

By: Representative Roberson

To: Medicaid

HOUSE BILL NO. 251

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO PROHIBIT A MANAGED CARE ORGANIZATION UNDER ANY MANAGED CARE
3 PROGRAM IMPLEMENTED BY THE DIVISION OF MEDICAID FROM TRANSFERRING
4 A BENEFICIARY WHO IS ENROLLED WITH THE MANAGED CARE ORGANIZATION
5 TO ANOTHER MANAGED CARE ORGANIZATION OR TO A FEE-FOR-SERVICE
6 MEDICAID PROVIDER MORE OFTEN THAN ONE TIME IN A PERIOD OF TWELVE
7 MONTHS UNLESS THERE IS A SIGNIFICANT MEDICAL REASON FOR MAKING
8 ANOTHER TRANSFER WITHIN THE TWELVE-MONTH PERIOD, AS DETERMINED BY
9 THE DIVISION; 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



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

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

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

(3) Laboratory and x-ray services.

(4) Nursing facility services.

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



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

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

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

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



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

(6) Physician services. Fees for physician's services that are covered only by Medicaid shall be reimbursed at ninety percent (90%) of the rate established on January 1, 2018, and as may be adjusted each July thereafter, under Medicare. The 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 The division shall increase the amount of the reimbursement rate
261 for restorative dental services for each of the fiscal years 2023,
262 2024 and 2025 by five percent (5%) above the amount of the
263 reimbursement rate for the previous fiscal year. It is the intent
264 of the Legislature that the reimbursement rate revision for
265 preventative dental services will be an incentive to increase the
266 number of dentists who actively provide Medicaid services. This
267 dental services reimbursement rate revision shall be known as the
268 "James Russell Dumas Medicaid Dental Services Incentive Program."



269 The Medical Care Advisory Committee, assisted by the Division
270 of Medicaid, shall annually determine the effect of this incentive
271 by evaluating the number of dentists who are Medicaid providers,
272 the number who and the degree to which they are actively billing
273 Medicaid, the geographic trends of where dentists are offering
274 what types of Medicaid services and other statistics pertinent to
275 the goals of this legislative intent. This data shall annually be
276 presented to the Chair of the Senate Medicaid Committee and the
277 Chair of the House Medicaid Committee.

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

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

290 (12) Intermediate care facility services.

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



year, that a patient is absent from the facility on home leave. Payment may be made for the following home leave days in addition to the sixty-three-day limitation: Christmas, the day before Christmas, the day after Christmas, Thanksgiving, the day before Thanksgiving and the day after Thanksgiving.

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

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

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

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

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

(b) Dialysis center services.

(15) Home- and community-based services for the elderly and disabled, as provided under Title XIX of the federal Social Security Act, as amended, under waivers, subject to the



319 availability of funds specifically appropriated for that purpose
320 by the Legislature.

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

339 (17) Durable medical equipment services and medical
340 supplies. Precertification of durable medical equipment and
341 medical supplies must be obtained as required by the division.
342 The Division of Medicaid may require durable medical equipment
343 providers to obtain a surety bond in the amount and to the



specifications as established by the Balanced Budget Act of 1997.
A maximum dollar amount of reimbursement for noninvasive ventilators or ventilation treatments properly ordered and being used in an appropriate care setting shall not be set by any health maintenance organization, coordinated care organization, provider-sponsored health plan, or other organization paid for services on a capitated basis by the division under any managed care program or coordinated care program implemented by the division under this section. Reimbursement by these organizations to durable medical equipment suppliers for home use of noninvasive and invasive ventilators shall be on a continuous monthly payment basis for the duration of medical need throughout a patient's valid prescription period.

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



participate in an intergovernmental transfer program as provided in Section 1903 of the federal Social Security Act and any applicable regulations.

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

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

(ii) The division shall assess each hospital, nursing facility, and emergency ambulance transportation provider for the sole purpose of financing the state portion of the Medicare Upper Payment Limits Program or other program(s) authorized under this subsection (A)(18)(b). The hospital assessment shall be as provided in Section 43-13-145(4)(a), and the nursing facility and the emergency ambulance transportation assessments, if established, shall be based on Medicaid utilization or other appropriate method, as determined by the



394 division, consistent with federal regulations. The assessments
395 will remain in effect as long as the state participates in the
396 Medicare Upper Payment Limits Program or other program(s)
397 authorized under this subsection (A)(18)(b). In addition to the
398 hospital assessment provided in Section 43-13-145(4)(a), hospitals
399 with physicians participating in the Medicare Upper Payment Limits
400 Program or other program(s) authorized under this subsection
401 (A)(18)(b) shall be required to participate in an
402 intergovernmental transfer or assessment, as determined by the
403 division, for the purpose of financing the state portion of the
404 physician UPL payments or other payment(s) authorized under this
405 subsection (A)(18)(b).

406 (iii) Subject to approval by the Centers for
407 Medicare and Medicaid Services (CMS) and the provisions of this
408 subsection (A)(18)(b), the division shall make additional
409 reimbursement to hospitals, nursing facilities, and emergency
410 ambulance transportation providers for the Medicare Upper Payment
411 Limits Program or other program(s) authorized under this
412 subsection (A)(18)(b), and, if the program is established for
413 physicians, shall make additional reimbursement for physicians, as
414 defined in Section 1902(a)(30) of the federal Social Security Act
415 and any applicable federal regulations, provided the assessment in
416 this subsection (A)(18)(b) is in effect.

417 (iv) Notwithstanding any other provision of
418 this article to the contrary, effective upon implementation of the



419 Mississippi Hospital Access Program (MHAP) provided in
420 subparagraph (c)(i) below, the hospital portion of the inpatient
421 Upper Payment Limits Program shall transition into and be replaced
422 by the MHAP program. However, the division is authorized to
423 develop and implement an alternative fee-for-service Upper Payment
424 Limits model in accordance with federal laws and regulations if
425 necessary to preserve supplemental funding. Further, the
426 division, in consultation with the hospital industry shall develop
427 alternative models for distribution of medical claims and
428 supplemental payments for inpatient and outpatient hospital
429 services, and such models may include, but shall not be limited to
430 the following: increasing rates for inpatient and outpatient
431 services; creating a low-income utilization pool of funds to
432 reimburse hospitals for the costs of uncompensated care, charity
433 care and bad debts as permitted and approved pursuant to federal
434 regulations and the Centers for Medicare and Medicaid Services;
435 supplemental payments based upon Medicaid utilization, quality,
436 service lines and/or costs of providing such services to Medicaid
437 beneficiaries and to uninsured patients. The goals of such
438 payment models shall be to ensure access to inpatient and
439 outpatient care and to maximize any federal funds that are
440 available to reimburse hospitals for services provided. Any such
441 documents required to achieve the goals described in this
442 paragraph shall be submitted to the Centers for Medicare and
443 Medicaid Services, with a proposed effective date of July 1, 2019,



444 to the extent possible, but in no event shall the effective date
445 of such payment models be later than July 1, 2020. The Chairmen
446 of the Senate and House Medicaid Committees shall be provided a
447 copy of the proposed payment model(s) prior to submission.
448 Effective July 1, 2018, and until such time as any payment
449 model(s) as described above become effective, the division, in
450 consultation with the hospital industry, is authorized to
451 implement a transitional program for inpatient and outpatient
452 payments and/or supplemental payments (including, but not limited
453 to, MHAP and directed payments), to redistribute available
454 supplemental funds among hospital providers, provided that when
455 compared to a hospital's prior year supplemental payments,
456 supplemental payments made pursuant to any such transitional
457 program shall not result in a decrease of more than five percent
458 (5%) and shall not increase by more than the amount needed to
459 maximize the distribution of the available funds.

460 (v) 1. To preserve and improve access to
461 ambulance transportation provider services, the division shall
462 seek CMS approval to make ambulance service access payments as set
463 forth in this subsection (A)(18)(b) for all covered emergency
464 ambulance services rendered on or after July 1, 2022, and shall
465 make such ambulance service access payments for all covered
466 services rendered on or after the effective date of CMS approval.

467 2. The division shall calculate the
468 ambulance service access payment amount as the balance of the



469 portion of the Medical Care Fund related to ambulance
470 transportation service provider assessments plus any federal
471 matching funds earned on the balance, up to, but not to exceed,
472 the upper payment limit gap for all emergency ambulance service
473 providers.

474 3. a. Except for ambulance services
475 exempt from the assessment provided in this paragraph (18)(b), all
476 ambulance transportation service providers shall be eligible for
477 ambulance service access payments each state fiscal year as set
478 forth in this paragraph (18)(b).

479 b. In addition to any other funds
480 paid to ambulance transportation service providers for emergency
481 medical services provided to Medicaid beneficiaries, each eligible
482 ambulance transportation service provider shall receive ambulance
483 service access payments each state fiscal year equal to the
484 ambulance transportation service provider's upper payment limit
485 gap. Subject to approval by the Centers for Medicare and Medicaid
486 Services, ambulance service access payments shall be made no less
487 than on a quarterly basis.

488 c. As used in this paragraph
489 (18)(b)(v), the term "upper payment limit gap" means the
490 difference between the total amount that the ambulance
491 transportation service provider received from Medicaid and the
492 average amount that the ambulance transportation service provider



would have received from commercial insurers for those services reimbursed by Medicaid.

4. An ambulance service access payment shall not be used to offset any other payment by the division for emergency or nonemergency services to Medicaid beneficiaries.

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

(ii) Subject to approval by the Centers for Medicare and Medicaid Services (CMS), the MHAP shall provide increased inpatient capitation (PMPM) payments to managed care entities contracting with the division pursuant to subsection (H) of this section to support availability of hospital services or



such other payments permissible under federal law necessary to accomplish the intent of this subsection.

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

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

(19) (a) Perinatal risk management services. The division shall promulgate regulations to be effective from and after October 1, 1988, to establish a comprehensive perinatal system for risk assessment of all pregnant and infant Medicaid recipients and for management, education and follow-up for those who are determined to be at risk. Services to be performed include case management, nutrition assessment/counseling,



543 psychosocial assessment/counseling and health education. The
544 division shall contract with the State Department of Health to
545 provide services within this paragraph (Perinatal High Risk
546 Management/Infant Services System (PHRM/ISS)). The State
547 Department of Health shall be reimbursed on a full reasonable cost
548 basis for services provided under this subparagraph (a).

549 (b) Early intervention system services. The
550 division shall cooperate with the State Department of Health,
551 acting as lead agency, in the development and implementation of a
552 statewide system of delivery of early intervention services, under
553 Part C of the Individuals with Disabilities Education Act (IDEA).
554 The State Department of Health shall certify annually in writing
555 to the executive director of the division the dollar amount of
556 state early intervention funds available that will be utilized as
557 a certified match for Medicaid matching funds. Those funds then
558 shall be used to provide expanded targeted case management
559 services for Medicaid eligible children with special needs who are
560 eligible for the state's early intervention system.

561 Qualifications for persons providing service coordination shall be
562 determined by the State Department of Health and the Division of
563 Medicaid.

564 (20) Home- and community-based services for physically
565 disabled approved services as allowed by a waiver from the United
566 States Department of Health and Human Services for home- and
567 community-based services for physically disabled people using



state funds that are provided from the appropriation to the State Department of Rehabilitation Services and used to match federal funds under a cooperative agreement between the division and the department, provided that funds for these services are specifically appropriated to the Department of Rehabilitation Services.

(21) Nurse practitioner services. Services furnished by a registered nurse who is licensed and certified by the Mississippi Board of Nursing as a nurse practitioner, including, but not limited to, nurse anesthetists, nurse midwives, family nurse practitioners, family planning nurse practitioners, pediatric nurse practitioners, obstetrics-gynecology nurse practitioners and neonatal nurse practitioners, under regulations adopted by the division. Reimbursement for those services shall not exceed ninety percent (90%) of the reimbursement rate for comparable services rendered by a physician. The division may provide for a reimbursement rate for nurse practitioner services of up to one hundred percent (100%) of the reimbursement rate for comparable services rendered by a physician for nurse practitioner services that are provided after the normal working hours of the nurse practitioner, as determined in accordance with regulations of the division.

(22) Ambulatory services delivered in federally qualified health centers, rural health centers and clinics of the local health departments of the State Department of Health for



593 individuals eligible for Medicaid under this article based on
594 reasonable costs as determined by the division. Federally
595 qualified health centers shall be reimbursed by the Medicaid
596 prospective payment system as approved by the Centers for Medicare
597 and Medicaid Services. The division shall recognize federally
598 qualified health centers (FQHCs), rural health clinics (RHCs) and
599 community mental health centers (CMHCs) as both an originating and
600 distant site provider for the purposes of telehealth
601 reimbursement. The division is further authorized and directed to
602 reimburse FQHCs, RHCs and CMHCs for both distant site and
603 originating site services when such services are appropriately
604 provided by the same organization.

605 (23) Inpatient psychiatric services.

606 (a) Inpatient psychiatric services to be
607 determined by the division for recipients under age twenty-one
608 (21) that are provided under the direction of a physician in an
609 inpatient program in a licensed acute care psychiatric facility or
610 in a licensed psychiatric residential treatment facility, before
611 the recipient reaches age twenty-one (21) or, if the recipient was
612 receiving the services immediately before he or she reached age
613 twenty-one (21), before the earlier of the date he or she no
614 longer requires the services or the date he or she reaches age
615 twenty-two (22), as provided by federal regulations. From and
616 after January 1, 2015, the division shall update the fair rental
617 reimbursement system for psychiatric residential treatment



618 facilities. Precertification of inpatient days and residential
619 treatment days must be obtained as required by the division. From
620 and after July 1, 2009, all state-owned and state-operated
621 facilities that provide inpatient psychiatric services to persons
622 under age twenty-one (21) who are eligible for Medicaid
623 reimbursement shall be reimbursed for those services on a full
624 reasonable cost basis.

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

629 (24) [Deleted]

630 (25) [Deleted]

631 (26) Hospice care. As used in this paragraph, the term
632 "hospice care" means a coordinated program of active professional
633 medical attention within the home and outpatient and inpatient
634 care that treats the terminally ill patient and family as a unit,
635 employing a medically directed interdisciplinary team. The
636 program provides relief of severe pain or other physical symptoms
637 and supportive care to meet the special needs arising out of
638 physical, psychological, spiritual, social and economic stresses
639 that are experienced during the final stages of illness and during
640 dying and bereavement and meets the Medicare requirements for
641 participation as a hospice as provided in federal regulations.



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

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

649 (29) The Division of Medicaid may apply for a waiver
650 from the United States Department of Health and Human Services for
651 home- and community-based services for developmentally disabled
652 people using state funds that are provided from the appropriation
653 to the State Department of Mental Health and/or funds transferred
654 to the department by a political subdivision or instrumentality of
655 the state and used to match federal funds under a cooperative
656 agreement between the division and the department, provided that
657 funds for these services are specifically appropriated to the
658 Department of Mental Health and/or transferred to the department
659 by a political subdivision or instrumentality of the state.

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

663 (31) Targeted case management services for children
664 with special needs, under waivers from the United States
665 Department of Health and Human Services, using state funds that
666 are provided from the appropriation to the Mississippi Department



of Human Services and used to match federal funds under a cooperative agreement between the division and the department.

(32) Care and services provided in Christian Science Sanatoria listed and certified by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc., rendered in connection with treatment by prayer or spiritual means to the extent that those services are subject to reimbursement under Section 1903 of the federal Social Security Act.

(33) Podiatrist services.

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

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

(36) Nonemergency transportation services for Medicaid-eligible persons as determined by the division. The PEER Committee shall conduct a performance evaluation of the nonemergency transportation program to evaluate the administration of the program and the providers of transportation services to determine the most cost-effective ways of providing nonemergency



692 transportation services to the patients served under the program.
693 The performance evaluation shall be completed and provided to the
694 members of the Senate Medicaid Committee and the House Medicaid
695 Committee not later than January 1, 2019, and every two (2) years
696 thereafter.

697 (37) [Deleted]

698 (38) Chiropractic services. A chiropractor's manual
699 manipulation of the spine to correct a subluxation, if x-ray
700 demonstrates that a subluxation exists and if the subluxation has
701 resulted in a neuromusculoskeletal condition for which
702 manipulation is appropriate treatment, and related spinal x-rays
703 performed to document these conditions. Reimbursement for
704 chiropractic services shall not exceed Seven Hundred Dollars
705 (\$700.00) per year per beneficiary.

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

714 (40) [Deleted]

715 (41) Services provided by the State Department of
716 Rehabilitation Services for the care and rehabilitation of persons



717 with spinal cord injuries or traumatic brain injuries, as allowed
718 under waivers from the United States Department of Health and
719 Human Services, using up to seventy-five percent (75%) of the
720 funds that are appropriated to the Department of Rehabilitation
721 Services from the Spinal Cord and Head Injury Trust Fund
722 established under Section 37-33-261 and used to match federal
723 funds under a cooperative agreement between the division and the
724 department.

725 (42) [Deleted]

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

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

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

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

739 (45) Physician assistant services. Services furnished
740 by a physician assistant who is licensed by the State Board of
741 Medical Licensure and is practicing with physician supervision



under regulations adopted by the board, under regulations adopted by the division. Reimbursement for those services shall not exceed ninety percent (90%) of the reimbursement rate for comparable services rendered by a physician. The division may provide for a reimbursement rate for physician assistant services of up to one hundred percent (100%) or the reimbursement rate for comparable services rendered by a physician for physician assistant services that are provided after the normal working hours of the physician assistant, as determined in accordance with regulations of the division.

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

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



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

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

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

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

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

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



792 (51) Upon determination of Medicaid eligibility and in
793 association with annual redetermination of Medicaid eligibility,
794 beneficiaries shall be encouraged to undertake a physical
795 examination that will establish a base-line level of health and
796 identification of a usual and customary source of care (a medical
797 home) to aid utilization of disease management tools. This
798 physical examination and utilization of these disease management
799 tools shall be consistent with current United States Preventive
800 Services Task Force or other recognized authority recommendations.

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

804 (52) Notwithstanding any provisions of this article,
805 the division may pay enhanced reimbursement fees related to trauma
806 care, as determined by the division in conjunction with the State
807 Department of Health, using funds appropriated to the State
808 Department of Health for trauma care and services and used to
809 match federal funds under a cooperative agreement between the
810 division and the State Department of Health. The division, in
811 conjunction with the State Department of Health, may use grants,
812 waivers, demonstrations, enhanced reimbursements, Upper Payment
813 Limits Programs, supplemental payments, or other projects as
814 necessary in the development and implementation of this
815 reimbursement program.



816 (53) Targeted case management services for high-cost
817 beneficiaries may be developed by the division for all services
818 under this section.

819 (54) [Deleted]

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

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

837 (57) No Medicaid benefit shall restrict coverage for
838 medically appropriate treatment prescribed by a physician and
839 agreed to by a fully informed individual, or if the individual
840 lacks legal capacity to consent by a person who has legal



841 authority to consent on his or her behalf, based on an
842 individual's diagnosis with a terminal condition. As used in this
843 paragraph (57), "terminal condition" means any aggressive
844 malignancy, chronic end-stage cardiovascular or cerebral vascular
845 disease, or any other disease, illness or condition which a
846 physician diagnoses as terminal.

847 (58) Treatment services for persons with opioid
848 dependency or other highly addictive substance use disorders. The
849 division is authorized to reimburse eligible providers for
850 treatment of opioid dependency and other highly addictive
851 substance use disorders, as determined by the division. Treatment
852 related to these conditions shall not count against any physician
853 visit limit imposed under this section.

854 (59) The division shall allow beneficiaries between the
855 ages of ten (10) and eighteen (18) years to receive vaccines
856 through a pharmacy venue. The division and the State Department
857 of Health shall coordinate and notify OB-GYN providers that the
858 Vaccines for Children program is available to providers free of
859 charge.

860 (60) Border city university-affiliated pediatric
861 teaching hospital.

862 (a) Payments may only be made to a border city
863 university-affiliated pediatric teaching hospital if the Centers
864 for Medicare and Medicaid Services (CMS) approve an increase in
865 the annual request for the provider payment initiative authorized



866 under 42 CFR Section 438.6(c) in an amount equal to or greater
867 than the estimated annual payment to be made to the border city
868 university-affiliated pediatric teaching hospital. The estimate
869 shall be based on the hospital's prior year Mississippi managed
870 care utilization.

871 (b) As used in this paragraph (60), the term
872 "border city university-affiliated pediatric teaching hospital"
873 means an out-of-state hospital located within a city bordering the
874 eastern bank of the Mississippi River and the State of Mississippi
875 that submits to the division a copy of a current and effective
876 affiliation agreement with an accredited university and other
877 documentation establishing that the hospital is
878 university-affiliated, is licensed and designated as a pediatric
879 hospital or pediatric primary hospital within its home state,
880 maintains at least five (5) different pediatric specialty training
881 programs, and maintains at least one hundred (100) operated beds
882 dedicated exclusively for the treatment of patients under the age
883 of twenty-one (21) years.

884 (c) The cost of providing services to Mississippi
885 Medicaid beneficiaries under the age of twenty-one (21) years who
886 are treated by a border city university-affiliated pediatric
887 teaching hospital shall not exceed the cost of providing the same
888 services to individuals in hospitals in the state.

889 (d) It is the intent of the Legislature that
890 payments shall not result in any in-state hospital receiving



891 payments lower than they would otherwise receive if not for the
892 payments made to any border city university-affiliated pediatric
893 teaching hospital.

894 (e) This paragraph (60) shall stand repealed on
895 July 1, 2024.

896 (B) Planning and development districts participating in the
897 home- and community-based services program for the elderly and
898 disabled as case management providers shall be reimbursed for case
899 management services at the maximum rate approved by the Centers
900 for Medicare and Medicaid Services (CMS).

901 (C) The division may pay to those providers who participate
902 in and accept patient referrals from the division's emergency room
903 redirection program a percentage, as determined by the division,
904 of savings achieved according to the performance measures and
905 reduction of costs required of that program. Federally qualified
906 health centers may participate in the emergency room redirection
907 program, and the division may pay those centers a percentage of
908 any savings to the Medicaid program achieved by the centers'
909 accepting patient referrals through the program, as provided in
910 this subsection (C).

911 (D) (1) As used in this subsection (D), the following terms
912 shall be defined as provided in this paragraph, except as
913 otherwise provided in this subsection:



914 (a) "Committees" means the Medicaid Committees of
915 the House of Representatives and the Senate, and "committee" means
916 either one of those committees.

917 (b) "Rate change" means an increase, decrease or
918 other change in the payments or rates of reimbursement, or a
919 change in any payment methodology that results in an increase,
920 decrease or other change in the payments or rates of
921 reimbursement, to any Medicaid provider that renders any services
922 authorized to be provided to Medicaid recipients under this
923 article.

924 (2) Whenever the Division of Medicaid proposes a rate
925 change, the division shall give notice to the chairmen of the
926 committees at least thirty (30) calendar days before the proposed
927 rate change is scheduled to take effect. The division shall
928 furnish the chairmen with a concise summary of each proposed rate
929 change along with the notice, and shall furnish the chairmen with
930 a copy of any proposed rate change upon request. The division
931 also shall provide a summary and copy of any proposed rate change
932 to any other member of the Legislature upon request.

933 (3) If the chairman of either committee or both
934 chairmen jointly object to the proposed rate change or any part
935 thereof, the chairman or chairmen shall notify the division and
936 provide the reasons for their objection in writing not later than
937 seven (7) calendar days after receipt of the notice from the
938 division. The chairman or chairmen may make written



939 recommendations to the division for changes to be made to a
940 proposed rate change.

941 (4) (a) The chairman of either committee or both
942 chairmen jointly may hold a committee meeting to review a proposed
943 rate change. If either chairman or both chairmen decide to hold a
944 meeting, they shall notify the division of their intention in
945 writing within seven (7) calendar days after receipt of the notice
946 from the division, and shall set the date and time for the meeting
947 in their notice to the division, which shall not be later than
948 fourteen (14) calendar days after receipt of the notice from the
949 division.

950 (b) After the committee meeting, the committee or
951 committees may object to the proposed rate change or any part
952 thereof. The committee or committees shall notify the division
953 and the reasons for their objection in writing not later than
954 seven (7) calendar days after the meeting. The committee or
955 committees may make written recommendations to the division for
956 changes to be made to a proposed rate change.

957 (5) If both chairmen notify the division in writing
958 within seven (7) calendar days after receipt of the notice from
959 the division that they do not object to the proposed rate change
960 and will not be holding a meeting to review the proposed rate
961 change, the proposed rate change will take effect on the original
962 date as scheduled by the division or on such other date as
963 specified by the division.



964 (6) (a) If there are any objections to a proposed rate
965 change or any part thereof from either or both of the chairmen or
966 the committees, the division may withdraw the proposed rate
967 change, make any of the recommended changes to the proposed rate
968 change, or not make any changes to the proposed rate change.

969 (b) If the division does not make any changes to
970 the proposed rate change, it shall notify the chairmen of that
971 fact in writing, and the proposed rate change shall take effect on
972 the original date as scheduled by the division or on such other
973 date as specified by the division.

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

978 (7) Nothing in this subsection (D) shall be construed
979 as giving the chairmen or the committees any authority to veto,
980 nullify or revise any rate change proposed by the division. The
981 authority of the chairmen or the committees under this subsection
982 shall be limited to reviewing, making objections to and making
983 recommendations for changes to rate changes proposed by the
984 division.

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



those changes without enabling legislation when the addition of recipients or services is ordered by a court of proper authority.

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

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

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

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

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

To the extent allowed under federal law, any reduction to services or reimbursement rates under this subsection (F) shall be accompanied by a reduction, to the fullest allowable amount, to the profit margin and administrative fee portions of capitated



1013 payments to organizations described in paragraph (1) of subsection
1014 (H) .

1015 Beginning in fiscal year 2010 and in fiscal years thereafter,
1016 when Medicaid expenditures are projected to exceed funds available
1017 for the fiscal year, the division shall submit the expected
1018 shortfall information to the PEER Committee not later than
1019 December 1 of the year in which the shortfall is projected to
1020 occur. PEER shall review the computations of the division and
1021 report its findings to the Legislative Budget Office not later
1022 than January 7 in any year.

1023 (G) Notwithstanding any other provision of this article, it
1024 shall be the duty of each provider participating in the Medicaid
1025 program to keep and maintain books, documents and other records as
1026 prescribed by the Division of Medicaid in accordance with federal
1027 laws and regulations.

1028 (H) (1) Notwithstanding any other provision of this
1029 article, the division is authorized to implement (a) a managed
1030 care program, (b) a coordinated care program, (c) a coordinated
1031 care organization program, (d) a health maintenance organization
1032 program, (e) a patient-centered medical home program, (f) an
1033 accountable care organization program, (g) provider-sponsored
1034 health plan, or (h) any combination of the above programs. As a
1035 condition for the approval of any program under this subsection
1036 (H)(1), the division shall require that no managed care program,
1037 coordinated care program, coordinated care organization program,



1038 health maintenance organization program, or provider-sponsored
1039 health plan may:

1040 (a) Pay providers at a rate that is less than the
1041 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
1042 reimbursement rate;

1043 (b) Override the medical decisions of hospital
1044 physicians or staff regarding patients admitted to a hospital for
1045 an emergency medical condition as defined by 42 US Code Section
1046 1395dd. This restriction (b) does not prohibit the retrospective
1047 review of the appropriateness of the determination that an
1048 emergency medical condition exists by chart review or coding
1049 algorithm, nor does it prohibit prior authorization for
1050 nonemergency hospital admissions;

1051 (c) Pay providers at a rate that is less than the
1052 normal Medicaid reimbursement rate. It is the intent of the
1053 Legislature that all managed care entities described in this
1054 subsection (H), in collaboration with the division, develop and
1055 implement innovative payment models that incentivize improvements
1056 in health care quality, outcomes, or value, as determined by the
1057 division. Participation in the provider network of any managed
1058 care, coordinated care, provider-sponsored health plan, or similar
1059 contractor shall not be conditioned on the provider's agreement to
1060 accept such alternative payment models;

1061 (d) Implement a prior authorization and
1062 utilization review program for medical services, transportation



1063 services and prescription drugs that is more stringent than the
1064 prior authorization processes used by the division in its
1065 administration of the Medicaid program. Not later than December
1066 2, 2021, the contractors that are receiving capitated payments
1067 under a managed care delivery system established under this
1068 subsection (H) shall submit a report to the Chairmen of the House
1069 and Senate Medicaid Committees on the status of the prior
1070 authorization and utilization review program for medical services,
1071 transportation services and prescription drugs that is required to
1072 be implemented under this subparagraph (d);

1073 (e) [Deleted]

1074 (f) Implement a preferred drug list that is more
1075 stringent than the mandatory preferred drug list established by
1076 the division under subsection (A)(9) of this section;

1077 (g) Implement a policy which denies beneficiaries
1078 with hemophilia access to the federally funded hemophilia
1079 treatment centers as part of the Medicaid Managed Care network of
1080 providers.

1081 Each health maintenance organization, coordinated care
1082 organization, provider-sponsored health plan, or other
1083 organization paid for services on a capitated basis by the
1084 division under any managed care program or coordinated care
1085 program implemented by the division under this section shall use a
1086 clear set of level of care guidelines in the determination of
1087 medical necessity and in all utilization management practices,



1088 including the prior authorization process, concurrent reviews,
1089 retrospective reviews and payments, that are consistent with
1090 widely accepted professional standards of care. Organizations
1091 participating in a managed care program or coordinated care
1092 program implemented by the division may not use any additional
1093 criteria that would result in denial of care that would be
1094 determined appropriate and, therefore, medically necessary under
1095 those levels of care guidelines.

1096 (2) Notwithstanding any provision of this section, the
1097 recipients eligible for enrollment into a Medicaid Managed Care
1098 Program authorized under this subsection (H) may include only
1099 those categories of recipients eligible for participation in the
1100 Medicaid Managed Care Program as of January 1, 2021, the
1101 Children's Health Insurance Program (CHIP), and the CMS-approved
1102 Section 1115 demonstration waivers in operation as of January 1,
1103 2021. No expansion of Medicaid Managed Care Program contracts may
1104 be implemented by the division without enabling legislation from
1105 the Mississippi Legislature.

1106 (3) (a) Any contractors receiving capitated payments
1107 under a managed care delivery system established in this section
1108 shall provide to the Legislature and the division statistical data
1109 to be shared with provider groups in order to improve patient
1110 access, appropriate utilization, cost savings and health outcomes
1111 not later than October 1 of each year. Additionally, each
1112 contractor shall disclose to the Chairmen of the Senate and House



1113 Medicaid Committees the administrative expenses costs for the
1114 prior calendar year, and the number of full-equivalent employees
1115 located in the State of Mississippi dedicated to the Medicaid and
1116 CHIP lines of business as of June 30 of the current year.

1117 (b) The division and the contractors participating
1118 in the managed care program, a coordinated care program or a
1119 provider-sponsored health plan shall be subject to annual program
1120 reviews or audits performed by the Office of the State Auditor,
1121 the PEER Committee, the Department of Insurance and/or independent
1122 third parties.

1123 (c) Those reviews shall include, but not be
1124 limited to, at least two (2) of the following items:

1125 (i) The financial benefit to the State of
1126 Mississippi of the managed care program,

1127 (ii) The difference between the premiums paid
1128 to the managed care contractors and the payments made by those
1129 contractors to health care providers,

1130 (iii) Compliance with performance measures
1131 required under the contracts,

1132 (iv) Administrative expense allocation
1133 methodologies,

1134 (v) Whether nonprovider payments assigned as
1135 medical expenses are appropriate,

1136 (vi) Capitated arrangements with related
1137 party subcontractors,



1138 (vii) Reasonableness of corporate
1139 allocations,
1140 (viii) Value-added benefits and the extent to
1141 which they are used,
1142 (ix) The effectiveness of subcontractor
1143 oversight, including subcontractor review,
1144 (x) Whether health care outcomes have been
1145 improved, and
1146 (xi) The most common claim denial codes to
1147 determine the reasons for the denials.

1148 The audit reports shall be considered public documents and
1149 shall be posted in their entirety on the division's website.

1150 (4) All health maintenance organizations, coordinated
1151 care organizations, provider-sponsored health plans, or other
1152 organizations paid for services on a capitated basis by the
1153 division under any managed care program or coordinated care
1154 program implemented by the division under this section shall
1155 reimburse all providers in those organizations at rates no lower
1156 than those provided under this section for beneficiaries who are
1157 not participating in those programs.

1158 (5) No health maintenance organization, coordinated
1159 care organization, provider-sponsored health plan, or other
1160 organization paid for services on a capitated basis by the
1161 division under any managed care program or coordinated care
1162 program implemented by the division under this section shall



1163 require its providers or beneficiaries to use any pharmacy that
1164 ships, mails or delivers prescription drugs or legend drugs or
1165 devices.

1166 (6) (a) Not later than December 1, 2021, the
1167 contractors who are receiving capitated payments under a managed
1168 care delivery system established under this subsection (H) shall
1169 develop and implement a uniform credentialing process for
1170 providers. Under that uniform credentialing process, a provider
1171 who meets the criteria for credentialing will be credentialed with
1172 all of those contractors and no such provider will have to be
1173 separately credentialed by any individual contractor in order to
1174 receive reimbursement from the contractor. Not later than
1175 December 2, 2021, those contractors shall submit a report to the
1176 Chairmen of the House and Senate Medicaid Committees on the status
1177 of the uniform credentialing process for providers that is
1178 required under this subparagraph (a).

1179 (b) If those contractors have not implemented a
1180 uniform credentialing process as described in subparagraph (a) by
1181 December 1, 2021, the division shall develop and implement, not
1182 later than July 1, 2022, a single, consolidated credentialing
1183 process by which all providers will be credentialed. Under the
1184 division's single, consolidated credentialing process, no such
1185 contractor shall require its providers to be separately
1186 credentialed by the contractor in order to receive reimbursement
1187 from the contractor, but those contractors shall recognize the



1188 credentialing of the providers by the division's credentialing
1189 process.

1190 (c) The division shall require a uniform provider
1191 credentialing application that shall be used in the credentialing
1192 process that is established under subparagraph (a) or (b). If the
1193 contractor or division, as applicable, has not approved or denied
1194 the provider credentialing application within sixty (60) days of
1195 receipt of the completed application that includes all required
1196 information necessary for credentialing, then the contractor or
1197 division, upon receipt of a written request from the applicant and
1198 within five (5) business days of its receipt, shall issue a
1199 temporary provider credential/enrollment to the applicant if the
1200 applicant has a valid Mississippi professional or occupational
1201 license to provide the health care services to which the
1202 credential/enrollment would apply. The contractor or the division
1203 shall not issue a temporary credential/enrollment if the applicant
1204 has reported on the application a history of medical or other
1205 professional or occupational malpractice claims, a history of
1206 substance abuse or mental health issues, a criminal record, or a
1207 history of medical or other licensing board, state or federal
1208 disciplinary action, including any suspension from participation
1209 in a federal or state program. The temporary
1210 credential/enrollment shall be effective upon issuance and shall
1211 remain in effect until the provider's credentialing/enrollment
1212 application is approved or denied by the contractor or division.



1213 The contractor or division shall render a final decision regarding
1214 credentialing/enrollment of the provider within sixty (60) days
1215 from the date that the temporary provider credential/enrollment is
1216 issued to the applicant.

1217 (d) If the contractor or division does not render
1218 a final decision regarding credentialing/enrollment of the
1219 provider within the time required in subparagraph (c), the
1220 provider shall be deemed to be credentialed by and enrolled with
1221 all of the contractors and eligible to receive reimbursement from
1222 the contractors.

1223 (7) (a) Each contractor that is receiving capitated
1224 payments under a managed care delivery system established under
1225 this subsection (H) shall provide to each provider for whom the
1226 contractor has denied the coverage of a procedure that was ordered
1227 or requested by the provider for or on behalf of a patient, a
1228 letter that provides a detailed explanation of the reasons for the
1229 denial of coverage of the procedure and the name and the
1230 credentials of the person who denied the coverage. The letter
1231 shall be sent to the provider in electronic format.

1232 (b) After a contractor that is receiving capitated
1233 payments under a managed care delivery system established under
1234 this subsection (H) has denied coverage for a claim submitted by a
1235 provider, the contractor shall issue to the provider within sixty
1236 (60) days a final ruling of denial of the claim that allows the
1237 provider to have a state fair hearing and/or agency appeal with



1238 the division. If a contractor does not issue a final ruling of
1239 denial within sixty (60) days as required by this subparagraph
1240 (b), the provider's claim shall be deemed to be automatically
1241 approved and the contractor shall pay the amount of the claim to
1242 the provider.

1243 (c) After a contractor has issued a final ruling
1244 of denial of a claim submitted by a provider, the division shall
1245 conduct a state fair hearing and/or agency appeal on the matter of
1246 the disputed claim between the contractor and the provider within
1247 sixty (60) days, and shall render a decision on the matter within
1248 thirty (30) days after the date of the hearing and/or appeal.

1249 (8) It is the intention of the Legislature that the
1250 division evaluate the feasibility of using a single vendor to
1251 administer pharmacy benefits provided under a managed care
1252 delivery system established under this subsection (H). Providers
1253 of pharmacy benefits shall cooperate with the division in any
1254 transition to a carve-out of pharmacy benefits under managed care.

1255 (9) The division shall evaluate the feasibility of
1256 using a single vendor to administer dental benefits provided under
1257 a managed care delivery system established in this subsection (H).
1258 Providers of dental benefits shall cooperate with the division in
1259 any transition to a carve-out of dental benefits under managed
1260 care.

1261 (10) It is the intent of the Legislature that any
1262 contractor receiving capitated payments under a managed care



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

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

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



1288 shall be revised to incorporate any provisions of this subsection
1289 (H) .

1290 (13) A health maintenance organization, coordinated
1291 care organization, provider-sponsored health plan, or other
1292 organization paid for services on a capitated basis by the
1293 division under any managed care program or coordinated care
1294 program implemented by the division under this section may not
1295 transfer a beneficiary who is enrolled with the managed care
1296 organization to another managed care organization or to a
1297 fee-for-service Medicaid provider more often than one time in a
1298 period of twelve (12) months unless there is a significant medical
1299 reason for making another transfer within the twelve-month period,
1300 as determined by the division.

1301 (I) [Deleted]

1302 (J) There shall be no cuts in inpatient and outpatient
1303 hospital payments, or allowable days or volumes, as long as the
1304 hospital assessment provided in Section 43-13-145 is in effect.
1305 This subsection (J) shall not apply to decreases in payments that
1306 are a result of: reduced hospital admissions, audits or payments
1307 under the APR-DRG or APC models, or a managed care program or
1308 similar model described in subsection (H) of this section.

1309 (K) In the negotiation and execution of such contracts
1310 involving services performed by actuarial firms, the Executive
1311 Director of the Division of Medicaid may negotiate a limitation on
1312 liability to the state of prospective contractors.



1313 (L) The Division of Medicaid shall reimburse for services
1314 provided to eligible Medicaid beneficiaries by a licensed birthing
1315 center in a method and manner to be determined by the division in
1316 accordance with federal laws and federal regulations. The
1317 division shall seek any necessary waivers, make any required
1318 amendments to its State Plan or revise any contracts authorized
1319 under subsection (H) of this section as necessary to provide the
1320 services authorized under this subsection. As used in this
1321 subsection, the term "birthing centers" shall have the meaning as
1322 defined in Section 41-77-1(a), which is a publicly or privately
1323 owned facility, place or institution constructed, renovated,
1324 leased or otherwise established where nonemergency births are
1325 planned to occur away from the mother's usual residence following
1326 a documented period of prenatal care for a normal uncomplicated
1327 pregnancy which has been determined to be low risk through a
1328 formal risk-scoring examination.

1329 (M) This section shall stand repealed on July 1, 2024.

1330 **SECTION 2.** This act shall take effect and be in force from
1331 and after July 1, 2023.

