MISSISSIPPI LEGISLATURE REGULAR SESSION 2024

By: Representative McGee

To: Medicaid

HOUSE BILL NO. 970

AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO EXTEND THE DATE OF THE REPEALER ON THE SERVICES AND MANAGED CARE PROVISIONS IN THE MEDICAID PROGRAM; TO AMEND SECTION 43-13-145, MISSISSIPPI CODE OF 1972, TO EXTEND THE DATE OF THE REPEALER ON THE MEDICAID PROVIDER ASSESSMENT PROVISIONS; AND FOR RELATED PURPOSES.

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

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

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

(1) Inpatient hospital services.

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

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

(2) Outpatient hospital services.

(a) Emergency services.

(b) Other outpatient hospital services. The division shall allow benefits for other medically necessary outpatient hospital services (such as chemotherapy, radiation, surgery and therapy), including outpatient services in a clinic or other facility that is not located inside the hospital, but that has been designated as an outpatient facility by the hospital, and that was in operation or under construction on July 1, 2009, provided that the costs and charges associated with the operation of the hospital clinic are included in the hospital's cost report. In addition, the Medicare thirty-five-mile rule will apply to those hospital clinics not located inside the hospital that are constructed after July 1, 2009. Where the same services are 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 before Christmas, the day after Christmas, Thanksgiving, the day before Thanksgiving and the day after Thanksgiving.

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

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

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

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

(e) The division shall develop and implement, not 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 services of up to one hundred percent (100%) of the rate established under Medicare for physician's services that are provided after the normal working hours of the physician, as determined in accordance with regulations of the division. The

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

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

(b) [Repealed]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

setting, to be reimbursed as either a medical claim or pharmacy claim, as determined by the division.

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

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

The division shall increase the amount of the reimbursement rate for diagnostic and preventative dental services for each of the fiscal years 2022, 2023 and 2024 by five percent (5%) above the amount of the reimbursement rate for the previous fiscal year. The division shall increase the amount of the reimbursement rate for restorative dental services for each of the fiscal years 2023, 2024 and 2025 by five percent (5%) above the amount of the reimbursement rate for the previous fiscal year. It is the intent of the Legislature that the reimbursement rate revision for preventative dental services will be an incentive to increase the number of dentists who actively provide Medicaid services. This dental services reimbursement rate revision shall be known as the "James Russell Dumas Medicaid Dental Services Incentive Program."

The Medical Care Advisory Committee, assisted by the Division of Medicaid, shall annually determine the effect of this incentive by evaluating the number of dentists who are Medicaid providers, the number who and the degree to which they are actively billing

Medicaid, the geographic trends of where dentists are offering what types of Medicaid services and other statistics pertinent to the goals of this legislative intent. This data shall annually be presented to the Chair of the Senate Medicaid Committee and the Chair of the House Medicaid Committee.

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

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

(12) Intermediate care facility services.

(a) The division shall make full payment to all intermediate care facilities for individuals with intellectual 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 availability of funds specifically appropriated for that purpose by the Legislature.

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

(17) Durable medical equipment services and medical supplies. Precertification of durable medical equipment and medical supplies must be obtained as required by the division. The Division of Medicaid may require durable medical equipment 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 division, consistent with federal regulations. The assessments

will remain in effect as long as the state participates in the Medicare Upper Payment Limits Program or other program(s) authorized under this subsection (A)(18)(b). In addition to the hospital assessment provided in Section 43-13-145(4)(a), hospitals with physicians participating in the Medicare Upper Payment Limits Program or other program(s) authorized under this subsection (A)(18)(b) shall be required to participate in an intergovernmental transfer or assessment, as determined by the division, for the purpose of financing the state portion of the physician UPL payments or other payment(s) authorized under this subsection (A)(18)(b).

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

(iv) Notwithstanding any other provision of this article to the contrary, effective upon implementation of the Mississippi Hospital Access Program (MHAP) provided in

subparagraph (c)(i) below, the hospital portion of the inpatient Upper Payment Limits Program shall transition into and be replaced by the MHAP program. However, the division is authorized to develop and implement an alternative fee-for-service Upper Payment Limits model in accordance with federal laws and regulations if necessary to preserve supplemental funding. Further, the division, in consultation with the hospital industry shall develop alternative models for distribution of medical claims and supplemental payments for inpatient and outpatient hospital services, and such models may include, but shall not be limited to the following: increasing rates for inpatient and outpatient services; creating a low-income utilization pool of funds to reimburse hospitals for the costs of uncompensated care, charity care and bad debts as permitted and approved pursuant to federal regulations and the Centers for Medicare and Medicaid Services; supplemental payments based upon Medicaid utilization, quality, service lines and/or costs of providing such services to Medicaid beneficiaries and to uninsured patients. The goals of such payment models shall be to ensure access to inpatient and outpatient care and to maximize any federal funds that are available to reimburse hospitals for services provided. Any such documents required to achieve the goals described in this paragraph shall be submitted to the Centers for Medicare and Medicaid Services, with a proposed effective date of July 1, 2019, to the extent possible, but in no event shall the effective date

of such payment models be later than July 1, 2020. The Chairmen of the Senate and House Medicaid Committees shall be provided a copy of the proposed payment model(s) prior to submission. Effective July 1, 2018, and until such time as any payment model(s) as described above become effective, the division, in consultation with the hospital industry, is authorized to implement a transitional program for inpatient and outpatient payments and/or supplemental payments (including, but not limited to, MHAP and directed payments), to redistribute available supplemental funds among hospital providers, provided that when compared to a hospital's prior year supplemental payments, supplemental payments made pursuant to any such transitional program shall not result in a decrease of more than five percent (5%) and shall not increase by more than the amount needed to maximize the distribution of the available funds.

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

2. The division shall calculate the ambulance service access payment amount as the balance of the portion of the Medical Care Fund related to ambulance

transportation service provider assessments plus any federal matching funds earned on the balance, up to, but not to exceed, the upper payment limit gap for all emergency ambulance service providers.

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

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

c. As used in this paragraph (18)(b)(v), the term "upper payment limit gap" means the difference between the total amount that the ambulance transportation service provider received from Medicaid and the 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, psychosocial assessment/counseling and health education. The division shall contract with the State Department of Health to

provide services within this paragraph (Perinatal High Risk Management/Infant Services System (PHRM/ISS)). The State Department of Health shall be reimbursed on a full reasonable cost basis for services provided under this subparagraph (a).

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

(20) Home- and community-based services for physically disabled approved services as allowed by a waiver from the United States Department of Health and Human Services for home- and 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 individuals eligible for Medicaid under this article based on reasonable costs as determined by the division. Federally

qualified health centers shall be reimbursed by the Medicaid prospective payment system as approved by the Centers for Medicare and Medicaid Services. The division shall recognize federally qualified health centers (FQHCs), rural health clinics (RHCs) and community mental health centers (CMHCs) as both an originating and distant site provider for the purposes of telehealth reimbursement. The division is further authorized and directed to reimburse FQHCs, RHCs and CMHCs for both distant site and originating site services when such services are appropriately provided by the same organization.

(23) Inpatient psychiatric services.

(a) Inpatient psychiatric services to be determined by the division for recipients under age twenty-one (21) that are provided under the direction of a physician in an inpatient program in a licensed acute care psychiatric facility or in a licensed psychiatric residential treatment facility, before the recipient reaches age twenty-one (21) or, if the recipient was receiving the services immediately before he or she reached age twenty-one (21), before the earlier of the date he or she no longer requires the services or the date he or she reaches age twenty-two (22), as provided by federal regulations. From and after January 1, 2015, the division shall update the fair rental reimbursement system for psychiatric residential treatment facilities. Precertification of inpatient days and residential treatment days must be obtained as required by the division. From

and after July 1, 2009, all state-owned and state-operated facilities that provide inpatient psychiatric services to persons under age twenty-one (21) who are eligible for Medicaid reimbursement shall be reimbursed for those services on a full reasonable cost basis.

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

(24) [Deleted]

(25) [Deleted]

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

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

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

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

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

(31) Targeted case management services for children with special needs, under waivers from the United States Department of Health and Human Services, 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.

(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 transportation services to the patients served under the program. The performance evaluation shall be completed and provided to the

members of the Senate Medicaid Committee and the House Medicaid Committee not later than January 1, 2019, and every two (2) years thereafter.

(37) [Deleted]

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

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

(40) [Deleted]

(41) Services provided by the State Department of Rehabilitation Services for the care and rehabilitation of persons with spinal cord injuries or traumatic brain injuries, as allowed under waivers from the United States Department of Health and

Human Services, using up to seventy-five percent (75%) of the funds that are appropriated to the Department of Rehabilitation Services from the Spinal Cord and Head Injury Trust Fund established under Section 37-33-261 and used to match federal funds under a cooperative agreement between the division and the department.

(42) [Deleted]

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

(44) Nursing facility services for the severely disabled.

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

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

(45) Physician assistant services. Services furnished by a physician assistant who is licensed by the State Board of 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 waivered 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.

(51) Upon determination of Medicaid eligibility and in association with annual redetermination of Medicaid eligibility,

beneficiaries shall be encouraged to undertake a physical examination that will establish a base-line level of health and identification of a usual and customary source of care (a medical home) to aid utilization of disease management tools. This physical examination and utilization of these disease management tools shall be consistent with current United States Preventive Services Task Force or other recognized authority recommendations.

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

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

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

(54) [Deleted]

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

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

(57) No Medicaid benefit shall restrict coverage for medically appropriate treatment prescribed by a physician and agreed to by a fully informed individual, or if the individual lacks legal capacity to consent by a person who has legal authority to consent on his or her behalf, based on an individual's diagnosis with a terminal condition. As used in this paragraph (57), "terminal condition" means any aggressive

malignancy, chronic end-stage cardiovascular or cerebral vascular disease, or any other disease, illness or condition which a physician diagnoses as terminal.

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

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

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

(a) Payments may only be made to a border city university-affiliated pediatric teaching hospital if the Centers for Medicare and Medicaid Services (CMS) approve an increase in the annual request for the provider payment initiative authorized under 42 CFR Section 438.6(c) in an amount equal to or greater than the estimated annual payment to be made to the border city university-affiliated pediatric teaching hospital. The estimate

shall be based on the hospital's prior year Mississippi managed care utilization.

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

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

(d) It is the intent of the Legislature that payments shall not result in any in-state hospital receiving payments lower than they would otherwise receive if not for the payments made to any border city university-affiliated pediatric teaching hospital.

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

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

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

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

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

(b) "Rate change" means an increase, decrease or other change in the payments or rates of reimbursement, or a

change in any payment methodology that results in an increase, decrease or other change in the payments or rates of reimbursement, to any Medicaid provider that renders any services authorized to be provided to Medicaid recipients under this article.

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

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

(4) (a) The chairman of either committee or both chairmen jointly may hold a committee meeting to review a proposed rate change. If either chairman or both chairmen decide to hold a

meeting, they shall notify the division of their intention in writing within seven (7) calendar days after receipt of the notice from the division, and shall set the date and time for the meeting in their notice to the division, which shall not be later than fourteen (14) calendar days after receipt of the notice from the division.

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

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

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

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

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

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

(E) Notwithstanding any provision of this article, no new groups or categories of recipients and new types of care and services may be added without enabling legislation from the 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 payments to organizations described in paragraph (1) of subsection (H).

Beginning in fiscal year 2010 and in fiscal years thereafter, when Medicaid expenditures are projected to exceed funds available for the fiscal year, the division shall submit the expected shortfall information to the PEER Committee not later than

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

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

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

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

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

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

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

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

(e) [Deleted]

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

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

Each 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 shall use a clear set of level of care guidelines in the determination of medical necessity and in all utilization management practices, including the prior authorization process, concurrent reviews, retrospective reviews and payments, that are consistent with widely accepted professional standards of care. Organizations participating in a managed care program or coordinated care program implemented by the division may not use any additional

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

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

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

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

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

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

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

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

(iv) Administrative expense allocation methodologies,

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

(vi) Capitated arrangements with related party subcontractors,

(vii) Reasonableness of corporate allocations,

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

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

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

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

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

(4) All health maintenance organizations, coordinated care organizations, provider-sponsored health plans, or other organizations 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 shall reimburse all providers in those organizations at rates no lower than those provided under this section for beneficiaries who are not participating in those programs.

(5) No 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 shall require its providers or beneficiaries to use any pharmacy that ships, mails or delivers prescription drugs or legend drugs or devices.

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

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

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

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

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

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

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

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

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

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

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

(10) It is the intent of the Legislature that any 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

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

(I) [Deleted]

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

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

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

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

(M) This section shall stand repealed on July 1, * * * 2028.

SECTION 2. Section 43-13-145, Mississippi Code of 1972, is amended as follows:

43-13-145. (1) (a) Upon each nursing facility licensed by the State of Mississippi, there is levied an assessment in an amount set by the division, equal to the maximum rate allowed by federal law or regulation, for each licensed and occupied bed of the facility.

(b) A nursing facility is exempt from the assessment levied under this subsection if the facility is operated under the direction and control of:

(i) The United States Veterans Administration or other agency or department of the United States government; or

(ii) The State Veterans Affairs Board.

(2) (a) Upon each intermediate care facility for individuals with intellectual disabilities licensed by the State of Mississippi, there is levied an assessment in an amount set by the division, equal to the maximum rate allowed by federal law or regulation, for each licensed and occupied bed of the facility.

(b) An intermediate care facility for individuals with intellectual disabilities is exempt from the assessment levied under this subsection if the facility is operated under the direction and control of:

(i) The United States Veterans Administration or other agency or department of the United States government;

(ii) The State Veterans Affairs Board; or

(iii) The University of Mississippi Medical Center.

(3) (a) Upon each psychiatric residential treatment facility licensed by the State of Mississippi, there is levied an assessment in an amount set by the division, equal to the maximum rate allowed by federal law or regulation, for each licensed and occupied bed of the facility.

(b) A psychiatric residential treatment facility is exempt from the assessment levied under this subsection if the facility is operated under the direction and control of:

(i) The United States Veterans Administration or other agency or department of the United States government;

(ii) The University of Mississippi Medical Center; or

(iii) A state agency or a state facility that either provides its own state match through intergovernmental transfer or certification of funds to the division.

(4) Hospital assessment.

(a) (i) Subject to and upon fulfillment of the requirements and conditions of paragraph (f) below, and notwithstanding any other provisions of this section, an annual assessment on each hospital licensed in the state is imposed on each non-Medicare hospital inpatient day as defined below at a rate that is determined by dividing the sum prescribed in this subparagraph (i), plus the nonfederal share necessary to maximize the Disproportionate Share Hospital (DSH) and Medicare Upper Payment Limits (UPL) Program payments and hospital access payments and such other supplemental payments as may be developed pursuant to Section 43-13-117(A)(18), by the total number of non-Medicare hospital inpatient days as defined below for all licensed Mississippi hospitals, except as provided in paragraph (d) below. If the state-matching funds percentage for the Mississippi Medicaid program is sixteen percent (16%) or less, the sum used in the formula under this subparagraph (i) shall be Seventy-four Million Dollars ($74,000,000.00). If the state-matching funds percentage for the Mississippi Medicaid program is twenty-four percent (24%) or higher, the sum used in the formula under this subparagraph (i) shall be One Hundred Four Million Dollars ($104,000,000.00). If the state-matching funds percentage for the Mississippi Medicaid program is between sixteen percent (16%) and twenty-four percent (24%), the sum used in the formula under this subparagraph (i) shall be a pro rata amount determined as follows: the current state-matching funds percentage rate minus sixteen

percent (16%) divided by eight percent (8%) multiplied by Thirty Million Dollars ($30,000,000.00) and add that amount to Seventy-four Million Dollars ($74,000,000.00). However, no assessment in a quarter under this subparagraph (i) may exceed the assessment in the previous quarter by more than Three Million Seven Hundred Fifty Thousand Dollars ($3,750,000.00) (which would be Fifteen Million Dollars ($15,000,000.00) on an annualized basis). The division shall publish the state-matching funds percentage rate applicable to the Mississippi Medicaid program on the tenth day of the first month of each quarter and the assessment determined under the formula prescribed above shall be applicable in the quarter following any adjustment in that state-matching funds percentage rate. The division shall notify each hospital licensed in the state as to any projected increases or decreases in the assessment determined under this subparagraph (i). However, if the Centers for Medicare and Medicaid Services (CMS) does not approve the provision in Section 43-13-117(39) requiring the division to reimburse crossover claims for inpatient hospital services and crossover claims covered under Medicare Part B for dually eligible beneficiaries in the same manner that was in effect on January 1, 2008, the sum that otherwise would have been used in the formula under this subparagraph (i) shall be reduced by Seven Million Dollars ($7,000,000.00).

(ii) In addition to the assessment provided under subparagraph (i), an additional annual assessment on each hospital

licensed in the state is imposed on each non-Medicare hospital inpatient day as defined below at a rate that is determined by dividing twenty-five percent (25%) of any provider reductions in the Medicaid program as authorized in Section 43-13-117(F) for that fiscal year up to the following maximum amount, plus the nonfederal share necessary to maximize the Disproportionate Share Hospital (DSH) and inpatient Medicare Upper Payment Limits (UPL) Program payments and inpatient hospital access payments, by the total number of non-Medicare hospital inpatient days as defined below for all licensed Mississippi hospitals: in fiscal year 2010, the maximum amount shall be Twenty-four Million Dollars ($24,000,000.00); in fiscal year 2011, the maximum amount shall be Thirty-two Million Dollars ($32,000,000.00); and in fiscal year 2012 and thereafter, the maximum amount shall be Forty Million Dollars ($40,000,000.00). Any such deficit in the Medicaid program shall be reviewed by the PEER Committee as provided in Section 43-13-117(F).

(iii) In addition to the assessments provided in subparagraphs (i) and (ii), an additional annual assessment on each hospital licensed in the state is imposed pursuant to the provisions of Section 43-13-117(F) if the cost-containment measures described therein have been implemented and there are insufficient funds in the Health Care Trust Fund to reconcile any remaining deficit in any fiscal year. If the Governor institutes any other additional cost-containment measures on any program or

programs authorized under the Medicaid program pursuant to Section 43-13-117(F), hospitals shall be responsible for twenty-five percent (25%) of any such additional imposed provider cuts, which shall be in the form of an additional assessment not to exceed the twenty-five percent (25%) of provider expenditure reductions. Such additional assessment shall be imposed on each non-Medicare hospital inpatient day in the same manner as assessments are imposed under subparagraphs (i) and (ii).

(b) Definitions.

(i) [Deleted]

(ii) For purposes of this subsection (4):

1. "Non-Medicare hospital inpatient day" means total hospital inpatient days including subcomponent days less Medicare inpatient days including subcomponent days from the hospital's most recent Medicare cost report for the second calendar year preceding the beginning of the state fiscal year, on file with CMS per the CMS HCRIS database, or cost report submitted to the Division if the HCRIS database is not available to the division, as of June 1 of each year.

a. Total hospital inpatient days shall be the sum of Worksheet S-3, Part 1, column 8 row 14, column 8 row 16, and column 8 row 17, excluding column 8 rows 5 and 6.

b. Hospital Medicare inpatient days shall be the sum of Worksheet S-3, Part 1, column 6 row 14, column 6 row 16.00, and column 6 row 17, excluding column 6 rows 5 and 6.

c. Inpatient days shall not include residential treatment or long-term care days.

2. "Subcomponent inpatient day" means the number of days of care charged to a beneficiary for inpatient hospital rehabilitation and psychiatric care services in units of full days. A day begins at midnight and ends twenty-four (24) hours later. A part of a day, including the day of admission and day on which a patient returns from leave of absence, counts as a full day. However, the day of discharge, death, or a day on which a patient begins a leave of absence is not counted as a day unless discharge or death occur on the day of admission. If admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one (1) subcomponent inpatient day.

(c) The assessment provided in this subsection is intended to satisfy and not be in addition to the assessment and intergovernmental transfers provided in Section 43-13-117(A)(18). Nothing in this section shall be construed to authorize any state agency, division or department, or county, municipality or other local governmental unit to license for revenue, levy or impose any other tax, fee or assessment upon hospitals in this state not authorized by a specific statute.

(d) Hospitals operated by the United States Department of Veterans Affairs and state-operated facilities that provide

only inpatient and outpatient psychiatric services shall not be subject to the hospital assessment provided in this subsection.

(e) Multihospital systems, closure, merger, change of ownership and new hospitals.

(i) If a hospital conducts, operates or maintains more than one (1) hospital licensed by the State Department of Health, the provider shall pay the hospital assessment for each hospital separately.

(ii) Notwithstanding any other provision in this section, if a hospital subject to this assessment operates or conducts business only for a portion of a fiscal year, the assessment for the state fiscal year shall be adjusted by multiplying the assessment by a fraction, the numerator of which is the number of days in the year during which the hospital operates, and the denominator of which is three hundred sixty-five (365). Immediately upon ceasing to operate, the hospital shall pay the assessment for the year as so adjusted (to the extent not previously paid).

(iii) The division shall determine the tax for new hospitals and hospitals that undergo a change of ownership in accordance with this section, using the best available information, as determined by the division.

(f) Applicability.

The hospital assessment imposed by this subsection shall not take effect and/or shall cease to be imposed if:

(i) The assessment is determined to be an impermissible tax under Title XIX of the Social Security Act; or

(ii) CMS revokes its approval of the division's 2009 Medicaid State Plan Amendment for the methodology for DSH payments to hospitals under Section 43-13-117(A)(18).

(5) Each health care facility that is subject to the provisions of this section shall keep and preserve such suitable books and records as may be necessary to determine the amount of assessment for which it is liable under this section. The books and records shall be kept and preserved for a period of not less than five (5) years, during which time those books and records shall be open for examination during business hours by the division, the Department of Revenue, the Office of the Attorney General and the State Department of Health.

(6) [Deleted]

(7) All assessments collected under this section shall be deposited in the Medical Care Fund created by Section 43-13-143.

(8) The assessment levied under this section shall be in addition to any other assessments, taxes or fees levied by law, and the assessment shall constitute a debt due the State of Mississippi from the time the assessment is due until it is paid.

(9) (a) If a health care facility that is liable for payment of an assessment levied by the division does not pay the assessment when it is due, the division shall give written notice to the health care facility demanding payment of the assessment

within ten (10) days from the date of delivery of the notice. If the health care facility fails or refuses to pay the assessment after receiving the notice and demand from the division, the division shall withhold from any Medicaid reimbursement payments that are due to the health care facility the amount of the unpaid assessment and a penalty of ten percent (10%) of the amount of the assessment, plus the legal rate of interest until the assessment is paid in full. If the health care facility does not participate in the Medicaid program, the division shall turn over to the Office of the Attorney General the collection of the unpaid assessment by civil action. In any such civil action, the Office of the Attorney General shall collect the amount of the unpaid assessment and a penalty of ten percent (10%) of the amount of the assessment, plus the legal rate of interest until the assessment is paid in full.

(b) As an additional or alternative method for collecting unpaid assessments levied by the division, if a health care facility fails or refuses to pay the assessment after receiving notice and demand from the division, the division may file a notice of a tax lien with the chancery clerk of the county in which the health care facility is located, for the amount of the unpaid assessment and a penalty of ten percent (10%) of the amount of the assessment, plus the legal rate of interest until the assessment is paid in full. Immediately upon receipt of notice of the tax lien for the assessment, the chancery clerk

shall forward the notice to the circuit clerk who shall enter the notice of the tax lien as a judgment upon the judgment roll and show in the appropriate columns the name of the health care facility as judgment debtor, the name of the division as judgment creditor, the amount of the unpaid assessment, and the date and time of enrollment. The judgment shall be valid as against mortgagees, pledgees, entrusters, purchasers, judgment creditors and other persons from the time of filing with the clerk. The amount of the judgment shall be a debt due the State of Mississippi and remain a lien upon the tangible property of the health care facility until the judgment is satisfied. The judgment shall be the equivalent of any enrolled judgment of a court of record and shall serve as authority for the issuance of writs of execution, writs of attachment or other remedial writs.

(10) (a) To further the provisions of Section 43-13-117(A)(18), the Division of Medicaid shall submit to the Centers for Medicare and Medicaid Services (CMS) any documents regarding the hospital assessment established under subsection (4) of this section. In addition to defining the assessment established in subsection (4) of this section if necessary, the documents shall describe any supplement payment programs and/or payment methodologies as authorized in Section 43-13-117(A)(18) if necessary.

(b) All hospitals satisfying the minimum federal DSH eligibility requirements (Section 1923(d) of the Social Security

Act) may, subject to OBRA 1993 payment limitations, receive a DSH payment. This DSH payment shall expend the balance of the federal DSH allotment and associated state share not utilized in DSH payments to state-owned institutions for treatment of mental diseases. The payment to each hospital shall be calculated by applying a uniform percentage to the uninsured costs of each eligible hospital, excluding state-owned institutions for treatment of mental diseases; however, that percentage for a state-owned teaching hospital located in Hinds County shall be multiplied by a factor of two (2).

(11) The division shall implement DSH and supplemental payment calculation methodologies that result in the maximization of available federal funds.

(12) The DSH payments shall be paid on or before December 31, March 31, and June 30 of each fiscal year, in increments of one-third (1/3) of the total calculated DSH amounts. Supplemental payments developed pursuant to Section 43-13-117(A)(18) shall be paid monthly.

(13) Payment.

(a) The hospital assessment as described in subsection (4) for the nonfederal share necessary to maximize the Medicare Upper Payments Limits (UPL) Program payments and hospital access payments and such other supplemental payments as may be developed pursuant to Section 43-3-117(A)(18) shall be assessed and

collected monthly no later than the fifteenth calendar day of each month.

(b) The hospital assessment as described in subsection (4) for the nonfederal share necessary to maximize the Disproportionate Share Hospital (DSH) payments shall be assessed and collected on December 15, March 15 and June 15.

(c) The annual hospital assessment and any additional hospital assessment as described in subsection (4) shall be assessed and collected on September 15 and on the 15th of each month from December through June.

(14) If for any reason any part of the plan for annual DSH and supplemental payment programs to hospitals provided under subsection (10) of this section and/or developed pursuant to Section 43-13-117(A)(18) is not approved by CMS, the remainder of the plan shall remain in full force and effect.

(15) Nothing in this section shall prevent the Division of Medicaid from facilitating participation in Medicaid supplemental hospital payment programs by a hospital located in a county contiguous to the State of Mississippi that is also authorized by federal law to submit intergovernmental transfers (IGTs) to the State of Mississippi to fund the state share of the hospital's supplemental and/or MHAP payments.

(16) This section shall stand repealed on July 1, *** * *** 2028.

SECTION 3. This act shall take effect and be in force from and after July 1, 2024.

~ OFFICIAL ~

ST: Medicaid; extend date of repealers on the services and managed care provisions and the provider assessment provisions.