

By: Representative Deweese

To: Medicaid

HOUSE BILL NO. 763

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,  
 2 TO PROVIDE THAT FROM AND AFTER OCTOBER 1, 2022, THE DIVISION OF  
 3 MEDICAID SHALL ESTABLISH AND IMPLEMENT A SEPARATE MANAGED CARE  
 4 PROGRAM OR COORDINATED CARE PROGRAM FOR DENTAL SERVICES AND DENTAL  
 5 SERVICES PROVIDERS; TO PROVIDE THAT AFTER THE SEPARATE PROGRAM HAS  
 6 BEEN IMPLEMENTED, DENTAL SERVICES AND DENTAL SERVICES PROVIDERS  
 7 SHALL NOT BE PART OF ANY OTHER MANAGED CARE PROGRAM OR COORDINATED  
 8 CARE PROGRAM ADMINISTERED BY THE DIVISION; AND FOR RELATED  
 9 PURPOSES.

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

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

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

20 (1) Inpatient hospital services.



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

24 (b) No service benefits or reimbursement  
25 limitations in this subsection (A)(1) shall apply to payments  
26 under an APR-DRG or Ambulatory Payment Classification (APC) model  
27 or a managed care program or similar model described in subsection  
28 (H) of this section unless specifically authorized by the  
29 division.

30 (2) Outpatient hospital services.

31 (a) Emergency services.

32 (b) Other outpatient hospital services. The  
33 division shall allow benefits for other medically necessary  
34 outpatient hospital services (such as chemotherapy, radiation,  
35 surgery and therapy), including outpatient services in a clinic or  
36 other facility that is not located inside the hospital, but that  
37 has been designated as an outpatient facility by the hospital, and  
38 that was in operation or under construction on July 1, 2009,  
39 provided that the costs and charges associated with the operation  
40 of the hospital clinic are included in the hospital's cost report.  
41 In addition, the Medicare thirty-five-mile rule will apply to  
42 those hospital clinics not located inside the hospital that are  
43 constructed after July 1, 2009. Where the same services are  
44 reimbursed as clinic services, the division may revise the rate or



45 methodology of outpatient reimbursement to maintain consistency,  
46 efficiency, economy and quality of care.

47 (c) The division is authorized to implement an  
48 Ambulatory Payment Classification (APC) methodology for outpatient  
49 hospital services. The division shall give rural hospitals that  
50 have fifty (50) or fewer licensed beds the option to not be  
51 reimbursed for outpatient hospital services using the APC  
52 methodology, but reimbursement for outpatient hospital services  
53 provided by those hospitals shall be based on one hundred one  
54 percent (101%) of the rate established under Medicare for  
55 outpatient hospital services. Those hospitals choosing to not be  
56 reimbursed under the APC methodology shall remain under cost-based  
57 reimbursement for a two-year period.

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

63 (3) Laboratory and x-ray services.

64 (4) Nursing facility services.

65 (a) The division shall make full payment to  
66 nursing facilities for each day, not exceeding forty-two (42) days  
67 per year, that a patient is absent from the facility on home  
68 leave. Payment may be made for the following home leave days in  
69 addition to the forty-two-day limitation: Christmas, the day



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

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

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

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

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



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

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

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

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



120 are included in the state plan. The division may include in its  
121 periodic screening and diagnostic program those discretionary  
122 services authorized under the federal regulations adopted to  
123 implement Title XIX of the federal Social Security Act, as  
124 amended. The division, in obtaining physical therapy services,  
125 occupational therapy services, and services for individuals with  
126 speech, hearing and language disorders, may enter into a  
127 cooperative agreement with the State Department of Education for  
128 the provision of those services to handicapped students by public  
129 school districts using state funds that are provided from the  
130 appropriation to the Department of Education to obtain federal  
131 matching funds through the division. The division, in obtaining  
132 medical and mental health assessments, treatment, care and  
133 services for children who are in, or at risk of being put in, the  
134 custody of the Mississippi Department of Human Services may enter  
135 into a cooperative agreement with the Mississippi Department of  
136 Human Services for the provision of those services using state  
137 funds that are provided from the appropriation to the Department  
138 of Human Services to obtain federal matching funds through the  
139 division.

140 (6) Physician services. Fees for physician's services  
141 that are covered only by Medicaid shall be reimbursed at ninety  
142 percent (90%) of the rate established on January 1, 2018, and as  
143 may be adjusted each July thereafter, under Medicare. The  
144 division may provide for a reimbursement rate for physician's



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

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

165 (b) [Repealed]

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

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



170 The division shall establish a mandatory preferred drug list.  
171 Drugs not on the mandatory preferred drug list shall be made  
172 available by utilizing prior authorization procedures established  
173 by the division.

174 The division may seek to establish relationships with other  
175 states in order to lower acquisition costs of prescription drugs  
176 to include single-source and innovator multiple-source drugs or  
177 generic drugs. In addition, if allowed by federal law or  
178 regulation, the division may seek to establish relationships with  
179 and negotiate with other countries to facilitate the acquisition  
180 of prescription drugs to include single-source and innovator  
181 multiple-source drugs or generic drugs, if that will lower the  
182 acquisition costs of those prescription drugs.

183 The division may allow for a combination of prescriptions for  
184 single-source and innovator multiple-source drugs and generic  
185 drugs to meet the needs of the beneficiaries.

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

189 Drugs prescribed for a resident of a psychiatric residential  
190 treatment facility must be provided in true unit doses when  
191 available. The division may require that drugs not covered by  
192 Medicare Part D for a resident of a long-term care facility be  
193 provided in true unit doses when available. Those drugs that were  
194 originally billed to the division but are not used by a resident





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

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

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

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

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



220           The division shall develop and implement a method or methods  
221 by which the division will provide on a regular basis to Medicaid  
222 providers who are authorized to prescribe drugs, information about  
223 the costs to the Medicaid program of single-source drugs and  
224 innovator multiple-source drugs, and information about other drugs  
225 that may be prescribed as alternatives to those single-source  
226 drugs and innovator multiple-source drugs and the costs to the  
227 Medicaid program of those alternative drugs.

228           Notwithstanding any law or regulation, information obtained  
229 or maintained by the division regarding the prescription drug  
230 program, including trade secrets and manufacturer or labeler  
231 pricing, is confidential and not subject to disclosure except to  
232 other state agencies.

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

237           The division shall not reimburse for single-source or  
238 innovator multiple-source drugs if there are equally effective  
239 generic equivalents available and if the generic equivalents are  
240 the least expensive.

241           It is the intent of the Legislature that the pharmacists  
242 providers be reimbursed for the reasonable costs of filling and  
243 dispensing prescriptions for Medicaid beneficiaries.



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

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

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

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

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



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

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

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

287 (12) Intermediate care facility services.

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



294 Christmas, the day after Christmas, Thanksgiving, the day before  
295 Thanksgiving and the day after Thanksgiving.

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

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

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

305 (14) Clinic services. Preventive, diagnostic,  
306 therapeutic, rehabilitative or palliative services that are  
307 furnished by a facility that is not part of a hospital but is  
308 organized and operated to provide medical care to outpatients.  
309 Clinic services include, but are not limited to:

310 (a) Services provided by ambulatory surgical  
311 centers (ACSS) as defined in Section 41-75-1(a); and

312 (b) Dialysis center services.

313 (15) Home- and community-based services for the elderly  
314 and disabled, as provided under Title XIX of the federal Social  
315 Security Act, as amended, under waivers, subject to the  
316 availability of funds specifically appropriated for that purpose  
317 by the Legislature.



318           (16) Mental health services. Certain services provided  
319 by a psychiatrist shall be reimbursed at up to one hundred percent  
320 (100%) of the Medicare rate. Approved therapeutic and case  
321 management services (a) provided by an approved regional mental  
322 health/intellectual disability center established under Sections  
323 41-19-31 through 41-19-39, or by another community mental health  
324 service provider meeting the requirements of the Department of  
325 Mental Health to be an approved mental health/intellectual  
326 disability center if determined necessary by the Department of  
327 Mental Health, using state funds that are provided in the  
328 appropriation to the division to match federal funds, or (b)  
329 provided by a facility that is certified by the State Department  
330 of Mental Health to provide therapeutic and case management  
331 services, to be reimbursed on a fee for service basis, or (c)  
332 provided in the community by a facility or program operated by the  
333 Department of Mental Health. Any such services provided by a  
334 facility described in subparagraph (b) must have the prior  
335 approval of the division to be reimbursable under this section.

336           (17) Durable medical equipment services and medical  
337 supplies. Precertification of durable medical equipment and  
338 medical supplies must be obtained as required by the division.  
339 The Division of Medicaid may require durable medical equipment  
340 providers to obtain a surety bond in the amount and to the  
341 specifications as established by the Balanced Budget Act of 1997.



342           (18) (a) Notwithstanding any other provision of this  
343 section to the contrary, as provided in the Medicaid state plan  
344 amendment or amendments as defined in Section 43-13-145(10), the  
345 division shall make additional reimbursement to hospitals that  
346 serve a disproportionate share of low-income patients and that  
347 meet the federal requirements for those payments as provided in  
348 Section 1923 of the federal Social Security Act and any applicable  
349 regulations. It is the intent of the Legislature that the  
350 division shall draw down all available federal funds allotted to  
351 the state for disproportionate share hospitals. However, from and  
352 after January 1, 1999, public hospitals participating in the  
353 Medicaid disproportionate share program may be required to  
354 participate in an intergovernmental transfer program as provided  
355 in Section 1903 of the federal Social Security Act and any  
356 applicable regulations.

357           (b) (i) The division may establish a Medicare  
358 Upper Payment Limits Program, as defined in Section 1902(a)(30) of  
359 the federal Social Security Act and any applicable federal  
360 regulations, or an allowable delivery system or provider payment  
361 initiative authorized under 42 CFR 438.6(c), for hospitals,  
362 nursing facilities, physicians employed or contracted by  
363 hospitals, and emergency ambulance transportation providers.

364           (ii) The division shall assess each hospital,  
365 nursing facility, and emergency ambulance transportation provider  
366 for the sole purpose of financing the state portion of the



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

385 (iii) Subject to approval by the Centers for  
386 Medicare and Medicaid Services (CMS) and the provisions of this  
387 subsection (A) (18) (b), the division shall make additional  
388 reimbursement to hospitals, nursing facilities, and emergency  
389 ambulance transportation providers for the Medicare Upper Payment  
390 Limits Program or other program(s) authorized under this  
391 subsection (A) (18) (b), and, if the program is established for





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

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



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

439 (c) (i) Not later than December 1, 2015, the  
440 division shall, subject to approval by the Centers for Medicare  
441 and Medicaid Services (CMS), establish, implement and operate a



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

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

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



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

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

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

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



492 acting as lead agency, in the development and implementation of a  
493 statewide system of delivery of early intervention services, under  
494 Part C of the Individuals with Disabilities Education Act (IDEA).  
495 The State Department of Health shall certify annually in writing  
496 to the executive director of the division the dollar amount of  
497 state early intervention funds available that will be utilized as  
498 a certified match for Medicaid matching funds. Those funds then  
499 shall be used to provide expanded targeted case management  
500 services for Medicaid eligible children with special needs who are  
501 eligible for the state's early intervention system.  
502 Qualifications for persons providing service coordination shall be  
503 determined by the State Department of Health and the Division of  
504 Medicaid.

505 (20) Home- and community-based services for physically  
506 disabled approved services as allowed by a waiver from the United  
507 States Department of Health and Human Services for home- and  
508 community-based services for physically disabled people using  
509 state funds that are provided from the appropriation to the State  
510 Department of Rehabilitation Services and used to match federal  
511 funds under a cooperative agreement between the division and the  
512 department, provided that funds for these services are  
513 specifically appropriated to the Department of Rehabilitation  
514 Services.

515 (21) Nurse practitioner services. Services furnished  
516 by a registered nurse who is licensed and certified by the



517 Mississippi Board of Nursing as a nurse practitioner, including,  
518 but not limited to, nurse anesthetists, nurse midwives, family  
519 nurse practitioners, family planning nurse practitioners,  
520 pediatric nurse practitioners, obstetrics-gynecology nurse  
521 practitioners and neonatal nurse practitioners, under regulations  
522 adopted by the division. Reimbursement for those services shall  
523 not exceed ninety percent (90%) of the reimbursement rate for  
524 comparable services rendered by a physician. The division may  
525 provide for a reimbursement rate for nurse practitioner services  
526 of up to one hundred percent (100%) of the reimbursement rate for  
527 comparable services rendered by a physician for nurse practitioner  
528 services that are provided after the normal working hours of the  
529 nurse practitioner, as determined in accordance with regulations  
530 of the division.

531           (22) Ambulatory services delivered in federally  
532 qualified health centers, rural health centers and clinics of the  
533 local health departments of the State Department of Health for  
534 individuals eligible for Medicaid under this article based on  
535 reasonable costs as determined by the division. Federally  
536 qualified health centers shall be reimbursed by the Medicaid  
537 prospective payment system as approved by the Centers for Medicare  
538 and Medicaid Services. The division shall recognize federally  
539 qualified health centers (FQHCs), rural health clinics (RHCs) and  
540 community mental health centers (CMHCs) as both an originating and  
541 distant site provider for the purposes of telehealth



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

546 (23) Inpatient psychiatric services.

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



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

570 (24) [Deleted]

571 (25) [Deleted]

572 (26) Hospice care. As used in this paragraph, the term  
573 "hospice care" means a coordinated program of active professional  
574 medical attention within the home and outpatient and inpatient  
575 care that treats the terminally ill patient and family as a unit,  
576 employing a medically directed interdisciplinary team. The  
577 program provides relief of severe pain or other physical symptoms  
578 and supportive care to meet the special needs arising out of  
579 physical, psychological, spiritual, social and economic stresses  
580 that are experienced during the final stages of illness and during  
581 dying and bereavement and meets the Medicare requirements for  
582 participation as a hospice as provided in federal regulations.

583 (27) Group health plan premiums and cost-sharing if it  
584 is cost-effective as defined by the United States Secretary of  
585 Health and Human Services.

586 (28) Other health insurance premiums that are  
587 cost-effective as defined by the United States Secretary of Health  
588 and Human Services. Medicare eligible must have Medicare Part B  
589 before other insurance premiums can be paid.





590           (29) The Division of Medicaid may apply for a waiver  
591 from the United States Department of Health and Human Services for  
592 home- and community-based services for developmentally disabled  
593 people using state funds that are provided from the appropriation  
594 to the State Department of Mental Health and/or funds transferred  
595 to the department by a political subdivision or instrumentality of  
596 the state and used to match federal funds under a cooperative  
597 agreement between the division and the department, provided that  
598 funds for these services are specifically appropriated to the  
599 Department of Mental Health and/or transferred to the department  
600 by a political subdivision or instrumentality of the state.

601           (30) Pediatric skilled nursing services as determined  
602 by the division and in a manner consistent with regulations  
603 promulgated by the Mississippi State Department of Health.

604           (31) Targeted case management services for children  
605 with special needs, under waivers from the United States  
606 Department of Health and Human Services, using state funds that  
607 are provided from the appropriation to the Mississippi Department  
608 of Human Services and used to match federal funds under a  
609 cooperative agreement between the division and the department.

610           (32) Care and services provided in Christian Science  
611 Sanatoria listed and certified by the Commission for Accreditation  
612 of Christian Science Nursing Organizations/Facilities, Inc.,  
613 rendered in connection with treatment by prayer or spiritual means



614 to the extent that those services are subject to reimbursement  
615 under Section 1903 of the federal Social Security Act.

616 (33) Podiatrist services.

617 (34) Assisted living services as provided through  
618 home- and community-based services under Title XIX of the federal  
619 Social Security Act, as amended, subject to the availability of  
620 funds specifically appropriated for that purpose by the  
621 Legislature.

622 (35) Services and activities authorized in Sections  
623 43-27-101 and 43-27-103, using state funds that are provided from  
624 the appropriation to the Mississippi Department of Human Services  
625 and used to match federal funds under a cooperative agreement  
626 between the division and the department.

627 (36) Nonemergency transportation services for  
628 Medicaid-eligible persons as determined by the division. The PEER  
629 Committee shall conduct a performance evaluation of the  
630 nonemergency transportation program to evaluate the administration  
631 of the program and the providers of transportation services to  
632 determine the most cost-effective ways of providing nonemergency  
633 transportation services to the patients served under the program.  
634 The performance evaluation shall be completed and provided to the  
635 members of the Senate Medicaid Committee and the House Medicaid  
636 Committee not later than January 1, 2019, and every two (2) years  
637 thereafter.

638 (37) [Deleted]



639           (38) Chiropractic services. A chiropractor's manual  
640 manipulation of the spine to correct a subluxation, if x-ray  
641 demonstrates that a subluxation exists and if the subluxation has  
642 resulted in a neuromusculoskeletal condition for which  
643 manipulation is appropriate treatment, and related spinal x-rays  
644 performed to document these conditions. Reimbursement for  
645 chiropractic services shall not exceed Seven Hundred Dollars  
646 (\$700.00) per year per beneficiary.

647           (39) Dually eligible Medicare/Medicaid beneficiaries.  
648 The division shall pay the Medicare deductible and coinsurance  
649 amounts for services available under Medicare, as determined by  
650 the division. From and after July 1, 2009, the division shall  
651 reimburse crossover claims for inpatient hospital services and  
652 crossover claims covered under Medicare Part B in the same manner  
653 that was in effect on January 1, 2008, unless specifically  
654 authorized by the Legislature to change this method.

655           (40) [Deleted]

656           (41) Services provided by the State Department of  
657 Rehabilitation Services for the care and rehabilitation of persons  
658 with spinal cord injuries or traumatic brain injuries, as allowed  
659 under waivers from the United States Department of Health and  
660 Human Services, using up to seventy-five percent (75%) of the  
661 funds that are appropriated to the Department of Rehabilitation  
662 Services from the Spinal Cord and Head Injury Trust Fund  
663 established under Section 37-33-261 and used to match federal



664 funds under a cooperative agreement between the division and the  
665 department.

666 (42) [Deleted]

667 (43) The division shall provide reimbursement,  
668 according to a payment schedule developed by the division, for  
669 smoking cessation medications for pregnant women during their  
670 pregnancy and other Medicaid-eligible women who are of  
671 child-bearing age.

672 (44) Nursing facility services for the severely  
673 disabled.

674 (a) Severe disabilities include, but are not  
675 limited to, spinal cord injuries, closed-head injuries and  
676 ventilator-dependent patients.

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

680 (45) Physician assistant services. Services furnished  
681 by a physician assistant who is licensed by the State Board of  
682 Medical Licensure and is practicing with physician supervision  
683 under regulations adopted by the board, under regulations adopted  
684 by the division. Reimbursement for those services shall not  
685 exceed ninety percent (90%) of the reimbursement rate for  
686 comparable services rendered by a physician. The division may  
687 provide for a reimbursement rate for physician assistant services  
688 of up to one hundred percent (100%) or the reimbursement rate for



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

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

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

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

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



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

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

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

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

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



739 physical examination and utilization of these disease management  
740 tools shall be consistent with current United States Preventive  
741 Services Task Force or other recognized authority recommendations.

742 For persons who are determined ineligible for Medicaid, the  
743 division will provide information and direction for accessing  
744 medical care and services in the area of their residence.

745 (52) Notwithstanding any provisions of this article,  
746 the division may pay enhanced reimbursement fees related to trauma  
747 care, as determined by the division in conjunction with the State  
748 Department of Health, using funds appropriated to the State  
749 Department of Health for trauma care and services and used to  
750 match federal funds under a cooperative agreement between the  
751 division and the State Department of Health. The division, in  
752 conjunction with the State Department of Health, may use grants,  
753 waivers, demonstrations, enhanced reimbursements, Upper Payment  
754 Limits Programs, supplemental payments, or other projects as  
755 necessary in the development and implementation of this  
756 reimbursement program.

757 (53) Targeted case management services for high-cost  
758 beneficiaries may be developed by the division for all services  
759 under this section.

760 (54) [Deleted]

761 (55) Therapy services. The plan of care for therapy  
762 services may be developed to cover a period of treatment for up to  
763 six (6) months, but in no event shall the plan of care exceed a



764 six-month period of treatment. The projected period of treatment  
765 must be indicated on the initial plan of care and must be updated  
766 with each subsequent revised plan of care. Based on medical  
767 necessity, the division shall approve certification periods for  
768 less than or up to six (6) months, but in no event shall the  
769 certification period exceed the period of treatment indicated on  
770 the plan of care. The appeal process for any reduction in therapy  
771 services shall be consistent with the appeal process in federal  
772 regulations.

773 (56) Prescribed pediatric extended care centers  
774 services for medically dependent or technologically dependent  
775 children with complex medical conditions that require continual  
776 care as prescribed by the child's attending physician, as  
777 determined by the division.

778 (57) No Medicaid benefit shall restrict coverage for  
779 medically appropriate treatment prescribed by a physician and  
780 agreed to by a fully informed individual, or if the individual  
781 lacks legal capacity to consent by a person who has legal  
782 authority to consent on his or her behalf, based on an  
783 individual's diagnosis with a terminal condition. As used in this  
784 paragraph (57), "terminal condition" means any aggressive  
785 malignancy, chronic end-stage cardiovascular or cerebral vascular  
786 disease, or any other disease, illness or condition which a  
787 physician diagnoses as terminal.





788           (58) Treatment services for persons with opioid  
789 dependency or other highly addictive substance use disorders. The  
790 division is authorized to reimburse eligible providers for  
791 treatment of opioid dependency and other highly addictive  
792 substance use disorders, as determined by the division. Treatment  
793 related to these conditions shall not count against any physician  
794 visit limit imposed under this section.

795           (59) The division shall allow beneficiaries between the  
796 ages of ten (10) and eighteen (18) years to receive vaccines  
797 through a pharmacy venue. The division and the State Department  
798 of Health shall coordinate and notify OB-GYN providers that the  
799 Vaccines for Children program is available to providers free of  
800 charge.

801           (B) [Deleted]

802           (C) The division may pay to those providers who participate  
803 in and accept patient referrals from the division's emergency room  
804 redirection program a percentage, as determined by the division,  
805 of savings achieved according to the performance measures and  
806 reduction of costs required of that program. Federally qualified  
807 health centers may participate in the emergency room redirection  
808 program, and the division may pay those centers a percentage of  
809 any savings to the Medicaid program achieved by the centers'  
810 accepting patient referrals through the program, as provided in  
811 this subsection (C).



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

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

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

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



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

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

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

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

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

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

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



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

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

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

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



887                   (b) Override the medical decisions of hospital  
888 physicians or staff regarding patients admitted to a hospital for  
889 an emergency medical condition as defined by 42 US Code Section  
890 1395dd. This restriction (b) does not prohibit the retrospective  
891 review of the appropriateness of the determination that an  
892 emergency medical condition exists by chart review or coding  
893 algorithm, nor does it prohibit prior authorization for  
894 nonemergency hospital admissions;

895                   (c) Pay providers at a rate that is less than the  
896 normal Medicaid reimbursement rate. It is the intent of the  
897 Legislature that all managed care entities described in this  
898 subsection (H), in collaboration with the division, develop and  
899 implement innovative payment models that incentivize improvements  
900 in health care quality, outcomes, or value, as determined by the  
901 division. Participation in the provider network of any managed  
902 care, coordinated care, provider-sponsored health plan, or similar  
903 contractor shall not be conditioned on the provider's agreement to  
904 accept such alternative payment models;

905                   (d) Implement a prior authorization and  
906 utilization review program for medical services, transportation  
907 services and prescription drugs that is more stringent than the  
908 prior authorization processes used by the division in its  
909 administration of the Medicaid program. Not later than December  
910 2, 2021, the contractors that are receiving capitated payments  
911 under a managed care delivery system established under this



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

917 (e) [Deleted]

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

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

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



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

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

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



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

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

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

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

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

976 (iv) Administrative expense allocation  
977 methodologies,

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

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

982 (vii) Reasonableness of corporate  
983 allocations,

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





986 (ix) The effectiveness of subcontractor  
987 oversight, including subcontractor review,

988 (x) Whether health care outcomes have been  
989 improved, and

990 (xi) The most common claim denial codes to  
991 determine the reasons for the denials.

992 The audit reports shall be considered public documents and  
993 shall be posted in their entirety on the division's website.

994 (4) All health maintenance organizations, coordinated  
995 care organizations, provider-sponsored health plans, or other  
996 organizations paid for services on a capitated basis by the  
997 division under any managed care program or coordinated care  
998 program implemented by the division under this section shall  
999 reimburse all providers in those organizations at rates no lower  
1000 than those provided under this section for beneficiaries who are  
1001 not participating in those programs.

1002 (5) No health maintenance organization, coordinated  
1003 care organization, provider-sponsored health plan, or other  
1004 organization paid for services on a capitated basis by the  
1005 division under any managed care program or coordinated care  
1006 program implemented by the division under this section shall  
1007 require its providers or beneficiaries to use any pharmacy that  
1008 ships, mails or delivers prescription drugs or legend drugs or  
1009 devices.



1010           (6)   (a)   Not later than December 1, 2021, the  
1011 contractors who are receiving capitated payments under a managed  
1012 care delivery system established under this subsection (H) shall  
1013 develop and implement a uniform credentialing process for  
1014 providers. Under that uniform credentialing process, a provider  
1015 who meets the criteria for credentialing will be credentialed with  
1016 all of those contractors and no such provider will have to be  
1017 separately credentialed by any individual contractor in order to  
1018 receive reimbursement from the contractor. Not later than  
1019 December 2, 2021, those contractors shall submit a report to the  
1020 Chairmen of the House and Senate Medicaid Committees on the status  
1021 of the uniform credentialing process for providers that is  
1022 required under this subparagraph (a).

1023           (b)   If those contractors have not implemented a  
1024 uniform credentialing process as described in subparagraph (a) by  
1025 December 1, 2021, the division shall develop and implement, not  
1026 later than July 1, 2022, a single, consolidated credentialing  
1027 process by which all providers will be credentialed. Under the  
1028 division's single, consolidated credentialing process, no such  
1029 contractor shall require its providers to be separately  
1030 credentialed by the contractor in order to receive reimbursement  
1031 from the contractor, but those contractors shall recognize the  
1032 credentialing of the providers by the division's credentialing  
1033 process.



1034 (c) The division shall require a uniform provider  
1035 credentialing application that shall be used in the credentialing  
1036 process that is established under subparagraph (a) or (b). If the  
1037 contractor or division, as applicable, has not approved or denied  
1038 the provider credentialing application within sixty (60) days of  
1039 receipt of the completed application that includes all required  
1040 information necessary for credentialing, then the contractor or  
1041 division, upon receipt of a written request from the applicant and  
1042 within five (5) business days of its receipt, shall issue a  
1043 temporary provider credential/enrollment to the applicant if the  
1044 applicant has a valid Mississippi professional or occupational  
1045 license to provide the health care services to which the  
1046 credential/enrollment would apply. The contractor or the division  
1047 shall not issue a temporary credential/enrollment if the applicant  
1048 has reported on the application a history of medical or other  
1049 professional or occupational malpractice claims, a history of  
1050 substance abuse or mental health issues, a criminal record, or a  
1051 history of medical or other licensing board, state or federal  
1052 disciplinary action, including any suspension from participation  
1053 in a federal or state program. The temporary  
1054 credential/enrollment shall be effective upon issuance and shall  
1055 remain in effect until the provider's credentialing/enrollment  
1056 application is approved or denied by the contractor or division.  
1057 The contractor or division shall render a final decision regarding  
1058 credentialing/enrollment of the provider within sixty (60) days



1059 from the date that the temporary provider credential/enrollment is  
1060 issued to the applicant.

1061 (d) If the contractor or division does not render  
1062 a final decision regarding credentialing/enrollment of the  
1063 provider within the time required in subparagraph (c), the  
1064 provider shall be deemed to be credentialed by and enrolled with  
1065 all of the contractors and eligible to receive reimbursement from  
1066 the contractors.

1067 (7) (a) Each contractor that is receiving capitated  
1068 payments under a managed care delivery system established under  
1069 this subsection (H) shall provide to each provider for whom the  
1070 contractor has denied the coverage of a procedure that was ordered  
1071 or requested by the provider for or on behalf of a patient, a  
1072 letter that provides a detailed explanation of the reasons for the  
1073 denial of coverage of the procedure and the name and the  
1074 credentials of the person who denied the coverage. The letter  
1075 shall be sent to the provider in electronic format.

1076 (b) After a contractor that is receiving capitated  
1077 payments under a managed care delivery system established under  
1078 this subsection (H) has denied coverage for a claim submitted by a  
1079 provider, the contractor shall issue to the provider within sixty  
1080 (60) days a final ruling of denial of the claim that allows the  
1081 provider to have a state fair hearing and/or agency appeal with  
1082 the division. If a contractor does not issue a final ruling of  
1083 denial within sixty (60) days as required by this subparagraph



1084 (b), the provider's claim shall be deemed to be automatically  
1085 approved and the contractor shall pay the amount of the claim to  
1086 the provider.

1087 (c) After a contractor has issued a final ruling  
1088 of denial of a claim submitted by a provider, the division shall  
1089 conduct a state fair hearing and/or agency appeal on the matter of  
1090 the disputed claim between the contractor and the provider within  
1091 sixty (60) days, and shall render a decision on the matter within  
1092 thirty (30) days after the date of the hearing and/or appeal.

1093 (8) It is the intention of the Legislature that the  
1094 division evaluate the feasibility of using a single vendor to  
1095 administer pharmacy benefits provided under a managed care  
1096 delivery system established under this subsection (H). Providers  
1097 of pharmacy benefits shall cooperate with the division in any  
1098 transition to a carve-out of pharmacy benefits under managed care.

1099 (9) \* \* \* From and after October 1, 2022, the division  
1100 shall establish and implement a separate managed care program or  
1101 coordinated care program for dental services and dental services  
1102 providers. After the separate program has been implemented,  
1103 dental services and dental services providers shall not be part of  
1104 any other managed care program or coordinated care program  
1105 administered by the division but shall be under the separate  
1106 program established under this paragraph (9).

1107 (10) It is the intent of the Legislature that any  
1108 contractor receiving capitated payments under a managed care



1109 delivery system established in this section shall implement  
1110 innovative programs to improve the health and well-being of  
1111 members diagnosed with prediabetes and diabetes.

1112 (11) It is the intent of the Legislature that any  
1113 contractors receiving capitated payments under a managed care  
1114 delivery system established under this subsection (H) shall work  
1115 with providers of Medicaid services to improve the utilization of  
1116 long-acting reversible contraceptives (LARCs). Not later than  
1117 December 1, 2021, any contractors receiving capitated payments  
1118 under a managed care delivery system established under this  
1119 subsection (H) shall provide to the Chairmen of the House and  
1120 Senate Medicaid Committees and House and Senate Public Health  
1121 Committees a report of LARC utilization for State Fiscal Years  
1122 2018 through 2020 as well as any programs, initiatives, or efforts  
1123 made by the contractors and providers to increase LARC  
1124 utilization. This report shall be updated annually to include  
1125 information for subsequent state fiscal years.

1126 (12) The division is authorized to make not more than  
1127 one (1) emergency extension of the contracts that are in effect on  
1128 July 1, 2021, with contractors who are receiving capitated  
1129 payments under a managed care delivery system established under  
1130 this subsection (H), as provided in this paragraph (12). The  
1131 maximum period of any such extension shall be one (1) year, and  
1132 under any such extensions, the contractors shall be subject to all  
1133 of the provisions of this subsection (H). The extended contracts



1134 shall be revised to incorporate any provisions of this subsection  
1135 (H).

1136 (I) [Deleted]

1137 (J) There shall be no cuts in inpatient and outpatient  
1138 hospital payments, or allowable days or volumes, as long as the  
1139 hospital assessment provided in Section 43-13-145 is in effect.

1140 This subsection (J) shall not apply to decreases in payments that  
1141 are a result of: reduced hospital admissions, audits or payments  
1142 under the APR-DRG or APC models, or a managed care program or  
1143 similar model described in subsection (H) of this section.

1144 (K) In the negotiation and execution of such contracts  
1145 involving services performed by actuarial firms, the Executive  
1146 Director of the Division of Medicaid may negotiate a limitation on  
1147 liability to the state of prospective contractors.

1148 (L) This section shall stand repealed on July 1, 2024.

1149 **SECTION 2.** This act shall take effect and be in force from  
1150 and after July 1, 2022.

