

By: Senator(s) Blackwell

To: Medicaid

SENATE BILL NO. 2386
(As Sent to Governor)

1 AN ACT TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972,
2 TO MAKE CERTAIN TECHNICAL AMENDMENTS TO THE PROVISIONS THAT
3 PROVIDE FOR MEDICAID ELIGIBILITY AND TO MODIFY AGE AND INCOME AND
4 ELIGIBILITY CRITERIA TO REFLECT THE CURRENT CRITERIA; TO REQUIRE
5 THE DIVISION OF MEDICAID TO SUBMIT A WAIVER BY JULY 1, 2025, TO
6 THE CENTER FOR MEDICARE AND MEDICAID SERVICES (CMS) TO AUTHORIZE
7 THE DIVISION TO CONDUCT LESS FREQUENT MEDICAL REDETERMINATIONS FOR
8 ELIGIBLE CHILDREN WHO HAVE CERTAIN LONG-TERM OR CHRONIC CONDITIONS
9 THAT DO NOT NEED TO BE REIDENTIFIED EVERY YEAR; TO PROVIDE THAT
10 MEN OF REPRODUCTIVE AGE ARE ELIGIBLE UNDER THE FAMILY PLANNING
11 PROGRAM; TO CONFORM WITH FEDERAL LAW TO ALLOW CHILDREN IN FOSTER
12 CARE TO BE ELIGIBLE UNTIL THEIR 26TH BIRTHDAY; TO ELIMINATE THE
13 REQUIREMENT THAT THE DIVISION MUST APPLY TO CMS FOR WAIVERS TO
14 PROVIDE SERVICES FOR CERTAIN INDIVIDUALS WHO ARE END-STAGE RENAL
15 DISEASE PATIENTS ON DIALYSIS, CANCER PATIENTS ON CHEMOTHERAPY OR
16 ORGAN TRANSPLANT RECIPIENTS ON ANTIREJECTION DRUGS; TO AMEND
17 SECTION 43-13-117, MISSISSIPPI CODE OF 1972, AS AMENDED BY HOUSE
18 BILL NO. 1401, 2025 REGULAR SESSION, TO MAKE CERTAIN TECHNICAL
19 AMENDMENTS TO THE PROVISIONS THAT PROVIDE FOR MEDICAID SERVICES TO
20 COMPLY WITH FEDERAL LAW; TO ELIMINATE THE OPTION FOR CERTAIN RURAL
21 HOSPITALS TO ELECT AGAINST REIMBURSEMENT FOR OUTPATIENT HOSPITAL
22 SERVICES USING THE AMBULATORY PAYMENT CLASSIFICATION (APC)
23 METHODOLOGY; TO REQUIRE THE DIVISION TO UPDATE THE CASE-MIX
24 PAYMENT SYSTEM AND FAIR RENTAL REIMBURSEMENT SYSTEM AS NECESSARY
25 TO MAINTAIN COMPLIANCE WITH FEDERAL LAW; TO AUTHORIZE THE DIVISION
26 TO IMPLEMENT A QUALITY OR VALUE-BASED COMPONENT TO THE NURSING
27 FACILITY PAYMENT SYSTEM; TO REQUIRE THE DIVISION TO REIMBURSE
28 PEDIATRICIANS FOR CERTAIN PRIMARY CARE SERVICES AS DEFINED BY THE
29 DIVISION AT 100% OF THE RATE ESTABLISHED UNDER MEDICARE; TO
30 REQUIRE THE DIVISION TO REIMBURSE FOR ONE PAIR OF EYEGLASSES EVERY
31 TWO YEARS INSTEAD OF EVERY FIVE YEARS FOR CERTAIN BENEFICIARIES;
32 TO AUTHORIZE ORAL CONTRACEPTIVES TO BE PRESCRIBED AND DISPENSED IN
33 TWELVE-MONTH SUPPLY INCREMENTS UNDER FAMILY PLANNING SERVICES; TO
34 AUTHORIZE THE DIVISION TO REIMBURSE AMBULATORY SURGICAL CARE (ASC)



35 BASED ON 90% OF THE MEDICARE ASC PAYMENT SYSTEM RATE IN EFFECT
36 JULY 1 OF EACH YEAR AS SET BY CMS; TO AUTHORIZE THE DIVISION TO
37 PROVIDE REIMBURSEMENT FOR DEVICES USED FOR THE REDUCTION OF
38 SNORING AND OBSTRUCTIVE SLEEP APNEA; TO PROVIDE THAT NO LATER THAN
39 DECEMBER 1, 2025, THE DIVISION SHALL, IN CONSULTATION WITH THE
40 MISSISSIPPI HOSPITAL ASSOCIATION, THE MISSISSIPPI HEALTHCARE
41 COLLABORATIVE, THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER AND
42 ANY OTHER HOSPITALS IN THE STATE, PROVIDE RECOMMENDATIONS TO THE
43 CHAIRMEN OF THE SENATE AND HOUSE MEDICAID COMMITTEES ON METHODS
44 FOR ALLOWING PHYSICIANS OR OTHER ELIGIBLE PROVIDERS EMPLOYED OR
45 CONTRACTED AT ANY HOSPITAL IN THE STATE TO PARTICIPATE IN ANY
46 MEDICARE UPPER PAYMENT LIMITS (UPL) PROGRAM, ALLOWABLE DELIVERY
47 SYSTEM OR PROVIDER PAYMENT INITIATIVE ESTABLISHED BY THE DIVISION,
48 SUBJECT TO FEDERAL LIMITATIONS ON COLLECTION OF PROVIDER TAXES; TO
49 PROVIDE THAT THE DIVISION SHALL, IN CONSULTATION WITH THE
50 MISSISSIPPI HOSPITAL ASSOCIATION, THE MISSISSIPPI HEALTHCARE
51 COLLABORATIVE, THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER AND
52 ANY OTHER HOSPITALS IN THE STATE, STUDY THE FEASIBILITY OF
53 OFFERING ALTERNATIVE MODELS FOR DISTRIBUTION OF MEDICAL CLAIMS AND
54 SUPPLEMENTAL PAYMENTS FOR INPATIENT AND OUTPATIENT HOSPITAL
55 SERVICES AND TO STUDY THE FEASIBILITY OF THE DIVISION ESTABLISHING
56 A MEDICARE UPPER PAYMENT LIMITS PROGRAM TO PHYSICIANS EMPLOYED OR
57 CONTRACTED BY HOSPITALS WHO ARE ABLE TO PARTICIPATE IN THE PROGRAM
58 THROUGH AN INTERGOVERNMENTAL TRANSFER; TO UPDATE AND CLARIFY
59 LANGUAGE ABOUT THE DIVISION'S TRANSITION FROM THE MEDICARE UPPER
60 PAYMENT LIMITS (UPL) PROGRAM TO THE MISSISSIPPI HOSPITAL ACCESS
61 PROGRAM (MHAP); TO PROVIDE THAT THE DIVISION SHALL MAXIMIZE TOTAL
62 FEDERAL FUNDING FOR MHAP, UPL AND OTHER SUPPLEMENTAL PAYMENT
63 PROGRAMS IN EFFECT FOR STATE FISCAL YEAR 2025 AND SHALL NOT CHANGE
64 THE METHODOLOGIES, FORMULAS, MODELS OR PREPRINTS USED TO CALCULATE
65 THE DISTRIBUTION OF SUPPLEMENTAL PAYMENTS TO HOSPITALS FROM THOSE
66 METHODOLOGIES, FORMULAS, MODELS OR PREPRINTS IN EFFECT AND AS
67 APPROVED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES FOR
68 STATE FISCAL YEAR 2025; TO AUTHORIZE THE DIVISION TO CONTRACT WITH
69 THE STATE DEPARTMENT OF HEALTH TO PROVIDE FOR A PERINATAL HIGH
70 RISK MANAGEMENT/INFANT SERVICES SYSTEM FOR ANY ELIGIBLE
71 BENEFICIARY WHO CANNOT RECEIVE SUCH SERVICES UNDER A DIFFERENT
72 PROGRAM; TO AUTHORIZE THE DIVISION TO REIMBURSE FOR SERVICES AT
73 CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTERS; TO EXTEND TO JULY
74 1, 2027, THE DATE OF THE REPEALER ON THE PROVISION OF LAW THAT
75 PROVIDES THAT THE DIVISION SHALL REIMBURSE FOR OUTPATIENT HOSPITAL
76 SERVICES PROVIDED TO ELIGIBLE MEDICAID BENEFICIARIES UNDER THE AGE
77 OF 21 YEARS BY BORDER CITY UNIVERSITY-AFFILIATED PEDIATRIC
78 TEACHING HOSPITALS, WHICH WAS REPEALED BY OPERATION OF LAW IN
79 2024; TO LIMIT THE PAYMENT FOR PROVIDING SERVICES TO MISSISSIPPI
80 MEDICAID BENEFICIARIES UNDER THE AGE OF 21 YEARS WHO ARE TREATED
81 BY A BORDER CITY UNIVERSITY-AFFILIATED PEDIATRIC TEACHING
82 HOSPITAL; TO REQUIRE THE DIVISION TO DEVELOP AND IMPLEMENT A
83 METHOD FOR REIMBURSEMENT OF AUTISM SPECTRUM DISORDER SERVICES
84 BASED ON A CONTINUUM OF CARE FOR BEST PRACTICES IN MEDICALLY
85 NECESSARY EARLY INTERVENTION TREATMENT; TO REQUIRE THE DIVISION TO



86 REIMBURSE FOR PREPARTICIPATION PHYSICAL EVALUATIONS; TO REQUIRE
87 THE DIVISION TO REIMBURSE FOR UNITED STATES FOOD AND DRUG
88 ADMINISTRATION APPROVED MEDICATIONS FOR CHRONIC WEIGHT MANAGEMENT
89 OR FOR ADDITIONAL CONDITIONS IN THE DISCRETION OF THE MEDICAL
90 PROVIDER; TO REQUIRE THE DIVISION TO PROVIDE COVERAGE AND
91 REIMBURSEMENT FOR ANY NONSTATIN MEDICATION APPROVED BY THE UNITED
92 STATES FOOD AND DRUG ADMINISTRATION THAT HAS A UNIQUE INDICATION
93 TO REDUCE THE RISK OF A MAJOR CARDIOVASCULAR EVENT IN PRIMARY
94 PREVENTION AND SECONDARY PREVENTION PATIENTS; TO REQUIRE THE
95 DIVISION TO PROVIDE COVERAGE AND REIMBURSEMENT FOR ANY NONOPIOID
96 MEDICATION APPROVED BY THE UNITED STATES FOOD AND DRUG
97 ADMINISTRATION FOR THE TREATMENT OR MANAGEMENT OF PAIN; TO REDUCE
98 THE LENGTH OF NOTICE THE DIVISION MUST PROVIDE THE MEDICAID
99 COMMITTEE CHAIRMEN FOR PROPOSED RATE CHANGES AND TO PROVIDE THAT
100 SUCH LEGISLATIVE NOTICE MAY BE EXPEDITED; TO REQUIRE THE DIVISION
101 TO REIMBURSE AMBULANCE TRANSPORTATION SERVICE PROVIDERS THAT
102 PROVIDE AN ASSESSMENT, TRIAGE OR TREATMENT FOR ELIGIBLE MEDICAID
103 BENEFICIARIES; TO SET CERTAIN REIMBURSEMENT LEVELS FOR SUCH
104 PROVIDERS; TO EXTEND TO JULY 1, 2029, THE DATE OF THE REPEALER ON
105 SUCH SECTION; TO AMEND SECTION 43-13-121, MISSISSIPPI CODE OF
106 1972, TO AUTHORIZE THE DIVISION TO EXTEND ITS MEDICAID ENTERPRISE
107 SYSTEM AND FISCAL AGENT SERVICES, INCLUDING ALL RELATED COMPONENTS
108 AND SERVICES, CONTRACTS IN EFFECT ON JUNE 30, 2025, FOR AN
109 ADDITIONAL TWO-YEAR PERIOD; TO AUTHORIZE THE DIVISION TO ENTER
110 INTO A TWO-YEAR CONTRACT WITH A VENDOR TO PROVIDE SUPPORT OF THE
111 DIVISION'S ELIGIBILITY SYSTEM; TO REDUCE THE LENGTH OF NOTICE THE
112 DIVISION MUST PROVIDE THE MEDICAID COMMITTEE CHAIRMEN FOR A
113 PROPOSED STATE PLAN AMENDMENT AND TO PROVIDE THAT SUCH LEGISLATIVE
114 NOTICE MAY BE EXPEDITED; TO AMEND SECTION 43-13-305, MISSISSIPPI
115 CODE OF 1972, TO PROVIDE THAT WHEN A THIRD-PARTY PAYOR REQUIRES
116 PRIOR AUTHORIZATION FOR AN ITEM OR SERVICE FURNISHED TO A MEDICAID
117 RECIPIENT, THE PAYOR SHALL ACCEPT AUTHORIZATION PROVIDED BY THE
118 DIVISION OF MEDICAID THAT THE ITEM OR SERVICE IS COVERED UNDER THE
119 STATE PLAN AS IF SUCH AUTHORIZATION WERE THE PRIOR AUTHORIZATION
120 MADE BY THE THIRD-PARTY PAYOR FOR SUCH ITEM OR SERVICE; TO AMEND
121 SECTION 43-13-117.7, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT THE
122 DIVISION SHALL NOT REIMBURSE OR PROVIDE COVERAGE FOR GENDER
123 TRANSITION PROCEDURES FOR ANY PERSON; TO AMEND SECTION 43-13-145,
124 MISSISSIPPI CODE OF 1972, TO PROVIDE THAT A QUARTERLY HOSPITAL
125 ASSESSMENT MAY EXCEED THE ASSESSMENT IN THE PRIOR QUARTER BY MORE
126 THAN \$3,750,000.00 IF SUCH INCREASE IS TO MAXIMIZE FEDERAL FUNDS
127 THAT ARE AVAILABLE TO REIMBURSE HOSPITALS FOR SERVICES PROVIDED
128 UNDER NEW PROGRAMS FOR HOSPITALS, FOR INCREASED SUPPLEMENTAL
129 PAYMENT PROGRAMS FOR HOSPITALS OR TO ASSIST WITH STATE-MATCHING
130 FUNDS AS AUTHORIZED BY THE LEGISLATURE; TO AUTHORIZE THE DIVISION
131 TO REDUCE OR ELIMINATE THE PORTION OF THE HOSPITAL ASSESSMENT
132 APPLICABLE TO LONG-TERM ACUTE CARE HOSPITALS AND REHABILITATION
133 HOSPITALS IF CMS WAIVES CERTAIN REQUIREMENTS; TO CREATE NEW
134 SECTION 41-140-1, MISSISSIPPI CODE OF 1972, TO DEFINE TERMS; TO
135 CREATE NEW SECTION 41-140-3, MISSISSIPPI CODE OF 1972, TO REQUIRE
136 THE STATE DEPARTMENT OF HEALTH TO DEVELOP AND PROMULGATE WRITTEN



137 EDUCATIONAL MATERIALS AND INFORMATION FOR HEALTH CARE
138 PROFESSIONALS AND PATIENTS ABOUT MATERNAL MENTAL HEALTH
139 CONDITIONS; TO REQUIRE HOSPITALS PROVIDING BIRTH SERVICES TO
140 PROVIDE SUCH EDUCATIONAL MATERIALS TO NEW PARENTS AND, AS
141 APPROPRIATE, OTHER FAMILY MEMBERS; TO REQUIRE THAT SUCH MATERIALS
142 BE PROVIDED TO ANY WOMAN WHO PRESENTS WITH SIGNS OF A MATERNAL
143 MENTAL HEALTH DISORDER; TO CREATE NEW SECTION 41-140-5,
144 MISSISSIPPI CODE OF 1972, TO REQUIRE ANY HEALTH CARE PROVIDER OR
145 NURSE MIDWIFE WHO RENDERS POSTNATAL CARE OR PEDIATRIC INFANT CARE
146 TO ENSURE THAT THE POSTNATAL CARE PATIENT OR BIRTHING MOTHER OF
147 THE PEDIATRIC INFANT CARE PATIENT, AS APPLICABLE, IS OFFERED
148 SCREENING FOR POSTPARTUM DEPRESSION AND TO PROVIDE APPROPRIATE
149 REFERRALS IF SUCH PATIENT OR MOTHER IS DEEMED LIKELY TO BE
150 SUFFERING FROM POSTPARTUM DEPRESSION; TO AMEND SECTION 43-13-107,
151 MISSISSIPPI CODE OF 1972, TO ESTABLISH A MEDICAID ADVISORY
152 COMMITTEE AND BENEFICIARY ADVISORY COMMITTEE AS REQUIRED PURSUANT
153 TO FEDERAL REGULATIONS; TO PROVIDE THAT ALL MEMBERS OF THE MEDICAL
154 CARE ADVISORY COMMITTEE SERVING ON JANUARY 1, 2025, SHALL BE
155 SELECTED TO SERVE ON THE MEDICAID ADVISORY COMMITTEE, AND SUCH
156 MEMBERS SHALL SERVE UNTIL JULY 1, 2028; AND FOR RELATED PURPOSES.

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

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

160 43-13-115. Recipients of Medicaid shall be the following
161 persons only:

162 (1) Those who are qualified for public assistance
163 grants under provisions of Title IV-A and E of the federal Social
164 Security Act, as amended, including those statutorily deemed to be
165 IV-A and low income families and children under Section 1931 of
166 the federal Social Security Act. For the purposes of this
167 paragraph (1) and paragraphs (8), (17) and (18) of this section,
168 any reference to Title IV-A or to Part A of Title IV of the
169 federal Social Security Act, as amended, or the state plan under
170 Title IV-A or Part A of Title IV, shall be considered as a
171 reference to Title IV-A of the federal Social Security Act, as



172 amended, and the state plan under Title IV-A, including the income
173 and resource standards and methodologies under Title IV-A and the
174 state plan, as they existed on July 16, 1996. The Department of
175 Human Services shall determine Medicaid eligibility for children
176 receiving public assistance grants under Title IV-E. The division
177 shall determine eligibility for low-income families under Section
178 1931 of the federal Social Security Act and shall redetermine
179 eligibility for those continuing under Title IV-A grants.

180 (2) Those qualified for Supplemental Security Income
181 (SSI) benefits under Title XVI of the federal Social Security Act,
182 as amended, and those who are deemed SSI eligible as contained in
183 federal statute. The eligibility of individuals covered in this
184 paragraph shall be determined by the Social Security
185 Administration and certified to the Division of Medicaid.

186 (3) Qualified pregnant women who would be eligible for
187 Medicaid as a low-income family member under Section 1931 of the
188 federal Social Security Act if her child were born. The
189 eligibility of the individuals covered under this paragraph shall
190 be determined by the division.

191 (4) [Deleted]

192 (5) A child born on or after October 1, 1984, to a
193 woman eligible for and receiving Medicaid under the state plan on
194 the date of the child's birth shall be deemed to have applied for
195 Medicaid and to have been found eligible for Medicaid under the
196 plan on the date of that birth, and will remain eligible for



197 Medicaid for a period of one (1) year so long as the child is a
198 member of the woman's household and the woman remains eligible for
199 Medicaid or would be eligible for Medicaid if pregnant. The
200 eligibility of individuals covered in this paragraph shall be
201 determined by the Division of Medicaid.

202 (6) Children certified by the State Department of Human
203 Services to the Division of Medicaid of whom the state and county
204 departments of human services have custody and financial
205 responsibility, and children who are in adoptions subsidized in
206 full or part by the Department of Human Services, including
207 special needs children in non-Title IV-E adoption assistance, who
208 are approvable under Title XIX of the Medicaid program. The
209 eligibility of the children covered under this paragraph shall be
210 determined by the State Department of Human Services.

211 (7) Persons certified by the Division of Medicaid who
212 are patients in a medical facility (nursing home, hospital,
213 tuberculosis sanatorium or institution for treatment of mental
214 diseases), and who, except for the fact that they are patients in
215 that medical facility, would qualify for grants under Title IV,
216 Supplementary Security Income (SSI) benefits under Title XVI or
217 state supplements, and those aged, blind and disabled persons who
218 would not be eligible for Supplemental Security Income (SSI)
219 benefits under Title XVI or state supplements if they were not
220 institutionalized in a medical facility but whose income is below



221 the maximum standard set by the Division of Medicaid, which
222 standard shall not exceed that prescribed by federal regulation.

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

229 (9) Individuals who are:

230 (a) Children born after September 30, 1983, * * *
231 between the ages of six (6) and nineteen (19), with family income
232 that does not exceed * * * one hundred thirty-three percent (133%)
233 of the * * * federal poverty level;

234 (b) Pregnant women, infants and children * * *
235 between the ages of one (1) and six (6), with family income that
236 does not exceed * * * one hundred forty-three percent (143%) of
237 the federal poverty level; and

238 (c) Pregnant women and infants who have not
239 attained the age of one (1), with family income that does not
240 exceed * * * one hundred ninety-four percent (194%) of the federal
241 poverty level.

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

244 (10) Certain disabled children age eighteen (18) or
245 under who are living at home, who would be eligible, if in a



246 medical institution, for SSI or a state supplemental payment under
247 Title XVI of the federal Social Security Act, as amended, and
248 therefore for Medicaid under the plan, and for whom the state has
249 made a determination as required under Section 1902(e)(3)(b) of
250 the federal Social Security Act, as amended. The eligibility of
251 individuals under this paragraph shall be determined by the
252 Division of Medicaid. The division shall submit a waiver by July
253 1, 2025, to the Centers for Medicare and Medicaid Services to
254 require less frequent medical redeterminations for children
255 eligible under this subsection who have certain long-term or
256 chronic conditions that do not need to be reidentified every year.

257 (11) * * * Individuals who are sixty-five (65) years of
258 age or older or are disabled as determined under Section
259 1614(a)(3) of the federal Social Security Act, as amended, and
260 whose income does not exceed one hundred thirty-five percent
261 (135%) of the * * * federal poverty level, and whose resources do
262 not exceed those established by the Division of Medicaid. The
263 eligibility of individuals covered under this paragraph shall be
264 determined by the Division of Medicaid. * * * Only those
265 individuals covered under the 1115(c) Healthier Mississippi waiver
266 will be covered under this category.

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



271 application and is still eligible for coverage under this
272 paragraph (11) on March 31, 2005, shall be eligible for Medicaid
273 coverage under this paragraph (11) from March 31, 2005, through
274 December 31, 2005. The division shall give priority in processing
275 the applications for those individuals to determine their
276 eligibility under this paragraph (11).

277 (12) Individuals who are qualified Medicare
278 beneficiaries (QMB) entitled to Part A Medicare as defined under
279 Section 301, Public Law 100-360, known as the Medicare
280 Catastrophic Coverage Act of 1988, and whose income does not
281 exceed one hundred percent (100%) of the * * * federal poverty
282 level.

283 The eligibility of individuals covered under this paragraph
284 shall be determined by the Division of Medicaid, and those
285 individuals determined eligible shall receive Medicare
286 cost-sharing expenses only as more fully defined by the Medicare
287 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
288 1997.

289 (13) (a) Individuals who are entitled to Medicare Part
290 A as defined in Section 4501 of the Omnibus Budget Reconciliation
291 Act of 1990, and whose income does not exceed one hundred twenty
292 percent (120%) of the * * * federal poverty level. Eligibility
293 for Medicaid benefits is limited to full payment of Medicare Part
294 B premiums.



295 (b) Individuals entitled to Part A of Medicare,
296 with income above one hundred twenty percent (120%), but less than
297 one hundred thirty-five percent (135%) of the federal poverty
298 level, and not otherwise eligible for Medicaid. Eligibility for
299 Medicaid benefits is limited to full payment of Medicare Part B
300 premiums. The number of eligible individuals is limited by the
301 availability of the federal capped allocation at one hundred
302 percent (100%) of federal matching funds, as more fully defined in
303 the Balanced Budget Act of 1997.

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

306 (14) [Deleted]

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

316 (16) In accordance with the terms and conditions of
317 approved Title XIX waiver from the United States Department of
318 Health and Human Services, persons provided home- and
319 community-based services who are physically disabled and certified



320 by the Division of Medicaid as eligible due to applying the income
321 and deeming requirements as if they were institutionalized.

322 (17) In accordance with the terms of the federal
323 Personal Responsibility and Work Opportunity Reconciliation Act of
324 1996 (Public Law 104-193), persons who become ineligible for
325 assistance under Title IV-A of the federal Social Security Act, as
326 amended, because of increased income from or hours of employment
327 of the caretaker relative or because of the expiration of the
328 applicable earned income disregards, who were eligible for
329 Medicaid for at least three (3) of the six (6) months preceding
330 the month in which the ineligibility begins, shall be eligible for
331 Medicaid for up to twelve (12) months. The eligibility of the
332 individuals covered under this paragraph shall be determined by
333 the division.

334 (18) Persons who become ineligible for assistance under
335 Title IV-A of the federal Social Security Act, as amended, as a
336 result, in whole or in part, of the collection or increased
337 collection of child or spousal support under Title IV-D of the
338 federal Social Security Act, as amended, who were eligible for
339 Medicaid for at least three (3) of the six (6) months immediately
340 preceding the month in which the ineligibility begins, shall be
341 eligible for Medicaid for an additional four (4) months beginning
342 with the month in which the ineligibility begins. The eligibility
343 of the individuals covered under this paragraph shall be
344 determined by the division.



345 (19) Disabled workers, whose incomes are above the
346 Medicaid eligibility limits, but below two hundred fifty percent
347 (250%) of the federal poverty level, shall be allowed to purchase
348 Medicaid coverage on a sliding fee scale developed by the Division
349 of Medicaid.

350 (20) Medicaid eligible children under age eighteen (18)
351 shall remain eligible for Medicaid benefits until the end of a
352 period of twelve (12) months following an eligibility
353 determination, or until such time that the individual exceeds age
354 eighteen (18).

355 (21) Women and men of * * * reproductive age whose
356 family income does not exceed * * * one hundred ninety-four
357 percent (194%) of the federal poverty level. The eligibility of
358 individuals covered under this paragraph (21) shall be determined
359 by the Division of Medicaid, and those individuals determined
360 eligible shall only receive family planning services covered under
361 Section 43-13-117(13) and not any other services covered under
362 Medicaid. However, any individual eligible under this paragraph
363 (21) who is also eligible under any other provision of this
364 section shall receive the benefits to which he or she is entitled
365 under that other provision, in addition to family planning
366 services covered under Section 43-13-117(13).

367 The Division of Medicaid * * * may apply to the United States
368 Secretary of Health and Human Services for a federal waiver of the
369 applicable provisions of Title XIX of the federal Social Security



370 Act, as amended, and any other applicable provisions of federal
371 law as necessary to allow for the implementation of this paragraph
372 (21). * * *

373 (22) Persons who are workers with a potentially severe
374 disability, as determined by the division, shall be allowed to
375 purchase Medicaid coverage. The term "worker with a potentially
376 severe disability" means a person who is at least sixteen (16)
377 years of age but under sixty-five (65) years of age, who has a
378 physical or mental impairment that is reasonably expected to cause
379 the person to become blind or disabled as defined under Section
380 1614(a) of the federal Social Security Act, as amended, if the
381 person does not receive items and services provided under
382 Medicaid.

383 The eligibility of persons under this paragraph (22) shall be
384 conducted as a demonstration project that is consistent with
385 Section 204 of the Ticket to Work and Work Incentives Improvement
386 Act of 1999, Public Law 106-170, for a certain number of persons
387 as specified by the division. The eligibility of individuals
388 covered under this paragraph (22) shall be determined by the
389 Division of Medicaid.

390 (23) Children certified by the Mississippi Department
391 of Human Services for whom the state and county departments of
392 human services have custody and financial responsibility who are
393 in foster care on their eighteenth birthday as reported by the
394 Mississippi Department of Human Services shall be certified



395 Medicaid eligible by the Division of Medicaid until their * * *
396 twenty-sixth birthday. Children who have aged out of foster care
397 while on Medicaid in other states shall qualify until their
398 twenty-sixth birthday.

399 (24) Individuals who have not attained age sixty-five
400 (65), are not otherwise covered by creditable coverage as defined
401 in the Public Health Services Act, and have been screened for
402 breast and cervical cancer under the Centers for Disease Control
403 and Prevention Breast and Cervical Cancer Early Detection Program
404 established under Title XV of the Public Health Service Act in
405 accordance with the requirements of that act and who need
406 treatment for breast or cervical cancer. Eligibility of
407 individuals under this paragraph (24) shall be determined by the
408 Division of Medicaid.

409 (25) The division shall apply to the Centers for
410 Medicare and Medicaid Services (CMS) for any necessary waivers to
411 provide services to individuals who are sixty-five (65) years of
412 age or older or are disabled as determined under Section
413 1614(a)(3) of the federal Social Security Act, as amended, and
414 whose income does not exceed one hundred thirty-five percent
415 (135%) of the * * * federal poverty level, and whose resources do
416 not exceed those established by the Division of Medicaid, and who
417 are not otherwise covered by Medicare. Nothing contained in this
418 paragraph (25) shall entitle an individual to benefits. The



419 eligibility of individuals covered under this paragraph shall be
420 determined by the Division of Medicaid.

421 (26) * * * [Deleted]

422 (27) Individuals who are entitled to Medicare Part D
423 and whose income does not exceed one hundred fifty percent (150%)
424 of the * * * federal poverty level. Eligibility for payment of
425 the Medicare Part D subsidy under this paragraph shall be
426 determined by the division.

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

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

435 **SECTION 2.** Section 43-13-117, Mississippi Code of 1972, as
436 amended by House Bill No. 1401, 2025 Regular Session, is amended
437 as follows:

438 43-13-117. (A) Medicaid as authorized by this article shall
439 include payment of part or all of the costs, at the discretion of
440 the division, with approval of the Governor and the Centers for
441 Medicare and Medicaid Services, of the following types of care and
442 services rendered to eligible applicants who have been determined



443 to be eligible for that care and services, within the limits of
444 state appropriations and federal matching funds:

445 (1) Inpatient hospital services.

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

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

455 (2) Outpatient hospital services.

456 (a) Emergency services.

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



468 constructed after July 1, 2009. Where the same services are
469 reimbursed as clinic services, the division may revise the rate or
470 methodology of outpatient reimbursement to maintain consistency,
471 efficiency, economy and quality of care.

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

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

488 (3) Laboratory and x-ray services.

489 (4) Nursing facility services.

490 (a) The division shall make full payment to
491 nursing facilities for each day, not exceeding forty-two (42) days
492 per year, that a patient is absent from the facility on home



493 leave. Payment may be made for the following home leave days in
494 addition to the forty-two-day limitation: Christmas, the day
495 before Christmas, the day after Christmas, Thanksgiving, the day
496 before Thanksgiving and the day after Thanksgiving.

497 (b) From and after July 1, 1997, the division
498 shall implement the integrated case-mix payment and quality
499 monitoring system, which includes the fair rental system for
500 property costs and in which recapture of depreciation is
501 eliminated. The division may reduce the payment for hospital
502 leave and therapeutic home leave days to the lower of the case-mix
503 category as computed for the resident on leave using the
504 assessment being utilized for payment at that point in time, or a
505 case-mix score of 1.000 for nursing facilities, and shall compute
506 case-mix scores of residents so that only services provided at the
507 nursing facility are considered in calculating a facility's per
508 diem.

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

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



517 (e) The division shall develop and implement, not
518 later than January 1, 2001, a case-mix payment add-on determined
519 by time studies and other valid statistical data that will
520 reimburse a nursing facility for the additional cost of caring for
521 a resident who has a diagnosis of Alzheimer's or other related
522 dementia and exhibits symptoms that require special care. Any
523 such case-mix add-on payment shall be supported by a determination
524 of additional cost. The division shall also develop and implement
525 as part of the fair rental reimbursement system for nursing
526 facility beds, an Alzheimer's resident bed depreciation enhanced
527 reimbursement system that will provide an incentive to encourage
528 nursing facilities to convert or construct beds for residents with
529 Alzheimer's or other related dementia.

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

534 (g) The division may implement a quality or
535 value-based component to the nursing facility payment system.

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

540 (5) Periodic screening and diagnostic services for
541 individuals under age twenty-one (21) years as are needed to



542 identify physical and mental defects and to provide health care
543 treatment and other measures designed to correct or ameliorate
544 defects and physical and mental illness and conditions discovered
545 by the screening services, regardless of whether these services
546 are included in the state plan. The division may include in its
547 periodic screening and diagnostic program those discretionary
548 services authorized under the federal regulations adopted to
549 implement Title XIX of the federal Social Security Act, as
550 amended. The division, in obtaining physical therapy services,
551 occupational therapy services, and services for individuals with
552 speech, hearing and language disorders, may enter into a
553 cooperative agreement with the State Department of Education for
554 the provision of those services to handicapped students by public
555 school districts using state funds that are provided from the
556 appropriation to the Department of Education to obtain federal
557 matching funds through the division. The division, in obtaining
558 medical and mental health assessments, treatment, care and
559 services for children who are in, or at risk of being put in, the
560 custody of the Mississippi Department of Human Services may enter
561 into a cooperative agreement with the Mississippi Department of
562 Human Services for the provision of those services using state
563 funds that are provided from the appropriation to the Department
564 of Human Services to obtain federal matching funds through the
565 division.



566 (6) Physician services. Fees for physician's services
567 that are covered only by Medicaid shall be reimbursed at ninety
568 percent (90%) of the rate established on January 1, 2018, and as
569 may be adjusted each July thereafter, under Medicare. The
570 division may provide for a reimbursement rate for physician's
571 services of up to one hundred percent (100%) of the rate
572 established under Medicare for physician's services that are
573 provided after the normal working hours of the physician, as
574 determined in accordance with regulations of the division. The
575 division may reimburse eligible providers, as determined by the
576 division, for certain primary care services at one hundred percent
577 (100%) of the rate established under Medicare. The division shall
578 reimburse obstetricians * * *, gynecologists and pediatricians for
579 certain primary care services as defined by the division at one
580 hundred percent (100%) of the rate established under Medicare.

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



591 (b) [Repealed]

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

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

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

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

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

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



615 Drugs prescribed for a resident of a psychiatric residential
616 treatment facility must be provided in true unit doses when
617 available. The division may require that drugs not covered by
618 Medicare Part D for a resident of a long-term care facility be
619 provided in true unit doses when available. Those drugs that were
620 originally billed to the division but are not used by a resident
621 in any of those facilities shall be returned to the billing
622 pharmacy for credit to the division, in accordance with the
623 guidelines of the State Board of Pharmacy and any requirements of
624 federal law and regulation. Drugs shall be dispensed to a
625 recipient and only one (1) dispensing fee per month may be
626 charged. The division shall develop a methodology for reimbursing
627 for restocked drugs, which shall include a restock fee as
628 determined by the division not exceeding Seven Dollars and
629 Eighty-two Cents (\$7.82).

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

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

637 All claims for drugs for dually eligible Medicare/Medicaid
638 beneficiaries that are paid for by Medicare must be submitted to



639 Medicare for payment before they may be processed by the
640 division's online payment system.

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

646 The division shall develop and implement a method or methods
647 by which the division will provide on a regular basis to Medicaid
648 providers who are authorized to prescribe drugs, information about
649 the costs to the Medicaid program of single-source drugs and
650 innovator multiple-source drugs, and information about other drugs
651 that may be prescribed as alternatives to those single-source
652 drugs and innovator multiple-source drugs and the costs to the
653 Medicaid program of those alternative drugs.

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

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



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

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

670 The division shall allow certain drugs, including
671 physician-administered drugs, and implantable drug system devices,
672 and medical supplies, with limited distribution or limited access
673 for beneficiaries and administered in an appropriate clinical
674 setting, to be reimbursed as either a medical claim or pharmacy
675 claim, as determined by the division.

676 * * *

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

679 The division shall increase the amount of the reimbursement
680 rate for diagnostic and preventative dental services for each of
681 the fiscal years 2022, 2023 and 2024 by five percent (5%) above
682 the amount of the reimbursement rate for the previous fiscal year.
683 The division shall increase the amount of the reimbursement rate
684 for restorative dental services for each of the fiscal years 2023,
685 2024 and 2025 by five percent (5%) above the amount of the
686 reimbursement rate for the previous fiscal year. It is the intent
687 of the Legislature that the reimbursement rate revision for



688 preventative dental services will be an incentive to increase the
689 number of dentists who actively provide Medicaid services. This
690 dental services reimbursement rate revision shall be known as the
691 "James Russell Dumas Medicaid Dental Services Incentive Program."

692 The Medical Care Advisory Committee, assisted by the Division
693 of Medicaid, shall annually determine the effect of this incentive
694 by evaluating the number of dentists who are Medicaid providers,
695 the number who and the degree to which they are actively billing
696 Medicaid, the geographic trends of where dentists are offering
697 what types of Medicaid services and other statistics pertinent to
698 the goals of this legislative intent. This data shall annually be
699 presented to the Chair of the Senate Medicaid Committee and the
700 Chair of the House Medicaid Committee.

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

704 (11) Eyeglasses for all Medicaid beneficiaries who have
705 (a) had surgery on the eyeball or ocular muscle that results in a
706 vision change for which eyeglasses or a change in eyeglasses is
707 medically indicated within six (6) months of the surgery and is in
708 accordance with policies established by the division, or (b) one
709 (1) pair every * * * two (2) years and in accordance with policies
710 established by the division. In either instance, the eyeglasses
711 must be prescribed by a physician skilled in diseases of the eye
712 or an optometrist, whichever the beneficiary may select.



713 (12) Intermediate care facility services.

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

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

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

728 (13) Family planning services, including drugs,
729 supplies and devices, when those services are under the
730 supervision of a physician or nurse practitioner. Oral
731 contraceptives may be prescribed and dispensed in twelve-month
732 supply increments.

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



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

740 (b) Dialysis center services.

741 Ambulatory Surgical Care (ASCs) may be reimbursed by the
742 division based on ninety percent (90%) of the Medicare ASC Payment
743 System rate in effect July 1 of each year as set by the Centers
744 for Medicare and Medicaid Services.

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

750 (16) Mental health services. Certain services provided
751 by a psychiatrist shall be reimbursed at up to one hundred percent
752 (100%) of the Medicare rate. Approved therapeutic and case
753 management services (a) provided by an approved regional mental
754 health/intellectual disability center established under Sections
755 41-19-31 through 41-19-39, or by another community mental health
756 service provider meeting the requirements of the Department of
757 Mental Health to be an approved mental health/intellectual
758 disability center if determined necessary by the Department of
759 Mental Health, using state funds that are provided in the
760 appropriation to the division to match federal funds, or (b)
761 provided by a facility that is certified by the State Department
762 of Mental Health to provide therapeutic and case management



763 services, to be reimbursed on a fee for service basis, or (c)
764 provided in the community by a facility or program operated by the
765 Department of Mental Health. Any such services provided by a
766 facility described in subparagraph (b) must have the prior
767 approval of the division to be reimbursable under this section.

768 (17) Durable medical equipment services and medical
769 supplies. Precertification of durable medical equipment and
770 medical supplies must be obtained as required by the division.
771 The Division of Medicaid may require durable medical equipment
772 providers to obtain a surety bond in the amount and to the
773 specifications as established by the Balanced Budget Act of 1997.
774 A maximum dollar amount of reimbursement for noninvasive
775 ventilators or ventilation treatments properly ordered and being
776 used in an appropriate care setting shall not be set by any health
777 maintenance organization, coordinated care organization,
778 provider-sponsored health plan, or other organization paid for
779 services on a capitated basis by the division under any managed
780 care program or coordinated care program implemented by the
781 division under this section. Reimbursement by these organizations
782 to durable medical equipment suppliers for home use of noninvasive
783 and invasive ventilators shall be on a continuous monthly payment
784 basis for the duration of medical need throughout a patient's
785 valid prescription period.

786 The division may provide reimbursement for devices used for
787 the reduction of snoring and obstructive sleep apnea.



788 (18) (a) Notwithstanding any other provision of this
789 section to the contrary, as provided in the Medicaid state plan
790 amendment or amendments as defined in Section 43-13-145(10), the
791 division shall make additional reimbursement to hospitals that
792 serve a disproportionate share of low-income patients and that
793 meet the federal requirements for those payments as provided in
794 Section 1923 of the federal Social Security Act and any applicable
795 regulations. It is the intent of the Legislature that the
796 division shall draw down all available federal funds allotted to
797 the state for disproportionate share hospitals. However, from and
798 after January 1, 1999, public hospitals participating in the
799 Medicaid disproportionate share program may be required to
800 participate in an intergovernmental transfer program as provided
801 in Section 1903 of the federal Social Security Act and any
802 applicable regulations.

803 (b) (i) 1. The division may establish a Medicare
804 Upper Payment Limits Program, as defined in Section 1902(a)(30) of
805 the federal Social Security Act and any applicable federal
806 regulations, or an allowable delivery system or provider payment
807 initiative authorized under 42 CFR 438.6(c), for hospitals,
808 nursing facilities and physicians employed or contracted by
809 hospitals. No later than December 1, 2025, the division shall, in
810 consultation with the Mississippi Hospital Association, the
811 Mississippi Healthcare Collaborative, the University of
812 Mississippi Medical Center and any other hospitals in the state,



838 authorized under this subsection (A) (18) (b). * * * Hospitals with
839 physicians participating in the Medicare Upper Payment Limits
840 Program or other program(s) authorized under this subsection
841 (A) (18) (b) shall be required to participate in an
842 intergovernmental transfer or assessment, as determined by the
843 division, for the purpose of financing the state portion of the
844 physician UPL payments or other payment(s) authorized under this
845 subsection (A) (18) (b).

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

857 (iv) * * * The division is authorized to
858 develop and implement an alternative fee-for-service Upper Payment
859 Limits model in accordance with federal laws and regulations if
860 necessary to preserve supplemental funding. * * * The division,
861 in consultation with the Mississippi Hospital Association, the
862 Mississippi Healthcare Collaborative, the University of



863 Mississippi Medical Center and any other hospitals in the state,
864 shall study:

865 1. The feasibility of offering
866 alternative models for distribution of medical claims and
867 supplemental payments for inpatient and outpatient hospital
868 services, with input from the stakeholders of such claims and
869 payments. The goals of such payment models shall be to ensure
870 access to inpatient and outpatient care and to maximize any
871 federal funds that are available to reimburse hospitals for
872 services provided; and

873 2. The feasibility of the division
874 establishing a Medicare Upper Payment Limits Program to physicians
875 employed or contracted by hospitals that are able to participate
876 in the program through an intergovernmental transfer.

877 The Chairmen of the Senate and House Medicaid Committees
878 shall be provided copies of the proposed payment model(s) before
879 submission, and shall also be provided the findings of the
880 feasibility studies.

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



888 2. The division shall calculate the
889 ambulance service access payment amount as the balance of the
890 portion of the Medical Care Fund related to ambulance
891 transportation service provider assessments plus any federal
892 matching funds earned on the balance, up to, but not to exceed,
893 the upper payment limit gap for all emergency ambulance service
894 providers.

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

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

909 c. As used in this paragraph
910 (18)(b)(v), the term "upper payment limit gap" means the
911 difference between the total amount that the ambulance
912 transportation service provider received from Medicaid and the



913 average amount that the ambulance transportation service provider
914 would have received from commercial insurers for those services
915 reimbursed by Medicaid.

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

919 (c) (i) * * * The division shall, subject to
920 approval by the Centers for Medicare and Medicaid Services (CMS),
921 establish, implement and operate a Mississippi Hospital Access
922 Program (MHAP) for the purpose of protecting patient access to
923 hospital care through hospital inpatient reimbursement programs
924 provided in this section designed to maintain total hospital
925 reimbursement for inpatient services rendered by in-state
926 hospitals and the out-of-state hospital that is authorized by
927 federal law to submit intergovernmental transfers (IGTs) to the
928 State of Mississippi and is classified as Level I trauma center
929 located in a county contiguous to the state line at the maximum
930 levels permissible under applicable federal statutes and
931 regulations * * *.

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



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

939 * * *

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

946 (iv) To stabilize access to hospital care,
947 the division shall maximize total federal funding for MHAP, UPL
948 and other supplemental payment programs that are in effect for
949 state fiscal year 2025 and shall not change the methodologies,
950 formulas, models or preprints used to calculate the distribution
951 of supplemental payments to hospitals from those methodologies,
952 formulas, models or preprints in effect and as approved by the
953 Centers for Medicare and Medicaid Services for state fiscal year
954 2025 as of December 31, 2024, except to update the time period to
955 the most recent annual period or as required by federal law or
956 regulation. The provisions of this subparagraph (iv) do not apply
957 if the hospital is no longer eligible to participate in the
958 supplemental payment program pursuant to federal or state law or
959 if a hospital that was not included in the distribution is
960 subsequently opened or if a hospital that was receiving
961 supplemental payments should close. Nothing in this subparagraph



962 (iv) shall be construed to prohibit an aggregate increase or
963 decrease in total funding to maximize the total funding available
964 for hospital supplemental payment programs so long as the
965 increased funding is distributed pursuant to the state fiscal year
966 2025 methodologies, formulas, models or preprints.
967 Notwithstanding the above, the division shall conform the penalty
968 for failure to satisfy quality standards to an amount that is more
969 comparable to the value of the encounter. Nothing in this
970 subparagraph (iv) shall prohibit a border city
971 university-affiliated pediatric teaching hospital as described in
972 paragraph (60) of this subsection (A) to be included in a payment
973 model authorized under this paragraph (18).

974 (19) (a) Perinatal risk-management services. The
975 division shall promulgate regulations to be effective from and
976 after October 1, 1988, to establish a comprehensive perinatal
977 system for risk assessment of all pregnant and infant Medicaid
978 recipients and for management, education and follow-up for those
979 who are determined to be at risk. Services to be performed
980 include case management, nutrition assessment/counseling,
981 psychosocial assessment/counseling and health education. The
982 division * * * may contract with the State Department of Health to
983 provide services within this paragraph (Perinatal High Risk
984 Management/Infant Services System (PHRM/ISS)) for any eligible
985 beneficiary who cannot receive these services under a different
986 program. The State Department of Health shall be reimbursed on a



987 full reasonable cost basis for services provided under this
988 subparagraph (a). Any program authorized under subsection (H) of
989 this section shall develop a perinatal risk-management services
990 program in consultation with the division and the State Department
991 of Health or may contract with the State Department of Health for
992 these services, and the programs shall begin providing these
993 services no later than January 1, 2026.

994 (b) Early intervention system services. The
995 division shall cooperate with the State Department of Health,
996 acting as lead agency, in the development and implementation of a
997 statewide system of delivery of early intervention services, under
998 Part C of the Individuals with Disabilities Education Act (IDEA).
999 The State Department of Health shall certify annually in writing
1000 to the executive director of the division the dollar amount of
1001 state early intervention funds available that will be utilized as
1002 a certified match for Medicaid matching funds. Those funds then
1003 shall be used to provide expanded targeted case management
1004 services for Medicaid eligible children with special needs who are
1005 eligible for the state's early intervention system.

1006 Qualifications for persons providing service coordination shall be
1007 determined by the State Department of Health and the Division of
1008 Medicaid.

1009 (20) Home- and community-based services for physically
1010 disabled approved services as allowed by a waiver from the United
1011 States Department of Health and Human Services for home- and



1012 community-based services for physically disabled people using
1013 state funds that are provided from the appropriation to the State
1014 Department of Rehabilitation Services and used to match federal
1015 funds under a cooperative agreement between the division and the
1016 department, provided that funds for these services are
1017 specifically appropriated to the Department of Rehabilitation
1018 Services.

1019 (21) Nurse practitioner services. Services furnished
1020 by a registered nurse who is licensed and certified by the
1021 Mississippi Board of Nursing as a nurse practitioner, including,
1022 but not limited to, nurse anesthetists, nurse midwives, family
1023 nurse practitioners, family planning nurse practitioners,
1024 pediatric nurse practitioners, obstetrics-gynecology nurse
1025 practitioners and neonatal nurse practitioners, under regulations
1026 adopted by the division. Reimbursement for those services shall
1027 not exceed ninety percent (90%) of the reimbursement rate for
1028 comparable services rendered by a physician. The division may
1029 provide for a reimbursement rate for nurse practitioner services
1030 of up to one hundred percent (100%) of the reimbursement rate for
1031 comparable services rendered by a physician for nurse practitioner
1032 services that are provided after the normal working hours of the
1033 nurse practitioner, as determined in accordance with regulations
1034 of the division.

1035 (22) Ambulatory services delivered in federally
1036 qualified health centers, rural health centers and clinics of the



1037 local health departments of the State Department of Health for
1038 individuals eligible for Medicaid under this article based on
1039 reasonable costs as determined by the division. Federally
1040 qualified health centers shall be reimbursed by the Medicaid
1041 prospective payment system as approved by the Centers for Medicare
1042 and Medicaid Services. The division shall recognize federally
1043 qualified health centers (FQHCs), rural health clinics (RHCs) and
1044 community mental health centers (CMHCs) as both an originating and
1045 distant site provider for the purposes of telehealth
1046 reimbursement. The division is further authorized and directed to
1047 reimburse FQHCs, RHCs and CMHCs for both distant site and
1048 originating site services when such services are appropriately
1049 provided by the same organization.

1050 (23) Inpatient psychiatric services.

1051 (a) Inpatient psychiatric services to be
1052 determined by the division for recipients under age twenty-one
1053 (21) that are provided under the direction of a physician in an
1054 inpatient program in a licensed acute care psychiatric facility or
1055 in a licensed psychiatric residential treatment facility, before
1056 the recipient reaches age twenty-one (21) or, if the recipient was
1057 receiving the services immediately before he or she reached age
1058 twenty-one (21), before the earlier of the date he or she no
1059 longer requires the services or the date he or she reaches age
1060 twenty-two (22), as provided by federal regulations. From and
1061 after January 1, 2015, the division shall update the fair rental



1062 reimbursement system for psychiatric residential treatment
1063 facilities. Precertification of inpatient days and residential
1064 treatment days must be obtained as required by the division. From
1065 and after July 1, 2009, all state-owned and state-operated
1066 facilities that provide inpatient psychiatric services to persons
1067 under age twenty-one (21) who are eligible for Medicaid
1068 reimbursement shall be reimbursed for those services on a full
1069 reasonable cost basis.

1070 (b) The division may reimburse for services
1071 provided by a licensed freestanding psychiatric hospital to
1072 Medicaid recipients over the age of twenty-one (21) in a method
1073 and manner consistent with the provisions of Section 43-13-117.5.

1074 (24) * * * Certified Community Behavioral Health
1075 Centers (CCBHCs). The division may reimburse CCBHCs in a manner
1076 as determined by the division.

1077 (25) [Deleted]

1078 (26) Hospice care. As used in this paragraph, the term
1079 "hospice care" means a coordinated program of active professional
1080 medical attention within the home and outpatient and inpatient
1081 care that treats the terminally ill patient and family as a unit,
1082 employing a medically directed interdisciplinary team. The
1083 program provides relief of severe pain or other physical symptoms
1084 and supportive care to meet the special needs arising out of
1085 physical, psychological, spiritual, social and economic stresses
1086 that are experienced during the final stages of illness and during



1087 dying and bereavement and meets the Medicare requirements for
1088 participation as a hospice as provided in federal regulations.

1089 (27) Group health plan premiums and cost-sharing if it
1090 is cost-effective as defined by the United States Secretary of
1091 Health and Human Services.

1092 (28) Other health insurance premiums that are
1093 cost-effective as defined by the United States Secretary of Health
1094 and Human Services. Medicare eligible must have Medicare Part B
1095 before other insurance premiums can be paid.

1096 (29) The Division of Medicaid may apply for a waiver
1097 from the United States Department of Health and Human Services for
1098 home- and community-based services for developmentally disabled
1099 people using state funds that are provided from the appropriation
1100 to the State Department of Mental Health and/or funds transferred
1101 to the department by a political subdivision or instrumentality of
1102 the state and used to match federal funds under a cooperative
1103 agreement between the division and the department, provided that
1104 funds for these services are specifically appropriated to the
1105 Department of Mental Health and/or transferred to the department
1106 by a political subdivision or instrumentality of the state.

1107 (30) Pediatric skilled nursing services as determined
1108 by the division and in a manner consistent with regulations
1109 promulgated by the Mississippi State Department of Health.

1110 (31) Targeted case management services for children
1111 with special needs, under waivers from the United States



1112 Department of Health and Human Services, using state funds that
1113 are provided from the appropriation to the Mississippi Department
1114 of Human Services and used to match federal funds under a
1115 cooperative agreement between the division and the department.

1116 (32) Care and services provided in Christian Science
1117 Sanatoria listed and certified by the Commission for Accreditation
1118 of Christian Science Nursing Organizations/Facilities, Inc.,
1119 rendered in connection with treatment by prayer or spiritual means
1120 to the extent that those services are subject to reimbursement
1121 under Section 1903 of the federal Social Security Act.

1122 (33) Podiatrist services.

1123 (34) Assisted living services as provided through
1124 home- and community-based services under Title XIX of the federal
1125 Social Security Act, as amended, subject to the availability of
1126 funds specifically appropriated for that purpose by the
1127 Legislature.

1128 (35) Services and activities authorized in Sections
1129 43-27-101 and 43-27-103, using state funds that are provided from
1130 the appropriation to the Mississippi Department of Human Services
1131 and used to match federal funds under a cooperative agreement
1132 between the division and the department.

1133 (36) Nonemergency transportation services for
1134 Medicaid-eligible persons as determined by the division. The PEER
1135 Committee shall conduct a performance evaluation of the
1136 nonemergency transportation program to evaluate the administration



1137 of the program and the providers of transportation services to
1138 determine the most cost-effective ways of providing nonemergency
1139 transportation services to the patients served under the program.
1140 The performance evaluation shall be completed and provided to the
1141 members of the Senate Medicaid Committee and the House Medicaid
1142 Committee not later than January 1, 2019, and every two (2) years
1143 thereafter.

1144 (37) [Deleted]

1145 (38) Chiropractic services. A chiropractor's manual
1146 manipulation of the spine to correct a subluxation, if x-ray
1147 demonstrates that a subluxation exists and if the subluxation has
1148 resulted in a neuromusculoskeletal condition for which
1149 manipulation is appropriate treatment, and related spinal x-rays
1150 performed to document these conditions. Reimbursement for
1151 chiropractic services shall not exceed Seven Hundred Dollars
1152 (\$700.00) per year per beneficiary.

1153 (39) Dually eligible Medicare/Medicaid beneficiaries.
1154 The division shall pay the Medicare deductible and coinsurance
1155 amounts for services available under Medicare, as determined by
1156 the division. From and after July 1, 2009, the division shall
1157 reimburse crossover claims for inpatient hospital services and
1158 crossover claims covered under Medicare Part B in the same manner
1159 that was in effect on January 1, 2008, unless specifically
1160 authorized by the Legislature to change this method.

1161 (40) [Deleted]



1162 (41) Services provided by the State Department of
1163 Rehabilitation Services for the care and rehabilitation of persons
1164 with spinal cord injuries or traumatic brain injuries, as allowed
1165 under waivers from the United States Department of Health and
1166 Human Services, using up to seventy-five percent (75%) of the
1167 funds that are appropriated to the Department of Rehabilitation
1168 Services from the Spinal Cord and Head Injury Trust Fund
1169 established under Section 37-33-261 and used to match federal
1170 funds under a cooperative agreement between the division and the
1171 department.

1172 (42) [Deleted]

1173 (43) The division shall provide reimbursement,
1174 according to a payment schedule developed by the division, for
1175 smoking cessation medications for pregnant women during their
1176 pregnancy and other Medicaid-eligible women who are of
1177 child-bearing age.

1178 (44) Nursing facility services for the severely
1179 disabled.

1180 (a) Severe disabilities include, but are not
1181 limited to, spinal cord injuries, closed-head injuries and
1182 ventilator-dependent patients.

1183 (b) Those services must be provided in a long-term
1184 care nursing facility dedicated to the care and treatment of
1185 persons with severe disabilities.



1186 (45) Physician assistant services. Services furnished
1187 by a physician assistant who is licensed by the State Board of
1188 Medical Licensure and is practicing with physician supervision
1189 under regulations adopted by the board, under regulations adopted
1190 by the division. Reimbursement for those services shall not
1191 exceed ninety percent (90%) of the reimbursement rate for
1192 comparable services rendered by a physician. The division may
1193 provide for a reimbursement rate for physician assistant services
1194 of up to one hundred percent (100%) or the reimbursement rate for
1195 comparable services rendered by a physician for physician
1196 assistant services that are provided after the normal working
1197 hours of the physician assistant, as determined in accordance with
1198 regulations of the division.

1199 (46) The division shall make application to the federal
1200 Centers for Medicare and Medicaid Services (CMS) for a waiver to
1201 develop and provide services for children with serious emotional
1202 disturbances as defined in Section 43-14-1(1), which may include
1203 home- and community-based services, case management services or
1204 managed care services through mental health providers certified by
1205 the Department of Mental Health. The division may implement and
1206 provide services under this waived program only if funds for
1207 these services are specifically appropriated for this purpose by
1208 the Legislature, or if funds are voluntarily provided by affected
1209 agencies.



1210 (47) (a) The division may develop and implement
1211 disease management programs for individuals with high-cost chronic
1212 diseases and conditions, including the use of grants, waivers,
1213 demonstrations or other projects as necessary.

1214 (b) Participation in any disease management
1215 program implemented under this paragraph (47) is optional with the
1216 individual. An individual must affirmatively elect to participate
1217 in the disease management program in order to participate, and may
1218 elect to discontinue participation in the program at any time.

1219 (48) Pediatric long-term acute care hospital services.

1220 (a) Pediatric long-term acute care hospital
1221 services means services provided to eligible persons under
1222 twenty-one (21) years of age by a freestanding Medicare-certified
1223 hospital that has an average length of inpatient stay greater than
1224 twenty-five (25) days and that is primarily engaged in providing
1225 chronic or long-term medical care to persons under twenty-one (21)
1226 years of age.

1227 (b) The services under this paragraph (48) shall
1228 be reimbursed as a separate category of hospital services.

1229 (49) The division may establish copayments and/or
1230 coinsurance for any Medicaid services for which copayments and/or
1231 coinsurance are allowable under federal law or regulation.

1232 (50) Services provided by the State Department of
1233 Rehabilitation Services for the care and rehabilitation of persons
1234 who are deaf and blind, as allowed under waivers from the United



1235 States Department of Health and Human Services to provide home-
1236 and community-based services using state funds that are provided
1237 from the appropriation to the State Department of Rehabilitation
1238 Services or if funds are voluntarily provided by another agency.

1239 (51) Upon determination of Medicaid eligibility and in
1240 association with annual redetermination of Medicaid eligibility,
1241 beneficiaries shall be encouraged to undertake a physical
1242 examination that will establish a base-line level of health and
1243 identification of a usual and customary source of care (a medical
1244 home) to aid utilization of disease management tools. This
1245 physical examination and utilization of these disease management
1246 tools shall be consistent with current United States Preventive
1247 Services Task Force or other recognized authority recommendations.

1248 For persons who are determined ineligible for Medicaid, the
1249 division will provide information and direction for accessing
1250 medical care and services in the area of their residence.

1251 (52) Notwithstanding any provisions of this article,
1252 the division may pay enhanced reimbursement fees related to trauma
1253 care, as determined by the division in conjunction with the State
1254 Department of Health, using funds appropriated to the State
1255 Department of Health for trauma care and services and used to
1256 match federal funds under a cooperative agreement between the
1257 division and the State Department of Health. The division, in
1258 conjunction with the State Department of Health, may use grants,
1259 waivers, demonstrations, enhanced reimbursements, Upper Payment



1260 Limits Programs, supplemental payments, or other projects as
1261 necessary in the development and implementation of this
1262 reimbursement program.

1263 (53) Targeted case management services for high-cost
1264 beneficiaries may be developed by the division for all services
1265 under this section.

1266 (54) [Deleted]

1267 (55) Therapy services. The plan of care for therapy
1268 services may be developed to cover a period of treatment for up to
1269 six (6) months, but in no event shall the plan of care exceed a
1270 six-month period of treatment. The projected period of treatment
1271 must be indicated on the initial plan of care and must be updated
1272 with each subsequent revised plan of care. Based on medical
1273 necessity, the division shall approve certification periods for
1274 less than or up to six (6) months, but in no event shall the
1275 certification period exceed the period of treatment indicated on
1276 the plan of care. The appeal process for any reduction in therapy
1277 services shall be consistent with the appeal process in federal
1278 regulations.

1279 (56) Prescribed pediatric extended care centers
1280 services for medically dependent or technologically dependent
1281 children with complex medical conditions that require continual
1282 care as prescribed by the child's attending physician, as
1283 determined by the division.



1284 (57) No Medicaid benefit shall restrict coverage for
1285 medically appropriate treatment prescribed by a physician and
1286 agreed to by a fully informed individual, or if the individual
1287 lacks legal capacity to consent by a person who has legal
1288 authority to consent on his or her behalf, based on an
1289 individual's diagnosis with a terminal condition. As used in this
1290 paragraph (57), "terminal condition" means any aggressive
1291 malignancy, chronic end-stage cardiovascular or cerebral vascular
1292 disease, or any other disease, illness or condition which a
1293 physician diagnoses as terminal.

1294 (58) Treatment services for persons with opioid
1295 dependency or other highly addictive substance use disorders. The
1296 division is authorized to reimburse eligible providers for
1297 treatment of opioid dependency and other highly addictive
1298 substance use disorders, as determined by the division. Treatment
1299 related to these conditions shall not count against any physician
1300 visit limit imposed under this section.

1301 (59) The division shall allow beneficiaries between the
1302 ages of ten (10) and eighteen (18) years to receive vaccines
1303 through a pharmacy venue. The division and the State Department
1304 of Health shall coordinate and notify OB-GYN providers that the
1305 Vaccines for Children program is available to providers free of
1306 charge.

1307 (60) Border city university-affiliated pediatric
1308 teaching hospital.



1309 (a) Payments may only be made to a border city
1310 university-affiliated pediatric teaching hospital if the Centers
1311 for Medicare and Medicaid Services (CMS) approve an increase in
1312 the annual request for the provider payment initiative authorized
1313 under 42 CFR Section 438.6(c) in an amount equal to or greater
1314 than the estimated annual payment to be made to the border city
1315 university-affiliated pediatric teaching hospital. The estimate
1316 shall be based on the hospital's prior year Mississippi managed
1317 care utilization.

1318 (b) As used in this paragraph (60), the term
1319 "border city university-affiliated pediatric teaching hospital"
1320 means an out-of-state hospital located within a city bordering the
1321 eastern bank of the Mississippi River and the State of Mississippi
1322 that submits to the division a copy of a current and effective
1323 affiliation agreement with an accredited university and other
1324 documentation establishing that the hospital is
1325 university-affiliated, is licensed and designated as a pediatric
1326 hospital or pediatric primary hospital within its home state,
1327 maintains at least five (5) different pediatric specialty training
1328 programs, and maintains at least one hundred (100) operated beds
1329 dedicated exclusively for the treatment of patients under the age
1330 of twenty-one (21) years.

1331 (c) The * * * payment for providing services to
1332 Mississippi Medicaid beneficiaries under the age of twenty-one
1333 (21) years who are treated by a border city university-affiliated



1334 pediatric teaching hospital shall not exceed * * * two hundred
1335 percent (200%) of its cost of providing the services to
1336 Mississippi Medicaid individuals.

1337 (d) It is the intent of the Legislature that
1338 payments shall not result in any in-state hospital receiving
1339 payments lower than they would otherwise receive if not for the
1340 payments made to any border city university-affiliated pediatric
1341 teaching hospital.

1342 (e) This paragraph (60) shall stand repealed on
1343 July 1, * * * 2027.

1344 (61) Services described in Section 2 of House Bill No.
1345 1401, 2025 Regular Session that are provided by certified
1346 community health workers employed and supervised by a Medicaid
1347 provider. Reimbursement for these services shall be provided only
1348 if the division has received approval from the Centers for
1349 Medicare and Medicaid Services for a state plan amendment, waiver
1350 or alternative payment model for services delivered by certified
1351 community health workers.

1352 (62) Autism spectrum disorder services. The division
1353 shall develop and implement a method for reimbursement of autism
1354 spectrum disorder services based on a continuum of care for best
1355 practices in medically necessary early intervention treatment.
1356 The division shall work in consultation with the Department of
1357 Mental Health, healthcare providers, the Autism Advisory
1358 Committee, and other stakeholders relevant to the autism industry



1359 to develop these reimbursement rates. The requirements of this
1360 subsection shall apply to any autism spectrum disorder services
1361 rendered under the authority of the Medicaid State Plan and any
1362 Home- and Community-Based Services Waiver authorized under this
1363 section through which autism spectrum disorder services are
1364 provided.

1365 (63) Preparticipation physical evaluations. The
1366 division shall reimburse for preparticipation physical evaluations
1367 of beneficiaries in a manner as determined by the division.

1368 (64) Medications that have been approved for chronic
1369 weight management by the United States Food and Drug
1370 Administration (FDA). The division shall, in a manner as
1371 determined by the division, reimburse for medications prescribed
1372 for chronic weight management and/or for management of additional
1373 conditions in the discretion of the medical provider.

1374 (65) Nonstatin medications. The division shall provide
1375 coverage and reimbursement, in a manner as determined by the
1376 division, for any nonstatin medication approved by the United
1377 States Food and Drug Administration that has a unique indication
1378 to reduce the risk of a major cardiovascular event in primary
1379 prevention and secondary prevention patients. The division (a)
1380 shall not designate any such nonstatin medication as a
1381 nonpreferred drug or otherwise exclude such nonstatin medication
1382 from the preferred drug list if any statin medication is
1383 designated as a preferred drug; and (b) shall not establish more



1384 restrictive or more extensive utilization controls for any such
1385 nonstatin medication than the least restrictive or extensive
1386 utilization controls applicable to any statin medication. This
1387 paragraph (65) also applies to nonstatin medications that are
1388 provided under a contract between the division and any managed
1389 care organization.

1390 (66) Nonopioid medications. The division shall provide
1391 coverage and reimbursement, in a manner as determined by the
1392 division, for any nonopioid medication approved by the United
1393 States Food and Drug Administration for the treatment or
1394 management of pain. The division (a) shall not designate any such
1395 nonopioid medication as a nonpreferred drug or otherwise exclude
1396 such nonopioid medication from the preferred drug list if any
1397 opioid medication for the treatment or management of pain is
1398 designated as a preferred drug; and (b) shall not establish more
1399 restrictive or more extensive utilization controls for any such
1400 nonopioid medication than the least restrictive or extensive
1401 utilization controls applicable to any opioid medication for the
1402 treatment or management of pain. This paragraph (66) also applies
1403 to such nonopioid medications that are provided under a contract
1404 between the division and any managed care organization.

1405 (B) Planning and development districts participating in the
1406 home- and community-based services program for the elderly and
1407 disabled as case management providers shall be reimbursed for case



1408 management services at the maximum rate approved by the Centers
1409 for Medicare and Medicaid Services (CMS).

1410 (C) The division may pay to those providers who participate
1411 in and accept patient referrals from the division's emergency room
1412 redirection program a percentage, as determined by the division,
1413 of savings achieved according to the performance measures and
1414 reduction of costs required of that program. Federally qualified
1415 health centers may participate in the emergency room redirection
1416 program, and the division may pay those centers a percentage of
1417 any savings to the Medicaid program achieved by the centers'
1418 accepting patient referrals through the program, as provided in
1419 this subsection (C).

1420 (D) (1) As used in this subsection (D), the following terms
1421 shall be defined as provided in this paragraph, except as
1422 otherwise provided in this subsection:

1423 (a) "Committees" means the Medicaid Committees of
1424 the House of Representatives and the Senate, and "committee" means
1425 either one of those committees.

1426 (b) "Rate change" means an increase, decrease or
1427 other change in the payments or rates of reimbursement, or a
1428 change in any payment methodology that results in an increase,
1429 decrease or other change in the payments or rates of
1430 reimbursement, to any Medicaid provider that renders any services
1431 authorized to be provided to Medicaid recipients under this
1432 article.



1433 (2) Whenever the Division of Medicaid proposes a rate
1434 change, the division shall give notice to the chairmen of the
1435 committees at least * * * fifteen (15) calendar days, when
1436 possible, before the proposed rate change is scheduled to take
1437 effect. If the division needs to expedite the fifteen-day notice,
1438 the division shall notify both chairmen of the fact as soon as
1439 possible. The division shall furnish the chairmen with a concise
1440 summary of each proposed rate change along with the notice, and
1441 shall furnish the chairmen with a copy of any proposed rate change
1442 upon request. The division also shall provide a summary and copy
1443 of any proposed rate change to any other member of the Legislature
1444 upon request.

1445 (3) If the chairman of either committee or both
1446 chairmen jointly object to the proposed rate change or any part
1447 thereof, the chairman or chairmen shall notify the division and
1448 provide the reasons for their objection in writing not later than
1449 seven (7) calendar days after receipt of the notice from the
1450 division. The chairman or chairmen may make written
1451 recommendations to the division for changes to be made to a
1452 proposed rate change.

1453 (4) (a) The chairman of either committee or both
1454 chairmen jointly may hold a committee meeting to review a proposed
1455 rate change. If either chairman or both chairmen decide to hold a
1456 meeting, they shall notify the division of their intention in
1457 writing within seven (7) calendar days after receipt of the notice



1458 from the division, and shall set the date and time for the meeting
1459 in their notice to the division, which shall not be later than
1460 fourteen (14) calendar days after receipt of the notice from the
1461 division.

1462 (b) After the committee meeting, the committee or
1463 committees may object to the proposed rate change or any part
1464 thereof. The committee or committees shall notify the division
1465 and the reasons for their objection in writing not later than
1466 seven (7) calendar days after the meeting. The committee or
1467 committees may make written recommendations to the division for
1468 changes to be made to a proposed rate change.

1469 (5) If both chairmen notify the division in writing
1470 within seven (7) calendar days after receipt of the notice from
1471 the division that they do not object to the proposed rate change
1472 and will not be holding a meeting to review the proposed rate
1473 change, the proposed rate change will take effect on the original
1474 date as scheduled by the division or on such other date as
1475 specified by the division.

1476 (6) (a) If there are any objections to a proposed rate
1477 change or any part thereof from either or both of the chairmen or
1478 the committees, the division may withdraw the proposed rate
1479 change, make any of the recommended changes to the proposed rate
1480 change, or not make any changes to the proposed rate change.

1481 (b) If the division does not make any changes to
1482 the proposed rate change, it shall notify the chairmen of that



1483 fact in writing, and the proposed rate change shall take effect on
1484 the original date as scheduled by the division or on such other
1485 date as specified by the division.

1486 (c) If the division makes any changes to the
1487 proposed rate change, the division shall notify the chairmen of
1488 its actions in writing, and the revised proposed rate change shall
1489 take effect on the date as specified by the division.

1490 (7) Nothing in this subsection (D) shall be construed
1491 as giving the chairmen or the committees any authority to veto,
1492 nullify or revise any rate change proposed by the division. The
1493 authority of the chairmen or the committees under this subsection
1494 shall be limited to reviewing, making objections to and making
1495 recommendations for changes to rate changes proposed by the
1496 division.

1497 (E) Notwithstanding any provision of this article, no new
1498 groups or categories of recipients and new types of care and
1499 services may be added without enabling legislation from the
1500 Mississippi Legislature, except that the division may authorize
1501 those changes without enabling legislation when the addition of
1502 recipients or services is ordered by a court of proper authority.

1503 (F) The executive director shall keep the Governor advised
1504 on a timely basis of the funds available for expenditure and the
1505 projected expenditures. Notwithstanding any other provisions of
1506 this article, if current or projected expenditures of the division
1507 are reasonably anticipated to exceed the amount of funds



1508 appropriated to the division for any fiscal year, the Governor,
1509 after consultation with the executive director, shall take all
1510 appropriate measures to reduce costs, which may include, but are
1511 not limited to:

1512 (1) Reducing or discontinuing any or all services that
1513 are deemed to be optional under Title XIX of the Social Security
1514 Act;

1515 (2) Reducing reimbursement rates for any or all service
1516 types;

1517 (3) Imposing additional assessments on health care
1518 providers; or

1519 (4) Any additional cost-containment measures deemed
1520 appropriate by the Governor.

1521 To the extent allowed under federal law, any reduction to
1522 services or reimbursement rates under this subsection (F) shall be
1523 accompanied by a reduction, to the fullest allowable amount, to
1524 the profit margin and administrative fee portions of capitated
1525 payments to organizations described in paragraph (1) of subsection
1526 (H).

1527 Beginning in fiscal year 2010 and in fiscal years thereafter,
1528 when Medicaid expenditures are projected to exceed funds available
1529 for the fiscal year, the division shall submit the expected
1530 shortfall information to the PEER Committee not later than
1531 December 1 of the year in which the shortfall is projected to
1532 occur. PEER shall review the computations of the division and



1533 report its findings to the Legislative Budget Office not later
1534 than January 7 in any year.

1535 (G) Notwithstanding any other provision of this article, it
1536 shall be the duty of each provider participating in the Medicaid
1537 program to keep and maintain books, documents and other records as
1538 prescribed by the Division of Medicaid in accordance with federal
1539 laws and regulations.

1540 (H) (1) Notwithstanding any other provision of this
1541 article, the division is authorized to implement (a) a managed
1542 care program, (b) a coordinated care program, (c) a coordinated
1543 care organization program, (d) a health maintenance organization
1544 program, (e) a patient-centered medical home program, (f) an
1545 accountable care organization program, (g) provider-sponsored
1546 health plan, or (h) any combination of the above programs. As a
1547 condition for the approval of any program under this subsection
1548 (H) (1), the division shall require that no managed care program,
1549 coordinated care program, coordinated care organization program,
1550 health maintenance organization program, or provider-sponsored
1551 health plan may:

1552 (a) Pay providers at a rate that is less than the
1553 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
1554 reimbursement rate;

1555 (b) Override the medical decisions of hospital
1556 physicians or staff regarding patients admitted to a hospital for
1557 an emergency medical condition as defined by 42 US Code Section



1558 1395dd. This restriction (b) does not prohibit the retrospective
1559 review of the appropriateness of the determination that an
1560 emergency medical condition exists by chart review or coding
1561 algorithm, nor does it prohibit prior authorization for
1562 nonemergency hospital admissions;

1563 (c) Pay providers at a rate that is less than the
1564 normal Medicaid reimbursement rate. It is the intent of the
1565 Legislature that all managed care entities described in this
1566 subsection (H), in collaboration with the division, develop and
1567 implement innovative payment models that incentivize improvements
1568 in health care quality, outcomes, or value, as determined by the
1569 division. Participation in the provider network of any managed
1570 care, coordinated care, provider-sponsored health plan, or similar
1571 contractor shall not be conditioned on the provider's agreement to
1572 accept such alternative payment models;

1573 (d) Implement a prior authorization and
1574 utilization review program for medical services, transportation
1575 services and prescription drugs that is more stringent than the
1576 prior authorization processes used by the division in its
1577 administration of the Medicaid program. Not later than December
1578 2, 2021, the contractors that are receiving capitated payments
1579 under a managed care delivery system established under this
1580 subsection (H) shall submit a report to the Chairmen of the House
1581 and Senate Medicaid Committees on the status of the prior
1582 authorization and utilization review program for medical services,



1583 transportation services and prescription drugs that is required to
1584 be implemented under this subparagraph (d);

1585 (e) [Deleted]

1586 (f) Implement a preferred drug list that is more
1587 stringent than the mandatory preferred drug list established by
1588 the division under subsection (A) (9) of this section;

1589 (g) Implement a policy which denies beneficiaries
1590 with hemophilia access to the federally funded hemophilia
1591 treatment centers as part of the Medicaid Managed Care network of
1592 providers.

1593 Each health maintenance organization, coordinated care
1594 organization, provider-sponsored health plan, or other
1595 organization paid for services on a capitated basis by the
1596 division under any managed care program or coordinated care
1597 program implemented by the division under this section shall use a
1598 clear set of level of care guidelines in the determination of
1599 medical necessity and in all utilization management practices,
1600 including the prior authorization process, concurrent reviews,
1601 retrospective reviews and payments, that are consistent with
1602 widely accepted professional standards of care. Organizations
1603 participating in a managed care program or coordinated care
1604 program implemented by the division may not use any additional
1605 criteria that would result in denial of care that would be
1606 determined appropriate and, therefore, medically necessary under
1607 those levels of care guidelines.



1608 (2) Notwithstanding any provision of this section, the
1609 recipients eligible for enrollment into a Medicaid Managed Care
1610 Program authorized under this subsection (H) may include only
1611 those categories of recipients eligible for participation in the
1612 Medicaid Managed Care Program as of January 1, 2021, the
1613 Children's Health Insurance Program (CHIP), and the CMS-approved
1614 Section 1115 demonstration waivers in operation as of January 1,
1615 2021. No expansion of Medicaid Managed Care Program contracts may
1616 be implemented by the division without enabling legislation from
1617 the Mississippi Legislature.

1618 (3) (a) Any contractors receiving capitated payments
1619 under a managed care delivery system established in this section
1620 shall provide to the Legislature and the division statistical data
1621 to be shared with provider groups in order to improve patient
1622 access, appropriate utilization, cost savings and health outcomes
1623 not later than October 1 of each year. Additionally, each
1624 contractor shall disclose to the Chairmen of the Senate and House
1625 Medicaid Committees the administrative expenses costs for the
1626 prior calendar year, and the number of full-equivalent employees
1627 located in the State of Mississippi dedicated to the Medicaid and
1628 CHIP lines of business as of June 30 of the current year.

1629 (b) The division and the contractors participating
1630 in the managed care program, a coordinated care program or a
1631 provider-sponsored health plan shall be subject to annual program
1632 reviews or audits performed by the Office of the State Auditor,



1633 the PEER Committee, the Department of Insurance and/or independent
1634 third parties.

1635 (c) Those reviews shall include, but not be
1636 limited to, at least two (2) of the following items:

1637 (i) The financial benefit to the State of
1638 Mississippi of the managed care program,

1639 (ii) The difference between the premiums paid
1640 to the managed care contractors and the payments made by those
1641 contractors to health care providers,

1642 (iii) Compliance with performance measures
1643 required under the contracts,

1644 (iv) Administrative expense allocation
1645 methodologies,

1646 (v) Whether nonprovider payments assigned as
1647 medical expenses are appropriate,

1648 (vi) Capitated arrangements with related
1649 party subcontractors,

1650 (vii) Reasonableness of corporate
1651 allocations,

1652 (viii) Value-added benefits and the extent to
1653 which they are used,

1654 (ix) The effectiveness of subcontractor
1655 oversight, including subcontractor review,

1656 (x) Whether health care outcomes have been
1657 improved, and



1658 (xi) The most common claim denial codes to
1659 determine the reasons for the denials.

1660 The audit reports shall be considered public documents and
1661 shall be posted in their entirety on the division's website.

1662 (4) All health maintenance organizations, coordinated
1663 care organizations, provider-sponsored health plans, or other
1664 organizations paid for services on a capitated basis by the
1665 division under any managed care program or coordinated care
1666 program implemented by the division under this section shall
1667 reimburse all providers in those organizations at rates no lower
1668 than those provided under this section for beneficiaries who are
1669 not participating in those programs.

1670 (5) No health maintenance organization, coordinated
1671 care organization, provider-sponsored health plan, or other
1672 organization paid for services on a capitated basis by the
1673 division under any managed care program or coordinated care
1674 program implemented by the division under this section shall
1675 require its providers or beneficiaries to use any pharmacy that
1676 ships, mails or delivers prescription drugs or legend drugs or
1677 devices.

1678 (6) (a) Not later than December 1, 2021, the
1679 contractors who are receiving capitated payments under a managed
1680 care delivery system established under this subsection (H) shall
1681 develop and implement a uniform credentialing process for
1682 providers. Under that uniform credentialing process, a provider



1683 who meets the criteria for credentialing will be credentialed with
1684 all of those contractors and no such provider will have to be
1685 separately credentialed by any individual contractor in order to
1686 receive reimbursement from the contractor. Not later than
1687 December 2, 2021, those contractors shall submit a report to the
1688 Chairmen of the House and Senate Medicaid Committees on the status
1689 of the uniform credentialing process for providers that is
1690 required under this subparagraph (a).

1691 (b) If those contractors have not implemented a
1692 uniform credentialing process as described in subparagraph (a) by
1693 December 1, 2021, the division shall develop and implement, not
1694 later than July 1, 2022, a single, consolidated credentialing
1695 process by which all providers will be credentialed. Under the
1696 division's single, consolidated credentialing process, no such
1697 contractor shall require its providers to be separately
1698 credentialed by the contractor in order to receive reimbursement
1699 from the contractor, but those contractors shall recognize the
1700 credentialing of the providers by the division's credentialing
1701 process.

1702 (c) The division shall require a uniform provider
1703 credentialing application that shall be used in the credentialing
1704 process that is established under subparagraph (a) or (b). If the
1705 contractor or division, as applicable, has not approved or denied
1706 the provider credentialing application within sixty (60) days of
1707 receipt of the completed application that includes all required



1708 information necessary for credentialing, then the contractor or
1709 division, upon receipt of a written request from the applicant and
1710 within five (5) business days of its receipt, shall issue a
1711 temporary provider credential/enrollment to the applicant if the
1712 applicant has a valid Mississippi professional or occupational
1713 license to provide the health care services to which the
1714 credential/enrollment would apply. The contractor or the division
1715 shall not issue a temporary credential/enrollment if the applicant
1716 has reported on the application a history of medical or other
1717 professional or occupational malpractice claims, a history of
1718 substance abuse or mental health issues, a criminal record, or a
1719 history of medical or other licensing board, state or federal
1720 disciplinary action, including any suspension from participation
1721 in a federal or state program. The temporary
1722 credential/enrollment shall be effective upon issuance and shall
1723 remain in effect until the provider's credentialing/enrollment
1724 application is approved or denied by the contractor or division.
1725 The contractor or division shall render a final decision regarding
1726 credentialing/enrollment of the provider within sixty (60) days
1727 from the date that the temporary provider credential/enrollment is
1728 issued to the applicant.

1729 (d) If the contractor or division does not render
1730 a final decision regarding credentialing/enrollment of the
1731 provider within the time required in subparagraph (c), the
1732 provider shall be deemed to be credentialed by and enrolled with



1733 all of the contractors and eligible to receive reimbursement from
1734 the contractors.

1735 (7) (a) Each contractor that is receiving capitated
1736 payments under a managed care delivery system established under
1737 this subsection (H) shall provide to each provider for whom the
1738 contractor has denied the coverage of a procedure that was ordered
1739 or requested by the provider for or on behalf of a patient, a
1740 letter that provides a detailed explanation of the reasons for the
1741 denial of coverage of the procedure and the name and the
1742 credentials of the person who denied the coverage. The letter
1743 shall be sent to the provider in electronic format.

1744 (b) After a contractor that is receiving capitated
1745 payments under a managed care delivery system established under
1746 this subsection (H) has denied coverage for a claim submitted by a
1747 provider, the contractor shall issue to the provider within sixty
1748 (60) days a final ruling of denial of the claim that allows the
1749 provider to have a state fair hearing and/or agency appeal with
1750 the division. If a contractor does not issue a final ruling of
1751 denial within sixty (60) days as required by this subparagraph
1752 (b), the provider's claim shall be deemed to be automatically
1753 approved and the contractor shall pay the amount of the claim to
1754 the provider.

1755 (c) After a contractor has issued a final ruling
1756 of denial of a claim submitted by a provider, the division
1757 shall conduct a state fair hearing and/or agency appeal on the



1758 matter of the disputed claim between the contractor and the
1759 provider within sixty (60) days, and shall render a decision on
1760 the matter within thirty (30) days after the date of the hearing
1761 and/or appeal.

1762 (8) It is the intention of the Legislature that the
1763 division evaluate the feasibility of using a single vendor to
1764 administer pharmacy benefits provided under a managed care
1765 delivery system established under this subsection (H). Providers
1766 of pharmacy benefits shall cooperate with the division in any
1767 transition to a carve-out of pharmacy benefits under managed care.

1768 (9) The division shall evaluate the feasibility of
1769 using a single vendor to administer dental benefits provided under
1770 a managed care delivery system established in this subsection (H).
1771 Providers of dental benefits shall cooperate with the division in
1772 any transition to a carve-out of dental benefits under managed
1773 care.

1774 (10) It is the intent of the Legislature that any
1775 contractor receiving capitated payments under a managed care
1776 delivery system established in this section shall implement
1777 innovative programs to improve the health and well-being of
1778 members diagnosed with prediabetes and diabetes.

1779 (11) It is the intent of the Legislature that any
1780 contractors receiving capitated payments under a managed care
1781 delivery system established under this subsection (H) shall work
1782 with providers of Medicaid services to improve the utilization of



1783 long-acting reversible contraceptives (LARCs). Not later than
1784 December 1, 2021, any contractors receiving capitated payments
1785 under a managed care delivery system established under this
1786 subsection (H) shall provide to the Chairmen of the House and
1787 Senate Medicaid Committees and House and Senate Public Health
1788 Committees a report of LARC utilization for State Fiscal Years
1789 2018 through 2020 as well as any programs, initiatives, or efforts
1790 made by the contractors and providers to increase LARC
1791 utilization. This report shall be updated annually to include
1792 information for subsequent state fiscal years.

1793 (12) The division is authorized to make not more than
1794 one (1) emergency extension of the contracts that are in effect on
1795 July 1, 2021, with contractors who are receiving capitated
1796 payments under a managed care delivery system established under
1797 this subsection (H), as provided in this paragraph (12). The
1798 maximum period of any such extension shall be one (1) year, and
1799 under any such extensions, the contractors shall be subject to all
1800 of the provisions of this subsection (H). The extended contracts
1801 shall be revised to incorporate any provisions of this subsection
1802 (H).

1803 (I) [Deleted]

1804 (J) There shall be no cuts in inpatient and outpatient
1805 hospital payments, or allowable days or volumes, as long as the
1806 hospital assessment provided in Section 43-13-145 is in effect.
1807 This subsection (J) shall not apply to decreases in payments that



1808 are a result of: reduced hospital admissions, audits or payments
1809 under the APR-DRG or APC models, or a managed care program or
1810 similar model described in subsection (H) of this section.

1811 (K) In the negotiation and execution of such contracts
1812 involving services performed by actuarial firms, the Executive
1813 Director of the Division of Medicaid may negotiate a limitation on
1814 liability to the state of prospective contractors.

1815 (L) The Division of Medicaid shall reimburse for services
1816 provided to eligible Medicaid beneficiaries by a licensed birthing
1817 center in a method and manner to be determined by the division in
1818 accordance with federal laws and federal regulations. The
1819 division shall seek any necessary waivers, make any required
1820 amendments to its State Plan or revise any contracts authorized
1821 under subsection (H) of this section as necessary to provide the
1822 services authorized under this subsection. As used in this
1823 subsection, the term "birthing centers" shall have the meaning as
1824 defined in Section 41-77-1(a), which is a publicly or privately
1825 owned facility, place or institution constructed, renovated,
1826 leased or otherwise established where nonemergency births are
1827 planned to occur away from the mother's usual residence following
1828 a documented period of prenatal care for a normal uncomplicated
1829 pregnancy which has been determined to be low risk through a
1830 formal risk-scoring examination.

1831 (M) The Division of Medicaid shall reimburse ambulance
1832 service providers that provide an assessment, triage or treatment



1833 for eligible Medicaid beneficiaries. The reimbursement rate for
1834 an ambulance service provider whose operators provide an
1835 assessment, triage or treatment shall be reimbursed at a rate or
1836 methodology as determined by the division. The division shall
1837 consult with the Mississippi Ambulance Alliance in determining the
1838 initial rate or methodology, and the division shall give due
1839 consideration of the inclusion in the Transforming Reimbursement
1840 for Emergency Ambulance Transportation program.

1841 (* * *N) This section shall stand repealed on July 1, * * *
1842 2029.

1843 **SECTION 3.** Section 43-13-121, Mississippi Code of 1972, is
1844 amended as follows:

1845 43-13-121. (1) The division shall administer the Medicaid
1846 program under the provisions of this article, and may do the
1847 following:

1848 (a) Adopt and promulgate reasonable rules, regulations
1849 and standards, with approval of the Governor, and in accordance
1850 with the Administrative Procedures Law, Section 25-43-1.101 et
1851 seq.:

1852 (i) Establishing methods and procedures as may be
1853 necessary for the proper and efficient administration of this
1854 article;

1855 (ii) Providing Medicaid to all qualified
1856 recipients under the provisions of this article as the division
1857 may determine and within the limits of appropriated funds;



1858 (iii) Establishing reasonable fees, charges and
1859 rates for medical services and drugs; in doing so, the division
1860 shall fix all of those fees, charges and rates at the minimum
1861 levels absolutely necessary to provide the medical assistance
1862 authorized by this article, and shall not change any of those
1863 fees, charges or rates except as may be authorized in Section
1864 43-13-117;

1865 (iv) Providing for fair and impartial hearings;

1866 (v) Providing safeguards for preserving the
1867 confidentiality of records; and

1868 (vi) For detecting and processing fraudulent
1869 practices and abuses of the program;

1870 (b) Receive and expend state, federal and other funds
1871 in accordance with court judgments or settlements and agreements
1872 between the State of Mississippi and the federal government, the
1873 rules and regulations promulgated by the division, with the
1874 approval of the Governor, and within the limitations and
1875 restrictions of this article and within the limits of funds
1876 available for that purpose;

1877 (c) Subject to the limits imposed by this article and
1878 subject to the provisions of subsection (8) of this section, to
1879 submit a Medicaid plan to the United States Department of Health
1880 and Human Services for approval under the provisions of the
1881 federal Social Security Act, to act for the state in making
1882 negotiations relative to the submission and approval of that plan,



1883 to make such arrangements, not inconsistent with the law, as may
1884 be required by or under federal law to obtain and retain that
1885 approval and to secure for the state the benefits of the
1886 provisions of that law.

1887 No agreements, specifically including the general plan for
1888 the operation of the Medicaid program in this state, shall be made
1889 by and between the division and the United States Department of
1890 Health and Human Services unless the Attorney General of the State
1891 of Mississippi has reviewed the agreements, specifically including
1892 the operational plan, and has certified in writing to the Governor
1893 and to the executive director of the division that the agreements,
1894 including the plan of operation, have been drawn strictly in
1895 accordance with the terms and requirements of this article;

1896 (d) In accordance with the purposes and intent of this
1897 article and in compliance with its provisions, provide for aged
1898 persons otherwise eligible for the benefits provided under Title
1899 XVIII of the federal Social Security Act by expenditure of funds
1900 available for those purposes;

1901 (e) To make reports to the United States Department of
1902 Health and Human Services as from time to time may be required by
1903 that federal department and to the Mississippi Legislature as
1904 provided in this section;

1905 (f) Define and determine the scope, duration and amount
1906 of Medicaid that may be provided in accordance with this article
1907 and establish priorities therefor in conformity with this article;



1908 (g) Cooperate and contract with other state agencies
1909 for the purpose of coordinating Medicaid provided under this
1910 article and eliminating duplication and inefficiency in the
1911 Medicaid program;

1912 (h) Adopt and use an official seal of the division;

1913 (i) Sue in its own name on behalf of the State of
1914 Mississippi and employ legal counsel on a contingency basis with
1915 the approval of the Attorney General;

1916 (j) To recover any and all payments incorrectly made by
1917 the division to a recipient or provider from the recipient or
1918 provider receiving the payments. The division shall be authorized
1919 to collect any overpayments to providers sixty (60) days after the
1920 conclusion of any administrative appeal unless the matter is
1921 appealed to a court of proper jurisdiction and bond is posted.
1922 Any appeal filed after July 1, 2015, shall be to the Chancery
1923 Court of the First Judicial District of Hinds County, Mississippi,
1924 within sixty (60) days after the date that the division has
1925 notified the provider by certified mail sent to the proper address
1926 of the provider on file with the division and the provider has
1927 signed for the certified mail notice, or sixty (60) days after the
1928 date of the final decision if the provider does not sign for the
1929 certified mail notice. To recover those payments, the division
1930 may use the following methods, in addition to any other methods
1931 available to the division:



1932 (i) The division shall report to the Department of
1933 Revenue the name of any current or former Medicaid recipient who
1934 has received medical services rendered during a period of
1935 established Medicaid ineligibility and who has not reimbursed the
1936 division for the related medical service payment(s). The
1937 Department of Revenue shall withhold from the state tax refund of
1938 the individual, and pay to the division, the amount of the
1939 payment(s) for medical services rendered to the ineligible
1940 individual that have not been reimbursed to the division for the
1941 related medical service payment(s).

1942 (ii) The division shall report to the Department
1943 of Revenue the name of any Medicaid provider to whom payments were
1944 incorrectly made that the division has not been able to recover by
1945 other methods available to the division. The Department of
1946 Revenue shall withhold from the state tax refund of the provider,
1947 and pay to the division, the amount of the payments that were
1948 incorrectly made to the provider that have not been recovered by
1949 other available methods;

1950 (k) To recover any and all payments by the division
1951 fraudulently obtained by a recipient or provider. Additionally,
1952 if recovery of any payments fraudulently obtained by a recipient
1953 or provider is made in any court, then, upon motion of the
1954 Governor, the judge of the court may award twice the payments
1955 recovered as damages;



1956 (1) Have full, complete and plenary power and authority
1957 to conduct such investigations as it may deem necessary and
1958 requisite of alleged or suspected violations or abuses of the
1959 provisions of this article or of the regulations adopted under
1960 this article, including, but not limited to, fraudulent or
1961 unlawful act or deed by applicants for Medicaid or other benefits,
1962 or payments made to any person, firm or corporation under the
1963 terms, conditions and authority of this article, to suspend or
1964 disqualify any provider of services, applicant or recipient for
1965 gross abuse, fraudulent or unlawful acts for such periods,
1966 including permanently, and under such conditions as the division
1967 deems proper and just, including the imposition of a legal rate of
1968 interest on the amount improperly or incorrectly paid. Recipients
1969 who are found to have misused or abused Medicaid benefits may be
1970 locked into one (1) physician and/or one (1) pharmacy of the
1971 recipient's choice for a reasonable amount of time in order to
1972 educate and promote appropriate use of medical services, in
1973 accordance with federal regulations. If an administrative hearing
1974 becomes necessary, the division may, if the provider does not
1975 succeed in his or her defense, tax the costs of the administrative
1976 hearing, including the costs of the court reporter or stenographer
1977 and transcript, to the provider. The convictions of a recipient
1978 or a provider in a state or federal court for abuse, fraudulent or
1979 unlawful acts under this chapter shall constitute an automatic



1980 disqualification of the recipient or automatic disqualification of
1981 the provider from participation under the Medicaid program.

1982 A conviction, for the purposes of this chapter, shall include
1983 a judgment entered on a plea of nolo contendere or a
1984 nonadjudicated guilty plea and shall have the same force as a
1985 judgment entered pursuant to a guilty plea or a conviction
1986 following trial. A certified copy of the judgment of the court of
1987 competent jurisdiction of the conviction shall constitute prima
1988 facie evidence of the conviction for disqualification purposes;

1989 (m) Establish and provide such methods of
1990 administration as may be necessary for the proper and efficient
1991 operation of the Medicaid program, fully utilizing computer
1992 equipment as may be necessary to oversee and control all current
1993 expenditures for purposes of this article, and to closely monitor
1994 and supervise all recipient payments and vendors rendering
1995 services under this article. Notwithstanding any other provision
1996 of state law, the division is authorized to enter into a ten-year
1997 contract(s) with a vendor(s) to provide services described in this
1998 paragraph (m). Notwithstanding any provision of law to the
1999 contrary, the division is authorized to extend its Medicaid * * *
2000 Enterprise System * * * and fiscal agent services, including all
2001 related components and services, contracts in effect on June
2002 30, * * * 2025, for * * * an additional two-year period.
2003 Notwithstanding any other provision of state law, the division is
2004 authorized to enter into a two-year contract ending no later than



2005 June 30, 2027, with a vendor to provide support of the division's
2006 eligibility system;

2007 (n) To cooperate and contract with the federal
2008 government for the purpose of providing Medicaid to Vietnamese and
2009 Cambodian refugees, under the provisions of Public Law 94-23 and
2010 Public Law 94-24, including any amendments to those laws, only to
2011 the extent that the Medicaid assistance and the administrative
2012 cost related thereto are one hundred percent (100%) reimbursable
2013 by the federal government. For the purposes of Section 43-13-117,
2014 persons receiving Medicaid under Public Law 94-23 and Public Law
2015 94-24, including any amendments to those laws, shall not be
2016 considered a new group or category of recipient; and

2017 (o) The division shall impose penalties upon Medicaid
2018 only, Title XIX participating long-term care facilities found to
2019 be in noncompliance with division and certification standards in
2020 accordance with federal and state regulations, including interest
2021 at the same rate calculated by the United States Department of
2022 Health and Human Services and/or the Centers for Medicare and
2023 Medicaid Services (CMS) under federal regulations.

2024 (2) The division also shall exercise such additional powers
2025 and perform such other duties as may be conferred upon the
2026 division by act of the Legislature.

2027 (3) The division, and the State Department of Health as the
2028 agency for licensure of health care facilities and certification
2029 and inspection for the Medicaid and/or Medicare programs, shall



2030 contract for or otherwise provide for the consolidation of on-site
2031 inspections of health care facilities that are necessitated by the
2032 respective programs and functions of the division and the
2033 department.

2034 (4) The division and its hearing officers shall have power
2035 to preserve and enforce order during hearings; to issue subpoenas
2036 for, to administer oaths to and to compel the attendance and
2037 testimony of witnesses, or the production of books, papers,
2038 documents and other evidence, or the taking of depositions before
2039 any designated individual competent to administer oaths; to
2040 examine witnesses; and to do all things conformable to law that
2041 may be necessary to enable them effectively to discharge the
2042 duties of their office. In compelling the attendance and
2043 testimony of witnesses, or the production of books, papers,
2044 documents and other evidence, or the taking of depositions, as
2045 authorized by this section, the division or its hearing officers
2046 may designate an individual employed by the division or some other
2047 suitable person to execute and return that process, whose action
2048 in executing and returning that process shall be as lawful as if
2049 done by the sheriff or some other proper officer authorized to
2050 execute and return process in the county where the witness may
2051 reside. In carrying out the investigatory powers under the
2052 provisions of this article, the executive director or other
2053 designated person or persons may examine, obtain, copy or
2054 reproduce the books, papers, documents, medical charts,



2055 prescriptions and other records relating to medical care and
2056 services furnished by the provider to a recipient or designated
2057 recipients of Medicaid services under investigation. In the
2058 absence of the voluntary submission of the books, papers,
2059 documents, medical charts, prescriptions and other records, the
2060 Governor, the executive director, or other designated person may
2061 issue and serve subpoenas instantly upon the provider, his or her
2062 agent, servant or employee for the production of the books,
2063 papers, documents, medical charts, prescriptions or other records
2064 during an audit or investigation of the provider. If any provider
2065 or his or her agent, servant or employee refuses to produce the
2066 records after being duly subpoenaed, the executive director may
2067 certify those facts and institute contempt proceedings in the
2068 manner, time and place as authorized by law for administrative
2069 proceedings. As an additional remedy, the division may recover
2070 all amounts paid to the provider covering the period of the audit
2071 or investigation, inclusive of a legal rate of interest and a
2072 reasonable attorney's fee and costs of court if suit becomes
2073 necessary. Division staff shall have immediate access to the
2074 provider's physical location, facilities, records, documents,
2075 books, and any other records relating to medical care and services
2076 rendered to recipients during regular business hours.

2077 (5) If any person in proceedings before the division
2078 disobeys or resists any lawful order or process, or misbehaves
2079 during a hearing or so near the place thereof as to obstruct the



2080 hearing, or neglects to produce, after having been ordered to do
2081 so, any pertinent book, paper or document, or refuses to appear
2082 after having been subpoenaed, or upon appearing refuses to take
2083 the oath as a witness, or after having taken the oath refuses to
2084 be examined according to law, the executive director shall certify
2085 the facts to any court having jurisdiction in the place in which
2086 it is sitting, and the court shall thereupon, in a summary manner,
2087 hear the evidence as to the acts complained of, and if the
2088 evidence so warrants, punish that person in the same manner and to
2089 the same extent as for a contempt committed before the court, or
2090 commit that person upon the same condition as if the doing of the
2091 forbidden act had occurred with reference to the process of, or in
2092 the presence of, the court.

2093 (6) In suspending or terminating any provider from
2094 participation in the Medicaid program, the division shall preclude
2095 the provider from submitting claims for payment, either personally
2096 or through any clinic, group, corporation or other association to
2097 the division or its fiscal agents for any services or supplies
2098 provided under the Medicaid program except for those services or
2099 supplies provided before the suspension or termination. No
2100 clinic, group, corporation or other association that is a provider
2101 of services shall submit claims for payment to the division or its
2102 fiscal agents for any services or supplies provided by a person
2103 within that organization who has been suspended or terminated from
2104 participation in the Medicaid program except for those services or



2105 supplies provided before the suspension or termination. When this
2106 provision is violated by a provider of services that is a clinic,
2107 group, corporation or other association, the division may suspend
2108 or terminate that organization from participation. Suspension may
2109 be applied by the division to all known affiliates of a provider,
2110 provided that each decision to include an affiliate is made on a
2111 case-by-case basis after giving due regard to all relevant facts
2112 and circumstances. The violation, failure or inadequacy of
2113 performance may be imputed to a person with whom the provider is
2114 affiliated where that conduct was accomplished within the course
2115 of his or her official duty or was effectuated by him or her with
2116 the knowledge or approval of that person.

2117 (7) The division may deny or revoke enrollment in the
2118 Medicaid program to a provider if any of the following are found
2119 to be applicable to the provider, his or her agent, a managing
2120 employee or any person having an ownership interest equal to five
2121 percent (5%) or greater in the provider:

2122 (a) Failure to truthfully or fully disclose any and all
2123 information required, or the concealment of any and all
2124 information required, on a claim, a provider application or a
2125 provider agreement, or the making of a false or misleading
2126 statement to the division relative to the Medicaid program.

2127 (b) Previous or current exclusion, suspension,
2128 termination from or the involuntary withdrawing from participation
2129 in the Medicaid program, any other state's Medicaid program,



2130 Medicare or any other public or private health or health insurance
2131 program. If the division ascertains that a provider has been
2132 convicted of a felony under federal or state law for an offense
2133 that the division determines is detrimental to the best interest
2134 of the program or of Medicaid beneficiaries, the division may
2135 refuse to enter into an agreement with that provider, or may
2136 terminate or refuse to renew an existing agreement.

2137 (c) Conviction under federal or state law of a criminal
2138 offense relating to the delivery of any goods, services or
2139 supplies, including the performance of management or
2140 administrative services relating to the delivery of the goods,
2141 services or supplies, under the Medicaid program, any other
2142 state's Medicaid program, Medicare or any other public or private
2143 health or health insurance program.

2144 (d) Conviction under federal or state law of a criminal
2145 offense relating to the neglect or abuse of a patient in
2146 connection with the delivery of any goods, services or supplies.

2147 (e) Conviction under federal or state law of a criminal
2148 offense relating to the unlawful manufacture, distribution,
2149 prescription or dispensing of a controlled substance.

2150 (f) Conviction under federal or state law of a criminal
2151 offense relating to fraud, theft, embezzlement, breach of
2152 fiduciary responsibility or other financial misconduct.



2153 (g) Conviction under federal or state law of a criminal
2154 offense punishable by imprisonment of a year or more that involves
2155 moral turpitude, or acts against the elderly, children or infirm.

2156 (h) Conviction under federal or state law of a criminal
2157 offense in connection with the interference or obstruction of any
2158 investigation into any criminal offense listed in paragraphs (c)
2159 through (i) of this subsection.

2160 (i) Sanction for a violation of federal or state laws
2161 or rules relative to the Medicaid program, any other state's
2162 Medicaid program, Medicare or any other public health care or
2163 health insurance program.

2164 (j) Revocation of license or certification.

2165 (k) Failure to pay recovery properly assessed or
2166 pursuant to an approved repayment schedule under the Medicaid
2167 program.

2168 (l) Failure to meet any condition of enrollment.

2169 (8) (a) As used in this subsection (8), the following terms
2170 shall be defined as provided in this paragraph, except as
2171 otherwise provided in this subsection:

2172 (i) "Committees" means the Medicaid Committees of
2173 the House of Representatives and the Senate, and "committee" means
2174 either one of those committees.

2175 (ii) "State Plan" means the agreement between the
2176 State of Mississippi and the federal government regarding the
2177 nature and scope of Mississippi's Medicaid Program.



2178 (iii) "State Plan Amendment" means a change to the
2179 State Plan, which must be approved by the Centers for Medicare and
2180 Medicaid Services (CMS) before its implementation.

2181 (b) Whenever the Division of Medicaid proposes a State
2182 Plan Amendment, the division shall give notice to the chairmen of
2183 the committees at least * * * fifteen (15) calendar days, when
2184 possible, before the proposed State Plan Amendment is filed with
2185 CMS. If the division needs to expedite the fifteen-day notice,
2186 the division will notify both chairmen of that fact as soon as
2187 possible. The division shall furnish the chairmen with a concise
2188 summary of each proposed State Plan Amendment along with the
2189 notice, and shall furnish the chairmen with a copy of any proposed
2190 State Plan Amendment upon request. The division also shall
2191 provide a summary and copy of any proposed State Plan Amendment to
2192 any other member of the Legislature upon request.

2193 (c) If the chairman of either committee or both
2194 chairmen jointly object to the proposed State Plan Amendment or
2195 any part thereof, the chairman or chairmen shall notify the
2196 division and provide the reasons for their objection in writing
2197 not later than seven (7) calendar days after receipt of the notice
2198 from the division. The chairman or chairmen may make written
2199 recommendations to the division for changes to be made to a
2200 proposed State Plan Amendment.

2201 (d) (i) The chairman of either committee or both
2202 chairmen jointly may hold a committee meeting to review a proposed



2203 State Plan Amendment. If either chairman or both chairmen decide
2204 to hold a meeting, they shall notify the division of their
2205 intention in writing within seven (7) calendar days after receipt
2206 of the notice from the division, and shall set the date and time
2207 for the meeting in their notice to the division, which shall not
2208 be later than fourteen (14) calendar days after receipt of the
2209 notice from the division.

2210 (ii) After the committee meeting, the committee or
2211 committees may object to the proposed State Plan Amendment or any
2212 part thereof. The committee or committees shall notify the
2213 division and the reasons for their objection in writing not later
2214 than seven (7) calendar days after the meeting. The committee or
2215 committees may make written recommendations to the division for
2216 changes to be made to a proposed State Plan Amendment.

2217 (e) If both chairmen notify the division in writing
2218 within seven (7) calendar days after receipt of the notice from
2219 the division that they do not object to the proposed State Plan
2220 Amendment and will not be holding a meeting to review the proposed
2221 State Plan Amendment, the division may proceed to file the
2222 proposed State Plan Amendment with CMS.

2223 (f) (i) If there are any objections to a proposed rate
2224 change or any part thereof from either or both of the chairmen or
2225 the committees, the division may withdraw the proposed State Plan
2226 Amendment, make any of the recommended changes to the proposed



2227 State Plan Amendment, or not make any changes to the proposed
2228 State Plan Amendment.

2229 (ii) If the division does not make any changes to
2230 the proposed State Plan Amendment, it shall notify the chairmen of
2231 that fact in writing, and may proceed to file the State Plan
2232 Amendment with CMS.

2233 (iii) If the division makes any changes to the
2234 proposed State Plan Amendment, the division shall notify the
2235 chairmen of its actions in writing, and may proceed to file the
2236 State Plan Amendment with CMS.

2237 (g) Nothing in this subsection (8) shall be construed
2238 as giving the chairmen or the committees any authority to veto,
2239 nullify or revise any State Plan Amendment proposed by the
2240 division. The authority of the chairmen or the committees under
2241 this subsection shall be limited to reviewing, making objections
2242 to and making recommendations for changes to State Plan Amendments
2243 proposed by the division.

2244 (i) If the division does not make any changes to
2245 the proposed State Plan Amendment, it shall notify the chairmen of
2246 that fact in writing, and may proceed to file the proposed State
2247 Plan Amendment with CMS.

2248 (ii) If the division makes any changes to the
2249 proposed State Plan Amendment, the division shall notify the
2250 chairmen of the changes in writing, and may proceed to file the
2251 proposed State Plan Amendment with CMS.



2252 (h) Nothing in this subsection (8) shall be construed
2253 as giving the chairmen of the committees any authority to veto,
2254 nullify or revise any State Plan Amendment proposed by the
2255 division. The authority of the chairmen of the committees under
2256 this subsection shall be limited to reviewing, making objections
2257 to and making recommendations for suggested changes to State Plan
2258 Amendments proposed by the division.

2259 **SECTION 4.** Section 43-13-305, Mississippi Code of 1972, is
2260 amended as follows:

2261 43-13-305. (1) By accepting Medicaid from the Division of
2262 Medicaid in the Office of the Governor, the recipient shall, to
2263 the extent of the payment of medical expenses by the Division of
2264 Medicaid, be deemed to have made an assignment to the Division of
2265 Medicaid of any and all rights and interests in any third-party
2266 benefits, hospitalization or indemnity contract or any cause of
2267 action, past, present or future, against any person, firm or
2268 corporation for Medicaid benefits provided to the recipient by the
2269 Division of Medicaid for injuries, disease or sickness caused or
2270 suffered under circumstances creating a cause of action in favor
2271 of the recipient against any such person, firm or corporation as
2272 set out in Section 43-13-125. The recipient shall be deemed,
2273 without the necessity of signing any document, to have appointed
2274 the Division of Medicaid as his or her true and lawful
2275 attorney-in-fact in his or her name, place and stead in collecting



2276 any and all amounts due and owing for medical expenses paid by the
2277 Division of Medicaid against such person, firm or corporation.

2278 (2) Whenever a provider of medical services or the Division
2279 of Medicaid submits claims to an insurer on behalf of a Medicaid
2280 recipient for whom an assignment of rights has been received, or
2281 whose rights have been assigned by the operation of law, the
2282 insurer must respond within sixty (60) days of receipt of a claim
2283 by forwarding payment or issuing a notice of denial directly to
2284 the submitter of the claim. The failure of the insuring entity to
2285 comply with the provisions of this section shall subject the
2286 insuring entity to recourse by the Division of Medicaid in
2287 accordance with the provision of Section 43-13-315. In the case
2288 of a responsible insurer, other than the insurers exempted under
2289 federal law, that requires prior authorization for an item or
2290 service furnished to a recipient, the insurer shall accept
2291 authorization provided by the Division of Medicaid that the item
2292 or service is covered under the state plan (or waiver of such
2293 plan) for such recipient, as if such authorization were the prior
2294 authorization made by the third party for such item or service.

2295 The Division of Medicaid shall be authorized to endorse any and
2296 all, including, but not limited to, multi-payee checks, drafts,
2297 money orders or other negotiable instruments representing Medicaid
2298 payment recoveries that are received by the Division of Medicaid.

2299 (3) Court orders or agreements for medical support shall
2300 direct such payments to the Division of Medicaid, which shall be



2301 authorized to endorse any and all checks, drafts, money orders or
2302 other negotiable instruments representing medical support payments
2303 which are received. Any designated medical support funds received
2304 by the State Department of Human Services or through its local
2305 county departments shall be paid over to the Division of Medicaid.
2306 When medical support for a Medicaid recipient is available through
2307 an absent parent or custodial parent, the insuring entity shall
2308 direct the medical support payment(s) to the provider of medical
2309 services or to the Division of Medicaid.

2310 **SECTION 5.** Section 43-13-117.7, Mississippi Code of 1972, is
2311 amended as follows:

2312 43-13-117.7. Notwithstanding any other provisions of Section
2313 43-13-117, the division shall not reimburse or provide coverage
2314 for gender transition procedures for * * * any person * * *.

2315 **SECTION 6.** Section 43-13-145, Mississippi Code of 1972, is
2316 amended as follows:

2317 43-13-145. (1) (a) Upon each nursing facility licensed by
2318 the State of Mississippi, there is levied an assessment in an
2319 amount set by the division, equal to the maximum rate allowed by
2320 federal law or regulation, for each licensed and occupied bed of
2321 the facility.

2322 (b) A nursing facility is exempt from the assessment
2323 levied under this subsection if the facility is operated under the
2324 direction and control of:



2325 (i) The United States Veterans Administration or
2326 other agency or department of the United States government; or

2327 (ii) The State Veterans Affairs Board.

2328 (2) (a) Upon each intermediate care facility for
2329 individuals with intellectual disabilities licensed by the State
2330 of Mississippi, there is levied an assessment in an amount set by
2331 the division, equal to the maximum rate allowed by federal law or
2332 regulation, for each licensed and occupied bed of the facility.

2333 (b) An intermediate care facility for individuals with
2334 intellectual disabilities is exempt from the assessment levied
2335 under this subsection if the facility is operated under the
2336 direction and control of:

2337 (i) The United States Veterans Administration or
2338 other agency or department of the United States government;

2339 (ii) The State Veterans Affairs Board; or

2340 (iii) The University of Mississippi Medical
2341 Center.

2342 (3) (a) Upon each psychiatric residential treatment
2343 facility licensed by the State of Mississippi, there is levied an
2344 assessment in an amount set by the division, equal to the maximum
2345 rate allowed by federal law or regulation, for each licensed and
2346 occupied bed of the facility.

2347 (b) A psychiatric residential treatment facility is
2348 exempt from the assessment levied under this subsection if the
2349 facility is operated under the direction and control of:



2350 (i) The United States Veterans Administration or
2351 other agency or department of the United States government;
2352 (ii) The University of Mississippi Medical Center;
2353 or
2354 (iii) A state agency or a state facility that
2355 either provides its own state match through intergovernmental
2356 transfer or certification of funds to the division.

2357 (4) Hospital assessment.

2358 (a) (i) Subject to and upon fulfillment of the
2359 requirements and conditions of paragraph (f) below, and
2360 notwithstanding any other provisions of this section, an annual
2361 assessment on each hospital licensed in the state is imposed on
2362 each non-Medicare hospital inpatient day as defined below at a
2363 rate that is determined by dividing the sum prescribed in this
2364 subparagraph (i), plus the nonfederal share necessary to maximize
2365 the Disproportionate Share Hospital (DSH) and Medicare Upper
2366 Payment Limits (UPL) Program payments and hospital access payments
2367 and such other supplemental payments as may be developed pursuant
2368 to Section 43-13-117(A)(18), by the total number of non-Medicare
2369 hospital inpatient days as defined below for all licensed
2370 Mississippi hospitals, except as provided in paragraph (d) below.
2371 If the state-matching funds percentage for the Mississippi
2372 Medicaid program is sixteen percent (16%) or less, the sum used in
2373 the formula under this subparagraph (i) shall be Seventy-four
2374 Million Dollars (\$74,000,000.00). If the state-matching funds



2375 percentage for the Mississippi Medicaid program is twenty-four
2376 percent (24%) or higher, the sum used in the formula under this
2377 subparagraph (i) shall be One Hundred Four Million Dollars
2378 (\$104,000,000.00). If the state-matching funds percentage for the
2379 Mississippi Medicaid program is between sixteen percent (16%) and
2380 twenty-four percent (24%), the sum used in the formula under this
2381 subparagraph (i) shall be a pro rata amount determined as follows:
2382 the current state-matching funds percentage rate minus sixteen
2383 percent (16%) divided by eight percent (8%) multiplied by Thirty
2384 Million Dollars (\$30,000,000.00) and add that amount to
2385 Seventy-four Million Dollars (\$74,000,000.00). However, no
2386 assessment in a quarter under this subparagraph (i) may exceed the
2387 assessment in the previous quarter by more than Three Million
2388 Seven Hundred Fifty Thousand Dollars (\$3,750,000.00) (which would
2389 be Fifteen Million Dollars (\$15,000,000.00) on an annualized
2390 basis), unless such increase is to maximize federal funds that are
2391 available to reimburse hospitals for services provided under new
2392 programs for hospitals, for increased supplemental payment
2393 programs for hospitals or to assist with state-matching funds as
2394 authorized by the Legislature. The division shall publish the
2395 state-matching funds percentage rate applicable to the Mississippi
2396 Medicaid program on the tenth day of the first month of each
2397 quarter and the assessment determined under the formula prescribed
2398 above shall be applicable in the quarter following any adjustment
2399 in that state-matching funds percentage rate. The division shall



2400 notify each hospital licensed in the state as to any projected
2401 increases or decreases in the assessment determined under this
2402 subparagraph (i). However, if the Centers for Medicare and
2403 Medicaid Services (CMS) does not approve the provision in Section
2404 43-13-117(39) requiring the division to reimburse crossover claims
2405 for inpatient hospital services and crossover claims covered under
2406 Medicare Part B for dually eligible beneficiaries in the same
2407 manner that was in effect on January 1, 2008, the sum that
2408 otherwise would have been used in the formula under this
2409 subparagraph (i) shall be reduced by Seven Million Dollars
2410 (\$7,000,000.00).

2411 (ii) In addition to the assessment provided under
2412 subparagraph (i), an additional annual assessment on each hospital
2413 licensed in the state is imposed on each non-Medicare hospital
2414 inpatient day as defined below at a rate that is determined by
2415 dividing twenty-five percent (25%) of any provider reductions in
2416 the Medicaid program as authorized in Section 43-13-117(F) for
2417 that fiscal year up to the following maximum amount, plus the
2418 nonfederal share necessary to maximize the Disproportionate Share
2419 Hospital (DSH) and inpatient Medicare Upper Payment Limits (UPL)
2420 Program payments and inpatient hospital access payments, by the
2421 total number of non-Medicare hospital inpatient days as defined
2422 below for all licensed Mississippi hospitals: in fiscal year
2423 2010, the maximum amount shall be Twenty-four Million Dollars
2424 (\$24,000,000.00); in fiscal year 2011, the maximum amount shall be



2425 Thirty-two Million Dollars (\$32,000,000.00); and in fiscal year
2426 2012 and thereafter, the maximum amount shall be Forty Million
2427 Dollars (\$40,000,000.00). Any such deficit in the Medicaid
2428 program shall be reviewed by the PEER Committee as provided in
2429 Section 43-13-117(F).

2430 (iii) In addition to the assessments provided in
2431 subparagraphs (i) and (ii), an additional annual assessment on
2432 each hospital licensed in the state is imposed pursuant to the
2433 provisions of Section 43-13-117(F) if the cost-containment
2434 measures described therein have been implemented and there are
2435 insufficient funds in the Health Care Trust Fund to reconcile any
2436 remaining deficit in any fiscal year. If the Governor institutes
2437 any other additional cost-containment measures on any program or
2438 programs authorized under the Medicaid program pursuant to Section
2439 43-13-117(F), hospitals shall be responsible for twenty-five
2440 percent (25%) of any such additional imposed provider cuts, which
2441 shall be in the form of an additional assessment not to exceed the
2442 twenty-five percent (25%) of provider expenditure reductions.
2443 Such additional assessment shall be imposed on each non-Medicare
2444 hospital inpatient day in the same manner as assessments are
2445 imposed under subparagraphs (i) and (ii).

2446 (b) Definitions.

2447 (i) [Deleted]

2448 (ii) For purposes of this subsection (4):



2449 1. "Non-Medicare hospital inpatient day"
2450 means total hospital inpatient days including subcomponent days
2451 less Medicare inpatient days including subcomponent days from the
2452 hospital's most recent Medicare cost report for the second
2453 calendar year preceding the beginning of the state fiscal year, on
2454 file with CMS per the CMS HCRIS database, or cost report submitted
2455 to the Division if the HCRIS database is not available to the
2456 division, as of June 1 of each year.

2457 a. Total hospital inpatient days shall
2458 be the sum of Worksheet S-3, Part 1, column 8 row 14, column 8 row
2459 16, and column 8 row 17, excluding column 8 rows 5 and 6.

2460 b. Hospital Medicare inpatient days
2461 shall be the sum of Worksheet S-3, Part 1, column 6 row 14, column
2462 6 row 16.00, and column 6 row 17, excluding column 6 rows 5 and 6.

2463 c. Inpatient days shall not include
2464 residential treatment or long-term care days.

2465 2. "Subcomponent inpatient day" means the
2466 number of days of care charged to a beneficiary for inpatient
2467 hospital rehabilitation and psychiatric care services in units of
2468 full days. A day begins at midnight and ends twenty-four (24)
2469 hours later. A part of a day, including the day of admission and
2470 day on which a patient returns from leave of absence, counts as a
2471 full day. However, the day of discharge, death, or a day on which
2472 a patient begins a leave of absence is not counted as a day unless
2473 discharge or death occur on the day of admission. If admission



2474 and discharge or death occur on the same day, the day is
2475 considered a day of admission and counts as one (1) subcomponent
2476 inpatient day.

2477 (c) The assessment provided in this subsection is
2478 intended to satisfy and not be in addition to the assessment and
2479 intergovernmental transfers provided in Section 43-13-117(A)(18).
2480 Nothing in this section shall be construed to authorize any state
2481 agency, division or department, or county, municipality or other
2482 local governmental unit to license for revenue, levy or impose any
2483 other tax, fee or assessment upon hospitals in this state not
2484 authorized by a specific statute.

2485 (d) Hospitals operated by the United States Department
2486 of Veterans Affairs and state-operated facilities that provide
2487 only inpatient and outpatient psychiatric services shall not be
2488 subject to the hospital assessment provided in this subsection.

2489 (e) Multihospital systems, closure, merger, change of
2490 ownership and new hospitals.

2491 (i) If a hospital conducts, operates or maintains
2492 more than one (1) hospital licensed by the State Department of
2493 Health, the provider shall pay the hospital assessment for each
2494 hospital separately.

2495 (ii) Notwithstanding any other provision in this
2496 section, if a hospital subject to this assessment operates or
2497 conducts business only for a portion of a fiscal year, the
2498 assessment for the state fiscal year shall be adjusted by



2499 multiplying the assessment by a fraction, the numerator of which
2500 is the number of days in the year during which the hospital
2501 operates, and the denominator of which is three hundred sixty-five
2502 (365). Immediately upon ceasing to operate, the hospital shall
2503 pay the assessment for the year as so adjusted (to the extent not
2504 previously paid).

2505 (iii) The division shall determine the tax for new
2506 hospitals and hospitals that undergo a change of ownership in
2507 accordance with this section, using the best available
2508 information, as determined by the division.

2509 (f) Applicability.

2510 The hospital assessment imposed by this subsection shall not
2511 take effect and/or shall cease to be imposed if:

2512 (i) The assessment is determined to be an
2513 impermissible tax under Title XIX of the Social Security Act; or

2514 (ii) CMS revokes its approval of the division's
2515 2009 Medicaid State Plan Amendment for the methodology for DSH
2516 payments to hospitals under Section 43-13-117(A)(18).

2517 Notwithstanding any provision of this article, the division
2518 is authorized to reduce or eliminate the portion of the assessment
2519 applicable to long-term acute care hospitals and rehabilitation
2520 hospitals if the Centers for Medicare and Medicaid Services waives
2521 the uniform and broad-based requirements set forth in federal
2522 regulation; however, any reduction or elimination of the portion
2523 of the assessment applicable to such hospitals under any waiver



2524 shall be rescinded at such time as the methodology for calculating
2525 the assessment under this subsection (4) is substantially changed
2526 by the Legislature.

2527 (5) Each health care facility that is subject to the
2528 provisions of this section shall keep and preserve such suitable
2529 books and records as may be necessary to determine the amount of
2530 assessment for which it is liable under this section. The books
2531 and records shall be kept and preserved for a period of not less
2532 than five (5) years, during which time those books and records
2533 shall be open for examination during business hours by the
2534 division, the Department of Revenue, the Office of the Attorney
2535 General and the State Department of Health.

2536 (6) [Deleted]

2537 (7) All assessments collected under this section shall be
2538 deposited in the Medical Care Fund created by Section 43-13-143.

2539 (8) The assessment levied under this section shall be in
2540 addition to any other assessments, taxes or fees levied by law,
2541 and the assessment shall constitute a debt due the State of
2542 Mississippi from the time the assessment is due until it is paid.

2543 (9) (a) If a health care facility that is liable for
2544 payment of an assessment levied by the division does not pay the
2545 assessment when it is due, the division shall give written notice
2546 to the health care facility demanding payment of the assessment
2547 within ten (10) days from the date of delivery of the notice. If
2548 the health care facility fails or refuses to pay the assessment



2549 after receiving the notice and demand from the division, the
2550 division shall withhold from any Medicaid reimbursement payments
2551 that are due to the health care facility the amount of the unpaid
2552 assessment and a penalty of ten percent (10%) of the amount of the
2553 assessment, plus the legal rate of interest until the assessment
2554 is paid in full. If the health care facility does not participate
2555 in the Medicaid program, the division shall turn over to the
2556 Office of the Attorney General the collection of the unpaid
2557 assessment by civil action. In any such civil action, the Office
2558 of the Attorney General shall collect the amount of the unpaid
2559 assessment and a penalty of ten percent (10%) of the amount of the
2560 assessment, plus the legal rate of interest until the assessment
2561 is paid in full.

2562 (b) As an additional or alternative method for
2563 collecting unpaid assessments levied by the division, if a health
2564 care facility fails or refuses to pay the assessment after
2565 receiving notice and demand from the division, the division may
2566 file a notice of a tax lien with the chancery clerk of the county
2567 in which the health care facility is located, for the amount of
2568 the unpaid assessment and a penalty of ten percent (10%) of the
2569 amount of the assessment, plus the legal rate of interest until
2570 the assessment is paid in full. Immediately upon receipt of
2571 notice of the tax lien for the assessment, the chancery clerk
2572 shall forward the notice to the circuit clerk who shall enter the
2573 notice of the tax lien as a judgment upon the judgment roll and



2574 show in the appropriate columns the name of the health care
2575 facility as judgment debtor, the name of the division as judgment
2576 creditor, the amount of the unpaid assessment, and the date and
2577 time of enrollment. The judgment shall be valid as against
2578 mortgagees, pledgees, entrusters, purchasers, judgment creditors
2579 and other persons from the time of filing with the clerk. The
2580 amount of the judgment shall be a debt due the State of
2581 Mississippi and remain a lien upon the tangible property of the
2582 health care facility until the judgment is satisfied. The
2583 judgment shall be the equivalent of any enrolled judgment of a
2584 court of record and shall serve as authority for the issuance of
2585 writs of execution, writs of attachment or other remedial writs.

2586 (10) (a) To further the provisions of Section
2587 43-13-117(A)(18), the Division of Medicaid shall submit to the
2588 Centers for Medicare and Medicaid Services (CMS) any documents
2589 regarding the hospital assessment established under subsection (4)
2590 of this section. In addition to defining the assessment
2591 established in subsection (4) of this section if necessary, the
2592 documents shall describe any supplement payment programs and/or
2593 payment methodologies as authorized in Section 43-13-117(A)(18) if
2594 necessary.

2595 (b) All hospitals satisfying the minimum federal DSH
2596 eligibility requirements (Section 1923(d) of the Social Security
2597 Act) may, subject to OBRA 1993 payment limitations, receive a DSH
2598 payment. This DSH payment shall expend the balance of the federal



2599 DSH allotment and associated state share not utilized in DSH
2600 payments to state-owned institutions for treatment of mental
2601 diseases. The payment to each hospital shall be calculated by
2602 applying a uniform percentage to the uninsured costs of each
2603 eligible hospital, excluding state-owned institutions for
2604 treatment of mental diseases; however, that percentage for a
2605 state-owned teaching hospital located in Hinds County shall be
2606 multiplied by a factor of two (2).

2607 (11) The division shall implement DSH and supplemental
2608 payment calculation methodologies that result in the maximization
2609 of available federal funds.

2610 (12) The DSH payments shall be paid on or before December
2611 31, March 31, and June 30 of each fiscal year, in increments of
2612 one-third (1/3) of the total calculated DSH amounts. Supplemental
2613 payments developed pursuant to Section 43-13-117(A)(18) shall be
2614 paid monthly.

2615 (13) Payment.

2616 (a) The hospital assessment as described in subsection
2617 (4) for the nonfederal share necessary to maximize the Medicare
2618 Upper Payments Limits (UPL) Program payments and hospital access
2619 payments and such other supplemental payments as may be developed
2620 pursuant to Section 43-3-117(A)(18) shall be assessed and
2621 collected monthly no later than the fifteenth calendar day of each
2622 month.



2623 (b) The hospital assessment as described in subsection
2624 (4) for the nonfederal share necessary to maximize the
2625 Disproportionate Share Hospital (DSH) payments shall be assessed
2626 and collected on December 15, March 15 and June 15.

2627 (c) The annual hospital assessment and any additional
2628 hospital assessment as described in subsection (4) shall be
2629 assessed and collected on September 15 and on the 15th of each
2630 month from December through June.

2631 (14) If for any reason any part of the plan for annual DSH
2632 and supplemental payment programs to hospitals provided under
2633 subsection (10) of this section and/or developed pursuant to
2634 Section 43-13-117(A) (18) is not approved by CMS, the remainder of
2635 the plan shall remain in full force and effect.

2636 (15) Nothing in this section shall prevent the Division of
2637 Medicaid from facilitating participation in Medicaid supplemental
2638 hospital payment programs by a hospital located in a county
2639 contiguous to the State of Mississippi that is also authorized by
2640 federal law to submit intergovernmental transfers (IGTs) to the
2641 State of Mississippi to fund the state share of the hospital's
2642 supplemental and/or MHAP payments.

2643 (16) This section shall stand repealed on July 1, 2028.

2644 **SECTION 7.** The following shall be codified as Section
2645 41-140-1, Mississippi Code of 1972:

2646 41-140-1. **Definitions.** As used in Sections 41-140-1 and
2647 41-140-5:



2648 (a) "Maternal health care facility" means any facility
2649 that provides prenatal or perinatal care, including, but not
2650 limited to, hospitals, clinics and other physician facilities.

2651 (b) "Maternal health care provider" means any
2652 physician, nurse or other authorized practitioner that attends to
2653 pregnant women and mothers of infants.

2654 **SECTION 8.** The following shall be codified as Section
2655 41-140-3, Mississippi Code of 1972:

2656 41-140-3. **Education and awareness.** (1) The State
2657 Department of Health shall develop written educational materials
2658 and information for maternal health care providers and patients
2659 about maternal mental health conditions, including postpartum
2660 depression.

2661 (a) The materials shall include information on the
2662 symptoms and methods of coping with postpartum depression, as well
2663 treatment options and resources;

2664 (b) The State Department of Health shall periodically
2665 review the materials and information to determine their
2666 effectiveness and ensure they reflect the most up-to-date and
2667 accurate information;

2668 (c) The State Department of Health shall post on its
2669 website the materials and information; and

2670 (d) The State Department of Health shall make available
2671 or distribute the materials and information in physical form upon
2672 request.



2673 (2) Hospitals that provide birth services and other maternal
2674 health care facilities shall provide departing new parents and
2675 other family members, as appropriate, with written materials and
2676 information developed under subsection (1) of this section, upon
2677 discharge from such institution.

2678 (3) Any maternal health care facility, maternal health care
2679 provider, or any other facility, physician, health care provider
2680 or nurse midwife who renders prenatal care, postnatal care, or
2681 pediatric infant care, shall provide the materials and information
2682 developed under subsection (1) of this section, to any woman who
2683 presents with signs of a maternal mental health disorder.

2684 **SECTION 9.** The following shall be codified as Section
2685 41-140-5, Mississippi Code of 1972:

2686 41-140-5. **Screening and linkage to care.** (1) Any maternal
2687 health care provider or any other physician, health care provider,
2688 or nurse midwife who renders postnatal care or who provides
2689 pediatric infant care shall ensure that the postnatal care patient
2690 or birthing mother of the pediatric infant care patient, as
2691 applicable, is offered screening for postpartum depression, and,
2692 if such patient or birthing mother does not object to such
2693 screening, shall ensure that such patient or birthing mother is
2694 appropriately screened for postpartum depression in line with
2695 evidence-based guidelines, such as the Bright Futures Toolkit
2696 developed by the American Academy of Pediatrics.



2697 (2) If a maternal health care provider or other health care
2698 provider administering screening in accordance with this section
2699 determines, based on the screening methodology administered, that
2700 the postnatal care patient or birthing mother of the pediatric
2701 infant care patient is likely to be suffering from postpartum
2702 depression, such health care provider shall provide appropriate
2703 referrals, including discussion of available treatments for
2704 postpartum depression, including pharmacological treatments.

2705 **SECTION 10.** Section 43-13-107, Mississippi Code of 1972, is
2706 amended as follows:

2707 43-13-107. (1) The Division of Medicaid is created in the
2708 Office of the Governor and established to administer this article
2709 and perform such other duties as are prescribed by law.

2710 (2) (a) The Governor shall appoint a full-time executive
2711 director, with the advice and consent of the Senate, who shall be
2712 either (i) a physician with administrative experience in a medical
2713 care or health program, or (ii) a person holding a graduate degree
2714 in medical care administration, public health, hospital
2715 administration, or the equivalent, or (iii) a person holding a
2716 bachelor's degree with at least three (3) years' experience in
2717 management-level administration of, or policy development for,
2718 Medicaid programs. Provided, however, no one who has been a
2719 member of the Mississippi Legislature during the previous three
2720 (3) years may be executive director. The executive director shall
2721 be the official secretary and legal custodian of the records of



2722 the division; shall be the agent of the division for the purpose
2723 of receiving all service of process, summons and notices directed
2724 to the division; shall perform such other duties as the Governor
2725 may prescribe from time to time; and shall perform all other
2726 duties that are now or may be imposed upon him or her by law.

2727 (b) The executive director shall serve at the will and
2728 pleasure of the Governor.

2729 (c) The executive director shall, before entering upon
2730 the discharge of the duties of the office, take and subscribe to
2731 the oath of office prescribed by the Mississippi Constitution and
2732 shall file the same in the Office of the Secretary of State, and
2733 shall execute a bond in some surety company authorized to do
2734 business in the state in the penal sum of One Hundred Thousand
2735 Dollars (\$100,000.00), conditioned for the faithful and impartial
2736 discharge of the duties of the office. The premium on the bond
2737 shall be paid as provided by law out of funds appropriated to the
2738 Division of Medicaid for contractual services.

2739 (d) The executive director, with the approval of the
2740 Governor and subject to the rules and regulations of the State
2741 Personnel Board, shall employ such professional, administrative,
2742 stenographic, secretarial, clerical and technical assistance as
2743 may be necessary to perform the duties required in administering
2744 this article and fix the compensation for those persons, all in
2745 accordance with a state merit system meeting federal requirements.
2746 When the salary of the executive director is not set by law, that



2747 salary shall be set by the State Personnel Board. No employees of
2748 the Division of Medicaid shall be considered to be staff members
2749 of the immediate Office of the Governor; however, Section
2750 25-9-107(c) (xv) shall apply to the executive director and other
2751 administrative heads of the division.

2752 (3) (a) * * * Effective July 9, 2025, there is established
2753 a Medicaid Advisory Committee and Beneficiary Advisory Committee
2754 as required pursuant to federal regulations. The Medicaid
2755 Advisory Committee shall consist of no more than twenty (20)
2756 members. All members of the Medical Care Advisory Committee
2757 -serving on January 1, 2025, shall be selected to serve on the
2758 Medicaid Advisory Committee, and such members shall serve until
2759 July 1, 2028. Such members shall not be reappointed for
2760 immediately successive and consecutive terms. If any such member
2761 resigns, then the division shall replace the member for the
2762 remainder of the term. Other members of the Medicaid Advisory
2763 Committee and Beneficiary Advisory Committee shall be selected by
2764 the division consistent with federal regulations. Committee
2765 member terms shall not be followed immediately by a consecutive
2766 term for the same member, on a rotating and continuous basis.

2767 * * *

2768 (* * * b) The executive director shall submit to the
2769 advisory committee all amendments, modifications and changes to
2770 the state plan for the operation of the Medicaid program, for



2771 review by the advisory committee before the amendments,
2772 modifications or changes may be implemented by the division.

2773 (* * * c) The advisory committee, among its duties and
2774 responsibilities, shall:

2775 (i) Advise the division with respect to
2776 amendments, modifications and changes to the state plan for the
2777 operation of the Medicaid program;

2778 (ii) Advise the division with respect to issues
2779 concerning receipt and disbursement of funds and eligibility for
2780 Medicaid;

2781 (iii) Advise the division with respect to
2782 determining the quantity, quality and extent of medical care
2783 provided under this article;

2784 (iv) Communicate the views of the medical care
2785 professions to the division and communicate the views of the
2786 division to the medical care professions;

2787 (v) Gather information on reasons that medical
2788 care providers do not participate in the Medicaid program and
2789 changes that could be made in the program to encourage more
2790 providers to participate in the Medicaid program, and advise the
2791 division with respect to encouraging physicians and other medical
2792 care providers to participate in the Medicaid program;

2793 (vi) Provide a written report on or before
2794 November 30 of each year to the Governor, Lieutenant Governor and
2795 Speaker of the House of Representatives.



2796 (4) (a) There is established a Drug Use Review Board, which
2797 shall be the board that is required by federal law to:

2798 (i) Review and initiate retrospective drug use,
2799 review including ongoing periodic examination of claims data and
2800 other records in order to identify patterns of fraud, abuse, gross
2801 overuse, or inappropriate or medically unnecessary care, among
2802 physicians, pharmacists and individuals receiving Medicaid
2803 benefits or associated with specific drugs or groups of drugs.

2804 (ii) Review and initiate ongoing interventions for
2805 physicians and pharmacists, targeted toward therapy problems or
2806 individuals identified in the course of retrospective drug use
2807 reviews.

2808 (iii) On an ongoing basis, assess data on drug use
2809 against explicit predetermined standards using the compendia and
2810 literature set forth in federal law and regulations.

2811 (b) The board shall consist of not less than twelve
2812 (12) members appointed by the Governor, or his designee.

2813 (c) The board shall meet at least quarterly, and board
2814 members shall be furnished written notice of the meetings at least
2815 ten (10) days before the date of the meeting.

2816 (d) The board meetings shall be open to the public,
2817 members of the press, legislators and consumers. Additionally,
2818 all documents provided to board members shall be available to
2819 members of the Legislature in the same manner, and shall be made
2820 available to others for a reasonable fee for copying. However,



2821 patient confidentiality and provider confidentiality shall be
2822 protected by blinding patient names and provider names with
2823 numerical or other anonymous identifiers. The board meetings
2824 shall be subject to the Open Meetings Act (Sections 25-41-1
2825 through 25-41-17). Board meetings conducted in violation of this
2826 section shall be deemed unlawful.

2827 (5) (a) There is established a Pharmacy and Therapeutics
2828 Committee, which shall be appointed by the Governor, or his
2829 designee.

2830 (b) The committee shall meet as often as needed to
2831 fulfill its responsibilities and obligations as set forth in this
2832 section, and committee members shall be furnished written notice
2833 of the meetings at least ten (10) days before the date of the
2834 meeting.

2835 (c) The committee meetings shall be open to the public,
2836 members of the press, legislators and consumers. Additionally,
2837 all documents provided to committee members shall be available to
2838 members of the Legislature in the same manner, and shall be made
2839 available to others for a reasonable fee for copying. However,
2840 patient confidentiality and provider confidentiality shall be
2841 protected by blinding patient names and provider names with
2842 numerical or other anonymous identifiers. The committee meetings
2843 shall be subject to the Open Meetings Act (Sections 25-41-1
2844 through 25-41-17). Committee meetings conducted in violation of
2845 this section shall be deemed unlawful.



2846 (d) After a thirty-day public notice, the executive
2847 director, or his or her designee, shall present the division's
2848 recommendation regarding prior approval for a therapeutic class of
2849 drugs to the committee. However, in circumstances where the
2850 division deems it necessary for the health and safety of Medicaid
2851 beneficiaries, the division may present to the committee its
2852 recommendations regarding a particular drug without a thirty-day
2853 public notice. In making that presentation, the division shall
2854 state to the committee the circumstances that precipitate the need
2855 for the committee to review the status of a particular drug
2856 without a thirty-day public notice. The committee may determine
2857 whether or not to review the particular drug under the
2858 circumstances stated by the division without a thirty-day public
2859 notice. If the committee determines to review the status of the
2860 particular drug, it shall make its recommendations to the
2861 division, after which the division shall file those
2862 recommendations for a thirty-day public comment under Section
2863 25-43-7(1).

2864 (e) Upon reviewing the information and recommendations,
2865 the committee shall forward a written recommendation approved by a
2866 majority of the committee to the executive director, or his or her
2867 designee. The decisions of the committee regarding any
2868 limitations to be imposed on any drug or its use for a specified
2869 indication shall be based on sound clinical evidence found in



2870 labeling, drug compendia, and peer-reviewed clinical literature
2871 pertaining to use of the drug in the relevant population.

2872 (f) Upon reviewing and considering all recommendations
2873 including recommendations of the committee, comments, and data,
2874 the executive director shall make a final determination whether to
2875 require prior approval of a therapeutic class of drugs, or modify
2876 existing prior approval requirements for a therapeutic class of
2877 drugs.

2878 (g) At least thirty (30) days before the executive
2879 director implements new or amended prior authorization decisions,
2880 written notice of the executive director's decision shall be
2881 provided to all prescribing Medicaid providers, all Medicaid
2882 enrolled pharmacies, and any other party who has requested the
2883 notification. However, notice given under Section 25-43-7(1) will
2884 substitute for and meet the requirement for notice under this
2885 subsection.

2886 (h) Members of the committee shall dispose of matters
2887 before the committee in an unbiased and professional manner. If a
2888 matter being considered by the committee presents a real or
2889 apparent conflict of interest for any member of the committee,
2890 that member shall disclose the conflict in writing to the
2891 committee chair and recuse himself or herself from any discussions
2892 and/or actions on the matter.

2893 **SECTION 11.** This act shall take effect and be in force from
2894 and after July 2, 2025.

