

By: Senator(s) Blackwell

To: Medicaid

SENATE BILL NO. 2664

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
 2 TO REQUIRE THE DIVISION OF MEDICAID TO REIMBURSE FOR SERVICES
 3 PROVIDED TO ELIGIBLE MEDICAID BENEFICIARIES BY A LICENSED BIRTHING
 4 CENTER IN A METHOD AND MANNER TO BE DETERMINED BY THE DIVISION IN
 5 ACCORDANCE WITH FEDERAL LAWS AND FEDERAL REGULATIONS; TO REQUIRE
 6 THE DIVISION TO SEEK ANY NECESSARY WAIVERS, MAKE ANY REQUIRED
 7 AMENDMENTS TO ITS STATE PLAN OR REVISE ANY CONTRACTS AUTHORIZED
 8 UNDER THE SECTION AS NECESSARY TO PROVIDE THE SERVICES AUTHORIZED
 9 UNDER THE ACT; AND FOR RELATED 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) It is the intention of the Legislature that the
1100 division evaluate the feasibility of using a single vendor to
1101 administer dental benefits provided under a managed care delivery
1102 system established in this subsection (H). Providers of dental
1103 benefits shall cooperate with the division in any transition to a
1104 carve-out of dental benefits under managed care.

1105 (10) It is the intent of the Legislature that any
1106 contractor receiving capitated payments under a managed care
1107 delivery system established in this section shall implement



1108 innovative programs to improve the health and well-being of
1109 members diagnosed with prediabetes and diabetes.

1110 (11) It is the intent of the Legislature that any
1111 contractors receiving capitated payments under a managed care
1112 delivery system established under this subsection (H) shall work
1113 with providers of Medicaid services to improve the utilization of
1114 long-acting reversible contraceptives (LARCs). Not later than
1115 December 1, 2021, any contractors receiving capitated payments
1116 under a managed care delivery system established under this
1117 subsection (H) shall provide to the Chairmen of the House and
1118 Senate Medicaid Committees and House and Senate Public Health
1119 Committees a report of LARC utilization for State Fiscal Years
1120 2018 through 2020 as well as any programs, initiatives, or efforts
1121 made by the contractors and providers to increase LARC
1122 utilization. This report shall be updated annually to include
1123 information for subsequent state fiscal years.

1124 (12) The division is authorized to make not more than
1125 one (1) emergency extension of the contracts that are in effect on
1126 July 1, 2021, with contractors who are receiving capitated
1127 payments under a managed care delivery system established under
1128 this subsection (H), as provided in this paragraph (12). The
1129 maximum period of any such extension shall be one (1) year, and
1130 under any such extensions, the contractors shall be subject to all
1131 of the provisions of this subsection (H). The extended contracts



1132 shall be revised to incorporate any provisions of this subsection
1133 (H).

1134 (I) [Deleted]

1135 (J) There shall be no cuts in inpatient and outpatient
1136 hospital payments, or allowable days or volumes, as long as the
1137 hospital assessment provided in Section 43-13-145 is in effect.
1138 This subsection (J) shall not apply to decreases in payments that
1139 are a result of: reduced hospital admissions, audits or payments
1140 under the APR-DRG or APC models, or a managed care program or
1141 similar model described in subsection (H) of this section.

1142 (K) In the negotiation and execution of such contracts
1143 involving services performed by actuarial firms, the Executive
1144 Director of the Division of Medicaid may negotiate a limitation on
1145 liability to the state of prospective contractors.

1146 (L) The Division of Medicaid shall reimburse for services
1147 provided to eligible Medicaid beneficiaries by a licensed birthing
1148 center in a method and manner to be determined by the division in
1149 accordance with federal laws and federal regulations. The
1150 division shall seek any necessary waivers, make any required
1151 amendments to its State Plan or revise any contracts authorized
1152 under subsection (H) of this section as necessary to provide the
1153 services authorized under this subsection. As used in this
1154 subsection, the term "birthing centers" shall have the meaning as
1155 defined in Section 41-77-1(a), which is a publicly or privately
1156 owned facility, place or institution constructed, renovated,



1157 leased or otherwise established where nonemergency births are
1158 planned to occur away from the mother's usual residence following
1159 a documented period of prenatal care for a normal uncomplicated
1160 pregnancy which has been determined to be low risk through a
1161 formal risk-scoring examination.

1162 (* * *M) This section shall stand repealed on July 1, 2024.

1163 **SECTION 2.** This act shall take effect and be in force from
1164 and after July 1, 2022.

