

By: Representative McGee

To: Medicaid

COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 1026

1 AN ACT TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972,
2 TO ALLOW THE FAMILY PLANNING WAIVER PROGRAM UNDER THE MEDICAID
3 PROGRAM TO BE CONDUCTED UNDER A WAIVER OR THE STATE PLAN; TO
4 PROVIDE THAT CHILDREN IN STATE CUSTODY WHO ARE IN FOSTER CARE ON
5 THEIR EIGHTEENTH BIRTHDAY SHALL BE MEDICAID ELIGIBLE UNTIL THEIR
6 TWENTY-SIXTH BIRTHDAY; TO PROVIDE THAT CHILDREN WHO HAVE AGED OUT
7 OF FOSTER CARE WHILE ON MEDICAID IN OTHER STATES SHALL QUALIFY
8 UNTIL THEIR TWENTY-SIXTH BIRTHDAY; TO AMEND SECTION 43-13-117,
9 MISSISSIPPI CODE OF 1972, TO DIRECT THE DIVISION OF MEDICAID TO
10 UPDATE THE CASE-MIX PAYMENT SYSTEM FAIR RENTAL REIMBURSEMENT
11 SYSTEM FOR NURSING FACILITY SERVICES AS NECESSARY TO MAINTAIN
12 COMPLIANCE WITH FEDERAL LAW; TO PROVIDE THAT THE DIVISION SHALL
13 REIMBURSE AMBULANCE SERVICE PROVIDERS THAT PROVIDE AN ASSESSMENT,
14 TRIAGE, TREATMENT OR TRANSPORTATION FOR ELIGIBLE MEDICAID
15 BENEFICIARIES TO AN ALTERNATIVE DESTINATION IN THIS STATE OR
16 PROVIDE AN ASSESSMENT OR TREAT ELIGIBLE MEDICAID BENEFICIARIES IN
17 PLACE; TO DELETE THE LEGISLATIVE INTENT FOR THE DIVISION TO
18 ENCOURAGE THE USE OF ALPHA HYDROXYPROGESTERONE CAPROATE TO PREVENT
19 RECURRENT PRETERM BIRTHS; TO AUTHORIZE CONTRACEPTIVES TO BE
20 PRESCRIBED AND DISPENSED IN TWELVE-MONTH SUPPLY INCREMENTS UNDER
21 FAMILY PLANNING SERVICES; TO UPDATE AND CLARIFY LANGUAGE ABOUT THE
22 DIVISION'S TRANSITION FROM THE MEDICARE UPPER PAYMENTS LIMITS
23 (UPL) PROGRAM TO THE MISSISSIPPI HOSPITAL ACCESS PROGRAM (MHAP);
24 TO AUTHORIZE THE DIVISION TO ESTABLISH A MEDICARE UPPER PAYMENT
25 LIMITS PROGRAM FOR OTHER ELIGIBLE LICENSED PROVIDERS AS DETERMINED
26 BY THE DIVISION; TO PROVIDE THAT SUPPLEMENTAL PAYMENTS TO A
27 HOSPITAL SHALL NOT DECREASE BY MORE THAN FIVE PERCENT WHEN
28 COMPARED TO A HOSPITAL'S PRIOR YEAR PAYMENT; TO PROVIDE THAT THE
29 DIVISION SHALL NOT SUBSTANTIALLY CHANGE THE METHODOLOGIES USED TO
30 CALCULATE A HOSPITAL'S SUPPLEMENTAL PAYMENT; TO REQUIRE THAT
31 POPULATIONS ELIGIBLE FOR RECEIVING PERINATAL RISK MANAGEMENT
32 SERVICES FROM MANAGED CARE ORGANIZATIONS RECEIVE THE SERVICES FROM
33 THE MANAGED CARE ORGANIZATIONS INSTEAD OF USING THE SERVICES AT
34 THE STATE DEPARTMENT OF HEALTH; TO AUTHORIZE THE DIVISION TO



35 REIMBURSE CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTERS IN A
36 MANNER DETERMINED BY THE DIVISION; TO EXTEND THE DATE OF THE
37 REPEALER ON MEDICAID REIMBURSEMENT FOR A BORDER CITY
38 UNIVERSITY-AFFILIATED PEDIATRIC TEACHING HOSPITAL; TO EXTEND THE
39 DATE OF THE REPEALER ON THIS SECTION; TO AMEND SECTION 43-13-145,
40 MISSISSIPPI CODE OF 1972, TO PROVIDE THAT A HOSPITAL ASSESSMENT
41 MAY EXCEED THE ASSESSMENT IN THE PREVIOUS QUARTER BY MORE THAN THE
42 SPECIFIED LIMIT WHEN SUCH INCREASE IS TO MAXIMIZE FEDERAL FUNDS
43 THAT ARE AVAILABLE TO REIMBURSE HOSPITALS FOR SERVICES PROVIDED
44 UNDER NEW PROGRAMS FOR HOSPITALS, INCREASED SUPPLEMENTAL PAYMENT
45 PROGRAMS FOR HOSPITALS OR TO ASSIST WITH STATE MATCHING FUNDS AS
46 AUTHORIZED BY THE LEGISLATURE; TO PROVIDE THAT STATE-OWNED ACUTE
47 CARE HOSPITAL SHALL SUBMIT AN INTERGOVERNMENTAL TRANSFER (IGT) TO
48 THE STATE OF MISSISSIPPI TO FUND THE NONFEDERAL SHARE OF THAT
49 HOSPITAL'S SUPPLEMENTAL PAYMENTS; TO PROVIDE THAT THE HOSPITAL'S
50 SUPPLEMENTAL PAYMENT SHALL NOT BE INCLUDED IN THE ASSESSMENT FOR
51 THE NONFEDERAL SHARE FOR WHICH OTHER HOSPITALS ARE ASSESSED; TO
52 EXTEND THE DATE OF THE REPEALER ON THIS SECTION; TO AMEND SECTION
53 43-13-305, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT WHEN A
54 THIRD-PARTY PAYOR REQUIRES PRIOR AUTHORIZATION FOR AN ITEM OR
55 SERVICE FURNISHED TO A MEDICAID RECIPIENT, THE PAYOR SHALL ACCEPT
56 AUTHORIZATION PROVIDED BY THE DIVISION OF MEDICAID THAT THE ITEM
57 OR SERVICE IS COVERED UNDER THE STATE PLAN AS IF SUCH
58 AUTHORIZATION WERE THE PRIOR AUTHORIZATION MADE BY THE THIRD-PARTY
59 PAYOR FOR SUCH ITEM OR SERVICE; AND FOR RELATED PURPOSES.

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

61 **SECTION 1.** Section 43-13-115, Mississippi Code of 1972, is
62 amended as follows:

63 43-13-115. Recipients of Medicaid shall be the following
64 persons only:

65 (1) Those who are qualified for public assistance
66 grants under provisions of Title IV-A and E of the federal Social
67 Security Act, as amended, including those statutorily deemed to be
68 IV-A and low income families and children under Section 1931 of
69 the federal Social Security Act. For the purposes of this
70 paragraph (1) and paragraphs (8), (17) and (18) of this section,
71 any reference to Title IV-A or to Part A of Title IV of the
72 federal Social Security Act, as amended, or the state plan under



73 Title IV-A or Part A of Title IV, shall be considered as a
74 reference to Title IV-A of the federal Social Security Act, as
75 amended, and the state plan under Title IV-A, including the income
76 and resource standards and methodologies under Title IV-A and the
77 state plan, as they existed on July 16, 1996. The Department of
78 Human Services shall determine Medicaid eligibility for children
79 receiving public assistance grants under Title IV-E. The division
80 shall determine eligibility for low income families under Section
81 1931 of the federal Social Security Act and shall redetermine
82 eligibility for those continuing under Title IV-A grants.

83 (2) Those qualified for Supplemental Security Income
84 (SSI) benefits under Title XVI of the federal Social Security Act,
85 as amended, and those who are deemed SSI eligible as contained in
86 federal statute. The eligibility of individuals covered in this
87 paragraph shall be determined by the Social Security
88 Administration and certified to the Division of Medicaid.

89 (3) Qualified pregnant women who would be eligible for
90 Medicaid as a low income family member under Section 1931 of the
91 federal Social Security Act if her child were born. The
92 eligibility of the individuals covered under this paragraph shall
93 be determined by the division.

94 (4) [Deleted]

95 (5) A child born on or after October 1, 1984, to a
96 woman eligible for and receiving Medicaid under the state plan on
97 the date of the child's birth shall be deemed to have applied for



98 Medicaid and to have been found eligible for Medicaid under the
99 plan on the date of that birth, and will remain eligible for
100 Medicaid for a period of one (1) year so long as the child is a
101 member of the woman's household and the woman remains eligible for
102 Medicaid or would be eligible for Medicaid if pregnant. The
103 eligibility of individuals covered in this paragraph shall be
104 determined by the Division of Medicaid.

105 (6) Children certified by the State Department of Human
106 Services to the Division of Medicaid of whom the state and county
107 departments of human services have custody and financial
108 responsibility, and children who are in adoptions subsidized in
109 full or part by the Department of Human Services, including
110 special needs children in non-Title IV-E adoption assistance, who
111 are approvable under Title XIX of the Medicaid program. The
112 eligibility of the children covered under this paragraph shall be
113 determined by the State Department of Human Services.

114 (7) Persons certified by the Division of Medicaid who
115 are patients in a medical facility (nursing home, hospital,
116 tuberculosis sanatorium or institution for treatment of mental
117 diseases), and who, except for the fact that they are patients in
118 that medical facility, would qualify for grants under Title IV,
119 Supplementary Security Income (SSI) benefits under Title XVI or
120 state supplements, and those aged, blind and disabled persons who
121 would not be eligible for Supplemental Security Income (SSI)
122 benefits under Title XVI or state supplements if they were not



123 institutionalized in a medical facility but whose income is below
124 the maximum standard set by the Division of Medicaid, which
125 standard shall not exceed that prescribed by federal regulation.

126 (8) Children under eighteen (18) years of age and
127 pregnant women (including those in intact families) who meet the
128 financial standards of the state plan approved under Title IV-A of
129 the federal Social Security Act, as amended. The eligibility of
130 children covered under this paragraph shall be determined by the
131 Division of Medicaid.

132 (9) Individuals who are:

133 (a) Children born after September 30, 1983, who
134 have not attained the age of nineteen (19), with family income
135 that does not exceed one hundred percent (100%) of the nonfarm
136 official poverty level;

137 (b) Pregnant women, infants and children who have
138 not attained the age of six (6), with family income that does not
139 exceed one hundred thirty-three percent (133%) of the federal
140 poverty level; and

141 (c) Pregnant women and infants who have not
142 attained the age of one (1), with family income that does not
143 exceed one hundred eighty-five percent (185%) of the federal
144 poverty level.

145 The eligibility of individuals covered in (a), (b) and (c) of
146 this paragraph shall be determined by the division.



147 (10) Certain disabled children age eighteen (18) or
148 under who are living at home, who would be eligible, if in a
149 medical institution, for SSI or a state supplemental payment under
150 Title XVI of the federal Social Security Act, as amended, and
151 therefore for Medicaid under the plan, and for whom the state has
152 made a determination as required under Section 1902(e)(3)(b) of
153 the federal Social Security Act, as amended. The eligibility of
154 individuals under this paragraph shall be determined by the
155 Division of Medicaid.

156 (11) Until the end of the day on December 31, 2005,
157 individuals who are sixty-five (65) years of age or older or are
158 disabled as determined under Section 1614(a)(3) of the federal
159 Social Security Act, as amended, and whose income does not exceed
160 one hundred thirty-five percent (135%) of the nonfarm official
161 poverty level as defined by the Office of Management and Budget
162 and revised annually, and whose resources do not exceed those
163 established by the Division of Medicaid. The eligibility of
164 individuals covered under this paragraph shall be determined by
165 the Division of Medicaid. After December 31, 2005, only those
166 individuals covered under the 1115(c) Healthier Mississippi waiver
167 will be covered under this category.

168 Any individual who applied for Medicaid during the period
169 from July 1, 2004, through March 31, 2005, who otherwise would
170 have been eligible for coverage under this paragraph (11) if it
171 had been in effect at the time the individual submitted his or her



172 application and is still eligible for coverage under this
173 paragraph (11) on March 31, 2005, shall be eligible for Medicaid
174 coverage under this paragraph (11) from March 31, 2005, through
175 December 31, 2005. The division shall give priority in processing
176 the applications for those individuals to determine their
177 eligibility under this paragraph (11).

178 (12) Individuals who are qualified Medicare
179 beneficiaries (QMB) entitled to Part A Medicare as defined under
180 Section 301, Public Law 100-360, known as the Medicare
181 Catastrophic Coverage Act of 1988, and whose income does not
182 exceed one hundred percent (100%) of the nonfarm official poverty
183 level as defined by the Office of Management and Budget and
184 revised annually.

185 The eligibility of individuals covered under this paragraph
186 shall be determined by the Division of Medicaid, and those
187 individuals determined eligible shall receive Medicare
188 cost-sharing expenses only as more fully defined by the Medicare
189 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
190 1997.

191 (13) (a) Individuals who are entitled to Medicare Part
192 A as defined in Section 4501 of the Omnibus Budget Reconciliation
193 Act of 1990, and whose income does not exceed one hundred twenty
194 percent (120%) of the nonfarm official poverty level as defined by
195 the Office of Management and Budget and revised annually.



196 Eligibility for Medicaid benefits is limited to full payment of
197 Medicare Part B premiums.

198 (b) Individuals entitled to Part A of Medicare,
199 with income above one hundred twenty percent (120%), but less than
200 one hundred thirty-five percent (135%) of the federal poverty
201 level, and not otherwise eligible for Medicaid. Eligibility for
202 Medicaid benefits is limited to full payment of Medicare Part B
203 premiums. The number of eligible individuals is limited by the
204 availability of the federal capped allocation at one hundred
205 percent (100%) of federal matching funds, as more fully defined in
206 the Balanced Budget Act of 1997.

207 The eligibility of individuals covered under this paragraph
208 shall be determined by the Division of Medicaid.

209 (14) [Deleted]

210 (15) Disabled workers who are eligible to enroll in
211 Part A Medicare as required by Public Law 101-239, known as the
212 Omnibus Budget Reconciliation Act of 1989, and whose income does
213 not exceed two hundred percent (200%) of the federal poverty level
214 as determined in accordance with the Supplemental Security Income
215 (SSI) program. The eligibility of individuals covered under this
216 paragraph shall be determined by the Division of Medicaid and
217 those individuals shall be entitled to buy-in coverage of Medicare
218 Part A premiums only under the provisions of this paragraph (15).

219 (16) In accordance with the terms and conditions of
220 approved Title XIX waiver from the United States Department of



221 Health and Human Services, persons provided home- and
222 community-based services who are physically disabled and certified
223 by the Division of Medicaid as eligible due to applying the income
224 and deeming requirements as if they were institutionalized.

225 (17) In accordance with the terms of the federal
226 Personal Responsibility and Work Opportunity Reconciliation Act of
227 1996 (Public Law 104-193), persons who become ineligible for
228 assistance under Title IV-A of the federal Social Security Act, as
229 amended, because of increased income from or hours of employment
230 of the caretaker relative or because of the expiration of the
231 applicable earned income disregards, who were eligible for
232 Medicaid for at least three (3) of the six (6) months preceding
233 the month in which the ineligibility begins, shall be eligible for
234 Medicaid for up to twelve (12) months. The eligibility of the
235 individuals covered under this paragraph shall be determined by
236 the division.

237 (18) Persons who become ineligible for assistance under
238 Title IV-A of the federal Social Security Act, as amended, as a
239 result, in whole or in part, of the collection or increased
240 collection of child or spousal support under Title IV-D of the
241 federal Social Security Act, as amended, who were eligible for
242 Medicaid for at least three (3) of the six (6) months immediately
243 preceding the month in which the ineligibility begins, shall be
244 eligible for Medicaid for an additional four (4) months beginning
245 with the month in which the ineligibility begins. The eligibility



246 of the individuals covered under this paragraph shall be
247 determined by the division.

248 (19) Disabled workers, whose incomes are above the
249 Medicaid eligibility limits, but below two hundred fifty percent
250 (250%) of the federal poverty level, shall be allowed to purchase
251 Medicaid coverage on a sliding fee scale developed by the Division
252 of Medicaid.

253 (20) Medicaid eligible children under age eighteen (18)
254 shall remain eligible for Medicaid benefits until the end of a
255 period of twelve (12) months following an eligibility
256 determination, or until such time that the individual exceeds age
257 eighteen (18).

258 (21) Women and men of * * * reproductive age whose
259 family income does not exceed one hundred eighty-five percent
260 (185%) of the federal poverty level. The eligibility of
261 individuals covered under this paragraph (21) shall be determined
262 by the Division of Medicaid, and those individuals determined
263 eligible shall only receive family planning services covered under
264 Section 43-13-117(13) and not any other services covered under
265 Medicaid. However, any individual eligible under this paragraph
266 (21) who is also eligible under any other provision of this
267 section shall receive the benefits to which he or she is entitled
268 under that other provision, in addition to family planning
269 services covered under Section 43-13-117(13).



270 The Division of Medicaid * * * may apply to the United States
271 Secretary of Health and Human Services for a federal waiver of the
272 applicable provisions of Title XIX of the federal Social Security
273 Act, as amended, and any other applicable provisions of federal
274 law as necessary to allow for the implementation of this paragraph
275 (21). * * *

276 (22) Persons who are workers with a potentially severe
277 disability, as determined by the division, shall be allowed to
278 purchase Medicaid coverage. The term "worker with a potentially
279 severe disability" means a person who is at least sixteen (16)
280 years of age but under sixty-five (65) years of age, who has a
281 physical or mental impairment that is reasonably expected to cause
282 the person to become blind or disabled as defined under Section
283 1614(a) of the federal Social Security Act, as amended, if the
284 person does not receive items and services provided under
285 Medicaid.

286 The eligibility of persons under this paragraph (22) shall be
287 conducted as a demonstration project that is consistent with
288 Section 204 of the Ticket to Work and Work Incentives Improvement
289 Act of 1999, Public Law 106-170, for a certain number of persons
290 as specified by the division. The eligibility of individuals
291 covered under this paragraph (22) shall be determined by the
292 Division of Medicaid.

293 (23) Children certified by the Mississippi Department
294 of Human Services for whom the state and county departments of



295 human services have custody and financial responsibility who are
296 in foster care on their eighteenth birthday as reported by the
297 Mississippi Department of Human Services shall be certified
298 Medicaid eligible by the Division of Medicaid until their * * *
299 twenty-sixth birthday. Children who have aged out of foster care
300 while on Medicaid in other states shall qualify until their
301 twenty-sixth birthday.

302 (24) Individuals who have not attained age sixty-five
303 (65), are not otherwise covered by creditable coverage as defined
304 in the Public Health Services Act, and have been screened for
305 breast and cervical cancer under the Centers for Disease Control
306 and Prevention Breast and Cervical Cancer Early Detection Program
307 established under Title XV of the Public Health Service Act in
308 accordance with the requirements of that act and who need
309 treatment for breast or cervical cancer. Eligibility of
310 individuals under this paragraph (24) shall be determined by the
311 Division of Medicaid.

312 (25) The division shall apply to the Centers for
313 Medicare and Medicaid Services (CMS) for any necessary waivers to
314 provide services to individuals who are sixty-five (65) years of
315 age or older or are disabled as determined under Section
316 1614(a)(3) of the federal Social Security Act, as amended, and
317 whose income does not exceed one hundred thirty-five percent
318 (135%) of the nonfarm official poverty level as defined by the
319 Office of Management and Budget and revised annually, and whose



320 resources do not exceed those established by the Division of
321 Medicaid, and who are not otherwise covered by Medicare. Nothing
322 contained in this paragraph (25) shall entitle an individual to
323 benefits. The eligibility of individuals covered under this
324 paragraph shall be determined by the Division of Medicaid.

325 (26) The division shall apply to the Centers for
326 Medicare and Medicaid Services (CMS) for any necessary waivers to
327 provide services to individuals who are sixty-five (65) years of
328 age or older or are disabled as determined under Section
329 1614(a)(3) of the federal Social Security Act, as amended, who are
330 end stage renal disease patients on dialysis, cancer patients on
331 chemotherapy or organ transplant recipients on antirejection
332 drugs, whose income does not exceed one hundred thirty-five
333 percent (135%) of the nonfarm official poverty level as defined by
334 the Office of Management and Budget and revised annually, and
335 whose resources do not exceed those established by the division.
336 Nothing contained in this paragraph (26) shall entitle an
337 individual to benefits. The eligibility of individuals covered
338 under this paragraph shall be determined by the Division of
339 Medicaid.

340 (27) Individuals who are entitled to Medicare Part D
341 and whose income does not exceed one hundred fifty percent (150%)
342 of the nonfarm official poverty level as defined by the Office of
343 Management and Budget and revised annually. Eligibility for



344 payment of the Medicare Part D subsidy under this paragraph shall
345 be determined by the division.

346 (28) The division is authorized and directed to provide
347 up to twelve (12) months of continuous coverage postpartum for any
348 individual who qualifies for Medicaid coverage under this section
349 as a pregnant woman, to the extent allowable under federal law and
350 as determined by the division.

351 The division shall redetermine eligibility for all categories
352 of recipients described in each paragraph of this section not less
353 frequently than required by federal law.

354 **SECTION 2.** Section 43-13-117, Mississippi Code of 1972, is
355 amended as follows:

356 43-13-117. (A) Medicaid as authorized by this article shall
357 include payment of part or all of the costs, at the discretion of
358 the division, with approval of the Governor and the Centers for
359 Medicare and Medicaid Services, of the following types of care and
360 services rendered to eligible applicants who have been determined
361 to be eligible for that care and services, within the limits of
362 state appropriations and federal matching funds:

363 (1) Inpatient hospital services.

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

367 (b) No service benefits or reimbursement
368 limitations in this subsection (A)(1) shall apply to payments



369 under an APR-DRG or Ambulatory Payment Classification (APC) model
370 or a managed care program or similar model described in subsection
371 (H) of this section unless specifically authorized by the
372 division.

373 (2) Outpatient hospital services.

374 (a) Emergency services.

375 (b) Other outpatient hospital services. The
376 division shall allow benefits for other medically necessary
377 outpatient hospital services (such as chemotherapy, radiation,
378 surgery and therapy), including outpatient services in a clinic or
379 other facility that is not located inside the hospital, but that
380 has been designated as an outpatient facility by the hospital, and
381 that was in operation or under construction on July 1, 2009,
382 provided that the costs and charges associated with the operation
383 of the hospital clinic are included in the hospital's cost report.
384 In addition, the Medicare thirty-five-mile rule will apply to
385 those hospital clinics not located inside the hospital that are
386 constructed after July 1, 2009. Where the same services are
387 reimbursed as clinic services, the division may revise the rate or
388 methodology of outpatient reimbursement to maintain consistency,
389 efficiency, economy and quality of care.

390 (c) The division is authorized to implement an
391 Ambulatory Payment Classification (APC) methodology for outpatient
392 hospital services. The division shall give rural hospitals that
393 have fifty (50) or fewer licensed beds the option to not be



394 reimbursed for outpatient hospital services using the APC
395 methodology, but reimbursement for outpatient hospital services
396 provided by those hospitals shall be based on one hundred one
397 percent (101%) of the rate established under Medicare for
398 outpatient hospital services. Those hospitals choosing to not be
399 reimbursed under the APC methodology shall remain under cost-based
400 reimbursement for a two-year period.

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

406 (3) Laboratory and x-ray services.

407 (4) Nursing facility services.

408 (a) The division shall make full payment to
409 nursing facilities for each day, not exceeding forty-two (42) days
410 per year, that a patient is absent from the facility on home
411 leave. Payment may be made for the following home leave days in
412 addition to the forty-two-day limitation: Christmas, the day
413 before Christmas, the day after Christmas, Thanksgiving, the day
414 before Thanksgiving and the day after Thanksgiving.

415 (b) From and after July 1, 1997, the division
416 shall implement the integrated case-mix payment and quality
417 monitoring system, which includes the fair rental system for
418 property costs and in which recapture of depreciation is



419 eliminated. The division may reduce the payment for hospital
420 leave and therapeutic home leave days to the lower of the case-mix
421 category as computed for the resident on leave using the
422 assessment being utilized for payment at that point in time, or a
423 case-mix score of 1.000 for nursing facilities, and shall compute
424 case-mix scores of residents so that only services provided at the
425 nursing facility are considered in calculating a facility's per
426 diem.

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

430 (d) * * * The division shall update the case-mix
431 payment system * * * and fair rental reimbursement system as
432 necessary to maintain compliance with federal law. The division
433 shall develop and implement a payment add-on to reimburse nursing
434 facilities for ventilator-dependent resident services.

435 (e) The division shall develop and implement, not
436 later than January 1, 2001, a case-mix payment add-on determined
437 by time studies and other valid statistical data that will
438 reimburse a nursing facility for the additional cost of caring for
439 a resident who has a diagnosis of Alzheimer's or other related
440 dementia and exhibits symptoms that require special care. Any
441 such case-mix add-on payment shall be supported by a determination
442 of additional cost. The division shall also develop and implement
443 as part of the fair rental reimbursement system for nursing



444 facility beds, an Alzheimer's resident bed depreciation enhanced
445 reimbursement system that will provide an incentive to encourage
446 nursing facilities to convert or construct beds for residents with
447 Alzheimer's or other related dementia.

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

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

456 (5) Periodic screening and diagnostic services for
457 individuals under age twenty-one (21) years as are needed to
458 identify physical and mental defects and to provide health care
459 treatment and other measures designed to correct or ameliorate
460 defects and physical and mental illness and conditions discovered
461 by the screening services, regardless of whether these services
462 are included in the state plan. The division may include in its
463 periodic screening and diagnostic program those discretionary
464 services authorized under the federal regulations adopted to
465 implement Title XIX of the federal Social Security Act, as
466 amended. The division, in obtaining physical therapy services,
467 occupational therapy services, and services for individuals with
468 speech, hearing and language disorders, may enter into a



469 cooperative agreement with the State Department of Education for
470 the provision of those services to handicapped students by public
471 school districts using state funds that are provided from the
472 appropriation to the Department of Education to obtain federal
473 matching funds through the division. The division, in obtaining
474 medical and mental health assessments, treatment, care and
475 services for children who are in, or at risk of being put in, the
476 custody of the Mississippi Department of Human Services may enter
477 into a cooperative agreement with the Mississippi Department of
478 Human Services for the provision of those services using state
479 funds that are provided from the appropriation to the Department
480 of Human Services to obtain federal matching funds through the
481 division.

482 (6) Physician services. Fees for physician's services
483 that are covered only by Medicaid shall be reimbursed at ninety
484 percent (90%) of the rate established on January 1, 2018, and as
485 may be adjusted each July thereafter, under Medicare. The
486 division may provide for a reimbursement rate for physician's
487 services of up to one hundred percent (100%) of the rate
488 established under Medicare for physician's services that are
489 provided after the normal working hours of the physician, as
490 determined in accordance with regulations of the division. The
491 division may reimburse eligible providers, as determined by the
492 division, for certain primary care services at one hundred percent
493 (100%) of the rate established under Medicare. The division shall



494 reimburse obstetricians and gynecologists for certain primary care
495 services as defined by the division at one hundred percent (100%)
496 of the rate established under Medicare.

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

507 (b) [Repealed]

508 (8) Emergency medical transportation services as
509 determined by the division. The division shall reimburse
510 ambulance service providers that provide an assessment, triage,
511 treatment or transportation for eligible Medicaid beneficiaries to
512 an alternative destination in this state or provide an assessment
513 or treat eligible Medicaid beneficiaries in place. The
514 reimbursement rate for an ambulance service provider that provides
515 an assessment, triage, treatment or transportation for an eligible
516 Medicaid beneficiary to an alternative destination in this state
517 shall be at a rate or methodology as determined by the division.
518 The division shall consult with the Mississippi Ambulance Alliance



519 in determining the initial rate or methodology, and the division
520 shall give due consideration to the CMS Emergency Triage, Treat,
521 and Transport (ET3) Model and shall give due consideration of the
522 inclusion in the Transforming Reimbursement for Emergency
523 Ambulance Transportation program. As used in this paragraph (8):

524 (a) "Alternative destination" means a lower-acuity
525 facility that provides medical services, including (i) an urgent
526 care center; (ii) a Federally Qualified Community Health Clinic;
527 (iv) a behavioral or mental health care facility, including a
528 crisis stabilization unit and a diversion center; and (v) any
529 other facilities as determined by the division with due
530 consideration of the CMS ET3 Model.

531 (b) "Alternative destination" does not include a: (i)
532 critical access hospital; (ii) dialysis center; (iii) hospital;
533 (iv) private residence; or (v) skilled nursing facility.

534 (c) "Ambulance service provider" means a person or
535 entity that provides ambulance transportation and emergency
536 medical services to a patient for which a permit is required under
537 Section 41-59-9.

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

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



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

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

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

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



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

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

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

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

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

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



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

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

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

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

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

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



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

620 * * *

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

623 The division shall increase the amount of the reimbursement
624 rate for diagnostic and preventative dental services for each of
625 the fiscal years 2022, 2023 and 2024 by five percent (5%) above
626 the amount of the reimbursement rate for the previous fiscal year.
627 The division shall increase the amount of the reimbursement rate
628 for restorative dental services for each of the fiscal years 2023,
629 2024 and 2025 by five percent (5%) above the amount of the
630 reimbursement rate for the previous fiscal year. It is the intent
631 of the Legislature that the reimbursement rate revision for
632 preventative dental services will be an incentive to increase the
633 number of dentists who actively provide Medicaid services. This
634 dental services reimbursement rate revision shall be known as the
635 "James Russell Dumas Medicaid Dental Services Incentive Program."

636 The Medical Care Advisory Committee, assisted by the Division
637 of Medicaid, shall annually determine the effect of this incentive
638 by evaluating the number of dentists who are Medicaid providers,
639 the number who and the degree to which they are actively billing
640 Medicaid, the geographic trends of where dentists are offering
641 what types of Medicaid services and other statistics pertinent to
642 the goals of this legislative intent. This data shall annually be



643 presented to the Chair of the Senate Medicaid Committee and the
644 Chair of the House Medicaid Committee.

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

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

657 (12) Intermediate care facility services.

658 (a) The division shall make full payment to all
659 intermediate care facilities for individuals with intellectual
660 disabilities for each day, not exceeding sixty-three (63) days per
661 year, that a patient is absent from the facility on home leave.
662 Payment may be made for the following home leave days in addition
663 to the sixty-three-day limitation: Christmas, the day before
664 Christmas, the day after Christmas, Thanksgiving, the day before
665 Thanksgiving and the day after Thanksgiving.



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

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

672 (13) Family planning services, including drugs,
673 supplies and devices, when those services are under the
674 supervision of a physician or nurse practitioner. Contraceptives
675 may be prescribed and dispensed in twelve-month supply increments.

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

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

683 (b) Dialysis center services.

684 (15) Home- and community-based services for the elderly
685 and disabled, as provided under Title XIX of the federal Social
686 Security Act, as amended, under waivers, subject to the
687 availability of funds specifically appropriated for that purpose
688 by the Legislature.

689 (16) Mental health services. Certain services provided
690 by a psychiatrist shall be reimbursed at up to one hundred percent



691 (100%) of the Medicare rate. Approved therapeutic and case
692 management services (a) provided by an approved regional mental
693 health/intellectual disability center established under Sections
694 41-19-31 through 41-19-39, or by another community mental health
695 service provider meeting the requirements of the Department of
696 Mental Health to be an approved mental health/intellectual
697 disability center if determined necessary by the Department of
698 Mental Health, using state funds that are provided in the
699 appropriation to the division to match federal funds, or (b)
700 provided by a facility that is certified by the State Department
701 of Mental Health to provide therapeutic and case management
702 services, to be reimbursed on a fee for service basis, or (c)
703 provided in the community by a facility or program operated by the
704 Department of Mental Health. Any such services provided by a
705 facility described in subparagraph (b) must have the prior
706 approval of the division to be reimbursable under this section.

707 (17) Durable medical equipment services and medical
708 supplies. Precertification of durable medical equipment and
709 medical supplies must be obtained as required by the division.
710 The Division of Medicaid may require durable medical equipment
711 providers to obtain a surety bond in the amount and to the
712 specifications as established by the Balanced Budget Act of 1997.
713 A maximum dollar amount of reimbursement for noninvasive
714 ventilators or ventilation treatments properly ordered and being
715 used in an appropriate care setting shall not be set by any health



716 maintenance organization, coordinated care organization,
717 provider-sponsored health plan, or other organization paid for
718 services on a capitated basis by the division under any managed
719 care program or coordinated care program implemented by the
720 division under this section. Reimbursement by these organizations
721 to durable medical equipment suppliers for home use of noninvasive
722 and invasive ventilators shall be on a continuous monthly payment
723 basis for the duration of medical need throughout a patient's
724 valid prescription period.

725 (18) (a) Notwithstanding any other provision of this
726 section to the contrary, as provided in the Medicaid state plan
727 amendment or amendments as defined in Section 43-13-145(10), the
728 division shall make additional reimbursement to hospitals that
729 serve a disproportionate share of low-income patients and that
730 meet the federal requirements for those payments as provided in
731 Section 1923 of the federal Social Security Act and any applicable
732 regulations. It is the intent of the Legislature that the
733 division shall draw down all available federal funds allotted to
734 the state for disproportionate share hospitals. However, from and
735 after January 1, 1999, public hospitals participating in the
736 Medicaid disproportionate share program may be required to
737 participate in an intergovernmental transfer program as provided
738 in Section 1903 of the federal Social Security Act and any
739 applicable regulations.



740 (b) (i) 1. The division may establish a Medicare
741 Upper Payment Limits Program, as defined in Section 1902(a)(30) of
742 the federal Social Security Act and any applicable federal
743 regulations, or an allowable delivery system or provider payment
744 initiative authorized under 42 CFR 438.6(c), for hospitals,
745 nursing facilities * * * and, physicians and other eligible
746 licensed providers as determined by the division who are employed
747 or contracted by hospitals.

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

754 (ii) The division shall assess each hospital,
755 nursing facility, and emergency ambulance transportation provider
756 for the sole purpose of financing the state portion of the
757 Medicare Upper Payment Limits Program or other program(s)
758 authorized under this subsection (A)(18)(b). The hospital
759 assessment shall be as provided in Section 43-13-145(4)(a), and
760 the nursing facility and the emergency ambulance transportation
761 assessments, if established, shall be based on Medicaid
762 utilization or other appropriate method, as determined by the
763 division, consistent with federal regulations. The assessments
764 will remain in effect as long as the state participates in the



765 Medicare Upper Payment Limits Program or other program(s)
766 authorized under this subsection (A) (18) (b). In addition to the
767 hospital assessment provided in Section 43-13-145(4) (a), hospitals
768 with physicians and other eligible licensed providers as
769 determined by the division participating in the Medicare Upper
770 Payment Limits Program or other program(s) authorized under this
771 subsection (A) (18) (b) shall be required to participate in an
772 intergovernmental transfer or assessment, as determined by the
773 division, for the purpose of financing the state portion of the
774 physician UPL payments or other payment(s) authorized under this
775 subsection (A) (18) (b).

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



789 (iv) * * * The division is authorized to
790 develop and implement an alternative fee-for-service Upper Payment
791 Limits model in accordance with federal laws and regulations if
792 necessary to preserve supplemental funding. * * *

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

800 2. The division shall calculate the
801 ambulance service access payment amount as the balance of the
802 portion of the Medical Care Fund related to ambulance
803 transportation service provider assessments plus any federal
804 matching funds earned on the balance, up to, but not to exceed,
805 the upper payment limit gap for all emergency ambulance service
806 providers.

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

812 b. In addition to any other funds
813 paid to ambulance transportation service providers for emergency



814 medical services provided to Medicaid beneficiaries, each eligible
815 ambulance transportation service provider shall receive ambulance
816 service access payments each state fiscal year equal to the
817 ambulance transportation service provider's upper payment limit
818 gap. Subject to approval by the Centers for Medicare and Medicaid
819 Services, ambulance service access payments shall be made no less
820 than on a quarterly basis.

821 c. As used in this paragraph
822 (18) (b) (v), the term "upper payment limit gap" means the
823 difference between the total amount that the ambulance
824 transportation service provider received from Medicaid and the
825 average amount that the ambulance transportation service provider
826 would have received from commercial insurers for those services
827 reimbursed by Medicaid.

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

831 (c) (i) * * * The division shall, subject to
832 approval by the Centers for Medicare and Medicaid Services (CMS),
833 establish, implement and operate a Mississippi Hospital Access
834 Program (MHAP) for the purpose of protecting patient access to
835 hospital care through hospital inpatient reimbursement programs
836 provided in this section designed to maintain total hospital
837 reimbursement for inpatient services rendered by in-state
838 hospitals and the out-of-state hospital that is authorized by



839 federal law to submit intergovernmental transfers (IGTs) to the
840 State of Mississippi and is classified as Level I trauma center
841 located in a county contiguous to the state line at the maximum
842 levels permissible under applicable federal statutes and
843 regulations * * *.

844 (ii) Subject to approval by the Centers for
845 Medicare and Medicaid Services (CMS), the MHAP shall provide
846 increased inpatient capitation (PMPM) payments to managed care
847 entities contracting with the division pursuant to subsection (H)
848 of this section to support availability of hospital services or
849 such other payments permissible under federal law necessary to
850 accomplish the intent of this subsection.

851 * * *

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

858 (v) Supplemental payments to a hospital shall
859 not decrease by more than five percent (5%) when compared to a
860 hospital's prior year payment and the division shall not
861 substantially change the methodologies used to calculate a
862 hospital's supplemental payment. Nothing in this subparagraph (v)



863 shall be construed to prohibit an increase in total funding
864 available for hospital supplemental payment programs.

865 (19) (a) Perinatal risk management services. The
866 division shall promulgate regulations to be effective from and
867 after October 1, 1988, to establish a comprehensive perinatal
868 system for risk assessment of all pregnant and infant Medicaid
869 recipients and for management, education and follow-up for those
870 who are determined to be at risk. Services to be performed
871 include case management, nutrition assessment/counseling,
872 psychosocial assessment/counseling and health education. The
873 division shall contract with the State Department of Health to
874 provide services within this paragraph (Perinatal High Risk
875 Management/Infant Services System (PHRM/ISS)) for any eligible
876 beneficiary that cannot receive these services under a different
877 program. The State Department of Health shall be reimbursed on a
878 full reasonable cost basis for services provided under this
879 subparagraph (a). Any program authorized under subsection (H) of
880 this section shall develop a perinatal risk management services
881 program in consultation with the division and the State Department
882 of Health or shall contract with the State Department of Health
883 for these services, and the programs shall begin providing these
884 services no later than January 1, 2025.

885 (b) Early intervention system services. The
886 division shall cooperate with the State Department of Health,
887 acting as lead agency, in the development and implementation of a



888 statewide system of delivery of early intervention services, under
889 Part C of the Individuals with Disabilities Education Act (IDEA).
890 The State Department of Health shall certify annually in writing
891 to the executive director of the division the dollar amount of
892 state early intervention funds available that will be utilized as
893 a certified match for Medicaid matching funds. Those funds then
894 shall be used to provide expanded targeted case management
895 services for Medicaid eligible children with special needs who are
896 eligible for the state's early intervention system.
897 Qualifications for persons providing service coordination shall be
898 determined by the State Department of Health and the Division of
899 Medicaid.

900 (20) Home- and community-based services for physically
901 disabled approved services as allowed by a waiver from the United
902 States Department of Health and Human Services for home- and
903 community-based services for physically disabled people using
904 state funds that are provided from the appropriation to the State
905 Department of Rehabilitation Services and used to match federal
906 funds under a cooperative agreement between the division and the
907 department, provided that funds for these services are
908 specifically appropriated to the Department of Rehabilitation
909 Services.

910 (21) Nurse practitioner services. Services furnished
911 by a registered nurse who is licensed and certified by the
912 Mississippi Board of Nursing as a nurse practitioner, including,



913 but not limited to, nurse anesthetists, nurse midwives, family
914 nurse practitioners, family planning nurse practitioners,
915 pediatric nurse practitioners, obstetrics-gynecology nurse
916 practitioners and neonatal nurse practitioners, under regulations
917 adopted by the division. Reimbursement for those services shall
918 not exceed ninety percent (90%) of the reimbursement rate for
919 comparable services rendered by a physician. The division may
920 provide for a reimbursement rate for nurse practitioner services
921 of up to one hundred percent (100%) of the reimbursement rate for
922 comparable services rendered by a physician for nurse practitioner
923 services that are provided after the normal working hours of the
924 nurse practitioner, as determined in accordance with regulations
925 of the division.

926 (22) Ambulatory services delivered in federally
927 qualified health centers, rural health centers and clinics of the
928 local health departments of the State Department of Health for
929 individuals eligible for Medicaid under this article based on
930 reasonable costs as determined by the division. Federally
931 qualified health centers shall be reimbursed by the Medicaid
932 prospective payment system as approved by the Centers for Medicare
933 and Medicaid Services. The division shall recognize federally
934 qualified health centers (FQHCs), rural health clinics (RHCs) and
935 community mental health centers (CMHCs) as both an originating and
936 distant site provider for the purposes of telehealth
937 reimbursement. The division is further authorized and directed to



938 reimburse FQHCs, RHCs and CMHCs for both distant site and
939 originating site services when such services are appropriately
940 provided by the same organization.

941 (23) Inpatient psychiatric services.

942 (a) Inpatient psychiatric services to be
943 determined by the division for recipients under age twenty-one
944 (21) that are provided under the direction of a physician in an
945 inpatient program in a licensed acute care psychiatric facility or
946 in a licensed psychiatric residential treatment facility, before
947 the recipient reaches age twenty-one (21) or, if the recipient was
948 receiving the services immediately before he or she reached age
949 twenty-one (21), before the earlier of the date he or she no
950 longer requires the services or the date he or she reaches age
951 twenty-two (22), as provided by federal regulations. From and
952 after January 1, 2015, the division shall update the fair rental
953 reimbursement system for psychiatric residential treatment
954 facilities. Precertification of inpatient days and residential
955 treatment days must be obtained as required by the division. From
956 and after July 1, 2009, all state-owned and state-operated
957 facilities that provide inpatient psychiatric services to persons
958 under age twenty-one (21) who are eligible for Medicaid
959 reimbursement shall be reimbursed for those services on a full
960 reasonable cost basis.

961 (b) The division may reimburse for services
962 provided by a licensed freestanding psychiatric hospital to



963 Medicaid recipients over the age of twenty-one (21) in a method
964 and manner consistent with the provisions of Section 43-13-117.5.

965 (24) * * * Certified community behavioral health
966 centers (CCBHCs). The division may reimburse CCBHCs in a manner
967 determined by the division.

968 (25) [Deleted]

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

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

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



987 (29) The Division of Medicaid may apply for a waiver
988 from the United States Department of Health and Human Services for
989 home- and community-based services for developmentally disabled
990 people using state funds that are provided from the appropriation
991 to the State Department of Mental Health and/or funds transferred
992 to the department by a political subdivision or instrumentality of
993 the state and used to match federal funds under a cooperative
994 agreement between the division and the department, provided that
995 funds for these services are specifically appropriated to the
996 Department of Mental Health and/or transferred to the department
997 by a political subdivision or instrumentality of the state.

998 (30) Pediatric skilled nursing services as determined
999 by the division and in a manner consistent with regulations
1000 promulgated by the Mississippi State Department of Health.

1001 (31) Targeted case management services for children
1002 with special needs, under waivers from the United States
1003 Department of Health and Human Services, using state funds that
1004 are provided from the appropriation to the Mississippi Department
1005 of Human Services and used to match federal funds under a
1006 cooperative agreement between the division and the department.

1007 (32) Care and services provided in Christian Science
1008 Sanatoria listed and certified by the Commission for Accreditation
1009 of Christian Science Nursing Organizations/Facilities, Inc.,
1010 rendered in connection with treatment by prayer or spiritual means



1011 to the extent that those services are subject to reimbursement
1012 under Section 1903 of the federal Social Security Act.

1013 (33) Podiatrist services.

1014 (34) Assisted living services as provided through
1015 home- and community-based services under Title XIX of the federal
1016 Social Security Act, as amended, subject to the availability of
1017 funds specifically appropriated for that purpose by the
1018 Legislature.

1019 (35) Services and activities authorized in Sections
1020 43-27-101 and 43-27-103, using state funds that are provided from
1021 the appropriation to the Mississippi Department of Human Services
1022 and used to match federal funds under a cooperative agreement
1023 between the division and the department.

1024 (36) Nonemergency transportation services for
1025 Medicaid-eligible persons as determined by the division. The PEER
1026 Committee shall conduct a performance evaluation of the
1027 nonemergency transportation program to evaluate the administration
1028 of the program and the providers of transportation services to
1029 determine the most cost-effective ways of providing nonemergency
1030 transportation services to the patients served under the program.
1031 The performance evaluation shall be completed and provided to the
1032 members of the Senate Medicaid Committee and the House Medicaid
1033 Committee not later than January 1, 2019, and every two (2) years
1034 thereafter.

1035 (37) [Deleted]



1036 (38) Chiropractic services. A chiropractor's manual
1037 manipulation of the spine to correct a subluxation, if x-ray
1038 demonstrates that a subluxation exists and if the subluxation has
1039 resulted in a neuromusculoskeletal condition for which
1040 manipulation is appropriate treatment, and related spinal x-rays
1041 performed to document these conditions. Reimbursement for
1042 chiropractic services shall not exceed Seven Hundred Dollars
1043 (\$700.00) per year per beneficiary.

1044 (39) Dually eligible Medicare/Medicaid beneficiaries.
1045 The division shall pay the Medicare deductible and coinsurance
1046 amounts for services available under Medicare, as determined by
1047 the division. From and after July 1, 2009, the division shall
1048 reimburse crossover claims for inpatient hospital services and
1049 crossover claims covered under Medicare Part B in the same manner
1050 that was in effect on January 1, 2008, unless specifically
1051 authorized by the Legislature to change this method.

1052 (40) [Deleted]

1053 (41) Services provided by the State Department of
1054 Rehabilitation Services for the care and rehabilitation of persons
1055 with spinal cord injuries or traumatic brain injuries, as allowed
1056 under waivers from the United States Department of Health and
1057 Human Services, using up to seventy-five percent (75%) of the
1058 funds that are appropriated to the Department of Rehabilitation
1059 Services from the Spinal Cord and Head Injury Trust Fund
1060 established under Section 37-33-261 and used to match federal



1061 funds under a cooperative agreement between the division and the
1062 department.

1063 (42) [Deleted]

1064 (43) The division shall provide reimbursement,
1065 according to a payment schedule developed by the division, for
1066 smoking cessation medications for pregnant women during their
1067 pregnancy and other Medicaid-eligible women who are of
1068 child-bearing age.

1069 (44) Nursing facility services for the severely
1070 disabled.

1071 (a) Severe disabilities include, but are not
1072 limited to, spinal cord injuries, closed-head injuries and
1073 ventilator-dependent patients.

1074 (b) Those services must be provided in a long-term
1075 care nursing facility dedicated to the care and treatment of
1076 persons with severe disabilities.

1077 (45) Physician assistant services. Services furnished
1078 by a physician assistant who is licensed by the State Board of
1079 Medical Licensure and is practicing with physician supervision
1080 under regulations adopted by the board, under regulations adopted
1081 by the division. Reimbursement for those services shall not
1082 exceed ninety percent (90%) of the reimbursement rate for
1083 comparable services rendered by a physician. The division may
1084 provide for a reimbursement rate for physician assistant services
1085 of up to one hundred percent (100%) or the reimbursement rate for



1086 comparable services rendered by a physician for physician
1087 assistant services that are provided after the normal working
1088 hours of the physician assistant, as determined in accordance with
1089 regulations of the division.

1090 (46) The division shall make application to the federal
1091 Centers for Medicare and Medicaid Services (CMS) for a waiver to
1092 develop and provide services for children with serious emotional
1093 disturbances as defined in Section 43-14-1(1), which may include
1094 home- and community-based services, case management services or
1095 managed care services through mental health providers certified by
1096 the Department of Mental Health. The division may implement and
1097 provide services under this waived program only if funds for
1098 these services are specifically appropriated for this purpose by
1099 the Legislature, or if funds are voluntarily provided by affected
1100 agencies.

1101 (47) (a) The division may develop and implement
1102 disease management programs for individuals with high-cost chronic
1103 diseases and conditions, including the use of grants, waivers,
1104 demonstrations or other projects as necessary.

1105 (b) Participation in any disease management
1106 program implemented under this paragraph (47) is optional with the
1107 individual. An individual must affirmatively elect to participate
1108 in the disease management program in order to participate, and may
1109 elect to discontinue participation in the program at any time.

1110 (48) Pediatric long-term acute care hospital services.



1111 (a) Pediatric long-term acute care hospital
1112 services means services provided to eligible persons under
1113 twenty-one (21) years of age by a freestanding Medicare-certified
1114 hospital that has an average length of inpatient stay greater than
1115 twenty-five (25) days and that is primarily engaged in providing
1116 chronic or long-term medical care to persons under twenty-one (21)
1117 years of age.

1118 (b) The services under this paragraph (48) shall
1119 be reimbursed as a separate category of hospital services.

1120 (49) The division may establish copayments and/or
1121 coinsurance for any Medicaid services for which copayments and/or
1122 coinsurance are allowable under federal law or regulation.

1123 (50) Services provided by the State Department of
1124 Rehabilitation Services for the care and rehabilitation of persons
1125 who are deaf and blind, as allowed under waivers from the United
1126 States Department of Health and Human Services to provide home-
1127 and community-based services using state funds that are provided
1128 from the appropriation to the State Department of Rehabilitation
1129 Services or if funds are voluntarily provided by another agency.

1130 (51) Upon determination of Medicaid eligibility and in
1131 association with annual redetermination of Medicaid eligibility,
1132 beneficiaries shall be encouraged to undertake a physical
1133 examination that will establish a base-line level of health and
1134 identification of a usual and customary source of care (a medical
1135 home) to aid utilization of disease management tools. This



1136 physical examination and utilization of these disease management
1137 tools shall be consistent with current United States Preventive
1138 Services Task Force or other recognized authority recommendations.

1139 For persons who are determined ineligible for Medicaid, the
1140 division will provide information and direction for accessing
1141 medical care and services in the area of their residence.

1142 (52) Notwithstanding any provisions of this article,
1143 the division may pay enhanced reimbursement fees related to trauma
1144 care, as determined by the division in conjunction with the State
1145 Department of Health, using funds appropriated to the State
1146 Department of Health for trauma care and services and used to
1147 match federal funds under a cooperative agreement between the
1148 division and the State Department of Health. The division, in
1149 conjunction with the State Department of Health, may use grants,
1150 waivers, demonstrations, enhanced reimbursements, Upper Payment
1151 Limits Programs, supplemental payments, or other projects as
1152 necessary in the development and implementation of this
1153 reimbursement program.

1154 (53) Targeted case management services for high-cost
1155 beneficiaries may be developed by the division for all services
1156 under this section.

1157 (54) [Deleted]

1158 (55) Therapy services. The plan of care for therapy
1159 services may be developed to cover a period of treatment for up to
1160 six (6) months, but in no event shall the plan of care exceed a



1161 six-month period of treatment. The projected period of treatment
1162 must be indicated on the initial plan of care and must be updated
1163 with each subsequent revised plan of care. Based on medical
1164 necessity, the division shall approve certification periods for
1165 less than or up to six (6) months, but in no event shall the
1166 certification period exceed the period of treatment indicated on
1167 the plan of care. The appeal process for any reduction in therapy
1168 services shall be consistent with the appeal process in federal
1169 regulations.

1170 (56) Prescribed pediatric extended care centers
1171 services for medically dependent or technologically dependent
1172 children with complex medical conditions that require continual
1173 care as prescribed by the child's attending physician, as
1174 determined by the division.

1175 (57) No Medicaid benefit shall restrict coverage for
1176 medically appropriate treatment prescribed by a physician and
1177 agreed to by a fully informed individual, or if the individual
1178 lacks legal capacity to consent by a person who has legal
1179 authority to consent on his or her behalf, based on an
1180 individual's diagnosis with a terminal condition. As used in this
1181 paragraph (57), "terminal condition" means any aggressive
1182 malignancy, chronic end-stage cardiovascular or cerebral vascular
1183 disease, or any other disease, illness or condition which a
1184 physician diagnoses as terminal.



1185 (58) Treatment services for persons with opioid
1186 dependency or other highly addictive substance use disorders. The
1187 division is authorized to reimburse eligible providers for
1188 treatment of opioid dependency and other highly addictive
1189 substance use disorders, as determined by the division. Treatment
1190 related to these conditions shall not count against any physician
1191 visit limit imposed under this section.

1192 (59) The division shall allow beneficiaries between the
1193 ages of ten (10) and eighteen (18) years to receive vaccines
1194 through a pharmacy venue. The division and the State Department
1195 of Health shall coordinate and notify OB-GYN providers that the
1196 Vaccines for Children program is available to providers free of
1197 charge.

1198 (60) Border city university-affiliated pediatric
1199 teaching hospital.

1200 (a) Payments may only be made to a border city
1201 university-affiliated pediatric teaching hospital if the Centers
1202 for Medicare and Medicaid Services (CMS) approve an increase in
1203 the annual request for the provider payment initiative authorized
1204 under 42 CFR Section 438.6(c) in an amount equal to or greater
1205 than the estimated annual payment to be made to the border city
1206 university-affiliated pediatric teaching hospital. The estimate
1207 shall be based on the hospital's prior year Mississippi managed
1208 care utilization.



1209 (b) As used in this paragraph (60), the term
1210 "border city university-affiliated pediatric teaching hospital"
1211 means an out-of-state hospital located within a city bordering the
1212 eastern bank of the Mississippi River and the State of Mississippi
1213 that submits to the division a copy of a current and effective
1214 affiliation agreement with an accredited university and other
1215 documentation establishing that the hospital is
1216 university-affiliated, is licensed and designated as a pediatric
1217 hospital or pediatric primary hospital within its home state,
1218 maintains at least five (5) different pediatric specialty training
1219 programs, and maintains at least one hundred (100) operated beds
1220 dedicated exclusively for the treatment of patients under the age
1221 of twenty-one (21) years.

1222 (c) The cost of providing services to Mississippi
1223 Medicaid beneficiaries under the age of twenty-one (21) years who
1224 are treated by a border city university-affiliated pediatric
1225 teaching hospital shall not exceed the cost of providing the same
1226 services to individuals in hospitals in the state.

1227 (d) It is the intent of the Legislature that
1228 payments shall not result in any in-state hospital receiving
1229 payments lower than they would otherwise receive if not for the
1230 payments made to any border city university-affiliated pediatric
1231 teaching hospital.

1232 (e) This paragraph (60) shall stand repealed on
1233 July 1, * * * 2028.



1234 (B) Planning and development districts participating in the
1235 home- and community-based services program for the elderly and
1236 disabled as case management providers shall be reimbursed for case
1237 management services at the maximum rate approved by the Centers
1238 for Medicare and Medicaid Services (CMS).

1239 (C) The division may pay to those providers who participate
1240 in and accept patient referrals from the division's emergency room
1241 redirection program a percentage, as determined by the division,
1242 of savings achieved according to the performance measures and
1243 reduction of costs required of that program. Federally qualified
1244 health centers may participate in the emergency room redirection
1245 program, and the division may pay those centers a percentage of
1246 any savings to the Medicaid program achieved by the centers'
1247 accepting patient referrals through the program, as provided in
1248 this subsection (C).

1249 (D) (1) As used in this subsection (D), the following terms
1250 shall be defined as provided in this paragraph, except as
1251 otherwise provided in this subsection:

1252 (a) "Committees" means the Medicaid Committees of
1253 the House of Representatives and the Senate, and "committee" means
1254 either one of those committees.

1255 (b) "Rate change" means an increase, decrease or
1256 other change in the payments or rates of reimbursement, or a
1257 change in any payment methodology that results in an increase,
1258 decrease or other change in the payments or rates of



1259 reimbursement, to any Medicaid provider that renders any services
1260 authorized to be provided to Medicaid recipients under this
1261 article.

1262 (2) Whenever the Division of Medicaid proposes a rate
1263 change, the division shall give notice to the chairmen of the
1264 committees at least thirty (30) calendar days before the proposed
1265 rate change is scheduled to take effect. The division shall
1266 furnish the chairmen with a concise summary of each proposed rate
1267 change along with the notice, and shall furnish the chairmen with
1268 a copy of any proposed rate change upon request. The division
1269 also shall provide a summary and copy of any proposed rate change
1270 to any other member of the Legislature upon request.

1271 (3) If the chairman of either committee or both
1272 chairmen jointly object to the proposed rate change or any part
1273 thereof, the chairman or chairmen shall notify the division and
1274 provide the reasons for their objection in writing not later than
1275 seven (7) calendar days after receipt of the notice from the
1276 division. The chairman or chairmen may make written
1277 recommendations to the division for changes to be made to a
1278 proposed rate change.

1279 (4) (a) The chairman of either committee or both
1280 chairmen jointly may hold a committee meeting to review a proposed
1281 rate change. If either chairman or both chairmen decide to hold a
1282 meeting, they shall notify the division of their intention in
1283 writing within seven (7) calendar days after receipt of the notice



1284 from the division, and shall set the date and time for the meeting
1285 in their notice to the division, which shall not be later than
1286 fourteen (14) calendar days after receipt of the notice from the
1287 division.

1288 (b) After the committee meeting, the committee or
1289 committees may object to the proposed rate change or any part
1290 thereof. The committee or committees shall notify the division
1291 and the reasons for their objection in writing not later than
1292 seven (7) calendar days after the meeting. The committee or
1293 committees may make written recommendations to the division for
1294 changes to be made to a proposed rate change.

1295 (5) If both chairmen notify the division in writing
1296 within seven (7) calendar days after receipt of the notice from
1297 the division that they do not object to the proposed rate change
1298 and will not be holding a meeting to review the proposed rate
1299 change, the proposed rate change will take effect on the original
1300 date as scheduled by the division or on such other date as
1301 specified by the division.

1302 (6) (a) If there are any objections to a proposed rate
1303 change or any part thereof from either or both of the chairmen or
1304 the committees, the division may withdraw the proposed rate
1305 change, make any of the recommended changes to the proposed rate
1306 change, or not make any changes to the proposed rate change.

1307 (b) If the division does not make any changes to
1308 the proposed rate change, it shall notify the chairmen of that



1309 fact in writing, and the proposed rate change shall take effect on
1310 the original date as scheduled by the division or on such other
1311 date as specified by the division.

1312 (c) If the division makes any changes to the
1313 proposed rate change, the division shall notify the chairmen of
1314 its actions in writing, and the revised proposed rate change shall
1315 take effect on the date as specified by the division.

1316 (7) Nothing in this subsection (D) shall be construed
1317 as giving the chairmen or the committees any authority to veto,
1318 nullify or revise any rate change proposed by the division. The
1319 authority of the chairmen or the committees under this subsection
1320 shall be limited to reviewing, making objections to and making
1321 recommendations for changes to rate changes proposed by the
1322 division.

1323 (E) Notwithstanding any provision of this article, no new
1324 groups or categories of recipients and new types of care and
1325 services may be added without enabling legislation from the
1326 Mississippi Legislature, except that the division may authorize
1327 those changes without enabling legislation when the addition of
1328 recipients or services is ordered by a court of proper authority.

1329 (F) The executive director shall keep the Governor advised
1330 on a timely basis of the funds available for expenditure and the
1331 projected expenditures. Notwithstanding any other provisions of
1332 this article, if current or projected expenditures of the division
1333 are reasonably anticipated to exceed the amount of funds



1334 appropriated to the division for any fiscal year, the Governor,
1335 after consultation with the executive director, shall take all
1336 appropriate measures to reduce costs, which may include, but are
1337 not limited to:

1338 (1) Reducing or discontinuing any or all services that
1339 are deemed to be optional under Title XIX of the Social Security
1340 Act;

1341 (2) Reducing reimbursement rates for any or all service
1342 types;

1343 (3) Imposing additional assessments on health care
1344 providers; or

1345 (4) Any additional cost-containment measures deemed
1346 appropriate by the Governor.

1347 To the extent allowed under federal law, any reduction to
1348 services or reimbursement rates under this subsection (F) shall be
1349 accompanied by a reduction, to the fullest allowable amount, to
1350 the profit margin and administrative fee portions of capitated
1351 payments to organizations described in paragraph (1) of subsection
1352 (H).

1353 Beginning in fiscal year 2010 and in fiscal years thereafter,
1354 when Medicaid expenditures are projected to exceed funds available
1355 for the fiscal year, the division shall submit the expected
1356 shortfall information to the PEER Committee not later than
1357 December 1 of the year in which the shortfall is projected to
1358 occur. PEER shall review the computations of the division and



1359 report its findings to the Legislative Budget Office not later
1360 than January 7 in any year.

1361 (G) Notwithstanding any other provision of this article, it
1362 shall be the duty of each provider participating in the Medicaid
1363 program to keep and maintain books, documents and other records as
1364 prescribed by the Division of Medicaid in accordance with federal
1365 laws and regulations.

1366 (H) (1) Notwithstanding any other provision of this
1367 article, the division is authorized to implement (a) a managed
1368 care program, (b) a coordinated care program, (c) a coordinated
1369 care organization program, (d) a health maintenance organization
1370 program, (e) a patient-centered medical home program, (f) an
1371 accountable care organization program, (g) provider-sponsored
1372 health plan, or (h) any combination of the above programs. As a
1373 condition for the approval of any program under this subsection
1374 (H) (1), the division shall require that no managed care program,
1375 coordinated care program, coordinated care organization program,
1376 health maintenance organization program, or provider-sponsored
1377 health plan may:

1378 (a) Pay providers at a rate that is less than the
1379 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
1380 reimbursement rate;

1381 (b) Override the medical decisions of hospital
1382 physicians or staff regarding patients admitted to a hospital for
1383 an emergency medical condition as defined by 42 US Code Section



1384 1395dd. This restriction (b) does not prohibit the retrospective
1385 review of the appropriateness of the determination that an
1386 emergency medical condition exists by chart review or coding
1387 algorithm, nor does it prohibit prior authorization for
1388 nonemergency hospital admissions;

1389 (c) Pay providers at a rate that is less than the
1390 normal Medicaid reimbursement rate. It is the intent of the
1391 Legislature that all managed care entities described in this
1392 subsection (H), in collaboration with the division, develop and
1393 implement innovative payment models that incentivize improvements
1394 in health care quality, outcomes, or value, as determined by the
1395 division. Participation in the provider network of any managed
1396 care, coordinated care, provider-sponsored health plan, or similar
1397 contractor shall not be conditioned on the provider's agreement to
1398 accept such alternative payment models;

1399 (d) Implement a prior authorization and
1400 utilization review program for medical services, transportation
1401 services and prescription drugs that is more stringent than the
1402 prior authorization processes used by the division in its
1403 administration of the Medicaid program. Not later than December
1404 2, 2021, the contractors that are receiving capitated payments
1405 under a managed care delivery system established under this
1406 subsection (H) shall submit a report to the Chairmen of the House
1407 and Senate Medicaid Committees on the status of the prior
1408 authorization and utilization review program for medical services,



1409 transportation services and prescription drugs that is required to
1410 be implemented under this subparagraph (d);

1411 (e) [Deleted]

1412 (f) Implement a preferred drug list that is more
1413 stringent than the mandatory preferred drug list established by
1414 the division under subsection (A) (9) of this section;

1415 (g) Implement a policy which denies beneficiaries
1416 with hemophilia access to the federally funded hemophilia
1417 treatment centers as part of the Medicaid Managed Care network of
1418 providers.

1419 Each health maintenance organization, coordinated care
1420 organization, provider-sponsored health plan, or other
1421 organization paid for services on a capitated basis by the
1422 division under any managed care program or coordinated care
1423 program implemented by the division under this section shall use a
1424 clear set of level of care guidelines in the determination of
1425 medical necessity and in all utilization management practices,
1426 including the prior authorization process, concurrent reviews,
1427 retrospective reviews and payments, that are consistent with
1428 widely accepted professional standards of care. Organizations
1429 participating in a managed care program or coordinated care
1430 program implemented by the division may not use any additional
1431 criteria that would result in denial of care that would be
1432 determined appropriate and, therefore, medically necessary under
1433 those levels of care guidelines.



1434 (2) Notwithstanding any provision of this section, the
1435 recipients eligible for enrollment into a Medicaid Managed Care
1436 Program authorized under this subsection (H) may include only
1437 those categories of recipients eligible for participation in the
1438 Medicaid Managed Care Program as of January 1, 2021, the
1439 Children's Health Insurance Program (CHIP), and the CMS-approved
1440 Section 1115 demonstration waivers in operation as of January 1,
1441 2021. No expansion of Medicaid Managed Care Program contracts may
1442 be implemented by the division without enabling legislation from
1443 the Mississippi Legislature.

1444 (3) (a) Any contractors receiving capitated payments
1445 under a managed care delivery system established in this section
1446 shall provide to the Legislature and the division statistical data
1447 to be shared with provider groups in order to improve patient
1448 access, appropriate utilization, cost savings and health outcomes
1449 not later than October 1 of each year. Additionally, each
1450 contractor shall disclose to the Chairmen of the Senate and House
1451 Medicaid Committees the administrative expenses costs for the
1452 prior calendar year, and the number of full-equivalent employees
1453 located in the State of Mississippi dedicated to the Medicaid and
1454 CHIP lines of business as of June 30 of the current year.

1455 (b) The division and the contractors participating
1456 in the managed care program, a coordinated care program or a
1457 provider-sponsored health plan shall be subject to annual program
1458 reviews or audits performed by the Office of the State Auditor,



1459 the PEER Committee, the Department of Insurance and/or independent
1460 third parties.

1461 (c) Those reviews shall include, but not be
1462 limited to, at least two (2) of the following items:

1463 (i) The financial benefit to the State of
1464 Mississippi of the managed care program,

1465 (ii) The difference between the premiums paid
1466 to the managed care contractors and the payments made by those
1467 contractors to health care providers,

1468 (iii) Compliance with performance measures
1469 required under the contracts,

1470 (iv) Administrative expense allocation
1471 methodologies,

1472 (v) Whether nonprovider payments assigned as
1473 medical expenses are appropriate,

1474 (vi) Capitated arrangements with related
1475 party subcontractors,

1476 (vii) Reasonableness of corporate
1477 allocations,

1478 (viii) Value-added benefits and the extent to
1479 which they are used,

1480 (ix) The effectiveness of subcontractor
1481 oversight, including subcontractor review,

1482 (x) Whether health care outcomes have been
1483 improved, and



1484 (xi) The most common claim denial codes to
1485 determine the reasons for the denials.

1486 The audit reports shall be considered public documents and
1487 shall be posted in their entirety on the division's website.

1488 (4) All health maintenance organizations, coordinated
1489 care organizations, provider-sponsored health plans, or other
1490 organizations paid for services on a capitated basis by the
1491 division under any managed care program or coordinated care
1492 program implemented by the division under this section shall
1493 reimburse all providers in those organizations at rates no lower
1494 than those provided under this section for beneficiaries who are
1495 not participating in those programs.

1496 (5) No health maintenance organization, coordinated
1497 care organization, provider-sponsored health plan, or other
1498 organization paid for services on a capitated basis by the
1499 division under any managed care program or coordinated care
1500 program implemented by the division under this section shall
1501 require its providers or beneficiaries to use any pharmacy that
1502 ships, mails or delivers prescription drugs or legend drugs or
1503 devices.

1504 (6) (a) Not later than December 1, 2021, the
1505 contractors who are receiving capitated payments under a managed
1506 care delivery system established under this subsection (H) shall
1507 develop and implement a uniform credentialing process for
1508 providers. Under that uniform credentialing process, a provider



1509 who meets the criteria for credentialing will be credentialed with
1510 all of those contractors and no such provider will have to be
1511 separately credentialed by any individual contractor in order to
1512 receive reimbursement from the contractor. Not later than
1513 December 2, 2021, those contractors shall submit a report to the
1514 Chairmen of the House and Senate Medicaid Committees on the status
1515 of the uniform credentialing process for providers that is
1516 required under this subparagraph (a).

1517 (b) If those contractors have not implemented a
1518 uniform credentialing process as described in subparagraph (a) by
1519 December 1, 2021, the division shall develop and implement, not
1520 later than July 1, 2022, a single, consolidated credentialing
1521 process by which all providers will be credentialed. Under the
1522 division's single, consolidated credentialing process, no such
1523 contractor shall require its providers to be separately
1524 credentialed by the contractor in order to receive reimbursement
1525 from the contractor, but those contractors shall recognize the
1526 credentialing of the providers by the division's credentialing
1527 process.

1528 (c) The division shall require a uniform provider
1529 credentialing application that shall be used in the credentialing
1530 process that is established under subparagraph (a) or (b). If the
1531 contractor or division, as applicable, has not approved or denied
1532 the provider credentialing application within sixty (60) days of
1533 receipt of the completed application that includes all required



1534 information necessary for credentialing, then the contractor or
1535 division, upon receipt of a written request from the applicant and
1536 within five (5) business days of its receipt, shall issue a
1537 temporary provider credential/enrollment to the applicant if the
1538 applicant has a valid Mississippi professional or occupational
1539 license to provide the health care services to which the
1540 credential/enrollment would apply. The contractor or the division
1541 shall not issue a temporary credential/enrollment if the applicant
1542 has reported on the application a history of medical or other
1543 professional or occupational malpractice claims, a history of
1544 substance abuse or mental health issues, a criminal record, or a
1545 history of medical or other licensing board, state or federal
1546 disciplinary action, including any suspension from participation
1547 in a federal or state program. The temporary
1548 credential/enrollment shall be effective upon issuance and shall
1549 remain in effect until the provider's credentialing/enrollment
1550 application is approved or denied by the contractor or division.
1551 The contractor or division shall render a final decision regarding
1552 credentialing/enrollment of the provider within sixty (60) days
1553 from the date that the temporary provider credential/enrollment is
1554 issued to the applicant.

1555 (d) If the contractor or division does not render
1556 a final decision regarding credentialing/enrollment of the
1557 provider within the time required in subparagraph (c), the
1558 provider shall be deemed to be credentialed by and enrolled with



1559 all of the contractors and eligible to receive reimbursement from
1560 the contractors.

1561 (7) (a) Each contractor that is receiving capitated
1562 payments under a managed care delivery system established under
1563 this subsection (H) shall provide to each provider for whom the
1564 contractor has denied the coverage of a procedure that was ordered
1565 or requested by the provider for or on behalf of a patient, a
1566 letter that provides a detailed explanation of the reasons for the
1567 denial of coverage of the procedure and the name and the
1568 credentials of the person who denied the coverage. The letter
1569 shall be sent to the provider in electronic format.

1570 (b) After a contractor that is receiving capitated
1571 payments under a managed care delivery system established under
1572 this subsection (H) has denied coverage for a claim submitted by a
1573 provider, the contractor shall issue to the provider within sixty
1574 (60) days a final ruling of denial of the claim that allows the
1575 provider to have a state fair hearing and/or agency appeal with
1576 the division. If a contractor does not issue a final ruling of
1577 denial within sixty (60) days as required by this subparagraph
1578 (b), the provider's claim shall be deemed to be automatically
1579 approved and the contractor shall pay the amount of the claim to
1580 the provider.

1581 (c) After a contractor has issued a final ruling
1582 of denial of a claim submitted by a provider, the division shall
1583 conduct a state fair hearing and/or agency appeal on the matter of



1584 the disputed claim between the contractor and the provider within
1585 sixty (60) days, and shall render a decision on the matter within
1586 thirty (30) days after the date of the hearing and/or appeal.

1587 (8) It is the intention of the Legislature that the
1588 division evaluate the feasibility of using a single vendor to
1589 administer pharmacy benefits provided under a managed care
1590 delivery system established under this subsection (H). Providers
1591 of pharmacy benefits shall cooperate with the division in any
1592 transition to a carve-out of pharmacy benefits under managed care.

1593 (9) The division shall evaluate the feasibility of
1594 using a single vendor to administer dental benefits provided under
1595 a managed care delivery system established in this subsection (H).
1596 Providers of dental benefits shall cooperate with the division in
1597 any transition to a carve-out of dental benefits under managed
1598 care.

1599 (10) It is the intent of the Legislature that any
1600 contractor receiving capitated payments under a managed care
1601 delivery system established in this section shall implement
1602 innovative programs to improve the health and well-being of
1603 members diagnosed with prediabetes and diabetes.

1604 (11) It is the intent of the Legislature that any
1605 contractors receiving capitated payments under a managed care
1606 delivery system established under this subsection (H) shall work
1607 with providers of Medicaid services to improve the utilization of
1608 long-acting reversible contraceptives (LARCs). Not later than



1609 December 1, 2021, any contractors receiving capitated payments
1610 under a managed care delivery system established under this
1611 subsection (H) shall provide to the Chairmen of the House and
1612 Senate Medicaid Committees and House and Senate Public Health
1613 Committees a report of LARC utilization for State Fiscal Years
1614 2018 through 2020 as well as any programs, initiatives, or efforts
1615 made by the contractors and providers to increase LARC
1616 utilization. This report shall be updated annually to include
1617 information for subsequent state fiscal years.

1618 (12) The division is authorized to make not more than
1619 one (1) emergency extension of the contracts that are in effect on
1620 July 1, 2021, with contractors who are receiving capitated
1621 payments under a managed care delivery system established under
1622 this subsection (H), as provided in this paragraph (12). The
1623 maximum period of any such extension shall be one (1) year, and
1624 under any such extensions, the contractors shall be subject to all
1625 of the provisions of this subsection (H). The extended contracts
1626 shall be revised to incorporate any provisions of this subsection
1627 (H).

1628 (I) [Deleted]

1629 (J) There shall be no cuts in inpatient and outpatient
1630 hospital payments, or allowable days or volumes, as long as the
1631 hospital assessment provided in Section 43-13-145 is in effect.
1632 This subsection (J) shall not apply to decreases in payments that
1633 are a result of: reduced hospital admissions, audits or payments



1634 under the APR-DRG or APC models, or a managed care program or
1635 similar model described in subsection (H) of this section.

1636 (K) In the negotiation and execution of such contracts
1637 involving services performed by actuarial firms, the Executive
1638 Director of the Division of Medicaid may negotiate a limitation on
1639 liability to the state of prospective contractors.

1640 (L) The Division of Medicaid shall reimburse for services
1641 provided to eligible Medicaid beneficiaries by a licensed birthing
1642 center in a method and manner to be determined by the division in
1643 accordance with federal laws and federal regulations. The
1644 division shall seek any necessary waivers, make any required
1645 amendments to its State Plan or revise any contracts authorized
1646 under subsection (H) of this section as necessary to provide the
1647 services authorized under this subsection. As used in this
1648 subsection, the term "birthing centers" shall have the meaning as
1649 defined in Section 41-77-1(a), which is a publicly or privately
1650 owned facility, place or institution constructed, renovated,
1651 leased or otherwise established where nonemergency births are
1652 planned to occur away from the mother's usual residence following
1653 a documented period of prenatal care for a normal uncomplicated
1654 pregnancy which has been determined to be low risk through a
1655 formal risk-scoring examination.

1656 (M) This section shall stand repealed on July 1, * * * 2028.

1657 **SECTION 3.** Section 43-13-145, Mississippi Code of 1972, is
1658 amended as follows:



1659 43-13-145. (1) (a) Upon each nursing facility licensed by
1660 the State of Mississippi, there is levied an assessment in an
1661 amount set by the division, equal to the maximum rate allowed by
1662 federal law or regulation, for each licensed and occupied bed of
1663 the facility.

1664 (b) A nursing facility is exempt from the assessment
1665 levied under this subsection if the facility is operated under the
1666 direction and control of:

1667 (i) The United States Veterans Administration or
1668 other agency or department of the United States government; or

1669 (ii) The State Veterans Affairs Board.

1670 (2) (a) Upon each intermediate care facility for
1671 individuals with intellectual disabilities licensed by the State
1672 of Mississippi, there is levied an assessment in an amount set by
1673 the division, equal to the maximum rate allowed by federal law or
1674 regulation, for each licensed and occupied bed of the facility.

1675 (b) An intermediate care facility for individuals with
1676 intellectual disabilities is exempt from the assessment levied
1677 under this subsection if the facility is operated under the
1678 direction and control of:

1679 (i) The United States Veterans Administration or
1680 other agency or department of the United States government;

1681 (ii) The State Veterans Affairs Board; or

1682 (iii) The University of Mississippi Medical
1683 Center.



1684 (3) (a) Upon each psychiatric residential treatment
1685 facility licensed by the State of Mississippi, there is levied an
1686 assessment in an amount set by the division, equal to the maximum
1687 rate allowed by federal law or regulation, for each licensed and
1688 occupied bed of the facility.

1689 (b) A psychiatric residential treatment facility is
1690 exempt from the assessment levied under this subsection if the
1691 facility is operated under the direction and control of:

1692 (i) The United States Veterans Administration or
1693 other agency or department of the United States government;

1694 (ii) The University of Mississippi Medical Center;
1695 or

1696 (iii) A state agency or a state facility that
1697 either provides its own state match through intergovernmental
1698 transfer or certification of funds to the division.

1699 (4) Hospital assessment.

1700 (a) (i) Subject to and upon fulfillment of the
1701 requirements and conditions of paragraph (f) below, and
1702 notwithstanding any other provisions of this section, an annual
1703 assessment on each hospital licensed in the state is imposed on
1704 each non-Medicare hospital inpatient day as defined below at a
1705 rate that is determined by dividing the sum prescribed in this
1706 subparagraph (i), plus the nonfederal share necessary to maximize
1707 the Disproportionate Share Hospital (DSH) and Medicare Upper
1708 Payment Limits (UPL) Program payments and hospital access payments



1709 and such other supplemental payments as may be developed pursuant
1710 to Section 43-13-117(A)(18), by the total number of non-Medicare
1711 hospital inpatient days as defined below for all licensed
1712 Mississippi hospitals, except as provided in paragraph (d) below.
1713 If the state-matching funds percentage for the Mississippi
1714 Medicaid program is sixteen percent (16%) or less, the sum used in
1715 the formula under this subparagraph (i) shall be Seventy-four
1716 Million Dollars (\$74,000,000.00). If the state-matching funds
1717 percentage for the Mississippi Medicaid program is twenty-four
1718 percent (24%) or higher, the sum used in the formula under this
1719 subparagraph (i) shall be One Hundred Four Million Dollars
1720 (\$104,000,000.00). If the state-matching funds percentage for the
1721 Mississippi Medicaid program is between sixteen percent (16%) and
1722 twenty-four percent (24%), the sum used in the formula under this
1723 subparagraph (i) shall be a pro rata amount determined as follows:
1724 the current state-matching funds percentage rate minus sixteen
1725 percent (16%) divided by eight percent (8%) multiplied by Thirty
1726 Million Dollars (\$30,000,000.00) and add that amount to
1727 Seventy-four Million Dollars (\$74,000,000.00). However, no
1728 assessment in a quarter under this subparagraph (i) may exceed the
1729 assessment in the previous quarter by more than Three Million
1730 Seven Hundred Fifty Thousand Dollars (\$3,750,000.00) (which would
1731 be Fifteen Million Dollars (\$15,000,000.00) on an annualized
1732 basis), unless such increase is to maximize federal funds that are
1733 available to reimburse hospitals for services provided under new



1734 programs for hospitals, increased supplemental payment programs
1735 for hospitals or to assist with state matching funds as authorized
1736 by the Legislature. The division shall publish the state-matching
1737 funds percentage rate applicable to the Mississippi Medicaid
1738 program on the tenth day of the first month of each quarter and
1739 the assessment determined under the formula prescribed above shall
1740 be applicable in the quarter following any adjustment in that
1741 state-matching funds percentage rate. The division shall notify
1742 each hospital licensed in the state as to any projected increases
1743 or decreases in the assessment determined under this subparagraph
1744 (i). However, if the Centers for Medicare and Medicaid Services
1745 (CMS) does not approve the provision in Section 43-13-117(39)
1746 requiring the division to reimburse crossover claims for inpatient
1747 hospital services and crossover claims covered under Medicare Part
1748 B for dually eligible beneficiaries in the same manner that was in
1749 effect on January 1, 2008, the sum that otherwise would have been
1750 used in the formula under this subparagraph (i) shall be reduced
1751 by Seven Million Dollars (\$7,000,000.00).

1752 (ii) In addition to the assessment provided under
1753 subparagraph (i), an additional annual assessment on each hospital
1754 licensed in the state is imposed on each non-Medicare hospital
1755 inpatient day as defined below at a rate that is determined by
1756 dividing twenty-five percent (25%) of any provider reductions in
1757 the Medicaid program as authorized in Section 43-13-117(F) for
1758 that fiscal year up to the following maximum amount, plus the



1759 nonfederal share necessary to maximize the Disproportionate Share
1760 Hospital (DSH) and inpatient Medicare Upper Payment Limits (UPL)
1761 Program payments and inpatient hospital access payments, by the
1762 total number of non-Medicare hospital inpatient days as defined
1763 below for all licensed Mississippi hospitals: in fiscal year
1764 2010, the maximum amount shall be Twenty-four Million Dollars
1765 (\$24,000,000.00); in fiscal year 2011, the maximum amount shall be
1766 Thirty-two Million Dollars (\$32,000,000.00); and in fiscal year
1767 2012 and thereafter, the maximum amount shall be Forty Million
1768 Dollars (\$40,000,000.00). Any such deficit in the Medicaid
1769 program shall be reviewed by the PEER Committee as provided in
1770 Section 43-13-117(F).

1771 (iii) In addition to the assessments provided in
1772 subparagraphs (i) and (ii), an additional annual assessment on
1773 each hospital licensed in the state is imposed pursuant to the
1774 provisions of Section 43-13-117(F) if the cost-containment
1775 measures described therein have been implemented and there are
1776 insufficient funds in the Health Care Trust Fund to reconcile any
1777 remaining deficit in any fiscal year. If the Governor institutes
1778 any other additional cost-containment measures on any program or
1779 programs authorized under the Medicaid program pursuant to Section
1780 43-13-117(F), hospitals shall be responsible for twenty-five
1781 percent (25%) of any such additional imposed provider cuts, which
1782 shall be in the form of an additional assessment not to exceed the
1783 twenty-five percent (25%) of provider expenditure reductions.



1784 Such additional assessment shall be imposed on each non-Medicare
1785 hospital inpatient day in the same manner as assessments are
1786 imposed under subparagraphs (i) and (ii).

1787 (b) Definitions.

1788 (i) [Deleted]

1789 (ii) For purposes of this subsection (4):

1790 1. "Non-Medicare hospital inpatient day"

1791 means total hospital inpatient days including subcomponent days
1792 less Medicare inpatient days including subcomponent days from the
1793 hospital's most recent Medicare cost report for the second
1794 calendar year preceding the beginning of the state fiscal year, on
1795 file with CMS per the CMS HCRIS database, or cost report submitted
1796 to the Division if the HCRIS database is not available to the
1797 division, as of June 1 of each year.

1798 a. Total hospital inpatient days shall
1799 be the sum of Worksheet S-3, Part 1, column 8 row 14, column 8 row
1800 16, and column 8 row 17, excluding column 8 rows 5 and 6.

1801 b. Hospital Medicare inpatient days
1802 shall be the sum of Worksheet S-3, Part 1, column 6 row 14, column
1803 6 row 16.00, and column 6 row 17, excluding column 6 rows 5 and 6.

1804 c. Inpatient days shall not include
1805 residential treatment or long-term care days.

1806 2. "Subcomponent inpatient day" means the
1807 number of days of care charged to a beneficiary for inpatient
1808 hospital rehabilitation and psychiatric care services in units of



1809 full days. A day begins at midnight and ends twenty-four (24)
1810 hours later. A part of a day, including the day of admission and
1811 day on which a patient returns from leave of absence, counts as a
1812 full day. However, the day of discharge, death, or a day on which
1813 a patient begins a leave of absence is not counted as a day unless
1814 discharge or death occur on the day of admission. If admission
1815 and discharge or death occur on the same day, the day is
1816 considered a day of admission and counts as one (1) subcomponent
1817 inpatient day.

1818 (c) The assessment provided in this subsection is
1819 intended to satisfy and not be in addition to the assessment and
1820 intergovernmental transfers provided in Section 43-13-117(A)(18).
1821 Nothing in this section shall be construed to authorize any state
1822 agency, division or department, or county, municipality or other
1823 local governmental unit to license for revenue, levy or impose any
1824 other tax, fee or assessment upon hospitals in this state not
1825 authorized by a specific statute.

1826 (d) Hospitals operated by the United States Department
1827 of Veterans Affairs and state-operated facilities that provide
1828 only inpatient and outpatient psychiatric services shall not be
1829 subject to the hospital assessment provided in this subsection.

1830 (e) Multihospital systems, closure, merger, change of
1831 ownership and new hospitals.

1832 (i) If a hospital conducts, operates or maintains
1833 more than one (1) hospital licensed by the State Department of



1834 Health, the provider shall pay the hospital assessment for each
1835 hospital separately.

1836 (ii) Notwithstanding any other provision in this
1837 section, if a hospital subject to this assessment operates or
1838 conducts business only for a portion of a fiscal year, the
1839 assessment for the state fiscal year shall be adjusted by
1840 multiplying the assessment by a fraction, the numerator of which
1841 is the number of days in the year during which the hospital
1842 operates, and the denominator of which is three hundred sixty-five
1843 (365). Immediately upon ceasing to operate, the hospital shall
1844 pay the assessment for the year as so adjusted (to the extent not
1845 previously paid).

1846 (iii) The division shall determine the tax for new
1847 hospitals and hospitals that undergo a change of ownership in
1848 accordance with this section, using the best available
1849 information, as determined by the division.

1850 (f) Applicability.

1851 The hospital assessment imposed by this subsection shall not
1852 take effect and/or shall cease to be imposed if:

1853 (i) The assessment is determined to be an
1854 impermissible tax under Title XIX of the Social Security Act; or

1855 (ii) CMS revokes its approval of the division's
1856 2009 Medicaid State Plan Amendment for the methodology for DSH
1857 payments to hospitals under Section 43-13-117(A)(18).



1858 (5) Each health care facility that is subject to the
1859 provisions of this section shall keep and preserve such suitable
1860 books and records as may be necessary to determine the amount of
1861 assessment for which it is liable under this section. The books
1862 and records shall be kept and preserved for a period of not less
1863 than five (5) years, during which time those books and records
1864 shall be open for examination during business hours by the
1865 division, the Department of Revenue, the Office of the Attorney
1866 General and the State Department of Health.

1867 (6) [Deleted]

1868 (7) All assessments collected under this section shall be
1869 deposited in the Medical Care Fund created by Section 43-13-143.

1870 (8) The assessment levied under this section shall be in
1871 addition to any other assessments, taxes or fees levied by law,
1872 and the assessment shall constitute a debt due the State of
1873 Mississippi from the time the assessment is due until it is paid.

1874 (9) (a) If a health care facility that is liable for
1875 payment of an assessment levied by the division does not pay the
1876 assessment when it is due, the division shall give written notice
1877 to the health care facility demanding payment of the assessment
1878 within ten (10) days from the date of delivery of the notice. If
1879 the health care facility fails or refuses to pay the assessment
1880 after receiving the notice and demand from the division, the
1881 division shall withhold from any Medicaid reimbursement payments
1882 that are due to the health care facility the amount of the unpaid



1883 assessment and a penalty of ten percent (10%) of the amount of the
1884 assessment, plus the legal rate of interest until the assessment
1885 is paid in full. If the health care facility does not participate
1886 in the Medicaid program, the division shall turn over to the
1887 Office of the Attorney General the collection of the unpaid
1888 assessment by civil action. In any such civil action, the Office
1889 of the Attorney General shall collect the amount of the unpaid
1890 assessment and a penalty of ten percent (10%) of the amount of the
1891 assessment, plus the legal rate of interest until the assessment
1892 is paid in full.

1893 (b) As an additional or alternative method for
1894 collecting unpaid assessments levied by the division, if a health
1895 care facility fails or refuses to pay the assessment after
1896 receiving notice and demand from the division, the division may
1897 file a notice of a tax lien with the chancery clerk of the county
1898 in which the health care facility is located, for the amount of
1899 the unpaid assessment and a penalty of ten percent (10%) of the
1900 amount of the assessment, plus the legal rate of interest until
1901 the assessment is paid in full. Immediately upon receipt of
1902 notice of the tax lien for the assessment, the chancery clerk
1903 shall forward the notice to the circuit clerk who shall enter the
1904 notice of the tax lien as a judgment upon the judgment roll and
1905 show in the appropriate columns the name of the health care
1906 facility as judgment debtor, the name of the division as judgment
1907 creditor, the amount of the unpaid assessment, and the date and



1908 time of enrollment. The judgment shall be valid as against
1909 mortgagees, pledgees, entrusters, purchasers, judgment creditors
1910 and other persons from the time of filing with the clerk. The
1911 amount of the judgment shall be a debt due the State of
1912 Mississippi and remain a lien upon the tangible property of the
1913 health care facility until the judgment is satisfied. The
1914 judgment shall be the equivalent of any enrolled judgment of a
1915 court of record and shall serve as authority for the issuance of
1916 writs of execution, writs of attachment or other remedial writs.

1917 (10) (a) To further the provisions of Section
1918 43-13-117(A)(18), the Division of Medicaid shall submit to the
1919 Centers for Medicare and Medicaid Services (CMS) any documents
1920 regarding the hospital assessment established under subsection (4)
1921 of this section. In addition to defining the assessment
1922 established in subsection (4) of this section if necessary, the
1923 documents shall describe any supplement payment programs and/or
1924 payment methodologies as authorized in Section 43-13-117(A)(18) if
1925 necessary.

1926 (b) All hospitals satisfying the minimum federal DSH
1927 eligibility requirements (Section 1923(d) of the Social Security
1928 Act) may, subject to OBRA 1993 payment limitations, receive a DSH
1929 payment. This DSH payment shall expend the balance of the federal
1930 DSH allotment and associated state share not utilized in DSH
1931 payments to state-owned institutions for treatment of mental
1932 diseases. The payment to each hospital shall be calculated by



1933 applying a uniform percentage to the uninsured costs of each
1934 eligible hospital, excluding state-owned institutions for
1935 treatment of mental diseases; however, that percentage for a
1936 state-owned teaching hospital located in Hinds County shall be
1937 multiplied by a factor of two (2).

1938 (11) The division shall implement DSH and supplemental
1939 payment calculation methodologies that result in the maximization
1940 of available federal funds.

1941 (12) The DSH payments shall be paid on or before December
1942 31, March 31, and June 30 of each fiscal year, in increments of
1943 one-third (1/3) of the total calculated DSH amounts. Supplemental
1944 payments developed pursuant to Section 43-13-117(A)(18) shall be
1945 paid monthly.

1946 (13) Payment.

1947 (a) The hospital assessment as described in subsection
1948 (4) for the nonfederal share necessary to maximize the Medicare
1949 Upper Payments Limits (UPL) Program payments and hospital access
1950 payments and such other supplemental payments as may be developed
1951 pursuant to Section 43-3-117(A)(18) shall be assessed and
1952 collected monthly no later than the fifteenth calendar day of each
1953 month.

1954 (b) The hospital assessment as described in subsection
1955 (4) for the nonfederal share necessary to maximize the
1956 Disproportionate Share Hospital (DSH) payments shall be assessed
1957 and collected on December 15, March 15 and June 15.



1958 (c) The annual hospital assessment and any additional
1959 hospital assessment as described in subsection (4) shall be
1960 assessed and collected on September 15 and on the 15th of each
1961 month from December through June.

1962 (14) If for any reason any part of the plan for annual DSH
1963 and supplemental payment programs to hospitals provided under
1964 subsection (10) of this section and/or developed pursuant to
1965 Section 43-13-117(A)(18) is not approved by CMS, the remainder of
1966 the plan shall remain in full force and effect.

1967 (15) Nothing in this section shall prevent the Division of
1968 Medicaid from facilitating participation in Medicaid supplemental
1969 hospital payment programs by a hospital located in a county
1970 contiguous to the State of Mississippi that is also authorized by
1971 federal law to submit intergovernmental transfers (IGTs) to the
1972 State of Mississippi to fund the state share of the hospital's
1973 supplemental and/or MHAP payments.

1974 (16) Notwithstanding any provision of this section, a
1975 state-owned acute care hospital shall submit an intergovernmental
1976 transfer (IGT) to the State of Mississippi to fund the nonfederal
1977 share of that hospital's supplemental payments. The IGT shall be
1978 assessed and collected similar to the schedule described in
1979 subsection (13) of this section and that hospital's supplemental
1980 payment shall not be included in the assessment for the nonfederal
1981 share for which other hospitals are assessed.



1982 (* * * 17) This section shall stand repealed on July
1983 1, * * * 2028.

1984 **SECTION 4.** Section 43-13-305, Mississippi Code of 1972, is
1985 amended as follows:

1986 43-13-305. (1) By accepting Medicaid from the Division of
1987 Medicaid in the Office of the Governor, the recipient shall, to
1988 the extent of the payment of medical expenses by the Division of
1989 Medicaid, be deemed to have made an assignment to the Division of
1990 Medicaid of any and all rights and interests in any third-party
1991 benefits, hospitalization or indemnity contract or any cause of
1992 action, past, present or future, against any person, firm or
1993 corporation for Medicaid benefits provided to the recipient by the
1994 Division of Medicaid for injuries, disease or sickness caused or
1995 suffered under circumstances creating a cause of action in favor
1996 of the recipient against any such person, firm or corporation as
1997 set out in Section 43-13-125. The recipient shall be deemed,
1998 without the necessity of signing any document, to have appointed
1999 the Division of Medicaid as his or her true and lawful
2000 attorney-in-fact in his or her name, place and stead in collecting
2001 any and all amounts due and owing for medical expenses paid by the
2002 Division of Medicaid against such person, firm or corporation.

2003 (2) Whenever a provider of medical services or the Division
2004 of Medicaid submits claims to an insurer on behalf of a Medicaid
2005 recipient for whom an assignment of rights has been received, or
2006 whose rights have been assigned by the operation of law, the



2007 insurer must respond within sixty (60) days of receipt of a claim
2008 by forwarding payment or issuing a notice of denial directly to
2009 the submitter of the claim. The failure of the insuring entity to
2010 comply with the provisions of this section shall subject the
2011 insuring entity to recourse by the Division of Medicaid in
2012 accordance with the provision of Section 43-13-315. In the case
2013 of a responsible insurer, other than the insurers exempted under
2014 federal law, that requires prior authorization for an item or
2015 service furnished to a recipient, the insurer shall accept
2016 authorization provided by the Division of Medicaid that the item
2017 or service is covered under the state plan (or waiver of such
2018 plan) for such recipient, as if such authorization were the prior
2019 authorization made by the insurer for such item or service. The
2020 Division of Medicaid shall be authorized to endorse any and all,
2021 including, but not limited to, multi-payee checks, drafts, money
2022 orders or other negotiable instruments representing Medicaid
2023 payment recoveries that are received by the Division of Medicaid.

2024 (3) Court orders or agreements for medical support shall
2025 direct such payments to the Division of Medicaid, which shall be
2026 authorized to endorse any and all checks, drafts, money orders or
2027 other negotiable instruments representing medical support payments
2028 which are received. Any designated medical support funds received
2029 by the State Department of Human Services or through its local
2030 county departments shall be paid over to the Division of Medicaid.
2031 When medical support for a Medicaid recipient is available through



2032 an absent parent or custodial parent, the insuring entity shall
2033 direct the medical support payment(s) to the provider of medical
2034 services or to the Division of Medicaid.

2035 **SECTION 5.** This act shall take effect and be in force from
2036 and after July 1, 2024, and shall stand repealed on June 30, 2024.

