

By: Senator(s) Blackwell

To: Public Health and
Welfare; Appropriations

SENATE BILL NO. 2728

1 AN ACT TO PROVIDE A THREE-YEAR PILOT PROGRAM FOR THE
2 LICENSURE AND REGULATION OF ADULT RESIDENTIAL TREATMENT FACILITIES
3 AND ADULT SUPPORTIVE RESIDENTIAL FACILITIES BY THE STATE
4 DEPARTMENT OF MENTAL HEALTH; TO DIRECT THE STATE BOARD OF MENTAL
5 HEALTH TO ADOPT RULES PROVIDING FOR FACILITY REQUIREMENTS AND
6 MINIMUM PROGRAMMATIC, STAFFING AND OPERATIONAL REQUIREMENTS OF
7 SERVICES OFFERED AT THE FACILITIES; TO PROVIDE THAT IT IS UNLAWFUL
8 FOR ANY PERSON, PARTNERSHIP, ASSOCIATION, CORPORATION OR OTHER
9 ENTITY TO OWN OR OPERATE AN ADULT MENTAL HEALTH FACILITY WITHOUT
10 HAVING APPLIED FOR AND OBTAINED A LICENSE FROM THE DEPARTMENT; TO
11 AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT
12 MENTAL HEALTH SERVICES PROVIDED BY ADULT RESIDENTIAL TREATMENT
13 FACILITIES AND ADULT SUPPORTIVE RESIDENTIAL FACILITIES SHALL BE
14 COVERED UNDER THE MEDICAID PROGRAM; TO PRESCRIBE THE INITIAL FEE
15 SCHEDULES FOR THE FOUR LEVELS OF CARE PROVIDED IN THOSE
16 FACILITIES; TO DIRECT THE DIVISION OF MEDICAID TO APPLY FOR A
17 FEDERAL WAIVER AS NECESSARY TO ALLOW FOR THE IMPLEMENTATION OF THE
18 PROVISIONS OF THIS ACT; AND FOR RELATED PURPOSES.

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

20 SECTION 1. (1) This section shall be conducted as a pilot
21 program with the Region 3 Community Mental Health Center. The
22 pilot program shall be conducted for three (3) years and shall be
23 limited to fifty (50) participants.

24 (2) As used in this section, the following terms shall be
25 defined as provided in this subsection:

26 (a) "Adult mental health facility" or "facility" means
27 an adult residential treatment facility or an adult supportive
28 residential facility.

35 (c) "Adult supportive residential facility" means a
36 mental health residential program that provides twenty-four-hour
37 residential care with a treatment and rehabilitation component
38 less intensive than required in an adult residential treatment
39 facility. Coordinated and structured services are provided for
40 adult service recipients that include personal care services,
41 training in community living skills, vocational skills and/or
42 socialization. Access to medical services, social services and
43 mental health services are ensured and are usually provided
44 off-site, although limited mental health treatment and
45 rehabilitation may be provided on site.

46 (d) "Board" means the State Board of Mental Health.

47 (e) "Department" means the State Department of Mental
48 Health.

51 administration of a program for adult mental health facilities.
52 Such rules shall provide for facility requirements and minimum
53 programmatic, staffing and operational requirements of services
54 offered at the facilities. At a minimum, the rules shall address
55 the adequacy of services, qualifications of professional staff,
56 facility conditions, consideration of the adequacy of environment,
57 life safety, treatment or habilitation services, educational and
58 training requirements of the staff, fees for the issuance and
59 renewal of licenses and such other considerations as are deemed
60 necessary by the board to determine the adequacy of providing
61 services in adult mental health facilities.

62 (4) (a) Any person, partnership, association, corporation
63 or other entity must obtain a license from the department in order
64 to lawfully establish, conduct, operate or maintain an adult
65 mental health facility.

66 (b) It is unlawful for any person, partnership,
67 association, corporation or other entity to own or operate an
68 adult mental health facility without having applied for and
69 obtained a license from the department.

70 (c) The department may maintain an action to enjoin any
71 person, partnership, association, corporation or other entity from
72 establishing, conducting, managing or operating an adult mental
73 health facility without having a license issued by the department.

74 (5) The department may suspend or revoke a license or impose
75 fines on licensees for violation of any of the provisions of this



76 section or the rules adopted by the board for the implementation
77 of this section.

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

80 43-13-117. (A) Medicaid as authorized by this article shall
81 include payment of part or all of the costs, at the discretion of
82 the division, with approval of the Governor and the Centers for
83 Medicare and Medicaid Services, of the following types of care and
84 services rendered to eligible applicants who have been determined
85 to be eligible for that care and services, within the limits of
86 state appropriations and federal matching funds:

87 (1) Inpatient hospital services.

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

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

97 (2) Outpatient hospital services.

98 (a) Emergency services.

99 (b) Other outpatient hospital services. The
100 division shall allow benefits for other medically necessary

101 outpatient hospital services (such as chemotherapy, radiation,
102 surgery and therapy), including outpatient services in a clinic or
103 other facility that is not located inside the hospital, but that
104 has been designated as an outpatient facility by the hospital, and
105 that was in operation or under construction on July 1, 2009,
106 provided that the costs and charges associated with the operation
107 of the hospital clinic are included in the hospital's cost report.
108 In addition, the Medicare thirty-five-mile rule will apply to
109 those hospital clinics not located inside the hospital that are
110 constructed after July 1, 2009. Where the same services are
111 reimbursed as clinic services, the division may revise the rate or
112 methodology of outpatient reimbursement to maintain consistency,
113 efficiency, economy and quality of care.

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

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

130 (3) Laboratory and x-ray services.

131 (4) Nursing facility services.

139 (b) From and after July 1, 1997, the division
140 shall implement the integrated case-mix payment and quality
141 monitoring system, which includes the fair rental system for
142 property costs and in which recapture of depreciation is
143 eliminated. The division may reduce the payment for hospital
144 leave and therapeutic home leave days to the lower of the case-mix
145 category as computed for the resident on leave using the
146 assessment being utilized for payment at that point in time, or a
147 case-mix score of 1.000 for nursing facilities, and shall compute
148 case-mix scores of residents so that only services provided at the

149 nursing facility are considered in calculating a facility's per
150 diem.

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

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

160 (e) The division shall develop and implement, not
161 later than January 1, 2001, a case-mix payment add-on determined
162 by time studies and other valid statistical data that will
163 reimburse a nursing facility for the additional cost of caring for
164 a resident who has a diagnosis of Alzheimer's or other related
165 dementia and exhibits symptoms that require special care. Any
166 such case-mix add-on payment shall be supported by a determination
167 of additional cost. The division shall also develop and implement
168 as part of the fair rental reimbursement system for nursing
169 facility beds, an Alzheimer's resident bed depreciation enhanced
170 reimbursement system that will provide an incentive to encourage
171 nursing facilities to convert or construct beds for residents with
172 Alzheimer's or other related dementia.

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

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

181 (5) Periodic screening and diagnostic services for
182 individuals under age twenty-one (21) years as are needed to
183 identify physical and mental defects and to provide health care
184 treatment and other measures designed to correct or ameliorate
185 defects and physical and mental illness and conditions discovered
186 by the screening services, regardless of whether these services
187 are included in the state plan. The division may include in its
188 periodic screening and diagnostic program those discretionary
189 services authorized under the federal regulations adopted to
190 implement Title XIX of the federal Social Security Act, as
191 amended. The division, in obtaining physical therapy services,
192 occupational therapy services, and services for individuals with
193 speech, hearing and language disorders, may enter into a
194 cooperative agreement with the State Department of Education for
195 the provision of those services to handicapped students by public
196 school districts using state funds that are provided from the
197 appropriation to the Department of Education to obtain federal



198 matching funds through the division. The division, in obtaining
199 medical and mental health assessments, treatment, care and
200 services for children who are in, or at risk of being put in, the
201 custody of the Mississippi Department of Human Services may enter
202 into a cooperative agreement with the Mississippi Department of
203 Human Services for the provision of those services using state
204 funds that are provided from the appropriation to the Department
205 of Human Services to obtain federal matching funds through the
206 division.

207 (6) Physician services. Fees for physician's services
208 that are covered only by Medicaid shall be reimbursed at ninety
209 percent (90%) of the rate established on January 1, 2018, and as
210 may be adjusted each July thereafter, under Medicare. The
211 division may provide for a reimbursement rate for physician's
212 services of up to one hundred percent (100%) of the rate
213 established under Medicare for physician's services that are
214 provided after the normal working hours of the physician, as
215 determined in accordance with regulations of the division. The
216 division may reimburse eligible providers, as determined by the
217 division, for certain primary care services at one hundred percent
218 (100%) of the rate established under Medicare. The division shall
219 reimburse obstetricians and gynecologists for certain primary care
220 services as defined by the division at one hundred percent (100%)
221 of the rate established under Medicare.

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

232 (b) [Repealed]

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

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

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

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

247 of prescription drugs to include single-source and innovator
248 multiple-source drugs or generic drugs, if that will lower the
249 acquisition costs of those prescription drugs.

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

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

256 Drugs prescribed for a resident of a psychiatric residential
257 treatment facility must be provided in true unit doses when
258 available. The division may require that drugs not covered by
259 Medicare Part D for a resident of a long-term care facility be
260 provided in true unit doses when available. Those drugs that were
261 originally billed to the division but are not used by a resident
262 in any of those facilities shall be returned to the billing
263 pharmacy for credit to the division, in accordance with the
264 guidelines of the State Board of Pharmacy and any requirements of
265 federal law and regulation. Drugs shall be dispensed to a
266 recipient and only one (1) dispensing fee per month may be
267 charged. The division shall develop a methodology for reimbursing
268 for restocked drugs, which shall include a restock fee as
269 determined by the division not exceeding Seven Dollars and
270 Eighty-two Cents (\$7.82).

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

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

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

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

287 The division shall develop and implement a method or methods
288 by which the division will provide on a regular basis to Medicaid
289 providers who are authorized to prescribe drugs, information about
290 the costs to the Medicaid program of single-source drugs and
291 innovator multiple-source drugs, and information about other drugs
292 that may be prescribed as alternatives to those single-source
293 drugs and innovator multiple-source drugs and the costs to the
294 Medicaid program of those alternative drugs.

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

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

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

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

311 The division shall allow certain drugs, including
312 physician-administered drugs, and implantable drug system devices,
313 and medical supplies, with limited distribution or limited access
314 for beneficiaries and administered in an appropriate clinical
315 setting, to be reimbursed as either a medical claim or pharmacy
316 claim, as determined by the division.

317 It is the intent of the Legislature that the division and any
318 managed care entity described in subsection (H) of this section

319 encourage the use of Alpha-Hydroxyprogesterone Caproate (17P) to
320 prevent recurrent preterm birth.

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

323 The division shall increase the amount of the reimbursement
324 rate for diagnostic and preventative dental services for each of
325 the fiscal years 2022, 2023 and 2024 by five percent (5%) above
326 the amount of the reimbursement rate for the previous fiscal year.

327 The division shall increase the amount of the reimbursement rate
328 for restorative dental services for each of the fiscal years 2023,
329 2024 and 2025 by five percent (5%) above the amount of the
330 reimbursement rate for the previous fiscal year. It is the intent
331 of the Legislature that the reimbursement rate revision for
332 preventative dental services will be an incentive to increase the
333 number of dentists who actively provide Medicaid services. This
334 dental services reimbursement rate revision shall be known as the
335 "James Russell Dumas Medicaid Dental Services Incentive Program."

336 The Medical Care Advisory Committee, assisted by the Division
337 of Medicaid, shall annually determine the effect of this incentive
338 by evaluating the number of dentists who are Medicaid providers,
339 the number who and the degree to which they are actively billing
340 Medicaid, the geographic trends of where dentists are offering
341 what types of Medicaid services and other statistics pertinent to
342 the goals of this legislative intent. This data shall annually be

343 presented to the Chair of the Senate Medicaid Committee and the
344 Chair of the House Medicaid Committee.

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

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

357 (12) Intermediate care facility services.

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

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

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

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

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

380 (a) Services provided by ambulatory surgical
381 centers (ACSS) as defined in Section 41-75-1(a); and
382 (b) Dialysis center services.

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



391 management services (a) provided by an approved regional mental
392 health/intellectual disability center established under Sections
393 41-19-31 through 41-19-39, or by another community mental health
394 service provider meeting the requirements of the Department of
395 Mental Health to be an approved mental health/intellectual
396 disability center if determined necessary by the Department of
397 Mental Health, using state funds that are provided in the
398 appropriation to the division to match federal funds, or (b)
399 provided by a facility that is certified by the State Department
400 of Mental Health to provide therapeutic and case management
401 services, to be reimbursed on a fee for service basis, or (c)
402 provided in the community by a facility or program operated by the
403 Department of Mental Health. Any such services provided by a
404 facility described in subparagraph (b) must have the prior
405 approval of the division to be reimbursable under this section.

406 (17) Durable medical equipment services and medical
407 supplies. Precertification of durable medical equipment and
408 medical supplies must be obtained as required by the division.
409 The Division of Medicaid may require durable medical equipment
410 providers to obtain a surety bond in the amount and to the
411 specifications as established by the Balanced Budget Act of 1997.
412 A maximum dollar amount of reimbursement for noninvasive
413 ventilators or ventilation treatments properly ordered and being
414 used in an appropriate care setting shall not be set by any health
415 maintenance organization, coordinated care organization,



416 provider-sponsored health plan, or other organization paid for
417 services on a capitated basis by the division under any managed
418 care program or coordinated care program implemented by the
419 division under this section. Reimbursement by these organizations
420 to durable medical equipment suppliers for home use of noninvasive
421 and invasive ventilators shall be on a continuous monthly payment
422 basis for the duration of medical need throughout a patient's
423 valid prescription period.

424 (18) (a) Notwithstanding any other provision of this
425 section to the contrary, as provided in the Medicaid state plan
426 amendment or amendments as defined in Section 43-13-145(10), the
427 division shall make additional reimbursement to hospitals that
428 serve a disproportionate share of low-income patients and that
429 meet the federal requirements for those payments as provided in
430 Section 1923 of the federal Social Security Act and any applicable
431 regulations. It is the intent of the Legislature that the
432 division shall draw down all available federal funds allotted to
433 the state for disproportionate share hospitals. However, from and
434 after January 1, 1999, public hospitals participating in the
435 Medicaid disproportionate share program may be required to
436 participate in an intergovernmental transfer program as provided
437 in Section 1903 of the federal Social Security Act and any
438 applicable regulations.

439 (b) (i) 1. The division may establish a Medicare
440 Upper Payment Limits Program, as defined in Section 1902(a)(30) of

441 the federal Social Security Act and any applicable federal
442 regulations, or an allowable delivery system or provider payment
443 initiative authorized under 42 CFR 438.6(c), for hospitals,
444 nursing facilities and physicians employed or contracted by
445 hospitals.

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

452 (ii) The division shall assess each hospital,
453 nursing facility, and emergency ambulance transportation provider
454 for the sole purpose of financing the state portion of the
455 Medicare Upper Payment Limits Program or other program(s)
456 authorized under this subsection (A) (18) (b). The hospital
457 assessment shall be as provided in Section 43-13-145(4)(a), and
458 the nursing facility and the emergency ambulance transportation
459 assessments, if established, shall be based on Medicaid
460 utilization or other appropriate method, as determined by the
461 division, consistent with federal regulations. The assessments
462 will remain in effect as long as the state participates in the
463 Medicare Upper Payment Limits Program or other program(s)
464 authorized under this subsection (A) (18) (b). In addition to the
465 hospital assessment provided in Section 43-13-145(4)(a), hospitals



466 with physicians participating in the Medicare Upper Payment Limits
467 Program or other program(s) authorized under this subsection
468 (A) (18) (b) shall be required to participate in an
469 intergovernmental transfer or assessment, as determined by the
470 division, for the purpose of financing the state portion of the
471 physician UPL payments or other payment(s) authorized under this
472 subsection (A) (18) (b).

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

484 (iv) Notwithstanding any other provision of
485 this article to the contrary, effective upon implementation of the
486 Mississippi Hospital Access Program (MHAP) provided in
487 subparagraph (c)(i) below, the hospital portion of the inpatient
488 Upper Payment Limits Program shall transition into and be replaced
489 by the MHAP program. However, the division is authorized to
490 develop and implement an alternative fee-for-service Upper Payment



491 Limits model in accordance with federal laws and regulations if
492 necessary to preserve supplemental funding. Further, the
493 division, in consultation with the hospital industry shall develop
494 alternative models for distribution of medical claims and
495 supplemental payments for inpatient and outpatient hospital
496 services, and such models may include, but shall not be limited to
497 the following: increasing rates for inpatient and outpatient
498 services; creating a low-income utilization pool of funds to
499 reimburse hospitals for the costs of uncompensated care, charity
500 care and bad debts as permitted and approved pursuant to federal
501 regulations and the Centers for Medicare and Medicaid Services;
502 supplemental payments based upon Medicaid utilization, quality,
503 service lines and/or costs of providing such services to Medicaid
504 beneficiaries and to uninsured patients. The goals of such
505 payment models shall be to ensure access to inpatient and
506 outpatient care and to maximize any federal funds that are
507 available to reimburse hospitals for services provided. Any such
508 documents required to achieve the goals described in this
509 paragraph shall be submitted to the Centers for Medicare and
510 Medicaid Services, with a proposed effective date of July 1, 2019,
511 to the extent possible, but in no event shall the effective date
512 of such payment models be later than July 1, 2020. The Chairmen
513 of the Senate and House Medicaid Committees shall be provided a
514 copy of the proposed payment model(s) prior to submission.
515 Effective July 1, 2018, and until such time as any payment



516 model(s) as described above become effective, the division, in
517 consultation with the hospital industry, is authorized to
518 implement a transitional program for inpatient and outpatient
519 payments and/or supplemental payments (including, but not limited
520 to, MHAP and directed payments), to redistribute available
521 supplemental funds among hospital providers, provided that when
522 compared to a hospital's prior year supplemental payments,
523 supplemental payments made pursuant to any such transitional
524 program shall not result in a decrease of more than five percent
525 (5%) and shall not increase by more than the amount needed to
526 maximize the distribution of the available funds.

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

534 2. The division shall calculate the
535 ambulance service access payment amount as the balance of the
536 portion of the Medical Care Fund related to ambulance
537 transportation service provider assessments plus any federal
538 matching funds earned on the balance, up to, but not to exceed,
539 the upper payment limit gap for all emergency ambulance service
540 providers.



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

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

555 c. As used in this paragraph
556 (18) (b) (v), the term "upper payment limit gap" means the
557 difference between the total amount that the ambulance
558 transportation service provider received from Medicaid and the
559 average amount that the ambulance transportation service provider
560 would have received from commercial insurers for those services
561 reimbursed by Medicaid.

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



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

580 (ii) Subject to approval by the Centers for
581 Medicare and Medicaid Services (CMS), the MHAP shall provide
582 increased inpatient capitation (PMPM) payments to managed care
583 entities contracting with the division pursuant to subsection (H)
584 of this section to support availability of hospital services or
585 such other payments permissible under federal law necessary to
586 accomplish the intent of this subsection.

587 (iii) The intent of this subparagraph (c) is
588 that effective for all inpatient hospital Medicaid services during
589 state fiscal year 2016, and so long as this provision shall remain



590 in effect hereafter, the division shall to the fullest extent
591 feasible replace the additional reimbursement for hospital
592 inpatient services under the inpatient Medicare Upper Payment
593 Limits (UPL) Program with additional reimbursement under the MHAP
594 and other payment programs for inpatient and/or outpatient
595 payments which may be developed under the authority of this
596 paragraph.

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

603 (19) (a) Perinatal risk management services. The
604 division shall promulgate regulations to be effective from and
605 after October 1, 1988, to establish a comprehensive perinatal
606 system for risk assessment of all pregnant and infant Medicaid
607 recipients and for management, education and follow-up for those
608 who are determined to be at risk. Services to be performed
609 include case management, nutrition assessment/counseling,
610 psychosocial assessment/counseling and health education. The
611 division shall contract with the State Department of Health to
612 provide services within this paragraph (Perinatal High Risk
613 Management/Infant Services System (PHRM/ISS)). The State

614 Department of Health shall be reimbursed on a full reasonable cost
615 basis for services provided under this subparagraph (a).

616 (b) Early intervention system services. The
617 division shall cooperate with the State Department of Health,
618 acting as lead agency, in the development and implementation of a
619 statewide system of delivery of early intervention services, under
620 Part C of the Individuals with Disabilities Education Act (IDEA).

621 The State Department of Health shall certify annually in writing
622 to the executive director of the division the dollar amount of
623 state early intervention funds available that will be utilized as
624 a certified match for Medicaid matching funds. Those funds then
625 shall be used to provide expanded targeted case management
626 services for Medicaid eligible children with special needs who are
627 eligible for the state's early intervention system.

628 Qualifications for persons providing service coordination shall be
629 determined by the State Department of Health and the Division of
630 Medicaid.

631 (20) Home- and community-based services for physically
632 disabled approved services as allowed by a waiver from the United
633 States Department of Health and Human Services for home- and
634 community-based services for physically disabled people using
635 state funds that are provided from the appropriation to the State
636 Department of Rehabilitation Services and used to match federal
637 funds under a cooperative agreement between the division and the
638 department, provided that funds for these services are



639 specifically appropriated to the Department of Rehabilitation
640 Services.

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

657 (22) Ambulatory services delivered in federally
658 qualified health centers, rural health centers and clinics of the
659 local health departments of the State Department of Health for
660 individuals eligible for Medicaid under this article based on
661 reasonable costs as determined by the division. Federally
662 qualified health centers shall be reimbursed by the Medicaid
663 prospective payment system as approved by the Centers for Medicare

664 and Medicaid Services. The division shall recognize federally
665 qualified health centers (FQHCs), rural health clinics (RHCs) and
666 community mental health centers (CMHCs) as both an originating and
667 distant site provider for the purposes of telehealth
668 reimbursement. The division is further authorized and directed to
669 reimburse FQHCs, RHCs and CMHCs for both distant site and
670 originating site services when such services are appropriately
671 provided by the same organization.

672 (23) Inpatient psychiatric services.

673 (a) Inpatient psychiatric services to be
674 determined by the division for recipients under age twenty-one
675 (21) that are provided under the direction of a physician in an
676 inpatient program in a licensed acute care psychiatric facility or
677 in a licensed psychiatric residential treatment facility, before
678 the recipient reaches age twenty-one (21) or, if the recipient was
679 receiving the services immediately before he or she reached age
680 twenty-one (21), before the earlier of the date he or she no
681 longer requires the services or the date he or she reaches age
682 twenty-two (22), as provided by federal regulations. From and
683 after January 1, 2015, the division shall update the fair rental
684 reimbursement system for psychiatric residential treatment
685 facilities. Precertification of inpatient days and residential
686 treatment days must be obtained as required by the division. From
687 and after July 1, 2009, all state-owned and state-operated
688 facilities that provide inpatient psychiatric services to persons



689 under age twenty-one (21) who are eligible for Medicaid
690 reimbursement shall be reimbursed for those services on a full
691 reasonable cost basis.

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

696 (24) [Deleted]

697 (25) [Deleted]

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

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

712 (28) Other health insurance premiums that are
713 cost-effective as defined by the United States Secretary of Health



714 and Human Services. Medicare eligible must have Medicare Part B
715 before other insurance premiums can be paid.

716 (29) The Division of Medicaid may apply for a waiver
717 from the United States Department of Health and Human Services for
718 home- and community-based services for developmentally disabled
719 people using state funds that are provided from the appropriation
720 to the State Department of Mental Health and/or funds transferred
721 to the department by a political subdivision or instrumentality of
722 the state and used to match federal funds under a cooperative
723 agreement between the division and the department, provided that
724 funds for these services are specifically appropriated to the
725 Department of Mental Health and/or transferred to the department
726 by a political subdivision or instrumentality of the state.

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

730 (31) Targeted case management services for children
731 with special needs, under waivers from the United States
732 Department of Health and Human Services, using state funds that
733 are provided from the appropriation to the Mississippi Department
734 of Human Services and used to match federal funds under a
735 cooperative agreement between the division and the department.

736 (32) Care and services provided in Christian Science
737 Sanatoria listed and certified by the Commission for Accreditation
738 of Christian Science Nursing Organizations/Facilities, Inc.,

739 rendered in connection with treatment by prayer or spiritual means
740 to the extent that those services are subject to reimbursement
741 under Section 1903 of the federal Social Security Act.

742 (33) Podiatrist services.

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

748 (35) Services and activities authorized in Sections
749 43-27-101 and 43-27-103, using state funds that are provided from
750 the appropriation to the Mississippi Department of Human Services
751 and used to match federal funds under a cooperative agreement
752 between the division and the department.

753 (36) Nonemergency transportation services for
754 Medicaid-eligible persons as determined by the division. The PEER
755 Committee shall conduct a performance evaluation of the
756 nonemergency transportation program to evaluate the administration
757 of the program and the providers of transportation services to
758 determine the most cost-effective ways of providing nonemergency
759 transportation services to the patients served under the program.
760 The performance evaluation shall be completed and provided to the
761 members of the Senate Medicaid Committee and the House Medicaid
762 Committee not later than January 1, 2019, and every two (2) years
763 thereafter.

764 (37) [Deleted]

765 (38) Chiropractic services. A chiropractor's manual
766 manipulation of the spine to correct a subluxation, if x-ray
767 demonstrates that a subluxation exists and if the subluxation has
768 resulted in a neuromusculoskeletal condition for which
769 manipulation is appropriate treatment, and related spinal x-rays
770 performed to document these conditions. Reimbursement for
771 chiropractic services shall not exceed Seven Hundred Dollars
772 (\$700.00) per year per beneficiary.

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

781 (40) [Deleted]

782 (41) Services provided by the State Department of
783 Rehabilitation Services for the care and rehabilitation of persons
784 with spinal cord injuries or traumatic brain injuries, as allowed
785 under waivers from the United States Department of Health and
786 Human Services, using up to seventy-five percent (75%) of the
787 funds that are appropriated to the Department of Rehabilitation
788 Services from the Spinal Cord and Head Injury Trust Fund

789 established under Section 37-33-261 and used to match federal
790 funds under a cooperative agreement between the division and the
791 department.

792 (42) [Deleted]

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

798 (44) Nursing facility services for the severely
799 disabled.

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

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

806 (45) Physician assistant services. Services furnished
807 by a physician assistant who is licensed by the State Board of
808 Medical Licensure and is practicing with physician supervision
809 under regulations adopted by the board, under regulations adopted
810 by the division. Reimbursement for those services shall not
811 exceed ninety percent (90%) of the reimbursement rate for
812 comparable services rendered by a physician. The division may
813 provide for a reimbursement rate for physician assistant services



814 of up to one hundred percent (100%) or the reimbursement rate for
815 comparable services rendered by a physician for physician
816 assistant services that are provided after the normal working
817 hours of the physician assistant, as determined in accordance with
818 regulations of the division.

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

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

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

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

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

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

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

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

859 (51) Upon determination of Medicaid eligibility and in
860 association with annual redetermination of Medicaid eligibility,
861 beneficiaries shall be encouraged to undertake a physical
862 examination that will establish a base-line level of health and
863 identification of a usual and customary source of care (a medical

864 home) to aid utilization of disease management tools. This
865 physical examination and utilization of these disease management
866 tools shall be consistent with current United States Preventive
867 Services Task Force or other recognized authority recommendations.

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

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

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

886 (54) [Deleted]

887 (55) Therapy services. The plan of care for therapy
888 services may be developed to cover a period of treatment for up to

889 six (6) months, but in no event shall the plan of care exceed a
890 six-month period of treatment. The projected period of treatment
891 must be indicated on the initial plan of care and must be updated
892 with each subsequent revised plan of care. Based on medical
893 necessity, the division shall approve certification periods for
894 less than or up to six (6) months, but in no event shall the
895 certification period exceed the period of treatment indicated on
896 the plan of care. The appeal process for any reduction in therapy
897 services shall be consistent with the appeal process in federal
898 regulations.

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

904 (57) No Medicaid benefit shall restrict coverage for
905 medically appropriate treatment prescribed by a physician and
906 agreed to by a fully informed individual, or if the individual
907 lacks legal capacity to consent by a person who has legal
908 authority to consent on his or her behalf, based on an
909 individual's diagnosis with a terminal condition. As used in this
910 paragraph (57), "terminal condition" means any aggressive
911 malignancy, chronic end-stage cardiovascular or cerebral vascular
912 disease, or any other disease, illness or condition which a
913 physician diagnoses as terminal.



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

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

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

929 (a) Payments may only be made to a border city
930 university-affiliated pediatric teaching hospital if the Centers
931 for Medicare and Medicaid Services (CMS) approve an increase in
932 the annual request for the provider payment initiative authorized
933 under 42 CFR Section 438.6(c) in an amount equal to or greater
934 than the estimated annual payment to be made to the border city
935 university-affiliated pediatric teaching hospital. The estimate
936 shall be based on the hospital's prior year Mississippi managed
937 care utilization.



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

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

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

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



(61) Mental health services provided by licensed adult residential treatment facilities and adult supportive residential facilities licensed under Section 1 of this act. The initial fee schedules for the four (4) levels of care provided in those facilities shall be as follows: basic supportive living services - Eighty-eight Dollars (\$88.00) per day; enhanced supportive living services - One Hundred Sixty Dollars (\$160.00) per day; medically fragile services - Two Hundred Ninety Dollars (\$290.00) per day; and adult residential treatment services - Three Hundred Fourteen Dollars and Eighty-two Cents (\$314.82) per day.

The Division of Medicaid shall apply to the United States Secretary of Health and Human Services for a federal waiver of the applicable provisions of Title XIX of the federal Social Security Act, as amended, and any other applicable provisions of federal law as necessary to allow for the implementation of this paragraph (61). The provisions of this paragraph (61) shall be implemented from and after the date that the Division of Medicaid receives the federal waiver.

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

(C) The division may pay to those providers who participate in and accept patient referrals from the division's emergency room

988 redirection program a percentage, as determined by the division,
989 of savings achieved according to the performance measures and
990 reduction of costs required of that program. Federally qualified
991 health centers may participate in the emergency room redirection
992 program, and the division may pay those centers a percentage of
993 any savings to the Medicaid program achieved by the centers'
994 accepting patient referrals through the program, as provided in
995 this subsection (C).

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

999 (a) "Committees" means the Medicaid Committees of
1000 the House of Representatives and the Senate, and "committee" means
1001 either one of those committees.

1002 (b) "Rate change" means an increase, decrease or
1003 other change in the payments or rates of reimbursement, or a
1004 change in any payment methodology that results in an increase,
1005 decrease or other change in the payments or rates of
1006 reimbursement, to any Medicaid provider that renders any services
1007 authorized to be provided to Medicaid recipients under this
1008 article.

1009 (2) Whenever the Division of Medicaid proposes a rate
1010 change, the division shall give notice to the chairmen of the
1011 committees at least thirty (30) calendar days before the proposed
1012 rate change is scheduled to take effect. The division shall



1013 furnish the chairmen with a concise summary of each proposed rate
1014 change along with the notice, and shall furnish the chairmen with
1015 a copy of any proposed rate change upon request. The division
1016 also shall provide a summary and copy of any proposed rate change
1017 to any other member of the Legislature upon request.

1018 (3) If the chairman of either committee or both
1019 chairmen jointly object to the proposed rate change or any part
1020 thereof, the chairman or chairmen shall notify the division and
1021 provide the reasons for their objection in writing not later than
1022 seven (7) calendar days after receipt of the notice from the
1023 division. The chairman or chairmen may make written
1024 recommendations to the division for changes to be made to a
1025 proposed rate change.

1026 (4) (a) The chairman of either committee or both
1027 chairmen jointly may hold a committee meeting to review a proposed
1028 rate change. If either chairman or both chairmen decide to hold a
1029 meeting, they shall notify the division of their intention in
1030 writing within seven (7) calendar days after receipt of the notice
1031 from the division, and shall set the date and time for the meeting
1032 in their notice to the division, which shall not be later than
1033 fourteen (14) calendar days after receipt of the notice from the
1034 division.

1035 (b) After the committee meeting, the committee or
1036 committees may object to the proposed rate change or any part
1037 thereof. The committee or committees shall notify the division



1038 and the reasons for their objection in writing not later than
1039 seven (7) calendar days after the meeting. The committee or
1040 committees may make written recommendations to the division for
1041 changes to be made to a proposed rate change.

1042 (5) If both chairmen notify the division in writing
1043 within seven (7) calendar days after receipt of the notice from
1044 the division that they do not object to the proposed rate change
1045 and will not be holding a meeting to review the proposed rate
1046 change, the proposed rate change will take effect on the original
1047 date as scheduled by the division or on such other date as
1048 specified by the division.

1049 (6) (a) If there are any objections to a proposed rate
1050 change or any part thereof from either or both of the chairmen or
1051 the committees, the division may withdraw the proposed rate
1052 change, make any of the recommended changes to the proposed rate
1053 change, or not make any changes to the proposed rate change.

1054 (b) If the division does not make any changes to
1055 the proposed rate change, it shall notify the chairmen of that
1056 fact in writing, and the proposed rate change shall take effect on
1057 the original date as scheduled by the division or on such other
1058 date as specified by the division.

1059 (c) If the division makes any changes to the
1060 proposed rate change, the division shall notify the chairmen of
1061 its actions in writing, and the revised proposed rate change shall
1062 take effect on the date as specified by the division.



1063 (7) Nothing in this subsection (D) shall be construed
1064 as giving the chairmen or the committees any authority to veto,
1065 nullify or revise any rate change proposed by the division. The
1066 authority of the chairmen or the committees under this subsection
1067 shall be limited to reviewing, making objections to and making
1068 recommendations for changes to rate changes proposed by the
1069 division.

1070 (E) Notwithstanding any provision of this article, no new
1071 groups or categories of recipients and new types of care and
1072 services may be added without enabling legislation from the
1073 Mississippi Legislature, except that the division may authorize
1074 those changes without enabling legislation when the addition of
1075 recipients or services is ordered by a court of proper authority.

1076 (F) The executive director shall keep the Governor advised
1077 on a timely basis of the funds available for expenditure and the
1078 projected expenditures. Notwithstanding any other provisions of
1079 this article, if current or projected expenditures of the division
1080 are reasonably anticipated to exceed the amount of funds
1081 appropriated to the division for any fiscal year, the Governor,
1082 after consultation with the executive director, shall take all
1083 appropriate measures to reduce costs, which may include, but are
1084 not limited to:

1085 (1) Reducing or discontinuing any or all services that
1086 are deemed to be optional under Title XIX of the Social Security
1087 Act;



1088 (2) Reducing reimbursement rates for any or all service
1089 types;
1090 (3) Imposing additional assessments on health care
1091 providers; or
1092 (4) Any additional cost-containment measures deemed
1093 appropriate by the Governor.

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

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

1108 (G) Notwithstanding any other provision of this article, it
1109 shall be the duty of each provider participating in the Medicaid
1110 program to keep and maintain books, documents and other records as
1111 prescribed by the Division of Medicaid in accordance with federal
1112 laws and regulations.



1113 (H) (1) Notwithstanding any other provision of this
1114 article, the division is authorized to implement (a) a managed
1115 care program, (b) a coordinated care program, (c) a coordinated
1116 care organization program, (d) a health maintenance organization
1117 program, (e) a patient-centered medical home program, (f) an
1118 accountable care organization program, (g) provider-sponsored
1119 health plan, or (h) any combination of the above programs. As a
1120 condition for the approval of any program under this subsection
1121 (H) (1), the division shall require that no managed care program,
1122 coordinated care program, coordinated care organization program,
1123 health maintenance organization program, or provider-sponsored
1124 health plan may:

1125 (a) Pay providers at a rate that is less than the
1126 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
1127 reimbursement rate;

1128 (b) Override the medical decisions of hospital
1129 physicians or staff regarding patients admitted to a hospital for
1130 an emergency medical condition as defined by 42 US Code Section
1131 1395dd. This restriction (b) does not prohibit the retrospective
1132 review of the appropriateness of the determination that an
1133 emergency medical condition exists by chart review or coding
1134 algorithm, nor does it prohibit prior authorization for
1135 nonemergency hospital admissions;

1136 (c) Pay providers at a rate that is less than the
1137 normal Medicaid reimbursement rate. It is the intent of the



1138 Legislature that all managed care entities described in this
1139 subsection (H), in collaboration with the division, develop and
1140 implement innovative payment models that incentivize improvements
1141 in health care quality, outcomes, or value, as determined by the
1142 division. Participation in the provider network of any managed
1143 care, coordinated care, provider-sponsored health plan, or similar
1144 contractor shall not be conditioned on the provider's agreement to
1145 accept such alternative payment models;

1146 (d) Implement a prior authorization and
1147 utilization review program for medical services, transportation
1148 services and prescription drugs that is more stringent than the
1149 prior authorization processes used by the division in its
1150 administration of the Medicaid program. Not later than December
1151 2, 2021, the contractors that are receiving capitated payments
1152 under a managed care delivery system established under this
1153 subsection (H) shall submit a report to the Chairmen of the House
1154 and Senate Medicaid Committees on the status of the prior
1155 authorization and utilization review program for medical services,
1156 transportation services and prescription drugs that is required to
1157 be implemented under this subparagraph (d);

1158 (e) [Deleted]

1159 (f) Implement a preferred drug list that is more
1160 stringent than the mandatory preferred drug list established by
1161 the division under subsection (A) (9) of this section;

1162 (g) Implement a policy which denies beneficiaries
1163 with hemophilia access to the federally funded hemophilia
1164 treatment centers as part of the Medicaid Managed Care network of
1165 providers.

1166 Each health maintenance organization, coordinated care
1167 organization, provider-sponsored health plan, or other
1168 organization paid for services on a capitated basis by the
1169 division under any managed care program or coordinated care
1170 program implemented by the division under this section shall use a
1171 clear set of level of care guidelines in the determination of
1172 medical necessity and in all utilization management practices,
1173 including the prior authorization process, concurrent reviews,
1174 retrospective reviews and payments, that are consistent with
1175 widely accepted professional standards of care. Organizations
1176 participating in a managed care program or coordinated care
1177 program implemented by the division may not use any additional
1178 criteria that would result in denial of care that would be
1179 determined appropriate and, therefore, medically necessary under
1180 those levels of care guidelines.

1181 (2) Notwithstanding any provision of this section, the
1182 recipients eligible for enrollment into a Medicaid Managed Care
1183 Program authorized under this subsection (H) may include only
1184 those categories of recipients eligible for participation in the
1185 Medicaid Managed Care Program as of January 1, 2021, the
1186 Children's Health Insurance Program (CHIP), and the CMS-approved



1187 Section 1115 demonstration waivers in operation as of January 1,
1188 2021. No expansion of Medicaid Managed Care Program contracts may
1189 be implemented by the division without enabling legislation from
1190 the Mississippi Legislature.

1191 (3) (a) Any contractors receiving capitated payments
1192 under a managed care delivery system established in this section
1193 shall provide to the Legislature and the division statistical data
1194 to be shared with provider groups in order to improve patient
1195 access, appropriate utilization, cost savings and health outcomes
1196 not later than October 1 of each year. Additionally, each
1197 contractor shall disclose to the Chairmen of the Senate and House
1198 Medicaid Committees the administrative expenses costs for the
1199 prior calendar year, and the number of full-equivalent employees
1200 located in the State of Mississippi dedicated to the Medicaid and
1201 CHIP lines of business as of June 30 of the current year.

1202 (b) The division and the contractors participating
1203 in the managed care program, a coordinated care program or a
1204 provider-sponsored health plan shall be subject to annual program
1205 reviews or audits performed by the Office of the State Auditor,
1206 the PEER Committee, the Department of Insurance and/or independent
1207 third parties.

1208 (c) Those reviews shall include, but not be
1209 limited to, at least two (2) of the following items:

1210 (i) The financial benefit to the State of
1211 Mississippi of the managed care program,

1212 (ii) The difference between the premiums paid
1213 to the managed care contractors and the payments made by those
1214 contractors to health care providers,
1215 (iii) Compliance with performance measures
1216 required under the contracts,
1217 (iv) Administrative expense allocation
1218 methodologies,
1219 (v) Whether nonprovider payments assigned as
1220 medical expenses are appropriate,
1221 (vi) Capitated arrangements with related
1222 party subcontractors,
1223 (vii) Reasonableness of corporate
1224 allocations,
1225 (viii) Value-added benefits and the extent to
1226 which they are used,
1227 (ix) The effectiveness of subcontractor
1228 oversight, including subcontractor review,
1229 (x) Whether health care outcomes have been
1230 improved, and
1231 (xi) The most common claim denial codes to
1232 determine the reasons for the denials.

1233 The audit reports shall be considered public documents and
1234 shall be posted in their entirety on the division's website.

1235 (4) All health maintenance organizations, coordinated
1236 care organizations, provider-sponsored health plans, or other



1237 organizations paid for services on a capitated basis by the
1238 division under any managed care program or coordinated care
1239 program implemented by the division under this section shall
1240 reimburse all providers in those organizations at rates no lower
1241 than those provided under this section for beneficiaries who are
1242 not participating in those programs.

1243 (5) No health maintenance organization, coordinated
1244 care organization, provider-sponsored health plan, or other
1245 organization paid for services on a capitated basis by the
1246 division under any managed care program or coordinated care
1247 program implemented by the division under this section shall
1248 require its providers or beneficiaries to use any pharmacy that
1249 ships, mails or delivers prescription drugs or legend drugs or
1250 devices.

1251 (6) (a) Not later than December 1, 2021, the
1252 contractors who are receiving capitated payments under a managed
1253 care delivery system established under this subsection (H) shall
1254 develop and implement a uniform credentialing process for
1255 providers. Under that uniform credentialing process, a provider
1256 who meets the criteria for credentialing will be credentialed with
1257 all of those contractors and no such provider will have to be
1258 separately credentialed by any individual contractor in order to
1259 receive reimbursement from the contractor. Not later than
1260 December 2, 2021, those contractors shall submit a report to the
1261 Chairmen of the House and Senate Medicaid Committees on the status



1262 of the uniform credentialing process for providers that is
1263 required under this subparagraph (a).

1264 (b) If those contractors have not implemented a
1265 uniform credentialing process as described in subparagraph (a) by
1266 December 1, 2021, the division shall develop and implement, not
1267 later than July 1, 2022, a single, consolidated credentialing
1268 process by which all providers will be credentialed. Under the
1269 division's single, consolidated credentialing process, no such
1270 contractor shall require its providers to be separately
1271 credentialed by the contractor in order to receive reimbursement
1272 from the contractor, but those contractors shall recognize the
1273 credentialing of the providers by the division's credentialing
1274 process.

1275 (c) The division shall require a uniform provider
1276 credentialing application that shall be used in the credentialing
1277 process that is established under subparagraph (a) or (b). If the
1278 contractor or division, as applicable, has not approved or denied
1279 the provider credentialing application within sixty (60) days of
1280 receipt of the completed application that includes all required
1281 information necessary for credentialing, then the contractor or
1282 division, upon receipt of a written request from the applicant and
1283 within five (5) business days of its receipt, shall issue a
1284 temporary provider credential/enrollment to the applicant if the
1285 applicant has a valid Mississippi professional or occupational
1286 license to provide the health care services to which the



1287 credential/enrollment would apply. The contractor or the division
1288 shall not issue a temporary credential/enrollment if the applicant
1289 has reported on the application a history of medical or other
1290 professional or occupational malpractice claims, a history of
1291 substance abuse or mental health issues, a criminal record, or a
1292 history of medical or other licensing board, state or federal
1293 disciplinary action, including any suspension from participation
1294 in a federal or state program. The temporary
1295 credential/enrollment shall be effective upon issuance and shall
1296 remain in effect until the provider's credentialing/enrollment
1297 application is approved or denied by the contractor or division.
1298 The contractor or division shall render a final decision regarding
1299 credentialing/enrollment of the provider within sixty (60) days
1300 from the date that the temporary provider credential/enrollment is
1301 issued to the applicant.

1302 (d) If the contractor or division does not render
1303 a final decision regarding credentialing/enrollment of the
1304 provider within the time required in subparagraph (c), the
1305 provider shall be deemed to be credentialed by and enrolled with
1306 all of the contractors and eligible to receive reimbursement from
1307 the contractors.

1308 (7) (a) Each contractor that is receiving capitated
1309 payments under a managed care delivery system established under
1310 this subsection (H) shall provide to each provider for whom the
1311 contractor has denied the coverage of a procedure that was ordered



1312 or requested by the provider for or on behalf of a patient, a
1313 letter that provides a detailed explanation of the reasons for the
1314 denial of coverage of the procedure and the name and the
1315 credentials of the person who denied the coverage. The letter
1316 shall be sent to the provider in electronic format.

1317 (b) After a contractor that is receiving capitated
1318 payments under a managed care delivery system established under
1319 this subsection (H) has denied coverage for a claim submitted by a
1320 provider, the contractor shall issue to the provider within sixty
1321 (60) days a final ruling of denial of the claim that allows the
1322 provider to have a state fair hearing and/or agency appeal with
1323 the division. If a contractor does not issue a final ruling of
1324 denial within sixty (60) days as required by this subparagraph
1325 (b), the provider's claim shall be deemed to be automatically
1326 approved and the contractor shall pay the amount of the claim to
1327 the provider.

1328 (c) After a contractor has issued a final ruling
1329 of denial of a claim submitted by a provider, the division shall
1330 conduct a state fair hearing and/or agency appeal on the matter of
1331 the disputed claim between the contractor and the provider within
1332 sixty (60) days, and shall render a decision on the matter within
1333 thirty (30) days after the date of the hearing and/or appeal.

1334 (8) It is the intention of the Legislature that the
1335 division evaluate the feasibility of using a single vendor to
1336 administer pharmacy benefits provided under a managed care



1337 delivery system established under this subsection (H). Providers
1338 of pharmacy benefits shall cooperate with the division in any
1339 transition to a carve-out of pharmacy benefits under managed care.

1340 (9) The division shall evaluate the feasibility of
1341 using a single vendor to administer dental benefits provided under
1342 a managed care delivery system established in this subsection (H).
1343 Providers of dental benefits shall cooperate with the division in
1344 any transition to a carve-out of dental benefits under managed
1345 care.

1346 (10) It is the intent of the Legislature that any
1347 contractor receiving capitated payments under a managed care
1348 delivery system established in this section shall implement
1349 innovative programs to improve the health and well-being of
1350 members diagnosed with prediabetes and diabetes.

1351 (11) It is the intent of the Legislature that any
1352 contractors receiving capitated payments under a managed care
1353 delivery system established under this subsection (H) shall work
1354 with providers of Medicaid services to improve the utilization of
1355 long-acting reversible contraceptives (LARCs). Not later than
1356 December 1, 2021, any contractors receiving capitated payments
1357 under a managed care delivery system established under this
1358 subsection (H) shall provide to the Chairmen of the House and
1359 Senate Medicaid Committees and House and Senate Public Health
1360 Committees a report of LARC utilization for State Fiscal Years
1361 2018 through 2020 as well as any programs, initiatives, or efforts

1362 made by the contractors and providers to increase LARC
1363 utilization. This report shall be updated annually to include
1364 information for subsequent state fiscal years.

1365 (12) The division is authorized to make not more than
1366 one (1) emergency extension of the contracts that are in effect on
1367 July 1, 2021, with contractors who are receiving capitated
1368 payments under a managed care delivery system established under
1369 this subsection (H), as provided in this paragraph (12). The
1370 maximum period of any such extension shall be one (1) year, and
1371 under any such extensions, the contractors shall be subject to all
1372 of the provisions of this subsection (H). The extended contracts
1373 shall be revised to incorporate any provisions of this subsection
1374 (H).

1375 (I) [Deleted]

1376 (J) There shall be no cuts in inpatient and outpatient
1377 hospital payments, or allowable days or volumes, as long as the
1378 hospital assessment provided in Section 43-13-145 is in effect.
1379 This subsection (J) shall not apply to decreases in payments that
1380 are a result of: reduced hospital admissions, audits or payments
1381 under the APR-DRG or APC models, or a managed care program or
1382 similar model described in subsection (H) of this section.

1383 (K) In the negotiation and execution of such contracts
1384 involving services performed by actuarial firms, the Executive
1385 Director of the Division of Medicaid may negotiate a limitation on
1386 liability to the state of prospective contractors.

1387 (L) The Division of Medicaid shall reimburse for services
1388 provided to eligible Medicaid beneficiaries by a licensed birthing
1389 center in a method and manner to be determined by the division in
1390 accordance with federal laws and federal regulations. The
1391 division shall seek any necessary waivers, make any required
1392 amendments to its State Plan or revise any contracts authorized
1393 under subsection (H) of this section as necessary to provide the
1394 services authorized under this subsection. As used in this
1395 subsection, the term "birthing centers" shall have the meaning as
1396 defined in Section 41-77-1(a), which is a publicly or privately
1397 owned facility, place or institution constructed, renovated,
1398 leased or otherwise established where nonemergency births are
1399 planned to occur away from the mother's usual residence following
1400 a documented period of prenatal care for a normal uncomplicated
1401 pregnancy which has been determined to be low risk through a
1402 formal risk-scoring examination.

1403 (M) This section shall stand repealed on July 1, 2028.

1404 **SECTION 3.** This act shall take effect and be in force from
1405 and after July 1, 2025.

