

By: Representative Karriem

To: Medicaid; Appropriations
A

HOUSE BILL NO. 1593

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE THAT NEONATAL CIRCUMCISION PROCEDURES WILL BE COVERED
3 UNDER MEDICAID; AND FOR RELATED PURPOSES.

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

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

7 43-13-117. (A) Medicaid as authorized by this article shall
8 include payment of part or all of the costs, at the discretion of
9 the division, with approval of the Governor and the Centers for
10 Medicare and Medicaid Services, of the following types of care and
11 services rendered to eligible applicants who have been determined
12 to be eligible for that care and services, within the limits of
13 state appropriations and federal matching funds:

14 (1) Inpatient hospital services.

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



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

24 (2) Outpatient hospital services.

25 (a) Emergency services.

26 (b) Other outpatient hospital services. The
27 division shall allow benefits for other medically necessary
28 outpatient hospital services (such as chemotherapy, radiation,
29 surgery and therapy), including outpatient services in a clinic or
30 other facility that is not located inside the hospital, but that
31 has been designated as an outpatient facility by the hospital, and
32 that was in operation or under construction on July 1, 2009,
33 provided that the costs and charges associated with the operation
34 of the hospital clinic are included in the hospital's cost report.
35 In addition, the Medicare thirty-five-mile rule will apply to
36 those hospital clinics not located inside the hospital that are
37 constructed after July 1, 2009. Where the same services are
38 reimbursed as clinic services, the division may revise the rate or
39 methodology of outpatient reimbursement to maintain consistency,
40 efficiency, economy and quality of care.

41 (c) The division is authorized to implement an
42 Ambulatory Payment Classification (APC) methodology for outpatient



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

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

57 (3) Laboratory and x-ray services.

58 (4) Nursing facility services.

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

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



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

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

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

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



93 such case-mix add-on payment shall be supported by a determination
94 of additional cost. The division shall also develop and implement
95 as part of the fair rental reimbursement system for nursing
96 facility beds, an Alzheimer's resident bed depreciation enhanced
97 reimbursement system that will provide an incentive to encourage
98 nursing facilities to convert or construct beds for residents with
99 Alzheimer's or other related dementia.

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

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

108 (5) Periodic screening and diagnostic services for
109 individuals under age twenty-one (21) years as are needed to
110 identify physical and mental defects and to provide health care
111 treatment and other measures designed to correct or ameliorate
112 defects and physical and mental illness and conditions discovered
113 by the screening services, regardless of whether these services
114 are included in the state plan. The division may include in its
115 periodic screening and diagnostic program those discretionary
116 services authorized under the federal regulations adopted to
117 implement Title XIX of the federal Social Security Act, as



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

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



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

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

159 (b) [Repealed]

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

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

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



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

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

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

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



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

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

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

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

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

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



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

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

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

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

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

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



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

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

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

250 The division shall increase the amount of the reimbursement
251 rate for diagnostic and preventative dental services for each of
252 the fiscal years 2022, 2023 and 2024 by five percent (5%) above
253 the amount of the reimbursement rate for the previous fiscal year.
254 The division shall increase the amount of the reimbursement rate
255 for restorative dental services for each of the fiscal years 2023,
256 2024 and 2025 by five percent (5%) above the amount of the
257 reimbursement rate for the previous fiscal year. It is the intent
258 of the Legislature that the reimbursement rate revision for
259 preventative dental services will be an incentive to increase the
260 number of dentists who actively provide Medicaid services. This
261 dental services reimbursement rate revision shall be known as the
262 "James Russell Dumas Medicaid Dental Services Incentive Program."

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



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

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

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

(12) Intermediate care facility services.

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



Christmas, the day after Christmas, Thanksgiving, the day before Thanksgiving and the day after Thanksgiving.

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

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

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

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

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

(b) Dialysis center services.

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



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

(17) Durable medical equipment services and medical supplies. Precertification of durable medical equipment and medical supplies must be obtained as required by the division. The Division of Medicaid may require durable medical equipment providers to obtain a surety bond in the amount and to the specifications as established by the Balanced Budget Act of 1997. A maximum dollar amount of reimbursement for noninvasive



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

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



in Section 1903 of the federal Social Security Act and any applicable regulations.

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

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

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



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

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

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



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



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

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

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



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

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

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

482 c. As used in this paragraph
483 (18)(b)(v), the term "upper payment limit gap" means the
484 difference between the total amount that the ambulance
485 transportation service provider received from Medicaid and the
486 average amount that the ambulance transportation service provider
487 would have received from commercial insurers for those services
488 reimbursed by Medicaid.



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

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

507 (ii) Subject to approval by the Centers for
508 Medicare and Medicaid Services (CMS), the MHAP shall provide
509 increased inpatient capitation (PMPM) payments to managed care
510 entities contracting with the division pursuant to subsection (H)
511 of this section to support availability of hospital services or
512 such other payments permissible under federal law necessary to
513 accomplish the intent of this subsection.



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

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

530 (19) (a) Perinatal risk management services. The
531 division shall promulgate regulations to be effective from and
532 after October 1, 1988, to establish a comprehensive perinatal
533 system for risk assessment of all pregnant and infant Medicaid
534 recipients and for management, education and follow-up for those
535 who are determined to be at risk. Services to be performed
536 include case management, nutrition assessment/counseling,
537 psychosocial assessment/counseling and health education. The
538 division shall contract with the State Department of Health to



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

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

555 Qualifications for persons providing service coordination shall be
556 determined by the State Department of Health and the Division of
557 Medicaid.

558 (20) Home- and community-based services for physically
559 disabled approved services as allowed by a waiver from the United
560 States Department of Health and Human Services for home- and
561 community-based services for physically disabled people using
562 state funds that are provided from the appropriation to the State
563 Department of Rehabilitation Services and used to match federal



funds under a cooperative agreement between the division and the department, provided that funds for these services are specifically appropriated to the Department of Rehabilitation Services.

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

(22) Ambulatory services delivered in federally qualified health centers, rural health centers and clinics of the local health departments of the State Department of Health for individuals eligible for Medicaid under this article based on reasonable costs as determined by the division. Federally



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

599 (23) Inpatient psychiatric services.

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



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

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

623 (24) [Deleted]

624 (25) [Deleted]

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

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



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

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

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

657 (31) Targeted case management services for children
658 with special needs, under waivers from the United States
659 Department of Health and Human Services, using state funds that
660 are provided from the appropriation to the Mississippi Department
661 of Human Services and used to match federal funds under a
662 cooperative agreement between the division and the department.



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

669 (33) Podiatrist services.

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

675 (35) Services and activities authorized in Sections
676 43-27-101 and 43-27-103, using state funds that are provided from
677 the appropriation to the Mississippi Department of Human Services
678 and used to match federal funds under a cooperative agreement
679 between the division and the department.

680 (36) Nonemergency transportation services for
681 Medicaid-eligible persons as determined by the division. The PEER
682 Committee shall conduct a performance evaluation of the
683 nonemergency transportation program to evaluate the administration
684 of the program and the providers of transportation services to
685 determine the most cost-effective ways of providing nonemergency
686 transportation services to the patients served under the program.
687 The performance evaluation shall be completed and provided to the



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

691 (37) [Deleted]

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

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

708 (40) [Deleted]

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



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

719 (42) [Deleted]

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

725 (44) Nursing facility services for the severely
726 disabled.

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

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

733 (45) Physician assistant services. Services furnished
734 by a physician assistant who is licensed by the State Board of
735 Medical Licensure and is practicing with physician supervision
736 under regulations adopted by the board, under regulations adopted
737 by the division. Reimbursement for those services shall not



738 exceed ninety percent (90%) of the reimbursement rate for
739 comparable services rendered by a physician. The division may
740 provide for a reimbursement rate for physician assistant services
741 of up to one hundred percent (100%) or the reimbursement rate for
742 comparable services rendered by a physician for physician
743 assistant services that are provided after the normal working
744 hours of the physician assistant, as determined in accordance with
745 regulations of the division.

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

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

761 (b) Participation in any disease management
762 program implemented under this paragraph (47) is optional with the



individual. An individual must affirmatively elect to participate in the disease management program in order to participate, and may elect to discontinue participation in the program at any time.

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

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

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

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

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

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



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

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

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

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



813 (54) [Deleted]

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

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

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



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

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

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

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

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



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

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

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

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



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

890 (61) Neonatal circumcision procedures.

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

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

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

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



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

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

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



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

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

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

959 (6) (a) If there are any objections to a proposed rate
960 change or any part thereof from either or both of the chairmen or



the committees, the division may withdraw the proposed rate change, make any of the recommended changes to the proposed rate change, or not make any changes to the proposed rate change.

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

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

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

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



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

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

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

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

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

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



1010 Beginning in fiscal year 2010 and in fiscal years thereafter,
1011 when Medicaid expenditures are projected to exceed funds available
1012 for the fiscal year, the division shall submit the expected
1013 shortfall information to the PEER Committee not later than
1014 December 1 of the year in which the shortfall is projected to
1015 occur. PEER shall review the computations of the division and
1016 report its findings to the Legislative Budget Office not later
1017 than January 7 in any year.

1018 (G) Notwithstanding any other provision of this article, it
1019 shall be the duty of each provider participating in the Medicaid
1020 program to keep and maintain books, documents and other records as
1021 prescribed by the Division of Medicaid in accordance with federal
1022 laws and regulations.

1023 (H) (1) Notwithstanding any other provision of this
1024 article, the division is authorized to implement (a) a managed
1025 care program, (b) a coordinated care program, (c) a coordinated
1026 care organization program, (d) a health maintenance organization
1027 program, (e) a patient-centered medical home program, (f) an
1028 accountable care organization program, (g) provider-sponsored
1029 health plan, or (h) any combination of the above programs. As a
1030 condition for the approval of any program under this subsection
1031 (H)(1), the division shall require that no managed care program,
1032 coordinated care program, coordinated care organization program,
1033 health maintenance organization program, or provider-sponsored
1034 health plan may:



1035 (a) Pay providers at a rate that is less than the
1036 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
1037 reimbursement rate;

1038 (b) Override the medical decisions of hospital
1039 physicians or staff regarding patients admitted to a hospital for
1040 an emergency medical condition as defined by 42 US Code Section
1041 1395dd. This restriction (b) does not prohibit the retrospective
1042 review of the appropriateness of the determination that an
1043 emergency medical condition exists by chart review or coding
1044 algorithm, nor does it prohibit prior authorization for
1045 nonemergency hospital admissions;

1046 (c) Pay providers at a rate that is less than the
1047 normal Medicaid reimbursement rate. It is the intent of the
1048 Legislature that all managed care entities described in this
1049 subsection (H), in collaboration with the division, develop and
1050 implement innovative payment models that incentivize improvements
1051 in health care quality, outcomes, or value, as determined by the
1052 division. Participation in the provider network of any managed
1053 care, coordinated care, provider-sponsored health plan, or similar
1054 contractor shall not be conditioned on the provider's agreement to
1055 accept such alternative payment models;

1056 (d) Implement a prior authorization and
1057 utilization review program for medical services, transportation
1058 services and prescription drugs that is more stringent than the
1059 prior authorization processes used by the division in its



1060 administration of the Medicaid program. Not later than December
1061 2, 2021, the contractors that are receiving capitated payments
1062 under a managed care delivery system established under this
1063 subsection (H) shall submit a report to the Chairmen of the House
1064 and Senate Medicaid Committees on the status of the prior
1065 authorization and utilization review program for medical services,
1066 transportation services and prescription drugs that is required to
1067 be implemented under this subparagraph (d);

1068 (e) [Deleted]

1069 (f) Implement a preferred drug list that is more
1070 stringent than the mandatory preferred drug list established by
1071 the division under subsection (A)(9) of this section;

1072 (g) Implement a policy which denies beneficiaries
1073 with hemophilia access to the federally funded hemophilia
1074 treatment centers as part of the Medicaid Managed Care network of
1075 providers.

1076 Each health maintenance organization, coordinated care
1077 organization, provider-sponsored health plan, or other
1078 organization paid for services on a capitated basis by the
1079 division under any managed care program or coordinated care
1080 program implemented by the division under this section shall use a
1081 clear set of level of care guidelines in the determination of
1082 medical necessity and in all utilization management practices,
1083 including the prior authorization process, concurrent reviews,
1084 retrospective reviews and payments, that are consistent with



1085 widely accepted professional standards of care. Organizations
1086 participating in a managed care program or coordinated care
1087 program implemented by the division may not use any additional
1088 criteria that would result in denial of care that would be
1089 determined appropriate and, therefore, medically necessary under
1090 those levels of care guidelines.

1091 (2) Notwithstanding any provision of this section, the
1092 recipients eligible for enrollment into a Medicaid Managed Care
1093 Program authorized under this subsection (H) may include only
1094 those categories of recipients eligible for participation in the
1095 Medicaid Managed Care Program as of January 1, 2021, the
1096 Children's Health Insurance Program (CHIP), and the CMS-approved
1097 Section 1115 demonstration waivers in operation as of January 1,
1098 2021. No expansion of Medicaid Managed Care Program contracts may
1099 be implemented by the division without enabling legislation from
1100 the Mississippi Legislature.

1101 (3) (a) Any contractors receiving capitated payments
1102 under a managed care delivery system established in this section
1103 shall provide to the Legislature and the division statistical data
1104 to be shared with provider groups in order to improve patient
1105 access, appropriate utilization, cost savings and health outcomes
1106 not later than October 1 of each year. Additionally, each
1107 contractor shall disclose to the Chairmen of the Senate and House
1108 Medicaid Committees the administrative expenses costs for the
1109 prior calendar year, and the number of full-equivalent employees



1110 located in the State of Mississippi dedicated to the Medicaid and
1111 CHIP lines of business as of June 30 of the current year.

1112 (b) The division and the contractors participating
1113 in the managed care program, a coordinated care program or a
1114 provider-sponsored health plan shall be subject to annual program
1115 reviews or audits performed by the Office of the State Auditor,
1116 the PEER Committee, the Department of Insurance and/or independent
1117 third parties.

1118 (c) Those reviews shall include, but not be
1119 limited to, at least two (2) of the following items:

1120 (i) The financial benefit to the State of
1121 Mississippi of the managed care program,

1122 (ii) The difference between the premiums paid
1123 to the managed care contractors and the payments made by those
1124 contractors to health care providers,

1125 (iii) Compliance with performance measures
1126 required under the contracts,

1127 (iv) Administrative expense allocation
1128 methodologies,

1129 (v) Whether nonprovider payments assigned as
1130 medical expenses are appropriate,

1131 (vi) Capitated arrangements with related
1132 party subcontractors,

1133 (vii) Reasonableness of corporate
1134 allocations,



1135 (viii) Value-added benefits and the extent to
1136 which they are used,
1137 (ix) The effectiveness of subcontractor
1138 oversight, including subcontractor review,
1139 (x) Whether health care outcomes have been
1140 improved, and
1141 (xi) The most common claim denial codes to
1142 determine the reasons for the denials.

1143 The audit reports shall be considered public documents and
1144 shall be posted in their entirety on the division's website.

1145 (4) All health maintenance organizations, coordinated
1146 care organizations, provider-sponsored health plans, or other
1147 organizations paid for services on a capitated basis by the
1148 division under any managed care program or coordinated care
1149 program implemented by the division under this section shall
1150 reimburse all providers in those organizations at rates no lower
1151 than those provided under this section for beneficiaries who are
1152 not participating in those programs.

1153 (5) No health maintenance organization, coordinated
1154 care organization, provider-sponsored health plan, or other
1155 organization paid for services on a capitated basis by the
1156 division under any managed care program or coordinated care
1157 program implemented by the division under this section shall
1158 require its providers or beneficiaries to use any pharmacy that



1159 ships, mails or delivers prescription drugs or legend drugs or
1160 devices.

1161 (6) (a) Not later than December 1, 2021, the
1162 contractors who are receiving capitated payments under a managed
1163 care delivery system established under this subsection (H) shall
1164 develop and implement a uniform credentialing process for
1165 providers. Under that uniform credentialing process, a provider
1166 who meets the criteria for credentialing will be credentialed with
1167 all of those contractors and no such provider will have to be
1168 separately credentialed by any individual contractor in order to
1169 receive reimbursement from the contractor. Not later than
1170 December 2, 2021, those contractors shall submit a report to the
1171 Chairmen of the House and Senate Medicaid Committees on the status
1172 of the uniform credentialing process for providers that is
1173 required under this subparagraph (a).

1174 (b) If those contractors have not implemented a
1175 uniform credentialing process as described in subparagraph (a) by
1176 December 1, 2021, the division shall develop and implement, not
1177 later than July 1, 2022, a single, consolidated credentialing
1178 process by which all providers will be credentialed. Under the
1179 division's single, consolidated credentialing process, no such
1180 contractor shall require its providers to be separately
1181 credentialed by the contractor in order to receive reimbursement
1182 from the contractor, but those contractors shall recognize the



1183 credentialing of the providers by the division's credentialing
1184 process.

1185 (c) The division shall require a uniform provider
1186 credentialing application that shall be used in the credentialing
1187 process that is established under subparagraph (a) or (b). If the
1188 contractor or division, as applicable, has not approved or denied
1189 the provider credentialing application within sixty (60) days of
1190 receipt of the completed application that includes all required
1191 information necessary for credentialing, then the contractor or
1192 division, upon receipt of a written request from the applicant and
1193 within five (5) business days of its receipt, shall issue a
1194 temporary provider credential/enrollment to the applicant if the
1195 applicant has a valid Mississippi professional or occupational
1196 license to provide the health care services to which the
1197 credential/enrollment would apply. The contractor or the division
1198 shall not issue a temporary credential/enrollment if the applicant
1199 has reported on the application a history of medical or other
1200 professional or occupational malpractice claims, a history of
1201 substance abuse or mental health issues, a criminal record, or a
1202 history of medical or other licensing board, state or federal
1203 disciplinary action, including any suspension from participation
1204 in a federal or state program. The temporary
1205 credential/enrollment shall be effective upon issuance and shall
1206 remain in effect until the provider's credentialing/enrollment
1207 application is approved or denied by the contractor or division.



1208 The contractor or division shall render a final decision regarding
1209 credentialing/enrollment of the provider within sixty (60) days
1210 from the date that the temporary provider credential/enrollment is
1211 issued to the applicant.

1212 (d) If the contractor or division does not render
1213 a final decision regarding credentialing/enrollment of the
1214 provider within the time required in subparagraph (c), the
1215 provider shall be deemed to be credentialed by and enrolled with
1216 all of the contractors and eligible to receive reimbursement from
1217 the contractors.

1218 (7) (a) Each contractor that is receiving capitated
1219 payments under a managed care delivery system established under
1220 this subsection (H) shall provide to each provider for whom the
1221 contractor has denied the coverage of a procedure that was ordered
1222 or requested by the provider for or on behalf of a patient, a
1223 letter that provides a detailed explanation of the reasons for the
1224 denial of coverage of the procedure and the name and the
1225 credentials of the person who denied the coverage. The letter
1226 shall be sent to the provider in electronic format.

1227 (b) After a contractor that is receiving capitated
1228 payments under a managed care delivery system established under
1229 this subsection (H) has denied coverage for a claim submitted by a
1230 provider, the contractor shall issue to the provider within sixty
1231 (60) days a final ruling of denial of the claim that allows the
1232 provider to have a state fair hearing and/or agency appeal with



1233 the division. If a contractor does not issue a final ruling of
1234 denial within sixty (60) days as required by this subparagraph
1235 (b), the provider's claim shall be deemed to be automatically
1236 approved and the contractor shall pay the amount of the claim to
1237 the provider.

1238 (c) After a contractor has issued a final ruling
1239 of denial of a claim submitted by a provider, the division shall
1240 conduct a state fair hearing and/or agency appeal on the matter of
1241 the disputed claim between the contractor and the provider within
1242 sixty (60) days, and shall render a decision on the matter within
1243 thirty (30) days after the date of the hearing and/or appeal.

1244 (8) It is the intention of the Legislature that the
1245 division evaluate the feasibility of using a single vendor to
1246 administer pharmacy benefits provided under a managed care
1247 delivery system established under this subsection (H). Providers
1248 of pharmacy benefits shall cooperate with the division in any
1249 transition to a carve-out of pharmacy benefits under managed care.

1250 (9) The division shall evaluate the feasibility of
1251 using a single vendor to administer dental benefits provided under
1252 a managed care delivery system established in this subsection (H).
1253 Providers of dental benefits shall cooperate with the division in
1254 any transition to a carve-out of dental benefits under managed
1255 care.

1256 (10) It is the intent of the Legislature that any
1257 contractor receiving capitated payments under a managed care



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

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

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



1283 shall be revised to incorporate any provisions of this subsection
1284 (H) .

1285 (I) [Deleted]

1286 (J) There shall be no cuts in inpatient and outpatient
1287 hospital payments, or allowable days or volumes, as long as the
1288 hospital assessment provided in Section 43-13-145 is in effect.
1289 This subsection (J) shall not apply to decreases in payments that
1290 are a result of: reduced hospital admissions, audits or payments
1291 under the APR-DRG or APC models, or a managed care program or
1292 similar model described in subsection (H) of this section.

1293 (K) In the negotiation and execution of such contracts
1294 involving services performed by actuarial firms, the Executive
1295 Director of the Division of Medicaid may negotiate a limitation on
1296 liability to the state of prospective contractors.

1297 (L) The Division of Medicaid shall reimburse for services
1298 provided to eligible Medicaid beneficiaries by a licensed birthing
1299 center in a method and manner to be determined by the division in
1300 accordance with federal laws and federal regulations. The
1301 division shall seek any necessary waivers, make any required
1302 amendments to its State Plan or revise any contracts authorized
1303 under subsection (H) of this section as necessary to provide the
1304 services authorized under this subsection. As used in this
1305 subsection, the term "birthing centers" shall have the meaning as
1306 defined in Section 41-77-1(a), which is a publicly or privately
1307 owned facility, place or institution constructed, renovated,



1308 leased or otherwise established where nonemergency births are
1309 planned to occur away from the mother's usual residence following
1310 a documented period of prenatal care for a normal uncomplicated
1311 pregnancy which has been determined to be low risk through a
1312 formal risk-scoring examination.

1313 (M) This section shall stand repealed on July 1, 2028.

1314 **SECTION 2.** This act shall take effect and be in force from
1315 and after July 1, 2025.

