mix
1329 category as computed for the resident on leave using the
1330 assessment being utilized for payment at that point in time, or a
1331 case-mix score of 1.000 for nursing facilities, and shall compute
1332 case-mix scores of residents so that only services provided at the
1333 nursing facility are considered in calculating a facility's per
1334 diem.
1335 (c) From and after July 1, 1997, all state-owned
1336 nursing facilities shall be reimbursed on a full reasonable cost
1337 basis.
1338 (d) On or after January 1, 2015, the division
1339 shall update the case-mix payment system resource utilization
1340 grouper and classifications and fair rental reimbursement system.

1341 The division shall develop and implement a payment add-on to
1342 reimburse nursing facilities for ventilator-dependent resident
1343 services.

1344 (e) The division shall develop and implement, not
1345 later than January 1, 2001, a case-mix payment add-on determined
1346 by time studies and other valid statistical data that will
1347 reimburse a nursing facility for the additional cost of caring for
1348 a resident who has a diagnosis of Alzheimer's or other related
1349 dementia and exhibits symptoms that require special care. Any
1350 such case-mix add-on payment shall be supported by a determination
1351 of additional cost. The division shall also develop and implement
1352 as part of the fair rental reimbursement system for nursing
1353 facility beds, an Alzheimer's resident bed depreciation enhanced
1354 reimbursement system that will provide an incentive to encourage
1355 nursing facilities to convert or construct beds for residents with
1356 Alzheimer's or other related dementia.

1357 (f) The division shall develop and implement an
1358 assessment process for long-term care services. The division may
1359 provide the assessment and related functions directly or through
1360 contract with the area agencies on aging.

1361 The division shall apply for necessary federal waivers to
1362 assure that additional services providing alternatives to nursing
1363 facility care are made available to applicants for nursing
1364 facility care.

1365 (5) Periodic screening and diagnostic services for
1366 individuals under age twenty-one (21) years as are needed to
1367 identify physical and mental defects and to provide health care
1368 treatment and other measures designed to correct or ameliorate
1369 defects and physical and mental illness and conditions discovered
1370 by the screening services, regardless of whether these services
1371 are included in the state plan. The division may include in its
1372 periodic screening and diagnostic program those discretionary
1373 services authorized under the federal regulations adopted to
1374 implement Title XIX of the federal Social Security Act, as
1375 amended. The division, in obtaining physical therapy services,
1376 occupational therapy services, and services for individuals with
1377 speech, hearing and language disorders, may enter into a
1378 cooperative agreement with the State Department of Education for
1379 the provision of those services to handicapped students by public
1380 school districts using state funds that are provided from the
1381 appropriation to the Department of Education to obtain federal
1382 matching funds through the division. The division, in obtaining
1383 medical and mental health assessments, treatment, care and
1384 services for children who are in, or at risk of being put in, the
1385 custody of the Mississippi Department of Human Services may enter
1386 into a cooperative agreement with the Mississippi Department of
1387 Human Services for the provision of those services using state
1388 funds that are provided from the appropriation to the Department

1389 of Human Services to obtain federal matching funds through the
1390 division.
1391 (6) Physician services. Fees for physician's services
1392 that are covered only by Medicaid shall be reimbursed at ninety
1393 percent (90%) of the rate established on January 1, 2018, and as
1394 may be adjusted each July thereafter, under Medicare. The
1395 division may provide for a reimbursement rate for physician's
1396 services of up to one hundred percent (100%) of the rate
1397 established under Medicare for physician's services that are
1398 provided after the normal working hours of the physician, as
1399 determined in accordance with regulations of the division. The
1400 division may reimburse eligible providers, as determined by the
1401 division, for certain primary care services at one hundred percent
1402 (100%) of the rate established under Medicare. The division shall
1403 reimburse obstetricians and gynecologists for certain primary care
1404 services as defined by the division at one hundred percent (100%)
1405 of the rate established under Medicare.
1406 (7) (a) Home health services for eligible persons, not
1407 to exceed in cost the prevailing cost of nursing facility
1408 services. All home health visits must be precertified as required
1409 by the division. In addition to physicians, certified registered
1410 nurse practitioners, physician assistants and clinical nurse
1411 specialists are authorized to prescribe or order home health
1412 services and plans of care, sign home health plans of care,
1413 certify and recertify eligibility for home health services and

1414 conduct the required initial face-to-face visit with the recipient
1415 of the services.
1416 (b) [Repealed]
1417 (8) Emergency medical transportation services as
1418 determined by the division.
1419 (9) Prescription drugs and other covered drugs and
1420 services as determined by the division.
1421 The division shall establish a mandatory preferred drug list.
1422 Drugs not on the mandatory preferred drug list shall be made
1423 available by utilizing prior authorization procedures established
1424 by the division.
1425 The division may seek to establish relationships with other
1426 states in order to lower acquisition costs of prescription drugs
1427 to include single-source and innovator multiple-source drugs or
1428 generic drugs. In addition, if allowed by federal law or
1429 regulation, the division may seek to establish relationships with
1430 and negotiate with other countries to facilitate the acquisition
1431 of prescription drugs to include single-source and innovator
1432 multiple-source drugs or generic drugs, if that will lower the
1433 acquisition costs of those prescription drugs.
1434 The division may allow for a combination of prescriptions for
1435 single-source and innovator multiple-source drugs and generic
1436 drugs to meet the needs of the beneficiaries.

1437 The executive director may approve specific maintenance drugs
1438 for beneficiaries with certain medical conditions, which may be
1439 prescribed and dispensed in three-month supply increments.
1440 Drugs prescribed for a resident of a psychiatric residential
1441 treatment facility must be provided in true unit doses when
1442 available. The division may require that drugs not covered by
1443 Medicare Part D for a resident of a long-term care facility be
1444 provided in true unit doses when available. Those drugs that were
1445 originally billed to the division but are not used by a resident
1446 in any of those facilities shall be returned to the billing
1447 pharmacy for credit to the division, in accordance with the
1448 guidelines of the State Board of Pharmacy and any requirements of
1449 federal law and regulation. Drugs shall be dispensed to a
1450 recipient and only one (1) dispensing fee per month may be
1451 charged. The division shall develop a methodology for reimbursing
1452 for restocked drugs, which shall include a restock fee as
1453 determined by the division not exceeding Seven Dollars and
1454 Eighty-two Cents ($7.82).
1455 Except for those specific maintenance drugs approved by the
1456 executive director, the division shall not reimburse for any
1457 portion of a prescription that exceeds a thirty-one-day supply of
1458 the drug based on the daily dosage.
1459 The division is authorized to develop and implement a program
1460 of payment for additional pharmacist services as determined by the
1461 division.

1462 All claims for drugs for dually eligible Medicare/Medicaid
1463 beneficiaries that are paid for by Medicare must be submitted to
1464 Medicare for payment before they may be processed by the
1465 division's online payment system.

1466 The division shall develop a pharmacy policy in which drugs
1467 in tamper-resistant packaging that are prescribed for a resident
1468 of a nursing facility but are not dispensed to the resident shall
1469 be returned to the pharmacy and not billed to Medicaid, in
1470 accordance with guidelines of the State Board of Pharmacy.

1471 The division shall develop and implement a method or methods
1472 by which the division will provide on a regular basis to Medicaid
1473 providers who are authorized to prescribe drugs, information about
1474 the costs to the Medicaid program of single-source drugs and
1475 innovator multiple-source drugs, and information about other drugs
1476 that may be prescribed as alternatives to those single-source
1477 drugs and innovator multiple-source drugs and the costs to the
1478 Medicaid program of those alternative drugs.

1479 Notwithstanding any law or regulation, information obtained
1480 or maintained by the division regarding the prescription drug
1481 program, including trade secrets and manufacturer or labeler
1482 pricing, is confidential and not subject to disclosure except to
1483 other state agencies.

1484 The dispensing fee for each new or refill prescription,
1485 including nonlegend or over-the-counter drugs covered by the

1486 division, shall be not less than Three Dollars and Ninety-one
1487 Cents ($3.91), as determined by the division.

1488 The division shall not reimburse for single-source or
1489 innovator multiple-source drugs if there are equally effective
1490 generic equivalents available and if the generic equivalents are
1491 the least expensive.

1492 It is the intent of the Legislature that the pharmacists
1493 providers be reimbursed for the reasonable costs of filling and
1494 dispensing prescriptions for Medicaid beneficiaries.

1495 The division shall allow certain drugs, including
1496 physician-administered drugs, and implantable drug system devices,
1497 and medical supplies, with limited distribution or limited access
1498 for beneficiaries and administered in an appropriate clinical
1499 setting, to be reimbursed as either a medical claim or pharmacy
1500 claim, as determined by the division.

1501 It is the intent of the Legislature that the division and any
1502 managed care entity described in subsection (H) of this section
1503 encourage the use of Alpha-Hydroxyprogesterone Caproate (17P) to
1504 prevent recurrent preterm birth.

1505 (10) Dental and orthodontic services to be determined
1506 by the division.

1507 The division shall increase the amount of the reimbursement
1508 rate for diagnostic and preventative dental services for each of
1509 the fiscal years 2022, 2023 and 2024 by five percent (5%) above
1510 the amount of the reimbursement rate for the previous fiscal year.

1511 The division shall increase the amount of the reimbursement rate
1512 for restorative dental services for each of the fiscal years 2023,
1513 2024 and 2025 by five percent (5%) above the amount of the
1514 reimbursement rate for the previous fiscal year. It is the intent
1515 of the Legislature that the reimbursement rate revision for
1516 preventative dental services will be an incentive to increase the
1517 number of dentists who actively provide Medicaid services. This
1518 dental services reimbursement rate revision shall be known as the
1519 "James Russell Dumas Medicaid Dental Services Incentive Program."
1520 The Medical Care Advisory Committee, assisted by the Division
1521 of Medicaid, shall annually determine the effect of this incentive
1522 by evaluating the number of dentists who are Medicaid providers,
1523 the number who and the degree to which they are actively billing
1524 Medicaid, the geographic trends of where dentists are offering
1525 what types of Medicaid services and other statistics pertinent to
1526 the goals of this legislative intent. This data shall annually be
1527 presented to the Chair of the Senate Medicaid Committee and the
1528 Chair of the House Medicaid Committee.
1529 The division shall include dental services as a necessary
1530 component of overall health services provided to children who are
1531 eligible for services.
1532 (11) Eyeglasses for all Medicaid beneficiaries who have
1533 (a) had surgery on the eyeball or ocular muscle that results in a
1534 vision change for which eyeglasses or a change in eyeglasses is
1535 medically indicated within six (6) months of the surgery and is in

1536 accordance with policies established by the division, or (b) one
1537 (1) pair every five (5) years and in accordance with policies
1538 established by the division. In either instance, the eyeglasses
1539 must be prescribed by a physician skilled in diseases of the eye
1540 or an optometrist, whichever the beneficiary may select.
1541 (12) Intermediate care facility services.
1542 (a) The division shall make full payment to all
1543 intermediate care facilities for individuals with intellectual
1544 disabilities for each day, not exceeding sixty-three (63) days per
1545 year, that a patient is absent from the facility on home leave.
1546 Payment may be made for the following home leave days in addition
1547 to the sixty-three-day limitation: Christmas, the day before
1548 Christmas, the day after Christmas, Thanksgiving, the day before
1549 Thanksgiving and the day after Thanksgiving.
1550 (b) All state-owned intermediate care facilities
1551 for individuals with intellectual disabilities shall be reimbursed
1552 on a full reasonable cost basis.
1553 (c) Effective January 1, 2015, the division shall
1554 update the fair rental reimbursement system for intermediate care
1555 facilities for individuals with intellectual disabilities.
1556 (13) Family planning services, including drugs,
1557 supplies and devices, when those services are under the
1558 supervision of a physician or nurse practitioner.
1559 (14) Clinic services. Preventive, diagnostic,
1560 therapeutic, rehabilitative or palliative services that are

1561 furnished by a facility that is not part of a hospital but is
1562 organized and operated to provide medical care to outpatients.
1563 Clinic services include, but are not limited to:
1564 (a) Services provided by ambulatory surgical
1565 centers (ACSs) as defined in Section 41-75-1(a); and
1566 (b) Dialysis center services.
1567 (15) Home- and community-based services for the elderly
1568 and disabled, as provided under Title XIX of the federal Social
1569 Security Act, as amended, under waivers, subject to the
1570 availability of funds specifically appropriated for that purpose
1571 by the Legislature.
1572 (16) Mental health services. Certain services provided
1573 by a psychiatrist shall be reimbursed at up to one hundred percent
1574 (100%) of the Medicare rate. Approved therapeutic and case
1575 management services (a) provided by an approved regional mental
1576 health/intellectual disability center established under Sections
1577 41-19-31 through 41-19-39, or by another community mental health
1578 service provider meeting the requirements of the Department of
1579 Mental Health to be an approved mental health/intellectual
1580 disability center if determined necessary by the Department of
1581 Mental Health, using state funds that are provided in the
1582 appropriation to the division to match federal funds, or (b)
1583 provided by a facility that is certified by the State Department
1584 of Mental Health to provide therapeutic and case management
1585 services, to be reimbursed on a fee for service basis, or (c)

1586 provided in the community by a facility or program operated by the
1587 Department of Mental Health. Any such services provided by a
1588 facility described in subparagraph (b) must have the prior
1589 approval of the division to be reimbursable under this section.
1590 (17) Durable medical equipment services and medical
1591 supplies. Precertification of durable medical equipment and
1592 medical supplies must be obtained as required by the division.
1593 The Division of Medicaid may require durable medical equipment
1594 providers to obtain a surety bond in the amount and to the
1595 specifications as established by the Balanced Budget Act of 1997.
1596 A maximum dollar amount of reimbursement for noninvasive
1597 ventilators or ventilation treatments properly ordered and being
1598 used in an appropriate care setting shall not be set by any health
1599 maintenance organization, coordinated care organization,
1600 provider-sponsored health plan, or other organization paid for
1601 services on a capitated basis by the division under any managed
1602 care program or coordinated care program implemented by the
1603 division under this section. Reimbursement by these organizations
1604 to durable medical equipment suppliers for home use of noninvasive
1605 and invasive ventilators shall be on a continuous monthly payment
1606 basis for the duration of medical need throughout a patient's
1607 valid prescription period.
1608 (18) (a) Notwithstanding any other provision of this
1609 section to the contrary, as provided in the Medicaid state plan
1610 amendment or amendments as defined in Section 43-13-145(10), the

1611 division shall make additional reimbursement to hospitals that
1612 serve a disproportionate share of low-income patients and that
1613 meet the federal requirements for those payments as provided in
1614 Section 1923 of the federal Social Security Act and any applicable
1615 regulations. It is the intent of the Legislature that the
1616 division shall draw down all available federal funds allotted to
1617 the state for disproportionate share hospitals. However, from and
1618 after January 1, 1999, public hospitals participating in the
1619 Medicaid disproportionate share program may be required to
1620 participate in an intergovernmental transfer program as provided
1621 in Section 1903 of the federal Social Security Act and any
1622 applicable regulations.

1623 (b) (i) 1. The division may establish a Medicare
1624 Upper Payment Limits Program, as defined in Section 1902(a)(30) of
1625 the federal Social Security Act and any applicable federal
1626 regulations, or an allowable delivery system or provider payment
1627 initiative authorized under 42 CFR 438.6(c), for hospitals,
1628 nursing facilities *** * *** and physicians employed or contracted by
1629 hospitals *** * ***.

1630 2. The division shall establish a
1631 Medicaid Supplemental Payment Program, as permitted by the federal
1632 Social Security Act and a comparable allowable delivery system or
1633 provider payment initiative authorized under 42 CFR 438.6(c), for
1634 emergency ambulance transportation providers in accordance with
1635 this subsection (A)(18)(b).

1636 (ii) The division shall assess each hospital,
1637 nursing facility, and emergency ambulance transportation provider
1638 for the sole purpose of financing the state portion of the
1639 Medicare Upper Payment Limits Program or other program(s)
1640 authorized under this subsection (A)(18)(b). The hospital
1641 assessment shall be as provided in Section 43-13-145(4)(a), and
1642 the nursing facility and the emergency ambulance transportation
1643 assessments, if established, shall be based on Medicaid
1644 utilization or other appropriate method, as determined by the
1645 division, consistent with federal regulations. The assessments
1646 will remain in effect as long as the state participates in the
1647 Medicare Upper Payment Limits Program or other program(s)
1648 authorized under this subsection (A)(18)(b). In addition to the
1649 hospital assessment provided in Section 43-13-145(4)(a), hospitals
1650 with physicians participating in the Medicare Upper Payment Limits
1651 Program or other program(s) authorized under this subsection
1652 (A)(18)(b) shall be required to participate in an
1653 intergovernmental transfer or assessment, as determined by the
1654 division, for the purpose of financing the state portion of the
1655 physician UPL payments or other payment(s) authorized under this
1656 subsection (A)(18)(b).
1657 (iii) Subject to approval by the Centers for
1658 Medicare and Medicaid Services (CMS) and the provisions of this
1659 subsection (A)(18)(b), the division shall make additional
1660 reimbursement to hospitals, nursing facilities, and emergency

1661 ambulance transportation providers for the Medicare Upper Payment
1662 Limits Program or other program(s) authorized under this
1663 subsection (A)(18)(b), and, if the program is established for
1664 physicians, shall make additional reimbursement for physicians, as
1665 defined in Section 1902(a)(30) of the federal Social Security Act
1666 and any applicable federal regulations, provided the assessment in
1667 this subsection (A)(18)(b) is in effect.
1668 (iv) Notwithstanding any other provision of
1669 this article to the contrary, effective upon implementation of the
1670 Mississippi Hospital Access Program (MHAP) provided in
1671 subparagraph (c)(i) below, the hospital portion of the inpatient
1672 Upper Payment Limits Program shall transition into and be replaced
1673 by the MHAP program. However, the division is authorized to
1674 develop and implement an alternative fee-for-service Upper Payment
1675 Limits model in accordance with federal laws and regulations if
1676 necessary to preserve supplemental funding. Further, the
1677 division, in consultation with the hospital industry shall develop
1678 alternative models for distribution of medical claims and
1679 supplemental payments for inpatient and outpatient hospital
1680 services, and such models may include, but shall not be limited to
1681 the following: increasing rates for inpatient and outpatient
1682 services; creating a low-income utilization pool of funds to
1683 reimburse hospitals for the costs of uncompensated care, charity
1684 care and bad debts as permitted and approved pursuant to federal
1685 regulations and the Centers for Medicare and Medicaid Services;

1686 supplemental payments based upon Medicaid utilization, quality,
1687 service lines and/or costs of providing such services to Medicaid
1688 beneficiaries and to uninsured patients. The goals of such
1689 payment models shall be to ensure access to inpatient and
1690 outpatient care and to maximize any federal funds that are
1691 available to reimburse hospitals for services provided. Any such
1692 documents required to achieve the goals described in this
1693 paragraph shall be submitted to the Centers for Medicare and
1694 Medicaid Services, with a proposed effective date of July 1, 2019,
1695 to the extent possible, but in no event shall the effective date
1696 of such payment models be later than July 1, 2020. The Chairmen
1697 of the Senate and House Medicaid Committees shall be provided a
1698 copy of the proposed payment model(s) prior to submission.
1699 Effective July 1, 2018, and until such time as any payment
1700 model(s) as described above become effective, the division, in
1701 consultation with the hospital industry, is authorized to
1702 implement a transitional program for inpatient and outpatient
1703 payments and/or supplemental payments (including, but not limited
1704 to, MHAP and directed payments), to redistribute available
1705 supplemental funds among hospital providers, provided that when
1706 compared to a hospital's prior year supplemental payments,
1707 supplemental payments made pursuant to any such transitional
1708 program shall not result in a decrease of more than five percent
1709 (5%) and shall not increase by more than the amount needed to
1710 maximize the distribution of the available funds.

1711 (v) 1. To preserve and improve access to
1712 ambulance transportation provider services, the division shall
1713 seek CMS approval to make ambulance service access payments as set
1714 forth in this subsection (A)(18)(b) for all covered emergency
1715 ambulance services rendered on or after July 1, 2022, and shall
1716 make such ambulance service access payments for all covered
1717 services rendered on or after the effective date of CMS approval.
1718 2. The division shall calculate the
1719 ambulance service access payment amount as the balance of the
1720 portion of the Medical Care Fund related to ambulance
1721 transportation service provider assessments plus any federal
1722 matching funds earned on the balance, up to, but not to exceed,
1723 the upper payment limit gap for all emergency ambulance service
1724 providers.
1725 3. a. Except for ambulance services
1726 exempt from the assessment provided in this paragraph (18)(b), all
1727 ambulance transportation service providers shall be eligible for
1728 ambulance service access payments each state fiscal year as set
1729 forth in this paragraph (18)(b).
1730 b. In addition to any other funds
1731 paid to ambulance transportation service providers for emergency
1732 medical services provided to Medicaid beneficiaries, each eligible
1733 ambulance transportation service provider shall receive ambulance
1734 service access payments each state fiscal year equal to the
1735 ambulance transportation service provider's upper payment limit

1736 gap. Subject to approval by the Centers for Medicare and Medicaid
1737 Services, ambulance service access payments shall be made no less
1738 than on a quarterly basis.
1739 c. As used in this paragraph
1740 (18)(b)(v), the term "upper payment limit gap" means the
1741 difference between the total amount that the ambulance
1742 transportation service provider received from Medicaid and the
1743 average amount that the ambulance transportation service provider
1744 would have received from commercial insurers for those services
1745 reimbursed by Medicaid.
1746 4. An ambulance service access payment
1747 shall not be used to offset any other payment by the division for
1748 emergency or nonemergency services to Medicaid beneficiaries.
1749 (c) (i) Not later than December 1, 2015, the
1750 division shall, subject to approval by the Centers for Medicare
1751 and Medicaid Services (CMS), establish, implement and operate a
1752 Mississippi Hospital Access Program (MHAP) for the purpose of
1753 protecting patient access to hospital care through hospital
1754 inpatient reimbursement programs provided in this section designed
1755 to maintain total hospital reimbursement for inpatient services
1756 rendered by in-state hospitals and the out-of-state hospital that
1757 is authorized by federal law to submit intergovernmental transfers
1758 (IGTs) to the State of Mississippi and is classified as Level I
1759 trauma center located in a county contiguous to the state line at
1760 the maximum levels permissible under applicable federal statutes

1761 and regulations, at which time the current inpatient Medicare
1762 Upper Payment Limits (UPL) Program for hospital inpatient services
1763 shall transition to the MHAP.

1764 (ii) Subject to approval by the Centers for
1765 Medicare and Medicaid Services (CMS), the MHAP shall provide
1766 increased inpatient capitation (PMPM) payments to managed care
1767 entities contracting with the division pursuant to subsection (H)
1768 of this section to support availability of hospital services or
1769 such other payments permissible under federal law necessary to
1770 accomplish the intent of this subsection.

1771 (iii) The intent of this subparagraph (c) is
1772 that effective for all inpatient hospital Medicaid services during
1773 state fiscal year 2016, and so long as this provision shall remain
1774 in effect hereafter, the division shall to the fullest extent
1775 feasible replace the additional reimbursement for hospital
1776 inpatient services under the inpatient Medicare Upper Payment
1777 Limits (UPL) Program with additional reimbursement under the MHAP
1778 and other payment programs for inpatient and/or outpatient
1779 payments which may be developed under the authority of this
1780 paragraph.

1781 (iv) The division shall assess each hospital
1782 as provided in Section 43-13-145(4)(a) for the purpose of
1783 financing the state portion of the MHAP, supplemental payments and
1784 such other purposes as specified in Section 43-13-145. The

1785 assessment will remain in effect as long as the MHAP and
1786 supplemental payments are in effect.
1787 (19) (a) Perinatal risk management services. The
1788 division shall promulgate regulations to be effective from and
1789 after October 1, 1988, to establish a comprehensive perinatal
1790 system for risk assessment of all pregnant and infant Medicaid
1791 recipients and for management, education and follow-up for those
1792 who are determined to be at risk. Services to be performed
1793 include case management, nutrition assessment/counseling,
1794 psychosocial assessment/counseling and health education. The
1795 division shall contract with the State Department of Health to
1796 provide services within this paragraph (Perinatal High Risk
1797 Management/Infant Services System (PHRM/ISS)). The State
1798 Department of Health shall be reimbursed on a full reasonable cost
1799 basis for services provided under this subparagraph (a).
1800 (b) Early intervention system services. The
1801 division shall cooperate with the State Department of Health,
1802 acting as lead agency, in the development and implementation of a
1803 statewide system of delivery of early intervention services, under
1804 Part C of the Individuals with Disabilities Education Act (IDEA).
1805 The State Department of Health shall certify annually in writing
1806 to the executive director of the division the dollar amount of
1807 state early intervention funds available that will be utilized as
1808 a certified match for Medicaid matching funds. Those funds then
1809 shall be used to provide expanded targeted case management

1810 services for Medicaid eligible children with special needs who are
1811 eligible for the state's early intervention system.
1812 Qualifications for persons providing service coordination shall be
1813 determined by the State Department of Health and the Division of
1814 Medicaid.

1815 (20) Home- and community-based services for physically
1816 disabled approved services as allowed by a waiver from the United
1817 States Department of Health and Human Services for home- and
1818 community-based services for physically disabled people using
1819 state funds that are provided from the appropriation to the State
1820 Department of Rehabilitation Services and used to match federal
1821 funds under a cooperative agreement between the division and the
1822 department, provided that funds for these services are
1823 specifically appropriated to the Department of Rehabilitation
1824 Services.

1825 (21) Nurse practitioner services. Services furnished
1826 by a registered nurse who is licensed and certified by the
1827 Mississippi Board of Nursing as a nurse practitioner, including,
1828 but not limited to, nurse anesthetists, nurse midwives, family
1829 nurse practitioners, family planning nurse practitioners,
1830 pediatric nurse practitioners, obstetrics-gynecology nurse
1831 practitioners and neonatal nurse practitioners, under regulations
1832 adopted by the division. Reimbursement for those services shall
1833 not exceed ninety percent (90%) of the reimbursement rate for
1834 comparable services rendered by a physician. The division may

1835 provide for a reimbursement rate for nurse practitioner services
1836 of up to one hundred percent (100%) of the reimbursement rate for
1837 comparable services rendered by a physician for nurse practitioner
1838 services that are provided after the normal working hours of the
1839 nurse practitioner, as determined in accordance with regulations
1840 of the division.

1841 (22) Ambulatory services delivered in federally
1842 qualified health centers, rural health centers and clinics of the
1843 local health departments of the State Department of Health for
1844 individuals eligible for Medicaid under this article based on
1845 reasonable costs as determined by the division. Federally
1846 qualified health centers shall be reimbursed by the Medicaid
1847 prospective payment system as approved by the Centers for Medicare
1848 and Medicaid Services. The division shall recognize federally
1849 qualified health centers (FQHCs), rural health clinics (RHCs) and
1850 community mental health centers (CMHCs) as both an originating and
1851 distant site provider for the purposes of telehealth
1852 reimbursement. The division is further authorized and directed to
1853 reimburse FQHCs, RHCs and CMHCs for both distant site and
1854 originating site services when such services are appropriately
1855 provided by the same organization.

1856 (23) Inpatient psychiatric services.

1857 (a) Inpatient psychiatric services to be
1858 determined by the division for recipients under age twenty-one
1859 (21) that are provided under the direction of a physician in an

1860 inpatient program in a licensed acute care psychiatric facility or
1861 in a licensed psychiatric residential treatment facility, before
1862 the recipient reaches age twenty-one (21) or, if the recipient was
1863 receiving the services immediately before he or she reached age
1864 twenty-one (21), before the earlier of the date he or she no
1865 longer requires the services or the date he or she reaches age
1866 twenty-two (22), as provided by federal regulations. From and
1867 after January 1, 2015, the division shall update the fair rental
1868 reimbursement system for psychiatric residential treatment
1869 facilities. Precertification of inpatient days and residential
1870 treatment days must be obtained as required by the division. From
1871 and after July 1, 2009, all state-owned and state-operated
1872 facilities that provide inpatient psychiatric services to persons
1873 under age twenty-one (21) who are eligible for Medicaid
1874 reimbursement shall be reimbursed for those services on a full
1875 reasonable cost basis.

1876 (b) The division may reimburse for services
1877 provided by a licensed freestanding psychiatric hospital to
1878 Medicaid recipients over the age of twenty-one (21) in a method
1879 and manner consistent with the provisions of Section 43-13-117.5.

1880 (24) [Deleted]

1881 (25) [Deleted]

1882 (26) Hospice care. As used in this paragraph, the term
1883 "hospice care" means a coordinated program of active professional
1884 medical attention within the home and outpatient and inpatient

1885 care that treats the terminally ill patient and family as a unit,
1886 employing a medically directed interdisciplinary team. The
1887 program provides relief of severe pain or other physical symptoms
1888 and supportive care to meet the special needs arising out of
1889 physical, psychological, spiritual, social and economic stresses
1890 that are experienced during the final stages of illness and during
1891 dying and bereavement and meets the Medicare requirements for
1892 participation as a hospice as provided in federal regulations.
1893 (27) Group health plan premiums and cost-sharing if it
1894 is cost-effective as defined by the United States Secretary of
1895 Health and Human Services.
1896 (28) Other health insurance premiums that are
1897 cost-effective as defined by the United States Secretary of Health
1898 and Human Services. Medicare eligible must have Medicare Part B
1899 before other insurance premiums can be paid.
1900 (29) The Division of Medicaid may apply for a waiver
1901 from the United States Department of Health and Human Services for
1902 home- and community-based services for developmentally disabled
1903 people using state funds that are provided from the appropriation
1904 to the State Department of Mental Health and/or funds transferred
1905 to the department by a political subdivision or instrumentality of
1906 the state and used to match federal funds under a cooperative
1907 agreement between the division and the department, provided that
1908 funds for these services are specifically appropriated to the

1909 Department of Mental Health and/or transferred to the department
1910 by a political subdivision or instrumentality of the state.
1911 (30) Pediatric skilled nursing services as determined
1912 by the division and in a manner consistent with regulations
1913 promulgated by the Mississippi State Department of Health.
1914 (31) Targeted case management services for children
1915 with special needs, under waivers from the United States
1916 Department of Health and Human Services, using state funds that
1917 are provided from the appropriation to the Mississippi Department
1918 of Human Services and used to match federal funds under a
1919 cooperative agreement between the division and the department.
1920 (32) Care and services provided in Christian Science
1921 Sanatoria listed and certified by the Commission for Accreditation
1922 of Christian Science Nursing Organizations/Facilities, Inc.,
1923 rendered in connection with treatment by prayer or spiritual means
1924 to the extent that those services are subject to reimbursement
1925 under Section 1903 of the federal Social Security Act.
1926 (33) Podiatrist services.
1927 (34) Assisted living services as provided through
1928 home- and community-based services under Title XIX of the federal
1929 Social Security Act, as amended, subject to the availability of
1930 funds specifically appropriated for that purpose by the
1931 Legislature.
1932 (35) Services and activities authorized in Sections
1933 43-27-101 and 43-27-103, using state funds that are provided from

1934 the appropriation to the Mississippi Department of Human Services
1935 and used to match federal funds under a cooperative agreement
1936 between the division and the department.
1937 (36) Nonemergency transportation services for
1938 Medicaid-eligible persons as determined by the division. The PEER
1939 Committee shall conduct a performance evaluation of the
1940 nonemergency transportation program to evaluate the administration
1941 of the program and the providers of transportation services to
1942 determine the most cost-effective ways of providing nonemergency
1943 transportation services to the patients served under the program.
1944 The performance evaluation shall be completed and provided to the
1945 members of the Senate Medicaid Committee and the House Medicaid
1946 Committee not later than January 1, 2019, and every two (2) years
1947 thereafter.
1948 (37) [Deleted]
1949 (38) Chiropractic services. A chiropractor's manual
1950 manipulation of the spine to correct a subluxation, if x-ray
1951 demonstrates that a subluxation exists and if the subluxation has
1952 resulted in a neuromusculoskeletal condition for which
1953 manipulation is appropriate treatment, and related spinal x-rays
1954 performed to document these conditions. Reimbursement for
1955 chiropractic services shall not exceed Seven Hundred Dollars
1956 ($700.00) per year per beneficiary.
1957 (39) Dually eligible Medicare/Medicaid beneficiaries.
1958 The division shall pay the Medicare deductible and coinsurance

1959 amounts for services available under Medicare, as determined by
1960 the division. From and after July 1, 2009, the division shall
1961 reimburse crossover claims for inpatient hospital services and
1962 crossover claims covered under Medicare Part B in the same manner
1963 that was in effect on January 1, 2008, unless specifically
1964 authorized by the Legislature to change this method.
1965 (40) [Deleted]
1966 (41) Services provided by the State Department of
1967 Rehabilitation Services for the care and rehabilitation of persons
1968 with spinal cord injuries or traumatic brain injuries, as allowed
1969 under waivers from the United States Department of Health and
1970 Human Services, using up to seventy-five percent (75%) of the
1971 funds that are appropriated to the Department of Rehabilitation
1972 Services from the Spinal Cord and Head Injury Trust Fund
1973 established under Section 37-33-261 and used to match federal
1974 funds under a cooperative agreement between the division and the
1975 department.
1976 (42) [Deleted]
1977 (43) The division shall provide reimbursement,
1978 according to a payment schedule developed by the division, for
1979 smoking cessation medications for pregnant women during their
1980 pregnancy and other Medicaid-eligible women who are of
1981 child-bearing age.
1982 (44) Nursing facility services for the severely
1983 disabled.

1984 (a) Severe disabilities include, but are not
1985 limited to, spinal cord injuries, closed-head injuries and
1986 ventilator-dependent patients.
1987 (b) Those services must be provided in a long-term
1988 care nursing facility dedicated to the care and treatment of
1989 persons with severe disabilities.
1990 (45) Physician assistant services. Services furnished
1991 by a physician assistant who is licensed by the State Board of
1992 Medical Licensure and is practicing with physician supervision
1993 under regulations adopted by the board, under regulations adopted
1994 by the division. Reimbursement for those services shall not
1995 exceed ninety percent (90%) of the reimbursement rate for
1996 comparable services rendered by a physician. The division may
1997 provide for a reimbursement rate for physician assistant services
1998 of up to one hundred percent (100%) or the reimbursement rate for
1999 comparable services rendered by a physician for physician
2000 assistant services that are provided after the normal working
2001 hours of the physician assistant, as determined in accordance with
2002 regulations of the division.
2003 (46) The division shall make application to the federal
2004 Centers for Medicare and Medicaid Services (CMS) for a waiver to
2005 develop and provide services for children with serious emotional
2006 disturbances as defined in Section 43-14-1(1), which may include
2007 home- and community-based services, case management services or
2008 managed care services through mental health providers certified by

2009 the Department of Mental Health. The division may implement and
2010 provide services under this waivered program only if funds for
2011 these services are specifically appropriated for this purpose by
2012 the Legislature, or if funds are voluntarily provided by affected
2013 agencies.

2014 (47) (a) The division may develop and implement
2015 disease management programs for individuals with high-cost chronic
2016 diseases and conditions, including the use of grants, waivers,
2017 demonstrations or other projects as necessary.

2018 (b) Participation in any disease management
2019 program implemented under this paragraph (47) is optional with the
2020 individual. An individual must affirmatively elect to participate
2021 in the disease management program in order to participate, and may
2022 elect to discontinue participation in the program at any time.

2023 (48) Pediatric long-term acute care hospital services.

2024 (a) Pediatric long-term acute care hospital
2025 services means services provided to eligible persons under
2026 twenty-one (21) years of age by a freestanding Medicare-certified
2027 hospital that has an average length of inpatient stay greater than
2028 twenty-five (25) days and that is primarily engaged in providing
2029 chronic or long-term medical care to persons under twenty-one (21)
2030 years of age.

2031 (b) The services under this paragraph (48) shall
2032 be reimbursed as a separate category of hospital services.

2033 (49) The division may establish copayments and/or
2034 coinsurance for any Medicaid services for which copayments and/or
2035 coinsurance are allowable under federal law or regulation.
2036 (50) Services provided by the State Department of
2037 Rehabilitation Services for the care and rehabilitation of persons
2038 who are deaf and blind, as allowed under waivers from the United
2039 States Department of Health and Human Services to provide home-
2040 and community-based services using state funds that are provided
2041 from the appropriation to the State Department of Rehabilitation
2042 Services or if funds are voluntarily provided by another agency.
2043 (51) Upon determination of Medicaid eligibility and in
2044 association with annual redetermination of Medicaid eligibility,
2045 beneficiaries shall be encouraged to undertake a physical
2046 examination that will establish a base-line level of health and
2047 identification of a usual and customary source of care (a medical
2048 home) to aid utilization of disease management tools. This
2049 physical examination and utilization of these disease management
2050 tools shall be consistent with current United States Preventive
2051 Services Task Force or other recognized authority recommendations.
2052 For persons who are determined ineligible for Medicaid, the
2053 division will provide information and direction for accessing
2054 medical care and services in the area of their residence.
2055 (52) Notwithstanding any provisions of this article,
2056 the division may pay enhanced reimbursement fees related to trauma
2057 care, as determined by the division in conjunction with the State

2058 Department of Health, using funds appropriated to the State
2059 Department of Health for trauma care and services and used to
2060 match federal funds under a cooperative agreement between the
2061 division and the State Department of Health. The division, in
2062 conjunction with the State Department of Health, may use grants,
2063 waivers, demonstrations, enhanced reimbursements, Upper Payment
2064 Limits Programs, supplemental payments, or other projects as
2065 necessary in the development and implementation of this
2066 reimbursement program.
2067 (53) Targeted case management services for high-cost
2068 beneficiaries may be developed by the division for all services
2069 under this section.
2070 (54) [Deleted]
2071 (55) Therapy services. The plan of care for therapy
2072 services may be developed to cover a period of treatment for up to
2073 six (6) months, but in no event shall the plan of care exceed a
2074 six-month period of treatment. The projected period of treatment
2075 must be indicated on the initial plan of care and must be updated
2076 with each subsequent revised plan of care. Based on medical
2077 necessity, the division shall approve certification periods for
2078 less than or up to six (6) months, but in no event shall the
2079 certification period exceed the period of treatment indicated on
2080 the plan of care. The appeal process for any reduction in therapy
2081 services shall be consistent with the appeal process in federal
2082 regulations.

2083 (56) Prescribed pediatric extended care centers
2084 services for medically dependent or technologically dependent
2085 children with complex medical conditions that require continual
2086 care as prescribed by the child's attending physician, as
2087 determined by the division.

2088 (57) No Medicaid benefit shall restrict coverage for
2089 medically appropriate treatment prescribed by a physician and
2090 agreed to by a fully informed individual, or if the individual
2091 lacks legal capacity to consent by a person who has legal
2092 authority to consent on his or her behalf, based on an
2093 individual's diagnosis with a terminal condition. As used in this
2094 paragraph (57), "terminal condition" means any aggressive
2095 malignancy, chronic end-stage cardiovascular or cerebral vascular
2096 disease, or any other disease, illness or condition which a
2097 physician diagnoses as terminal.

2098 (58) Treatment services for persons with opioid
2099 dependency or other highly addictive substance use disorders. The
2100 division is authorized to reimburse eligible providers for
2101 treatment of opioid dependency and other highly addictive
2102 substance use disorders, as determined by the division. Treatment
2103 related to these conditions shall not count against any physician
2104 visit limit imposed under this section.

2105 (59) The division shall allow beneficiaries between the
2106 ages of ten (10) and eighteen (18) years to receive vaccines
2107 through a pharmacy venue. The division and the State Department

2108 of Health shall coordinate and notify OB-GYN providers that the
2109 Vaccines for Children program is available to providers free of
2110 charge.

2111 (60) Border city university-affiliated pediatric
2112 teaching hospital.

2113 (a) Payments may only be made to a border city
2114 university-affiliated pediatric teaching hospital if the Centers
2115 for Medicare and Medicaid Services (CMS) approve an increase in
2116 the annual request for the provider payment initiative authorized
2117 under 42 CFR Section 438.6(c) in an amount equal to or greater
2118 than the estimated annual payment to be made to the border city
2119 university-affiliated pediatric teaching hospital. The estimate
2120 shall be based on the hospital's prior year Mississippi managed
2121 care utilization.

2122 (b) As used in this paragraph (60), the term
2123 "border city university-affiliated pediatric teaching hospital"
2124 means an out-of-state hospital located within a city bordering the
2125 eastern bank of the Mississippi River and the State of Mississippi
2126 that submits to the division a copy of a current and effective
2127 affiliation agreement with an accredited university and other
2128 documentation establishing that the hospital is
2129 university-affiliated, is licensed and designated as a pediatric
2130 hospital or pediatric primary hospital within its home state,
2131 maintains at least five (5) different pediatric specialty training
2132 programs, and maintains at least one hundred (100) operated beds

2133 dedicated exclusively for the treatment of patients under the age
2134 of twenty-one (21) years.
2135 (c) The cost of providing services to Mississippi
2136 Medicaid beneficiaries under the age of twenty-one (21) years who
2137 are treated by a border city university-affiliated pediatric
2138 teaching hospital shall not exceed the cost of providing the same
2139 services to individuals in hospitals in the state.
2140 (d) It is the intent of the Legislature that
2141 payments shall not result in any in-state hospital receiving
2142 payments lower than they would otherwise receive if not for the
2143 payments made to any border city university-affiliated pediatric
2144 teaching hospital.
2145 (e) This paragraph (60) shall stand repealed on
2146 July 1, 2024.
2147 (B) *** Planning and development districts participating
2148 in the home- and community-based services program for the elderly
2149 and disabled as case management providers shall be reimbursed for
2150 case management services at the maximum rate approved by the
2151 Centers for Medicare and Medicaid Services (CMS).
2152 (C) The division may pay to those providers who participate
2153 in and accept patient referrals from the division's emergency room
2154 redirection program a percentage, as determined by the division,
2155 of savings achieved according to the performance measures and
2156 reduction of costs required of that program. Federally qualified
2157 health centers may participate in the emergency room redirection

2158 program, and the division may pay those centers a percentage of
2159 any savings to the Medicaid program achieved by the centers'
2160 accepting patient referrals through the program, as provided in
2161 this subsection (C).

2162 (D) (1) *** * *** As used in this subsection (D), the following
2163 terms shall be defined as provided in this paragraph, except as
2164 otherwise provided in this subsection:

2165 (a) "Committees" means the Medicaid Committees of
2166 the House of Representatives and the Senate, and "committee" means
2167 either one of those committees.

2168 (b) "Rate change" means an increase, decrease or
2169 other change in the payments or rates of reimbursement, or a
2170 change in any payment methodology that results in an increase,
2171 decrease or other change in the payments or rates of
2172 reimbursement, to any Medicaid provider that renders any services
2173 authorized to be provided to Medicaid recipients under this
2174 article.

2175 (2) *** * *** Whenever the Division of Medicaid proposes a
2176 rate change, the division shall give notice to the chairmen of the
2177 committees at least thirty (30) calendar days before the proposed
2178 rate change is scheduled to take effect. The division shall
2179 furnish the chairmen with a concise summary of each proposed rate
2180 change along with the notice, and shall furnish the chairmen with
2181 a copy of any proposed rate change upon request. The division

2182 also shall provide a summary and copy of any proposed rate change
2183 to any other member of the Legislature upon request.
2184 (3) If the chairman of either committee or both
2185 chairmen jointly object to the proposed rate change or any part
2186 thereof, the chairman or chairmen shall notify the division and
2187 provide the reasons for their objection in writing not later than
2188 seven (7) calendar days after receipt of the notice from the
2189 division. The chairman or chairmen may make written
2190 recommendations to the division for changes to be made to a
2191 proposed rate change.
2192 (4) (a) The chairman of either committee or both
2193 chairmen jointly may hold a committee meeting to review a proposed
2194 rate change. If either chairman or both chairmen decide to hold a
2195 meeting, they shall notify the division of their intention in
2196 writing within seven (7) calendar days after receipt of the notice
2197 from the division, and shall set the date and time for the meeting
2198 in their notice to the division, which shall not be later than
2199 fourteen (14) calendar days after receipt of the notice from the
2200 division.
2201 (b) After the committee meeting, the committee or
2202 committees may object to the proposed rate change or any part
2203 thereof. The committee or committees shall notify the division
2204 and the reasons for their objection in writing not later than
2205 seven (7) calendar days after the meeting. The committee or

2206 committees may make written recommendations to the division for
2207 changes to be made to a proposed rate change.

2208 (5) If both chairmen notify the division in writing
2209 within seven (7) calendar days after receipt of the notice from
2210 the division that they do not object to the proposed rate change
2211 and will not be holding a meeting to review the proposed rate
2212 change, the proposed rate change will take effect on the original
2213 date as scheduled by the division or on such other date as
2214 specified by the division.

2215 (6) (a) If there are any objections to a proposed rate
2216 change or any part thereof from either or both of the chairmen or
2217 the committees, the division may withdraw the proposed rate
2218 change, make any of the recommended changes to the proposed rate
2219 change, or not make any changes to the proposed rate change.

2220 (b) If the division does not make any changes to
2221 the proposed rate change, it shall notify the chairmen of that
2222 fact in writing, and the proposed rate change shall take effect on
2223 the original date as scheduled by the division or on such other
2224 date as specified by the division.

2225 (c) If the division makes any changes to the
2226 proposed rate change, the division shall notify the chairmen of
2227 its actions in writing, and the revised proposed rate change shall
2228 take effect on the date as specified by the division.

2229 (7) Nothing in this subsection (D) shall be construed
2230 as giving the chairmen or the committees any authority to veto,

2231 nullify or revise any rate change proposed by the division. The
2232 authority of the chairmen or the committees under this subsection
2233 shall be limited to reviewing, making objections to and making
2234 recommendations for changes to rate changes proposed by the
2235 division.

2236 (E) Notwithstanding any provision of this article, no new
2237 groups or categories of recipients and new types of care and
2238 services may be added without enabling legislation from the
2239 Mississippi Legislature, except that the division may authorize
2240 those changes without enabling legislation when the addition of
2241 recipients or services is ordered by a court of proper authority.

2242 (F) The executive director shall keep the Governor advised
2243 on a timely basis of the funds available for expenditure and the
2244 projected expenditures. Notwithstanding any other provisions of
2245 this article, if current or projected expenditures of the division
2246 are reasonably anticipated to exceed the amount of funds
2247 appropriated to the division for any fiscal year, the Governor,
2248 after consultation with the executive director, shall take all
2249 appropriate measures to reduce costs, which may include, but are
2250 not limited to:

2251 (1) Reducing or discontinuing any or all services that
2252 are deemed to be optional under Title XIX of the Social Security
2253 Act;

2254 (2) Reducing reimbursement rates for any or all service
2255 types;

2256 (3) Imposing additional assessments on health care
2257 providers; or
2258 (4) Any additional cost-containment measures deemed
2259 appropriate by the Governor.
2260 To the extent allowed under federal law, any reduction to
2261 services or reimbursement rates under this subsection (F) shall be
2262 accompanied by a reduction, to the fullest allowable amount, to
2263 the profit margin and administrative fee portions of capitated
2264 payments to organizations described in paragraph (1) of subsection
2265 (H).
2266 Beginning in fiscal year 2010 and in fiscal years thereafter,
2267 when Medicaid expenditures are projected to exceed funds available
2268 for the fiscal year, the division shall submit the expected
2269 shortfall information to the PEER Committee not later than
2270 December 1 of the year in which the shortfall is projected to
2271 occur. PEER shall review the computations of the division and
2272 report its findings to the Legislative Budget Office not later
2273 than January 7 in any year.
2274 (G) Notwithstanding any other provision of this article, it
2275 shall be the duty of each provider participating in the Medicaid
2276 program to keep and maintain books, documents and other records as
2277 prescribed by the Division of Medicaid in accordance with federal
2278 laws and regulations.
2279 (H) (1) Notwithstanding any other provision of this
2280 article, the division is authorized to implement (a) a managed

2281 care program, (b) a coordinated care program, (c) a coordinated
2282 care organization program, (d) a health maintenance organization
2283 program, (e) a patient-centered medical home program, (f) an
2284 accountable care organization program, (g) provider-sponsored
2285 health plan, or (h) any combination of the above programs. As a
2286 condition for the approval of any program under this subsection
2287 (H)(1), the division shall require that no managed care program,
2288 coordinated care program, coordinated care organization program,
2289 health maintenance organization program, or provider-sponsored
2290 health plan may:

2291 (a) Pay providers at a rate that is less than the
2292 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
2293 reimbursement rate;

2294 (b) Override the medical decisions of hospital
2295 physicians or staff regarding patients admitted to a hospital for
2296 an emergency medical condition as defined by 42 US Code Section
2297 1395dd. This restriction (b) does not prohibit the retrospective
2298 review of the appropriateness of the determination that an
2299 emergency medical condition exists by chart review or coding
2300 algorithm, nor does it prohibit prior authorization for
2301 nonemergency hospital admissions;

2302 (c) Pay providers at a rate that is less than the
2303 normal Medicaid reimbursement rate. It is the intent of the
2304 Legislature that all managed care entities described in this
2305 subsection (H), in collaboration with the division, develop and

2306 implement innovative payment models that incentivize improvements
2307 in health care quality, outcomes, or value, as determined by the
2308 division. Participation in the provider network of any managed
2309 care, coordinated care, provider-sponsored health plan, or similar
2310 contractor shall not be conditioned on the provider's agreement to
2311 accept such alternative payment models;

2312 (d) Implement a prior authorization and
2313 utilization review program for medical services, transportation
2314 services and prescription drugs that is more stringent than the
2315 prior authorization processes used by the division in its
2316 administration of the Medicaid program. Not later than December
2317 2, 2021, the contractors that are receiving capitated payments
2318 under a managed care delivery system established under this
2319 subsection (H) shall submit a report to the Chairmen of the House
2320 and Senate Medicaid Committees on the status of the prior
2321 authorization and utilization review program for medical services,
2322 transportation services and prescription drugs that is required to
2323 be implemented under this subparagraph (d);

2324 (e) [Deleted]

2325 (f) Implement a preferred drug list that is more
2326 stringent than the mandatory preferred drug list established by
2327 the division under subsection (A)(9) of this section;

2328 (g) Implement a policy which denies beneficiaries
2329 with hemophilia access to the federally funded hemophilia

2330 treatment centers as part of the Medicaid Managed Care network of
2331 providers.
2332 Each health maintenance organization, coordinated care
2333 organization, provider-sponsored health plan, or other
2334 organization paid for services on a capitated basis by the
2335 division under any managed care program or coordinated care
2336 program implemented by the division under this section shall use a
2337 clear set of level of care guidelines in the determination of
2338 medical necessity and in all utilization management practices,
2339 including the prior authorization process, concurrent reviews,
2340 retrospective reviews and payments, that are consistent with
2341 widely accepted professional standards of care. Organizations
2342 participating in a managed care program or coordinated care
2343 program implemented by the division may not use any additional
2344 criteria that would result in denial of care that would be
2345 determined appropriate and, therefore, medically necessary under
2346 those levels of care guidelines.
2347 (2) Notwithstanding any provision of this section, the
2348 recipients eligible for enrollment into a Medicaid Managed Care
2349 Program authorized under this subsection (H) may include only
2350 those categories of recipients eligible for participation in the
2351 Medicaid Managed Care Program as of January 1, 2021, the
2352 Children's Health Insurance Program (CHIP), and the CMS-approved
2353 Section 1115 demonstration waivers in operation as of January 1,
2354 2021. No expansion of Medicaid Managed Care Program contracts may

2355 be implemented by the division without enabling legislation from
2356 the Mississippi Legislature.
2357 (3) (a) Any contractors receiving capitated payments
2358 under a managed care delivery system established in this section
2359 shall provide to the Legislature and the division statistical data
2360 to be shared with provider groups in order to improve patient
2361 access, appropriate utilization, cost savings and health outcomes
2362 not later than October 1 of each year. Additionally, each
2363 contractor shall disclose to the Chairmen of the Senate and House
2364 Medicaid Committees the administrative expenses costs for the
2365 prior calendar year, and the number of full-equivalent employees
2366 located in the State of Mississippi dedicated to the Medicaid and
2367 CHIP lines of business as of June 30 of the current year.
2368 (b) The division and the contractors participating
2369 in the managed care program, a coordinated care program or a
2370 provider-sponsored health plan shall be subject to annual program
2371 reviews or audits performed by the Office of the State Auditor,
2372 the PEER Committee, the Department of Insurance and/or independent
2373 third parties.
2374 (c) Those reviews shall include, but not be
2375 limited to, at least two (2) of the following items:
2376 (i) The financial benefit to the State of
2377 Mississippi of the managed care program,

2378 (ii) The difference between the premiums paid
2379 to the managed care contractors and the payments made by those
2380 contractors to health care providers,
2381 (iii) Compliance with performance measures
2382 required under the contracts,
2383 (iv) Administrative expense allocation
2384 methodologies,
2385 (v) Whether nonprovider payments assigned as
2386 medical expenses are appropriate,
2387 (vi) Capitated arrangements with related
2388 party subcontractors,
2389 (vii) Reasonableness of corporate
2390 allocations,
2391 (viii) Value-added benefits and the extent to
2392 which they are used,
2393 (ix) The effectiveness of subcontractor
2394 oversight, including subcontractor review,
2395 (x) Whether health care outcomes have been
2396 improved, and
2397 (xi) The most common claim denial codes to
2398 determine the reasons for the denials.
2399 The audit reports shall be considered public documents and
2400 shall be posted in their entirety on the division's website.
2401 (4) All health maintenance organizations, coordinated
2402 care organizations, provider-sponsored health plans, or other

2403 organizations paid for services on a capitated basis by the
2404 division under any managed care program or coordinated care
2405 program implemented by the division under this section shall
2406 reimburse all providers in those organizations at rates no lower
2407 than those provided under this section for beneficiaries who are
2408 not participating in those programs.

2409 (5) No health maintenance organization, coordinated
2410 care organization, provider-sponsored health plan, or other
2411 organization paid for services on a capitated basis by the
2412 division under any managed care program or coordinated care
2413 program implemented by the division under this section shall
2414 require its providers or beneficiaries to use any pharmacy that
2415 ships, mails or delivers prescription drugs or legend drugs or
2416 devices.

2417 (6) (a) Not later than December 1, 2021, the
2418 contractors who are receiving capitated payments under a managed
2419 care delivery system established under this subsection (H) shall
2420 develop and implement a uniform credentialing process for
2421 providers. Under that uniform credentialing process, a provider
2422 who meets the criteria for credentialing will be credentialed with
2423 all of those contractors and no such provider will have to be
2424 separately credentialed by any individual contractor in order to
2425 receive reimbursement from the contractor. Not later than
2426 December 2, 2021, those contractors shall submit a report to the
2427 Chairmen of the House and Senate Medicaid Committees on the status

2428 of the uniform credentialing process for providers that is
2429 required under this subparagraph (a).
2430 (b) If those contractors have not implemented a
2431 uniform credentialing process as described in subparagraph (a) by
2432 December 1, 2021, the division shall develop and implement, not
2433 later than July 1, 2022, a single, consolidated credentialing
2434 process by which all providers will be credentialed. Under the
2435 division's single, consolidated credentialing process, no such
2436 contractor shall require its providers to be separately
2437 credentialed by the contractor in order to receive reimbursement
2438 from the contractor, but those contractors shall recognize the
2439 credentialing of the providers by the division's credentialing
2440 process.
2441 (c) The division shall require a uniform provider
2442 credentialing application that shall be used in the credentialing
2443 process that is established under subparagraph (a) or (b). If the
2444 contractor or division, as applicable, has not approved or denied
2445 the provider credentialing application within sixty (60) days of
2446 receipt of the completed application that includes all required
2447 information necessary for credentialing, then the contractor or
2448 division, upon receipt of a written request from the applicant and
2449 within five (5) business days of its receipt, shall issue a
2450 temporary provider credential/enrollment to the applicant if the
2451 applicant has a valid Mississippi professional or occupational
2452 license to provide the health care services to which the

2453 credential/enrollment would apply. The contractor or the division
2454 shall not issue a temporary credential/enrollment if the applicant
2455 has reported on the application a history of medical or other
2456 professional or occupational malpractice claims, a history of
2457 substance abuse or mental health issues, a criminal record, or a
2458 history of medical or other licensing board, state or federal
2459 disciplinary action, including any suspension from participation
2460 in a federal or state program. The temporary
2461 credential/enrollment shall be effective upon issuance and shall
2462 remain in effect until the provider's credentialing/enrollment
2463 application is approved or denied by the contractor or division.
2464 The contractor or division shall render a final decision regarding
2465 credentialing/enrollment of the provider within sixty (60) days
2466 from the date that the temporary provider credential/enrollment is
2467 issued to the applicant.

2468 (d) If the contractor or division does not render
2469 a final decision regarding credentialing/enrollment of the
2470 provider within the time required in subparagraph (c), the
2471 provider shall be deemed to be credentialed by and enrolled with
2472 all of the contractors and eligible to receive reimbursement from
2473 the contractors.

2474 (7) (a) Each contractor that is receiving capitated
2475 payments under a managed care delivery system established under
2476 this subsection (H) shall provide to each provider for whom the
2477 contractor has denied the coverage of a procedure that was ordered

2478 or requested by the provider for or on behalf of a patient, a
2479 letter that provides a detailed explanation of the reasons for the
2480 denial of coverage of the procedure and the name and the
2481 credentials of the person who denied the coverage. The letter
2482 shall be sent to the provider in electronic format.
2483 (b) After a contractor that is receiving capitated
2484 payments under a managed care delivery system established under
2485 this subsection (H) has denied coverage for a claim submitted by a
2486 provider, the contractor shall issue to the provider within sixty
2487 (60) days a final ruling of denial of the claim that allows the
2488 provider to have a state fair hearing and/or agency appeal with
2489 the division. If a contractor does not issue a final ruling of
2490 denial within sixty (60) days as required by this subparagraph
2491 (b), the provider's claim shall be deemed to be automatically
2492 approved and the contractor shall pay the amount of the claim to
2493 the provider.
2494 (c) After a contractor has issued a final ruling
2495 of denial of a claim submitted by a provider, the division shall
2496 conduct a state fair hearing and/or agency appeal on the matter of
2497 the disputed claim between the contractor and the provider within
2498 sixty (60) days, and shall render a decision on the matter within
2499 thirty (30) days after the date of the hearing and/or appeal.
2500 (8) It is the intention of the Legislature that the
2501 division evaluate the feasibility of using a single vendor to
2502 administer pharmacy benefits provided under a managed care

2503 delivery system established under this subsection (H). Providers
2504 of pharmacy benefits shall cooperate with the division in any
2505 transition to a carve-out of pharmacy benefits under managed care.
2506 (9) *** * *** The division shall evaluate the feasibility
2507 of using a single vendor to administer dental benefits provided
2508 under a managed care delivery system established in this
2509 subsection (H). Providers of dental benefits shall cooperate with
2510 the division in any transition to a carve-out of dental benefits
2511 under managed care.
2512 (10) It is the intent of the Legislature that any
2513 contractor receiving capitated payments under a managed care
2514 delivery system established in this section shall implement
2515 innovative programs to improve the health and well-being of
2516 members diagnosed with prediabetes and diabetes.
2517 (11) It is the intent of the Legislature that any
2518 contractors receiving capitated payments under a managed care
2519 delivery system established under this subsection (H) shall work
2520 with providers of Medicaid services to improve the utilization of
2521 long-acting reversible contraceptives (LARCs). Not later than
2522 December 1, 2021, any contractors receiving capitated payments
2523 under a managed care delivery system established under this
2524 subsection (H) shall provide to the Chairmen of the House and
2525 Senate Medicaid Committees and House and Senate Public Health
2526 Committees a report of LARC utilization for State Fiscal Years
2527 2018 through 2020 as well as any programs, initiatives, or efforts

2528 made by the contractors and providers to increase LARC
2529 utilization. This report shall be updated annually to include
2530 information for subsequent state fiscal years.
2531 (12) The division is authorized to make not more than
2532 one (1) emergency extension of the contracts that are in effect on
2533 July 1, 2021, with contractors who are receiving capitated
2534 payments under a managed care delivery system established under
2535 this subsection (H), as provided in this paragraph (12). The
2536 maximum period of any such extension shall be one (1) year, and
2537 under any such extensions, the contractors shall be subject to all
2538 of the provisions of this subsection (H). The extended contracts
2539 shall be revised to incorporate any provisions of this subsection
2540 (H).
2541 (I) [Deleted]
2542 (J) There shall be no cuts in inpatient and outpatient
2543 hospital payments, or allowable days or volumes, as long as the
2544 hospital assessment provided in Section 43-13-145 is in effect.
2545 This subsection (J) shall not apply to decreases in payments that
2546 are a result of: reduced hospital admissions, audits or payments
2547 under the APR-DRG or APC models, or a managed care program or
2548 similar model described in subsection (H) of this section.
2549 (K) In the negotiation and execution of such contracts
2550 involving services performed by actuarial firms, the Executive
2551 Director of the Division of Medicaid may negotiate a limitation on
2552 liability to the state of prospective contractors.

2553 (L) The Division of Medicaid shall reimburse for services
2554 provided to eligible Medicaid beneficiaries by a licensed birthing
2555 center in a method and manner to be determined by the division in
2556 accordance with federal laws and federal regulations. The
2557 division shall seek any necessary waivers, make any required
2558 amendments to its State Plan or revise any contracts authorized
2559 under subsection (H) of this section as necessary to provide the
2560 services authorized under this subsection. As used in this
2561 subsection, the term "birthing centers" shall have the meaning as
2562 defined in Section 41-77-1(a), which is a publicly or privately
2563 owned facility, place or institution constructed, renovated,
2564 leased or otherwise established where nonemergency births are
2565 planned to occur away from the mother's usual residence following
2566 a documented period of prenatal care for a normal uncomplicated
2567 pregnancy which has been determined to be low risk through a
2568 formal risk-scoring examination.
2569 (M) This section shall stand repealed on July 1, 2024.
2570 **SECTION 2.** Section 43-13-121, Mississippi Code of 1972, is
2571 amended as follows:
2572 43-13-121. (1) The division shall administer the Medicaid
2573 program under the provisions of this article, and may do the
2574 following:
2575 (a) Adopt and promulgate reasonable rules, regulations
2576 and standards, with approval of the Governor, and in accordance

2577 with the Administrative Procedures Law, Section 25-43-1.101 et
2578 seq.:
2579 (i) Establishing methods and procedures as may be
2580 necessary for the proper and efficient administration of this
2581 article;
2582 (ii) Providing Medicaid to all qualified
2583 recipients under the provisions of this article as the division
2584 may determine and within the limits of appropriated funds;
2585 (iii) Establishing reasonable fees, charges and
2586 rates for medical services and drugs; in doing so, the division
2587 shall fix all of those fees, charges and rates at the minimum
2588 levels absolutely necessary to provide the medical assistance
2589 authorized by this article, and shall not change any of those
2590 fees, charges or rates except as may be authorized in Section
2591 43-13-117;
2592 (iv) Providing for fair and impartial hearings;
2593 (v) Providing safeguards for preserving the
2594 confidentiality of records; and
2595 (vi) For detecting and processing fraudulent
2596 practices and abuses of the program;
2597 (b) Receive and expend state, federal and other funds
2598 in accordance with court judgments or settlements and agreements
2599 between the State of Mississippi and the federal government, the
2600 rules and regulations promulgated by the division, with the
2601 approval of the Governor, and within the limitations and

2602 restrictions of this article and within the limits of funds
2603 available for that purpose;
2604 (c) Subject to the limits imposed by this article and
2605 subject to the provisions of subsection (8) of this section, to
2606 submit a Medicaid plan to the United States Department of Health
2607 and Human Services for approval under the provisions of the
2608 federal Social Security Act, to act for the state in making
2609 negotiations relative to the submission and approval of that plan,
2610 to make such arrangements, not inconsistent with the law, as may
2611 be required by or under federal law to obtain and retain that
2612 approval and to secure for the state the benefits of the
2613 provisions of that law.
2614 No agreements, specifically including the general plan for
2615 the operation of the Medicaid program in this state, shall be made
2616 by and between the division and the United States Department of
2617 Health and Human Services unless the Attorney General of the State
2618 of Mississippi has reviewed the agreements, specifically including
2619 the operational plan, and has certified in writing to the Governor
2620 and to the executive director of the division that the agreements,
2621 including the plan of operation, have been drawn strictly in
2622 accordance with the terms and requirements of this article;
2623 (d) In accordance with the purposes and intent of this
2624 article and in compliance with its provisions, provide for aged
2625 persons otherwise eligible for the benefits provided under Title

2626 XVIII of the federal Social Security Act by expenditure of funds
2627 available for those purposes;
2628 (e) To make reports to the United States Department of
2629 Health and Human Services as from time to time may be required by
2630 that federal department and to the Mississippi Legislature as
2631 provided in this section;
2632 (f) Define and determine the scope, duration and amount
2633 of Medicaid that may be provided in accordance with this article
2634 and establish priorities therefor in conformity with this article;
2635 (g) Cooperate and contract with other state agencies
2636 for the purpose of coordinating Medicaid provided under this
2637 article and eliminating duplication and inefficiency in the
2638 Medicaid program;
2639 (h) Adopt and use an official seal of the division;
2640 (i) Sue in its own name on behalf of the State of
2641 Mississippi and employ legal counsel on a contingency basis with
2642 the approval of the Attorney General;
2643 (j) To recover any and all payments incorrectly made by
2644 the division to a recipient or provider from the recipient or
2645 provider receiving the payments. The division shall be authorized
2646 to collect any overpayments to providers sixty (60) days after the
2647 conclusion of any administrative appeal unless the matter is
2648 appealed to a court of proper jurisdiction and bond is posted.
2649 Any appeal filed after July 1, 2015, shall be to the Chancery
2650 Court of the First Judicial District of Hinds County, Mississippi,

2651 within sixty (60) days after the date that the division has
2652 notified the provider by certified mail sent to the proper address
2653 of the provider on file with the division and the provider has
2654 signed for the certified mail notice, or sixty (60) days after the
2655 date of the final decision if the provider does not sign for the
2656 certified mail notice. To recover those payments, the division
2657 may use the following methods, in addition to any other methods
2658 available to the division:

2659 (i) The division shall report to the Department of
2660 Revenue the name of any current or former Medicaid recipient who
2661 has received medical services rendered during a period of
2662 established Medicaid ineligibility and who has not reimbursed the
2663 division for the related medical service payment(s). The
2664 Department of Revenue shall withhold from the state tax refund of
2665 the individual, and pay to the division, the amount of the
2666 payment(s) for medical services rendered to the ineligible
2667 individual that have not been reimbursed to the division for the
2668 related medical service payment(s).

2669 (ii) The division shall report to the Department
2670 of Revenue the name of any Medicaid provider to whom payments were
2671 incorrectly made that the division has not been able to recover by
2672 other methods available to the division. The Department of
2673 Revenue shall withhold from the state tax refund of the provider,
2674 and pay to the division, the amount of the payments that were

2675 incorrectly made to the provider that have not been recovered by
2676 other available methods;
2677 (k) To recover any and all payments by the division
2678 fraudulently obtained by a recipient or provider. Additionally,
2679 if recovery of any payments fraudulently obtained by a recipient
2680 or provider is made in any court, then, upon motion of the
2681 Governor, the judge of the court may award twice the payments
2682 recovered as damages;
2683 (l) Have full, complete and plenary power and authority
2684 to conduct such investigations as it may deem necessary and
2685 requisite of alleged or suspected violations or abuses of the
2686 provisions of this article or of the regulations adopted under
2687 this article, including, but not limited to, fraudulent or
2688 unlawful act or deed by applicants for Medicaid or other benefits,
2689 or payments made to any person, firm or corporation under the
2690 terms, conditions and authority of this article, to suspend or
2691 disqualify any provider of services, applicant or recipient for
2692 gross abuse, fraudulent or unlawful acts for such periods,
2693 including permanently, and under such conditions as the division
2694 deems proper and just, including the imposition of a legal rate of
2695 interest on the amount improperly or incorrectly paid. Recipients
2696 who are found to have misused or abused Medicaid benefits may be
2697 locked into one (1) physician and/or one (1) pharmacy of the
2698 recipient's choice for a reasonable amount of time in order to
2699 educate and promote appropriate use of medical services, in

2700 accordance with federal regulations. If an administrative hearing
2701 becomes necessary, the division may, if the provider does not
2702 succeed in his or her defense, tax the costs of the administrative
2703 hearing, including the costs of the court reporter or stenographer
2704 and transcript, to the provider. The convictions of a recipient
2705 or a provider in a state or federal court for abuse, fraudulent or
2706 unlawful acts under this chapter shall constitute an automatic
2707 disqualification of the recipient or automatic disqualification of
2708 the provider from participation under the Medicaid program.

2709 A conviction, for the purposes of this chapter, shall include
2710 a judgment entered on a plea of nolo contendere or a
2711 nonadjudicated guilty plea and shall have the same force as a
2712 judgment entered pursuant to a guilty plea or a conviction
2713 following trial. A certified copy of the judgment of the court of
2714 competent jurisdiction of the conviction shall constitute prima
2715 facie evidence of the conviction for disqualification purposes;

2716 (m) Establish and provide such methods of
2717 administration as may be necessary for the proper and efficient
2718 operation of the Medicaid program, fully utilizing computer
2719 equipment as may be necessary to oversee and control all current
2720 expenditures for purposes of this article, and to closely monitor
2721 and supervise all recipient payments and vendors rendering
2722 services under this article. Notwithstanding any other provision
2723 of state law, the division is authorized to enter into a ten-year
2724 contract(s) with a vendor(s) to provide services described in this

2725 paragraph (m). Notwithstanding any provision of law to the
2726 contrary, the division is authorized to extend its Medicaid
2727 Management Information System, including all related components
2728 and services, and Decision Support System, including all related
2729 components and services, contracts in effect on June 30, 2020, for
2730 a period not to exceed two (2) years without complying with state
2731 procurement regulations;

2732 (n) To cooperate and contract with the federal
2733 government for the purpose of providing Medicaid to Vietnamese and
2734 Cambodian refugees, under the provisions of Public Law 94-23 and
2735 Public Law 94-24, including any amendments to those laws, only to
2736 the extent that the Medicaid assistance and the administrative
2737 cost related thereto are one hundred percent (100%) reimbursable
2738 by the federal government. For the purposes of Section 43-13-117,
2739 persons receiving Medicaid under Public Law 94-23 and Public Law
2740 94-24, including any amendments to those laws, shall not be
2741 considered a new group or category of recipient; and

2742 (o) The division shall impose penalties upon Medicaid
2743 only, Title XIX participating long-term care facilities found to
2744 be in noncompliance with division and certification standards in
2745 accordance with federal and state regulations, including interest
2746 at the same rate calculated by the United States Department of
2747 Health and Human Services and/or the Centers for Medicare and
2748 Medicaid Services (CMS) under federal regulations.

2749 (2) The division also shall exercise such additional powers
2750 and perform such other duties as may be conferred upon the
2751 division by act of the Legislature.
2752 (3) The division, and the State Department of Health as the
2753 agency for licensure of health care facilities and certification
2754 and inspection for the Medicaid and/or Medicare programs, shall
2755 contract for or otherwise provide for the consolidation of on-site
2756 inspections of health care facilities that are necessitated by the
2757 respective programs and functions of the division and the
2758 department.
2759 (4) The division and its hearing officers shall have power
2760 to preserve and enforce order during hearings; to issue subpoenas
2761 for, to administer oaths to and to compel the attendance and
2762 testimony of witnesses, or the production of books, papers,
2763 documents and other evidence, or the taking of depositions before
2764 any designated individual competent to administer oaths; to
2765 examine witnesses; and to do all things conformable to law that
2766 may be necessary to enable them effectively to discharge the
2767 duties of their office. In compelling the attendance and
2768 testimony of witnesses, or the production of books, papers,
2769 documents and other evidence, or the taking of depositions, as
2770 authorized by this section, the division or its hearing officers
2771 may designate an individual employed by the division or some other
2772 suitable person to execute and return that process, whose action
2773 in executing and returning that process shall be as lawful as if

2774 done by the sheriff or some other proper officer authorized to
2775 execute and return process in the county where the witness may
2776 reside. In carrying out the investigatory powers under the
2777 provisions of this article, the executive director or other
2778 designated person or persons may examine, obtain, copy or
2779 reproduce the books, papers, documents, medical charts,
2780 prescriptions and other records relating to medical care and
2781 services furnished by the provider to a recipient or designated
2782 recipients of Medicaid services under investigation. In the
2783 absence of the voluntary submission of the books, papers,
2784 documents, medical charts, prescriptions and other records, the
2785 Governor, the executive director, or other designated person may
2786 issue and serve subpoenas instantly upon the provider, his or her
2787 agent, servant or employee for the production of the books,
2788 papers, documents, medical charts, prescriptions or other records
2789 during an audit or investigation of the provider. If any provider
2790 or his or her agent, servant or employee refuses to produce the
2791 records after being duly subpoenaed, the executive director may
2792 certify those facts and institute contempt proceedings in the
2793 manner, time and place as authorized by law for administrative
2794 proceedings. As an additional remedy, the division may recover
2795 all amounts paid to the provider covering the period of the audit
2796 or investigation, inclusive of a legal rate of interest and a
2797 reasonable attorney's fee and costs of court if suit becomes
2798 necessary. Division staff shall have immediate access to the

2799 provider's physical location, facilities, records, documents,
2800 books, and any other records relating to medical care and services
2801 rendered to recipients during regular business hours.

2802 (5) If any person in proceedings before the division
2803 disobeys or resists any lawful order or process, or misbehaves
2804 during a hearing or so near the place thereof as to obstruct the
2805 hearing, or neglects to produce, after having been ordered to do
2806 so, any pertinent book, paper or document, or refuses to appear
2807 after having been subpoenaed, or upon appearing refuses to take
2808 the oath as a witness, or after having taken the oath refuses to
2809 be examined according to law, the executive director shall certify
2810 the facts to any court having jurisdiction in the place in which
2811 it is sitting, and the court shall thereupon, in a summary manner,
2812 hear the evidence as to the acts complained of, and if the
2813 evidence so warrants, punish that person in the same manner and to
2814 the same extent as for a contempt committed before the court, or
2815 commit that person upon the same condition as if the doing of the
2816 forbidden act had occurred with reference to the process of, or in
2817 the presence of, the court.

2818 (6) In suspending or terminating any provider from
2819 participation in the Medicaid program, the division shall preclude
2820 the provider from submitting claims for payment, either personally
2821 or through any clinic, group, corporation or other association to
2822 the division or its fiscal agents for any services or supplies
2823 provided under the Medicaid program except for those services or

2824 supplies provided before the suspension or termination. No
2825 clinic, group, corporation or other association that is a provider
2826 of services shall submit claims for payment to the division or its
2827 fiscal agents for any services or supplies provided by a person
2828 within that organization who has been suspended or terminated from
2829 participation in the Medicaid program except for those services or
2830 supplies provided before the suspension or termination. When this
2831 provision is violated by a provider of services that is a clinic,
2832 group, corporation or other association, the division may suspend
2833 or terminate that organization from participation. Suspension may
2834 be applied by the division to all known affiliates of a provider,
2835 provided that each decision to include an affiliate is made on a
2836 case-by-case basis after giving due regard to all relevant facts
2837 and circumstances. The violation, failure or inadequacy of
2838 performance may be imputed to a person with whom the provider is
2839 affiliated where that conduct was accomplished within the course
2840 of his or her official duty or was effectuated by him or her with
2841 the knowledge or approval of that person.

2842 (7) The division may deny or revoke enrollment in the
2843 Medicaid program to a provider if any of the following are found
2844 to be applicable to the provider, his or her agent, a managing
2845 employee or any person having an ownership interest equal to five
2846 percent (5%) or greater in the provider:

2847 (a) Failure to truthfully or fully disclose any and all
2848 information required, or the concealment of any and all

2849 information required, on a claim, a provider application or a
2850 provider agreement, or the making of a false or misleading
2851 statement to the division relative to the Medicaid program.
2852 (b) Previous or current exclusion, suspension,
2853 termination from or the involuntary withdrawing from participation
2854 in the Medicaid program, any other state's Medicaid program,
2855 Medicare or any other public or private health or health insurance
2856 program. If the division ascertains that a provider has been
2857 convicted of a felony under federal or state law for an offense
2858 that the division determines is detrimental to the best interest
2859 of the program or of Medicaid beneficiaries, the division may
2860 refuse to enter into an agreement with that provider, or may
2861 terminate or refuse to renew an existing agreement.
2862 (c) Conviction under federal or state law of a criminal
2863 offense relating to the delivery of any goods, services or
2864 supplies, including the performance of management or
2865 administrative services relating to the delivery of the goods,
2866 services or supplies, under the Medicaid program, any other
2867 state's Medicaid program, Medicare or any other public or private
2868 health or health insurance program.
2869 (d) Conviction under federal or state law of a criminal
2870 offense relating to the neglect or abuse of a patient in
2871 connection with the delivery of any goods, services or supplies.

2872 (e) Conviction under federal or state law of a criminal
2873 offense relating to the unlawful manufacture, distribution,
2874 prescription or dispensing of a controlled substance.
2875 (f) Conviction under federal or state law of a criminal
2876 offense relating to fraud, theft, embezzlement, breach of
2877 fiduciary responsibility or other financial misconduct.
2878 (g) Conviction under federal or state law of a criminal
2879 offense punishable by imprisonment of a year or more that involves
2880 moral turpitude, or acts against the elderly, children or infirm.
2881 (h) Conviction under federal or state law of a criminal
2882 offense in connection with the interference or obstruction of any
2883 investigation into any criminal offense listed in paragraphs (c)
2884 through (i) of this subsection.
2885 (i) Sanction for a violation of federal or state laws
2886 or rules relative to the Medicaid program, any other state's
2887 Medicaid program, Medicare or any other public health care or
2888 health insurance program.
2889 (j) Revocation of license or certification.
2890 (k) Failure to pay recovery properly assessed or
2891 pursuant to an approved repayment schedule under the Medicaid
2892 program.
2893 (l) Failure to meet any condition of enrollment.
2894 (8) (a) As used in this subsection (8), the following terms
2895 shall be defined as provided in this paragraph, except as
2896 otherwise provided in this subsection:

2897 (i) "Committees" means the Medicaid Committees of
2898 the House of Representatives and the Senate, and "committee" means
2899 either one of those committees.
2900 (ii) "State Plan" means the agreement between the
2901 State of Mississippi and the federal government regarding the
2902 nature and scope of Mississippi's Medicaid Program.
2903 (iii) "State Plan Amendment" means a change to the
2904 State Plan, which must be approved by the Centers for Medicare and
2905 Medicaid Services (CMS) before its implementation.
2906 (b) Whenever the Division of Medicaid proposes a State
2907 Plan Amendment, the division shall give notice to the chairmen of
2908 the committees at least thirty (30) calendar days before the
2909 proposed State Plan Amendment is filed with CMS. The division
2910 shall furnish the chairmen with a concise summary of each proposed
2911 State Plan Amendment along with the notice, and shall furnish the
2912 chairmen with a copy of any proposed State Plan Amendment upon
2913 request. The division also shall provide a summary and copy of
2914 any proposed State Plan Amendment to any other member of the
2915 Legislature upon request.
2916 (c) If the chairman of either committee or both
2917 chairmen jointly object to the proposed State Plan Amendment or
2918 any part thereof, the chairman or chairmen shall notify the
2919 division and provide the reasons for their objection in writing
2920 not later than seven (7) calendar days after receipt of the notice
2921 from the division. The chairman or chairmen may make written

2922 recommendations to the division for changes to be made to a
2923 proposed State Plan Amendment.
2924 (d) (i) The chairman of either committee or both
2925 chairmen jointly may hold a committee meeting to review a proposed
2926 State Plan Amendment. If either chairman or both chairmen decide
2927 to hold a meeting, they shall notify the division of their
2928 intention in writing within seven (7) calendar days after receipt
2929 of the notice from the division, and shall set the date and time
2930 for the meeting in their notice to the division, which shall not
2931 be later than fourteen (14) calendar days after receipt of the
2932 notice from the division.
2933 (ii) After the committee meeting, the committee or
2934 committees may object to the proposed State Plan Amendment or any
2935 part thereof. The committee or committees shall notify the
2936 division and the reasons for their objection in writing not later
2937 than seven (7) calendar days after the meeting. The committee or
2938 committees may make written recommendations to the division for
2939 changes to be made to a proposed State Plan Amendment.
2940 (e) If both chairmen notify the division in writing
2941 within seven (7) calendar days after receipt of the notice from
2942 the division that they do not object to the proposed State Plan
2943 Amendment and will not be holding a meeting to review the proposed
2944 State Plan Amendment, the division may proceed to file the
2945 proposed State Plan Amendment with CMS.

2946 (f) (i) If there are any objections to a proposed rate
2947 change or any part thereof from either or both of the chairmen or
2948 the committees, the division may withdraw the proposed State Plan
2949 Amendment, make any of the recommended changes to the proposed
2950 State Plan Amendment, or not make any changes to the proposed
2951 State Plan Amendment.

2952 (ii) If the division does not make any changes to
2953 the proposed State Plan Amendment, it shall notify the chairmen of
2954 that fact in writing, and may proceed to file the State Plan
2955 Amendment with CMS.

2956 (iii) If the division makes any changes to the
2957 proposed State Plan Amendment, the division shall notify the
2958 chairmen of its actions in writing, and may proceed to file the
2959 State Plan Amendment with CMS.

2960 (g) Nothing in this subsection (8) shall be construed
2961 as giving the chairmen or the committees any authority to veto,
2962 nullify or revise any State Plan Amendment proposed by the
2963 division. The authority of the chairmen or the committees under
2964 this subsection shall be limited to reviewing, making objections
2965 to and making recommendations for changes to State Plan Amendments
2966 proposed by the division.

2967 (i) If the division does not make any changes to
2968 the proposed State Plan Amendment, it shall notify the chairmen of
2969 that fact in writing, and may proceed to file the proposed State
2970 Plan Amendment with CMS.

2971 (ii) If the division makes any changes to the
2972 proposed State Plan Amendment, the division shall notify the
2973 chairmen of the changes in writing, and may proceed to file the
2974 proposed State Plan Amendment with CMS.
2975 (h) Nothing in this subsection (8) shall be construed
2976 as giving the chairmen of the committees any authority to veto,
2977 nullify or revise any State Plan Amendment proposed by the
2978 division. The authority of the chairmen of the committees under
2979 this subsection shall be limited to reviewing, making objections
2980 to and making recommendations for suggested changes to State Plan
2981 Amendments proposed by the division.
2982 **SECTION 3.** Section 43-13-139, Mississippi Code of 1972, is
2983 amended as follows:
2984 43-13-139. Nothing contained in this article shall be
2985 construed to prevent the Governor, in his discretion, from
2986 discontinuing or limiting medical assistance to any individuals
2987 who are classified or deemed to be within any optional group or
2988 optional category of recipients as prescribed under Title XIX of
2989 the federal Social Security Act or the implementing federal
2990 regulations. If the Congress or the United States Department of
2991 Health and Human Services ceases to provide federal matching funds
2992 for any group or category of recipients or any type of care and
2993 services, the division shall cease state funding for such group or
2994 category or such type of care and services, notwithstanding any
2995 provision of this article. If any state plan amendment submitted

2996 to comply with the provisions of Section 43-13-117 is disapproved
2997 by the United States Department of Health and Human Services, the
2998 division may operate under the state plan as previously approved
2999 by the United States Department of Health and Human Services in
3000 order to preserve federal matching funds. The division shall
3001 provide notice of the disapproval to the Chairmen of the House and
3002 Senate Medicaid Committees.

3003 **SECTION 4.** Section 41-71-1, Mississippi Code of 1972, is
3004 amended as follows:

3005 41-71-1. As used in this chapter, unless the context
3006 otherwise requires:

3007 (a) "Home health agency" means a public or privately
3008 owned agency or organization, or a subdivision of such an agency
3009 or organization, properly authorized to conduct business in
3010 Mississippi, which is primarily engaged in providing to
3011 individuals, at the written direction of a licensed physician,
3012 nurse practitioner, physician assistant or clinical nurse
3013 specialist, in the individual's place of residence, skilled
3014 nursing services provided by or under the supervision of a
3015 registered nurse licensed to practice in Mississippi, and one or
3016 more of the following services or items:

3017 (i) Physical, occupational or speech therapy;

3018 (ii) Medical social services;

3019 (iii) Part-time or intermittent services of a home
3020 health aide;

3021 (iv) Other services as approved by the licensing
3022 agency;
3023 (v) Medical supplies, other than drugs and
3024 biologicals, and the use of medical appliances; or
3025 (vi) Medical services provided by an intern or
3026 resident in training at a hospital under a teaching program of
3027 such hospital.
3028 (b) "Licensing agency" means the State Department of
3029 Health.
3030 **SECTION 5.** Section 41-71-13, Mississippi Code of 1972, is
3031 amended as follows:
3032 41-71-13. The licensing agency shall adopt, amend,
3033 promulgate and enforce rules, regulations and standards, including
3034 classifications, with respect to home health agencies licensed, or
3035 which may be licensed, to further the accomplishment of the
3036 purpose of this chapter in protecting and promoting the health,
3037 safety and welfare of the public by insuring adequate care of
3038 individuals receiving such services. Such rules, regulations and
3039 standards shall be adopted and promulgated by the licensing agency
3040 in accordance with the provisions of Section 25-43-1 et seq., and
3041 shall be recorded and indexed in a book to be maintained by the
3042 licensing agency in its office in the City of Jackson,
3043 Mississippi, entitled "Records of Rules, Regulations and
3044 Standards." The book shall be open and available to all home
3045 health agencies and the public generally at all reasonable times.

3046 Such rules, regulations and standards shall authorize
3047 licensed physicians, nurse practitioners, physician assistants and
3048 clinical nurse specialists to prescribe or order home health
3049 services and plans of care, certify and recertify eligibility for
3050 home health services and conduct the required initial face-to-face
3051 visit with recipients of the services.

3052 **SECTION 6.** The amendments to Sections 41-71-1 and 41-71-13
3053 in this act are retroactive to May 8, 2020, and any action taken
3054 on or after May 8, 2020, by a home health agency, physician, nurse
3055 practitioner, physician assistant or clinical nurse specialist, or
3056 by any other person or entity with regard to a home health agency,
3057 physician, nurse practitioner, physician assistant or clinical
3058 nurse specialist, that would have been valid and lawful if those
3059 amendments had been in effect at the time that the action was
3060 ratified, approved and confirmed.

3061 **SECTION 7.** This act shall take effect and be in force from
3062 and after its passage.