MISSISSIPPI LEGISLATURE REGULAR SESSION 2022

By: Representatives Powell, Shanks To: Medicaid

HOUSE BILL NO. 785

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO REMOVE FROM THE MEDICAID SERVICES SECTION THE PROVISION THAT
3 PROHIBITS THE DIVISION OF MEDICAID FROM MAKING ANY CHANGES TO THE
4 RATES OF REIMBURSEMENT TO MEDICAID PROVIDERS WITHOUT AN AMENDMENT
5 TO THIS SECTION BY THE LEGISLATURE; AND FOR RELATED PURPOSES.

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

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

9 43-13-117. (A) Medicaid as authorized by this article shall
10 include payment of part or all of the costs, at the discretion of
11 the division, with approval of the Governor and the Centers for
12 Medicare and Medicaid Services, of the following types of care and
13 services rendered to eligible applicants who have been determined
14 to be eligible for that care and services, within the limits of
15 state appropriations and federal matching funds:

16 (1) Inpatient hospital services.

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

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

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

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

59 (3) Laboratory and x-ray services.

60 (4) Nursing facility services.

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

68 (b) From and after July 1, 1997, the division
69 shall implement the integrated case-mix payment and quality

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

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

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

89 (e) The division shall develop and implement, not
90 later than January 1, 2001, a case-mix payment add-on determined
91 by time studies and other valid statistical data that will
92 reimburse a nursing facility for the additional cost of caring for
93 a resident who has a diagnosis of Alzheimer's or other related
94 dementia and exhibits symptoms that require special care. Any

95 such case-mix add-on payment shall be supported by a determination
96 of additional cost. The division shall also develop and implement
97 as part of the fair rental reimbursement system for nursing
98 facility beds, an Alzheimer's resident bed depreciation enhanced
99 reimbursement system that will provide an incentive to encourage
100 nursing facilities to convert or construct beds for residents with
101 Alzheimer's or other related dementia.
102 (f) The division shall develop and implement an
103 assessment process for long-term care services. The division may
104 provide the assessment and related functions directly or through
105 contract with the area agencies on aging.
106 The division shall apply for necessary federal waivers to
107 assure that additional services providing alternatives to nursing
108 facility care are made available to applicants for nursing
109 facility care.
110 (5) Periodic screening and diagnostic services for
111 individuals under age twenty-one (21) years as are needed to
112 identify physical and mental defects and to provide health care
113 treatment and other measures designed to correct or ameliorate
114 defects and physical and mental illness and conditions discovered
115 by the screening services, regardless of whether these services
116 are included in the state plan. The division may include in its
117 periodic screening and diagnostic program those discretionary
118 services authorized under the federal regulations adopted to
119 implement Title XIX of the federal Social Security Act, as

120 amended. The division, in obtaining physical therapy services,
121 occupational therapy services, and services for individuals with
122 speech, hearing and language disorders, may enter into a
123 cooperative agreement with the State Department of Education for
124 the provision of those services to handicapped students by public
125 school districts using state funds that are provided from the
126 appropriation to the Department of Education to obtain federal
127 matching funds through the division. The division, in obtaining
128 medical and mental health assessments, treatment, care and
129 services for children who are in, or at risk of being put in, the
130 custody of the Mississippi Department of Human Services may enter
131 into a cooperative agreement with the Mississippi Department of
132 Human Services for the provision of those services using state
133 funds that are provided from the appropriation to the Department
134 of Human Services to obtain federal matching funds through the
135 division.

136 (6) Physician services. Fees for physician's services
137 that are covered only by Medicaid shall be reimbursed at ninety
138 percent (90%) of the rate established on January 1, 2018, and as
139 may be adjusted each July thereafter, under Medicare. The
140 division may provide for a reimbursement rate for physician's
141 services of up to one hundred percent (100%) of the rate
142 established under Medicare for physician's services that are
143 provided after the normal working hours of the physician, as
144 determined in accordance with regulations of the division. The

145 division may reimburse eligible providers, as determined by the
146 division, for certain primary care services at one hundred percent
147 (100%) of the rate established under Medicare. The division shall
148 reimburse obstetricians and gynecologists for certain primary care
149 services as defined by the division at one hundred percent (100%)
150 of the rate established under Medicare.

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

161 (b) [Repealed]

162 (8) Emergency medical transportation services as
163 determined by the division.

164 (9) Prescription drugs and other covered drugs and
165 services as determined by the division.

166 The division shall establish a mandatory preferred drug list.
167 Drugs not on the mandatory preferred drug list shall be made
168 available by utilizing prior authorization procedures established
169 by the division.

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

179 The division may allow for a combination of prescriptions for
180 single-source and innovator multiple-source drugs and generic
181 drugs to meet the needs of the beneficiaries.

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

185 Drugs prescribed for a resident of a psychiatric residential
186 treatment facility must be provided in true unit doses when
187 available. The division may require that drugs not covered by
188 Medicare Part D for a resident of a long-term care facility be
189 provided in true unit doses when available. Those drugs that were
190 originally billed to the division but are not used by a resident
191 in any of those facilities shall be returned to the billing
192 pharmacy for credit to the division, in accordance with the
193 guidelines of the State Board of Pharmacy and any requirements of
194 federal law and regulation. Drugs shall be dispensed to a

195 recipient and only one (1) dispensing fee per month may be
196 charged. The division shall develop a methodology for reimbursing
197 for restocked drugs, which shall include a restock fee as
198 determined by the division not exceeding Seven Dollars and
199 Eighty-two Cents ($7.82).

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

204 The division is authorized to develop and implement a program
205 of payment for additional pharmacist services as determined by the
206 division.

207 All claims for drugs for dually eligible Medicare/Medicaid
208 beneficiaries that are paid for by Medicare must be submitted to
209 Medicare for payment before they may be processed by the
210 division's online payment system.

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

216 The division shall develop and implement a method or methods
217 by which the division will provide on a regular basis to Medicaid
218 providers who are authorized to prescribe drugs, information about
219 the costs to the Medicaid program of single-source drugs and

220 innovator multiple-source drugs, and information about other drugs
221 that may be prescribed as alternatives to those single-source
222 drugs and innovator multiple-source drugs and the costs to the
223 Medicaid program of those alternative drugs.

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

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

233 The division shall not reimburse for single-source or
234 innovator multiple-source drugs if there are equally effective
235 generic equivalents available and if the generic equivalents are
236 the least expensive.

237 It is the intent of the Legislature that the pharmacists
238 providers be reimbursed for the reasonable costs of filling and
239 dispensing prescriptions for Medicaid beneficiaries.

240 The division shall allow certain drugs, including
241 physician-administered drugs, and implantable drug system devices,
242 and medical supplies, with limited distribution or limited access
243 for beneficiaries and administered in an appropriate clinical

244 setting, to be reimbursed as either a medical claim or pharmacy
245 claim, as determined by the division.
246 It is the intent of the Legislature that the division and any
247 managed care entity described in subsection (H) of this section
248 encourage the use of Alpha-Hydroxyprogesterone Caproate (17P) to
249 prevent recurrent preterm birth.
250 (10) Dental and orthodontic services to be determined
251 by the division.
252 The division shall increase the amount of the reimbursement
253 rate for diagnostic and preventative dental services for each of
254 the fiscal years 2022, 2023 and 2024 by five percent (5%) above
255 the amount of the reimbursement rate for the previous fiscal year.
256 It is the intent of the Legislature that the reimbursement rate
257 revision for preventative dental services will be an incentive to
258 increase the number of dentists who actively provide Medicaid
259 services. This dental services reimbursement rate revision shall
260 be known as the "James Russell Dumas Medicaid Dental Services
261 Incentive Program."
262 The Medical Care Advisory Committee, assisted by the Division
263 of Medicaid, shall annually determine the effect of this incentive
264 by evaluating the number of dentists who are Medicaid providers,
265 the number who and the degree to which they are actively billing
266 Medicaid, the geographic trends of where dentists are offering
267 what types of Medicaid services and other statistics pertinent to
268 the goals of this legislative intent. This data shall annually be

269 presented to the Chair of the Senate Medicaid Committee and the
270 Chair of the House Medicaid Committee.

271 The division shall include dental services as a necessary
272 component of overall health services provided to children who are
273 eligible for services.

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

283 (12) Intermediate care facility services.

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

292 (b) All state-owned intermediate care facilities
293 for individuals with intellectual disabilities shall be reimbursed
294 on a full reasonable cost basis.
295 (c) Effective January 1, 2015, the division shall
296 update the fair rental reimbursement system for intermediate care
297 facilities for individuals with intellectual disabilities.
298 (13) Family planning services, including drugs,
299 supplies and devices, when those services are under the
300 supervision of a physician or nurse practitioner.
301 (14) Clinic services. Preventive, diagnostic,
302 therapeutic, rehabilitative or palliative services that are
303 furnished by a facility that is not part of a hospital but is
304 organized and operated to provide medical care to outpatients.
305 Clinic services include, but are not limited to:
306 (a) Services provided by ambulatory surgical
307 centers (ACSs) as defined in Section 41-75-1(a); and
308 (b) Dialysis center services.
309 (15) Home- and community-based services for the elderly
310 and disabled, as provided under Title XIX of the federal Social
311 Security Act, as amended, under waivers, subject to the
312 availability of funds specifically appropriated for that purpose
313 by the Legislature.
314 (16) Mental health services. Certain services provided
315 by a psychiatrist shall be reimbursed at up to one hundred percent
316 (100%) of the Medicare rate. Approved therapeutic and case

317 management services (a) provided by an approved regional mental
318 health/intellectual disability center established under Sections
319 41-19-31 through 41-19-39, or by another community mental health
320 service provider meeting the requirements of the Department of
321 Mental Health to be an approved mental health/intellectual
322 disability center if determined necessary by the Department of
323 Mental Health, using state funds that are provided in the
324 appropriation to the division to match federal funds, or (b)
325 provided by a facility that is certified by the State Department
326 of Mental Health to provide therapeutic and case management
327 services, to be reimbursed on a fee for service basis, or (c)
328 provided in the community by a facility or program operated by the
329 Department of Mental Health. Any such services provided by a
330 facility described in subparagraph (b) must have the prior
331 approval of the division to be reimbursable under this section.
332 (17) Durable medical equipment services and medical
333 supplies. Precertification of durable medical equipment and
334 medical supplies must be obtained as required by the division.
335 The Division of Medicaid may require durable medical equipment
336 providers to obtain a surety bond in the amount and to the
337 specifications as established by the Balanced Budget Act of 1997.
338 (18) (a) Notwithstanding any other provision of this
339 section to the contrary, as provided in the Medicaid state plan
340 amendment or amendments as defined in Section 43-13-145(10), the
341 division shall make additional reimbursement to hospitals that

342 serve a disproportionate share of low-income patients and that
343 meet the federal requirements for those payments as provided in
344 Section 1923 of the federal Social Security Act and any applicable
345 regulations. It is the intent of the Legislature that the
346 division shall draw down all available federal funds allotted to
347 the state for disproportionate share hospitals. However, from and
348 after January 1, 1999, public hospitals participating in the
349 Medicaid disproportionate share program may be required to
350 participate in an intergovernmental transfer program as provided
351 in Section 1903 of the federal Social Security Act and any
352 applicable regulations.
353 (b) (i) The division may establish a Medicare
354 Upper Payment Limits Program, as defined in Section 1902(a)(30) of
355 the federal Social Security Act and any applicable federal
356 regulations, or an allowable delivery system or provider payment
357 initiative authorized under 42 CFR 438.6(c), for hospitals,
358 nursing facilities, physicians employed or contracted by
359 hospitals, and emergency ambulance transportation providers.
360 (ii) The division shall assess each hospital,
361 nursing facility, and emergency ambulance transportation provider
362 for the sole purpose of financing the state portion of the
363 Medicare Upper Payment Limits Program or other program(s)
364 authorized under this subsection (A)(18)(b). The hospital
365 assessment shall be as provided in Section 43-13-145(4)(a), and
366 the nursing facility and the emergency ambulance transportation

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

381 (iii) Subject to approval by the Centers for
382 Medicare and Medicaid Services (CMS) and the provisions of this
383 subsection (A)(18)(b), the division shall make additional
384 reimbursement to hospitals, nursing facilities, and emergency
385 ambulance transportation providers for the Medicare Upper Payment
386 Limits Program or other program(s) authorized under this
387 subsection (A)(18)(b), and, if the program is established for
388 physicians, shall make additional reimbursement for physicians, as
389 defined in Section 1902(a)(30) of the federal Social Security Act
390 and any applicable federal regulations, provided the assessment in
391 this subsection (A)(18)(b) is in effect.

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

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

442 rendered by in-state hospitals and the out-of-state hospital that
443 is authorized by federal law to submit intergovernmental transfers
444 (IGTs) to the State of Mississippi and is classified as Level I
445 trauma center located in a county contiguous to the state line at
446 the maximum levels permissible under applicable federal statutes
447 and regulations, at which time the current inpatient Medicare
448 Upper Payment Limits (UPL) Program for hospital inpatient services
449 shall transition to the MHAP.

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

457 (iii) The intent of this subparagraph (c) is
458 that effective for all inpatient hospital Medicaid services during
459 state fiscal year 2016, and so long as this provision shall remain
460 in effect hereafter, the division shall to the fullest extent
461 feasible replace the additional reimbursement for hospital
462 inpatient services under the inpatient Medicare Upper Payment
463 Limits (UPL) Program with additional reimbursement under the MHAP
464 and other payment programs for inpatient and/or outpatient
465 payments which may be developed under the authority of this
466 paragraph.

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

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

486 (b) Early intervention system services. The
487 division shall cooperate with the State Department of Health,
488 acting as lead agency, in the development and implementation of a
489 statewide system of delivery of early intervention services, under
490 Part C of the Individuals with Disabilities Education Act (IDEA).
491 The State Department of Health shall certify annually in writing

492 to the executive director of the division the dollar amount of
493 state early intervention funds available that will be utilized as
494 a certified match for Medicaid matching funds. Those funds then
495 shall be used to provide expanded targeted case management
496 services for Medicaid eligible children with special needs who are
497 eligible for the state's early intervention system.
498 Qualifications for persons providing service coordination shall be
499 determined by the State Department of Health and the Division of
500 Medicaid.

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

511 (21) Nurse practitioner services. Services furnished
512 by a registered nurse who is licensed and certified by the
513 Mississippi Board of Nursing as a nurse practitioner, including,
514 but not limited to, nurse anesthetists, nurse midwives, family
515 nurse practitioners, family planning nurse practitioners,
516 pediatric nurse practitioners, obstetrics-gynecology nurse

517 practitioners and neonatal nurse practitioners, under regulations
518 adopted by the division. Reimbursement for those services shall
519 not exceed ninety percent (90%) of the reimbursement rate for
520 comparable services rendered by a physician. The division may
521 provide for a reimbursement rate for nurse practitioner services
522 of up to one hundred percent (100%) of the reimbursement rate for
523 comparable services rendered by a physician for nurse practitioner
524 services that are provided after the normal working hours of the
525 nurse practitioner, as determined in accordance with regulations
526 of the division.

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

542 (23) Inpatient psychiatric services.

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

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

566 (24) [Deleted]

567 (25) [Deleted]

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

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

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

586 (29) The Division of Medicaid may apply for a waiver
587 from the United States Department of Health and Human Services for
588 home- and community-based services for developmentally disabled
589 people using state funds that are provided from the appropriation
590 to the State Department of Mental Health and/or funds transferred
591 to the department by a political subdivision or instrumentality of

592 the state and used to match federal funds under a cooperative
593 agreement between the division and the department, provided that
594 funds for these services are specifically appropriated to the
595 Department of Mental Health and/or transferred to the department
596 by a political subdivision or instrumentality of the state.
597 (30) Pediatric skilled nursing services as determined
598 by the division and in a manner consistent with regulations
599 promulgated by the Mississippi State Department of Health.
600 (31) Targeted case management services for children
601 with special needs, under waivers from the United States
602 Department of Health and Human Services, using state funds that
603 are provided from the appropriation to the Mississippi Department
604 of Human Services and used to match federal funds under a
605 cooperative agreement between the division and the department.
606 (32) Care and services provided in Christian Science
607 Sanatoria listed and certified by the Commission for Accreditation
608 of Christian Science Nursing Organizations/Facilities, Inc.,
609 rendered in connection with treatment by prayer or spiritual means
610 to the extent that those services are subject to reimbursement
611 under Section 1903 of the federal Social Security Act.
612 (33) Podiatrist services.
613 (34) Assisted living services as provided through
614 home- and community-based services under Title XIX of the federal
615 Social Security Act, as amended, subject to the availability of

616 funds specifically appropriated for that purpose by the
617 Legislature.

618 (35) Services and activities authorized in Sections
619 43-27-101 and 43-27-103, using state funds that are provided from
620 the appropriation to the Mississippi Department of Human Services
621 and used to match federal funds under a cooperative agreement
622 between the division and the department.

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

634 (37) [Deleted]

635 (38) Chiropractic services. A chiropractor's manual
636 manipulation of the spine to correct a subluxation, if x-ray
637 demonstrates that a subluxation exists and if the subluxation has
638 resulted in a neuromusculoskeletal condition for which
639 manipulation is appropriate treatment, and related spinal x-rays
640 performed to document these conditions. Reimbursement for

641 chiropractic services shall not exceed Seven Hundred Dollars
642 ($700.00) per year per beneficiary.
643 (39) Dually eligible Medicare/Medicaid beneficiaries.
644 The division shall pay the Medicare deductible and coinsurance
645 amounts for services available under Medicare, as determined by
646 the division. From and after July 1, 2009, the division shall
647 reimburse crossover claims for inpatient hospital services and
648 crossover claims covered under Medicare Part B in the same manner
649 that was in effect on January 1, 2008, unless specifically
650 authorized by the Legislature to change this method.
651 (40) [Deleted]
652 (41) Services provided by the State Department of
653 Rehabilitation Services for the care and rehabilitation of persons
654 with spinal cord injuries or traumatic brain injuries, as allowed
655 under waivers from the United States Department of Health and
656 Human Services, using up to seventy-five percent (75%) of the
657 funds that are appropriated to the Department of Rehabilitation
658 Services from the Spinal Cord and Head Injury Trust Fund
659 established under Section 37-33-261 and used to match federal
660 funds under a cooperative agreement between the division and the
661 department.
662 (42) [Deleted]
663 (43) The division shall provide reimbursement,
664 according to a payment schedule developed by the division, for
665 smoking cessation medications for pregnant women during their

666 pregnancy and other Medicaid-eligible women who are of
667 child-bearing age.
668 (44) Nursing facility services for the severely
669 disabled.
670 (a) Severe disabilities include, but are not
671 limited to, spinal cord injuries, closed-head injuries and
672 ventilator-dependent patients.
673 (b) Those services must be provided in a long-term
674 care nursing facility dedicated to the care and treatment of
675 persons with severe disabilities.
676 (45) Physician assistant services. Services furnished
677 by a physician assistant who is licensed by the State Board of
678 Medical Licensure and is practicing with physician supervision
679 under regulations adopted by the board, under regulations adopted
680 by the division. Reimbursement for those services shall not
681 exceed ninety percent (90%) of the reimbursement rate for
682 comparable services rendered by a physician. The division may
683 provide for a reimbursement rate for physician assistant services
684 of up to one hundred percent (100%) or the reimbursement rate for
685 comparable services rendered by a physician for physician
686 assistant services that are provided after the normal working
687 hours of the physician assistant, as determined in accordance with
688 regulations of the division.
689 (46) The division shall make application to the federal
690 Centers for Medicare and Medicaid Services (CMS) for a waiver to

691 develop and provide services for children with serious emotional
692 disturbances as defined in Section 43-14-1(1), which may include
693 home- and community-based services, case management services or
694 managed care services through mental health providers certified by
695 the Department of Mental Health. The division may implement and
696 provide services under this waivered program only if funds for
697 these services are specifically appropriated for this purpose by
698 the Legislature, or if funds are voluntarily provided by affected
699 agencies.
700 (47) (a) The division may develop and implement
701 disease management programs for individuals with high-cost chronic
702 diseases and conditions, including the use of grants, waivers,
703 demonstrations or other projects as necessary.
704 (b) Participation in any disease management
705 program implemented under this paragraph (47) is optional with the
706 individual. An individual must affirmatively elect to participate
707 in the disease management program in order to participate, and may
708 elect to discontinue participation in the program at any time.
709 (48) Pediatric long-term acute care hospital services.
710 (a) Pediatric long-term acute care hospital
711 services means services provided to eligible persons under
712 twenty-one (21) years of age by a freestanding Medicare-certified
713 hospital that has an average length of inpatient stay greater than
714 twenty-five (25) days and that is primarily engaged in providing

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

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

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

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

729 (51) Upon determination of Medicaid eligibility and in
730 association with annual redetermination of Medicaid eligibility,
731 beneficiaries shall be encouraged to undertake a physical
732 examination that will establish a base-line level of health and
733 identification of a usual and customary source of care (a medical
734 home) to aid utilization of disease management tools. This
735 physical examination and utilization of these disease management
736 tools shall be consistent with current United States Preventive
737 Services Task Force or other recognized authority recommendations.

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

763 necessity, the division shall approve certification periods for
764 less than or up to six (6) months, but in no event shall the
765 certification period exceed the period of treatment indicated on
766 the plan of care. The appeal process for any reduction in therapy
767 services shall be consistent with the appeal process in federal
768 regulations.

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

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

784 (58) Treatment services for persons with opioid
785 dependency or other highly addictive substance use disorders. The
786 division is authorized to reimburse eligible providers for
787 treatment of opioid dependency and other highly addictive

788 substance use disorders, as determined by the division. Treatment
789 related to these conditions shall not count against any physician
790 visit limit imposed under this section.

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

797 (B) [Deleted]

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

808 (D) *** * *** [Deleted]

809 (E) Notwithstanding any provision of this article, no new
810 groups or categories of recipients and new types of care and
811 services may be added without enabling legislation from the
812 Mississippi Legislature, except that the division may authorize

813 those changes without enabling legislation when the addition of
814 recipients or services is ordered by a court of proper authority.
815 (F) The executive director shall keep the Governor advised
816 on a timely basis of the funds available for expenditure and the
817 projected expenditures. Notwithstanding any other provisions of
818 this article, if current or projected expenditures of the division
819 are reasonably anticipated to exceed the amount of funds
820 appropriated to the division for any fiscal year, the Governor,
821 after consultation with the executive director, shall take all
822 appropriate measures to reduce costs, which may include, but are
823 not limited to:
824 (1) Reducing or discontinuing any or all services that
825 are deemed to be optional under Title XIX of the Social Security
826 Act;
827 (2) Reducing reimbursement rates for any or all service
828 types;
829 (3) Imposing additional assessments on health care
830 providers; or
831 (4) Any additional cost-containment measures deemed
832 appropriate by the Governor.
833 To the extent allowed under federal law, any reduction to
834 services or reimbursement rates under this subsection (F) shall be
835 accompanied by a reduction, to the fullest allowable amount, to
836 the profit margin and administrative fee portions of capitated

837 payments to organizations described in paragraph (1) of subsection
838 (H).

839 Beginning in fiscal year 2010 and in fiscal years thereafter,
840 when Medicaid expenditures are projected to exceed funds available
841 for the fiscal year, the division shall submit the expected
842 shortfall information to the PEER Committee not later than
843 December 1 of the year in which the shortfall is projected to
844 occur. PEER shall review the computations of the division and
845 report its findings to the Legislative Budget Office not later
846 than January 7 in any year.

847 (G) Notwithstanding any other provision of this article, it
848 shall be the duty of each provider participating in the Medicaid
849 program to keep and maintain books, documents and other records as
850 prescribed by the Division of Medicaid in accordance with federal
851 laws and regulations.

852 (H) (1) Notwithstanding any other provision of this
853 article, the division is authorized to implement (a) a managed
854 care program, (b) a coordinated care program, (c) a coordinated
855 care organization program, (d) a health maintenance organization
856 program, (e) a patient-centered medical home program, (f) an
857 accountable care organization program, (g) provider-sponsored
858 health plan, or (h) any combination of the above programs. As a
859 condition for the approval of any program under this subsection
860 (H)(1), the division shall require that no managed care program,
861 coordinated care program, coordinated care organization program,

862 health maintenance organization program, or provider-sponsored
863 health plan may:
864 (a) Pay providers at a rate that is less than the
865 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
866 reimbursement rate;
867 (b) Override the medical decisions of hospital
868 physicians or staff regarding patients admitted to a hospital for
869 an emergency medical condition as defined by 42 US Code Section
870 1395dd. This restriction (b) does not prohibit the retrospective
871 review of the appropriateness of the determination that an
872 emergency medical condition exists by chart review or coding
873 algorithm, nor does it prohibit prior authorization for
874 nonemergency hospital admissions;
875 (c) Pay providers at a rate that is less than the
876 normal Medicaid reimbursement rate. It is the intent of the
877 Legislature that all managed care entities described in this
878 subsection (H), in collaboration with the division, develop and
879 implement innovative payment models that incentivize improvements
880 in health care quality, outcomes, or value, as determined by the
881 division. Participation in the provider network of any managed
882 care, coordinated care, provider-sponsored health plan, or similar
883 contractor shall not be conditioned on the provider's agreement to
884 accept such alternative payment models;
885 (d) Implement a prior authorization and
886 utilization review program for medical services, transportation

887 services and prescription drugs that is more stringent than the
888 prior authorization processes used by the division in its
889 administration of the Medicaid program. Not later than December
890 2, 2021, the contractors that are receiving capitated payments
891 under a managed care delivery system established under this
892 subsection (H) shall submit a report to the Chairmen of the House
893 and Senate Medicaid Committees on the status of the prior
894 authorization and utilization review program for medical services,
895 transportation services and prescription drugs that is required to
896 be implemented under this subparagraph (d);
897 (e) [Deleted]
898 (f) Implement a preferred drug list that is more
899 stringent than the mandatory preferred drug list established by
900 the division under subsection (A)(9) of this section;
901 (g) Implement a policy which denies beneficiaries
902 with hemophilia access to the federally funded hemophilia
903 treatment centers as part of the Medicaid Managed Care network of
904 providers.
905 Each health maintenance organization, coordinated care
906 organization, provider-sponsored health plan, or other
907 organization paid for services on a capitated basis by the
908 division under any managed care program or coordinated care
909 program implemented by the division under this section shall use a
910 clear set of level of care guidelines in the determination of
911 medical necessity and in all utilization management practices,

912 including the prior authorization process, concurrent reviews,
913 retrospective reviews and payments, that are consistent with
914 widely accepted professional standards of care. Organizations
915 participating in a managed care program or coordinated care
916 program implemented by the division may not use any additional
917 criteria that would result in denial of care that would be
918 determined appropriate and, therefore, medically necessary under
919 those levels of care guidelines.

920 (2) Notwithstanding any provision of this section, the
921 recipients eligible for enrollment into a Medicaid Managed Care
922 Program authorized under this subsection (H) may include only
923 those categories of recipients eligible for participation in the
924 Medicaid Managed Care Program as of January 1, 2021, the
925 Children's Health Insurance Program (CHIP), and the CMS-approved
926 Section 1115 demonstration waivers in operation as of January 1,
927 2021. No expansion of Medicaid Managed Care Program contracts may
928 be implemented by the division without enabling legislation from
929 the Mississippi Legislature.

930 (3) (a) Any contractors receiving capitated payments
931 under a managed care delivery system established in this section
932 shall provide to the Legislature and the division statistical data
933 to be shared with provider groups in order to improve patient
934 access, appropriate utilization, cost savings and health outcomes
935 not later than October 1 of each year. Additionally, each
936 contractor shall disclose to the Chairmen of the Senate and House

937 Medicaid Committees the administrative expenses costs for the
938 prior calendar year, and the number of full-equivalent employees
939 located in the State of Mississippi dedicated to the Medicaid and
940 CHIP lines of business as of June 30 of the current year.

941 (b) The division and the contractors participating
942 in the managed care program, a coordinated care program or a
943 provider-sponsored health plan shall be subject to annual program
944 reviews or audits performed by the Office of the State Auditor,
945 the PEER Committee, the Department of Insurance and/or independent
946 third parties.

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

949 (i) The financial benefit to the State of
950 Mississippi of the managed care program,

951 (ii) The difference between the premiums paid
952 to the managed care contractors and the payments made by those
953 contractors to health care providers,

954 (iii) Compliance with performance measures
955 required under the contracts,

956 (iv) Administrative expense allocation
957 methodologies,

958 (v) Whether nonprovider payments assigned as
959 medical expenses are appropriate,

960 (vi) Capitated arrangements with related
961 party subcontractors,

962 (vii) Reasonableness of corporate
963 allocations,
964 (viii) Value-added benefits and the extent to
965 which they are used,
966 (ix) The effectiveness of subcontractor
967 oversight, including subcontractor review,
968 (x) Whether health care outcomes have been
969 improved, and
970 (xi) The most common claim denial codes to
971 determine the reasons for the denials.
972 The audit reports shall be considered public documents and
973 shall be posted in their entirety on the division's website.
974 (4) All health maintenance organizations, coordinated
975 care organizations, provider-sponsored health plans, or other
976 organizations paid for services on a capitated basis by the
977 division under any managed care program or coordinated care
978 program implemented by the division under this section shall
979 reimburse all providers in those organizations at rates no lower
980 than those provided under this section for beneficiaries who are
981 not participating in those programs.
982 (5) No health maintenance organization, coordinated
983 care organization, provider-sponsored health plan, or other
984 organization paid for services on a capitated basis by the
985 division under any managed care program or coordinated care
986 program implemented by the division under this section shall

987 require its providers or beneficiaries to use any pharmacy that
988 ships, mails or delivers prescription drugs or legend drugs or
989 devices.

990 (6) (a) Not later than December 1, 2021, the
991 contractors who are receiving capitated payments under a managed
992 care delivery system established under this subsection (H) shall
993 develop and implement a uniform credentialing process for
994 providers. Under that uniform credentialing process, a provider
995 who meets the criteria for credentialing will be credentialed with
996 all of those contractors and no such provider will have to be
997 separately credentialed by any individual contractor in order to
998 receive reimbursement from the contractor. Not later than
999 December 2, 2021, those contractors shall submit a report to the
1000 Chairmen of the House and Senate Medicaid Committees on the status
1001 of the uniform credentialing process for providers that is
1002 required under this subparagraph (a).

1003 (b) If those contractors have not implemented a
1004 uniform credentialing process as described in subparagraph (a) by
1005 December 1, 2021, the division shall develop and implement, not
1006 later than July 1, 2022, a single, consolidated credentialing
1007 process by which all providers will be credentialed. Under the
1008 division's single, consolidated credentialing process, no such
1009 contractor shall require its providers to be separately
1010 credentialed by the contractor in order to receive reimbursement
1011 from the contractor, but those contractors shall recognize the

1012 credentialing of the providers by the division's credentialing
1013 process.
1014 (c) The division shall require a uniform provider
1015 credentialing application that shall be used in the credentialing
1016 process that is established under subparagraph (a) or (b). If the
1017 contractor or division, as applicable, has not approved or denied
1018 the provider credentialing application within sixty (60) days of
1019 receipt of the completed application that includes all required
1020 information necessary for credentialing, then the contractor or
1021 division, upon receipt of a written request from the applicant and
1022 within five (5) business days of its receipt, shall issue a
1023 temporary provider credential/enrollment to the applicant if the
1024 applicant has a valid Mississippi professional or occupational
1025 license to provide the health care services to which the
1026 credential/enrollment would apply. The contractor or the division
1027 shall not issue a temporary credential/enrollment if the applicant
1028 has reported on the application a history of medical or other
1029 professional or occupational malpractice claims, a history of
1030 substance abuse or mental health issues, a criminal record, or a
1031 history of medical or other licensing board, state or federal
1032 disciplinary action, including any suspension from participation
1033 in a federal or state program. The temporary
1034 credential/enrollment shall be effective upon issuance and shall
1035 remain in effect until the provider's credentialing/enrollment
1036 application is approved or denied by the contractor or division.

1037 The contractor or division shall render a final decision regarding
1038 credentialing/enrollment of the provider within sixty (60) days
1039 from the date that the temporary provider credential/enrollment is
1040 issued to the applicant.

1041 (d) If the contractor or division does not render
1042 a final decision regarding credentialing/enrollment of the
1043 provider within the time required in subparagraph (c), the
1044 provider shall be deemed to be credentialed by and enrolled with
1045 all of the contractors and eligible to receive reimbursement from
1046 the contractors.

1047 (7) (a) Each contractor that is receiving capitated
1048 payments under a managed care delivery system established under
1049 this subsection (H) shall provide to each provider for whom the
1050 contractor has denied the coverage of a procedure that was ordered
1051 or requested by the provider for or on behalf of a patient, a
1052 letter that provides a detailed explanation of the reasons for the
1053 denial of coverage of the procedure and the name and the
1054 credentials of the person who denied the coverage. The letter
1055 shall be sent to the provider in electronic format.

1056 (b) After a contractor that is receiving capitated
1057 payments under a managed care delivery system established under
1058 this subsection (H) has denied coverage for a claim submitted by a
1059 provider, the contractor shall issue to the provider within sixty
1060 (60) days a final ruling of denial of the claim that allows the
1061 provider to have a state fair hearing and/or agency appeal with

1062 the division. If a contractor does not issue a final ruling of
1063 denial within sixty (60) days as required by this subparagraph
1064 (b), the provider's claim shall be deemed to be automatically
1065 approved and the contractor shall pay the amount of the claim to
1066 the provider.

1067 (c) After a contractor has issued a final ruling
1068 of denial of a claim submitted by a provider, the division shall
1069 conduct a state fair hearing and/or agency appeal on the matter of
1070 the disputed claim between the contractor and the provider within
1071 sixty (60) days, and shall render a decision on the matter within
1072 thirty (30) days after the date of the hearing and/or appeal.

1073 (8) It is the intention of the Legislature that the
1074 division evaluate the feasibility of using a single vendor to
1075 administer pharmacy benefits provided under a managed care
1076 delivery system established under this subsection (H). Providers
1077 of pharmacy benefits shall cooperate with the division in any
1078 transition to a carve-out of pharmacy benefits under managed care.

1079 (9) It is the intention of the Legislature that the
1080 division evaluate the feasibility of using a single vendor to
1081 administer dental benefits provided under a managed care delivery
1082 system established in this subsection (H). Providers of dental
1083 benefits shall cooperate with the division in any transition to a
1084 carve-out of dental benefits under managed care.

1085 (10) It is the intent of the Legislature that any
1086 contractor receiving capitated payments under a managed care

1087 delivery system established in this section shall implement
1088 innovative programs to improve the health and well-being of
1089 members diagnosed with prediabetes and diabetes.

1090 (11) It is the intent of the Legislature that any
1091 contractors receiving capitated payments under a managed care
1092 delivery system established under this subsection (H) shall work
1093 with providers of Medicaid services to improve the utilization of
1094 long-acting reversible contraceptives (LARCs). Not later than
1095 December 1, 2021, any contractors receiving capitated payments
1096 under a managed care delivery system established under this
1097 subsection (H) shall provide to the Chairmen of the House and
1098 Senate Medicaid Committees and House and Senate Public Health
1099 Committees a report of LARC utilization for State Fiscal Years
1100 2018 through 2020 as well as any programs, initiatives, or efforts
1101 made by the contractors and providers to increase LARC
1102 utilization. This report shall be updated annually to include
1103 information for subsequent state fiscal years.

1104 (12) The division is authorized to make not more than
1105 one (1) emergency extension of the contracts that are in effect on
1106 July 1, 2021, with contractors who are receiving capitated
1107 payments under a managed care delivery system established under
1108 this subsection (H), as provided in this paragraph (12). The
1109 maximum period of any such extension shall be one (1) year, and
1110 under any such extensions, the contractors shall be subject to all
1111 of the provisions of this subsection (H). The extended contracts

1112 shall be revised to incorporate any provisions of this subsection
1113 (H).

1114 (I) [Deleted]

1115 (J) There shall be no cuts in inpatient and outpatient
1116 hospital payments, or allowable days or volumes, as long as the
1117 hospital assessment provided in Section 43-13-145 is in effect.
1118 This subsection (J) shall not apply to decreases in payments that
1119 are a result of: reduced hospital admissions, audits or payments
1120 under the APR-DRG or APC models, or a managed care program or
1121 similar model described in subsection (H) of this section.

1122 (K) In the negotiation and execution of such contracts
1123 involving services performed by actuarial firms, the Executive
1124 Director of the Division of Medicaid may negotiate a limitation on
1125 liability to the state of prospective contractors.

1126 (L) This section shall stand repealed on July 1, 2024.

1127 **SECTION 2.** This act shall take effect and be in force from
1128 and after July 1, 2022.