

By: Senator(s) Younger, Blackwell

To: Medicaid

SENATE BILL NO. 2898

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO REQUIRE THE PEER COMMITTEE TO CONDUCT A PERFORMANCE EVALUATION
3 OF THE DIVISION OF MEDICAID'S NONEMERGENCY TRANSPORTATION PROGRAM
4 TWO YEARS AFTER THE IMPLEMENTATION DATE OF EACH NEW CONTRACT; AND
5 FOR RELATED PURPOSES.

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

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

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

16 (1) Inpatient hospital services.

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



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

(2) Outpatient hospital services.

(a) Emergency services.

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

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



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

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

(3) Laboratory and x-ray services.

(4) Nursing facility services.

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

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



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

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

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

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



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

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

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

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



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

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



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

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

161 (b) [Repealed]

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

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

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



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

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

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

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



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

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

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

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

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

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



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

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

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

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

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

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



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

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

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

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

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



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

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

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

(12) Intermediate care facility services.

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



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

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

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

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

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

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

(b) Dialysis center services.

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



317 (16) Mental health services. Certain services provided
318 by a psychiatrist shall be reimbursed at up to one hundred percent
319 (100%) of the Medicare rate. Approved therapeutic and case
320 management services (a) provided by an approved regional mental
321 health/intellectual disability center established under Sections
322 41-19-31 through 41-19-39, or by another community mental health
323 service provider meeting the requirements of the Department of
324 Mental Health to be an approved mental health/intellectual
325 disability center if determined necessary by the Department of
326 Mental Health, using state funds that are provided in the
327 appropriation to the division to match federal funds, or (b)
328 provided by a facility that is certified by the State Department
329 of Mental Health to provide therapeutic and case management
330 services, to be reimbursed on a fee for service basis, or (c)
331 provided in the community by a facility or program operated by the
332 Department of Mental Health. Any such services provided by a
333 facility described in subparagraph (b) must have the prior
334 approval of the division to be reimbursable under this section.

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



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

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



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

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

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

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



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

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

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



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



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

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

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



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

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

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

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



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

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

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



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

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

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



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

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

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



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

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

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



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

601 (23) Inpatient psychiatric services.

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



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

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

625 (24) [Deleted]

626 (25) [Deleted]

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

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



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

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

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

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



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

671 (33) Podiatrist services.

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

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

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



members of the Senate Medicaid Committee and the House Medicaid Committee not later than January 1, 2019, and every two (2) years after the implementation date of each new contract thereafter.

(37) [Deleted]

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

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

(40) [Deleted]

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



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

(42) [Deleted]

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

(44) Nursing facility services for the severely disabled.

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

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

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



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

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

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

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



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

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

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

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

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

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

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



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

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

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

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



815 (54) [Deleted]

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

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

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



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

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

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

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

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



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

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

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

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



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

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

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

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

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

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



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

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

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

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



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

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

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

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



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

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

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

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

987 (F) The executive director shall keep the Governor advised
988 on a timely basis of the funds available for expenditure and the
989 projected expenditures. Notwithstanding any other provisions of



this article, if current or projected expenditures of the division are reasonably anticipated to exceed the amount of funds appropriated to the division for any fiscal year, the Governor, after consultation with the executive director, shall take all appropriate measures to reduce costs, which may include, but are not limited to:

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

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

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

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

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

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



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

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

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

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



1039 (b) Override the medical decisions of hospital
1040 physicians or staff regarding patients admitted to a hospital for
1041 an emergency medical condition as defined by 42 US Code Section
1042 1395dd. This restriction (b) does not prohibit the retrospective
1043 review of the appropriateness of the determination that an
1044 emergency medical condition exists by chart review or coding
1045 algorithm, nor does it prohibit prior authorization for
1046 nonemergency hospital admissions;

1047 (c) Pay providers at a rate that is less than the
1048 normal Medicaid reimbursement rate. It is the intent of the
1049 Legislature that all managed care entities described in this
1050 subsection (H), in collaboration with the division, develop and
1051 implement innovative payment models that incentivize improvements
1052 in health care quality, outcomes, or value, as determined by the
1053 division. Participation in the provider network of any managed
1054 care, coordinated care, provider-sponsored health plan, or similar
1055 contractor shall not be conditioned on the provider's agreement to
1056 accept such alternative payment models;

1057 (d) Implement a prior authorization and
1058 utilization review program for medical services, transportation
1059 services and prescription drugs that is more stringent than the
1060 prior authorization processes used by the division in its
1061 administration of the Medicaid program. Not later than December
1062 2, 2021, the contractors that are receiving capitated payments
1063 under a managed care delivery system established under this



1064 subsection (H) shall submit a report to the Chairmen of the House
1065 and Senate Medicaid Committees on the status of the prior
1066 authorization and utilization review program for medical services,
1067 transportation services and prescription drugs that is required to
1068 be implemented under this subparagraph (d);

1069 (e) [Deleted]

1070 (f) Implement a preferred drug list that is more
1071 stringent than the mandatory preferred drug list established by
1072 the division under subsection (A)(9) of this section;

1073 (g) Implement a policy which denies beneficiaries
1074 with hemophilia access to the federally funded hemophilia
1075 treatment centers as part of the Medicaid Managed Care network of
1076 providers.

1077 Each health maintenance organization, coordinated care
1078 organization, provider-sponsored health plan, or other
1079 organization paid for services on a capitated basis by the
1080 division under any managed care program or coordinated care
1081 program implemented by the division under this section shall use a
1082 clear set of level of care guidelines in the determination of
1083 medical necessity and in all utilization management practices,
1084 including the prior authorization process, concurrent reviews,
1085 retrospective reviews and payments, that are consistent with
1086 widely accepted professional standards of care. Organizations
1087 participating in a managed care program or coordinated care
1088 program implemented by the division may not use any additional



1089 criteria that would result in denial of care that would be
1090 determined appropriate and, therefore, medically necessary under
1091 those levels of care guidelines.

1092 (2) Notwithstanding any provision of this section, the
1093 recipients eligible for enrollment into a Medicaid Managed Care
1094 Program authorized under this subsection (H) may include only
1095 those categories of recipients eligible for participation in the
1096 Medicaid Managed Care Program as of January 1, 2021, the
1097 Children's Health Insurance Program (CHIP), and the CMS-approved
1098 Section 1115 demonstration waivers in operation as of January 1,
1099 2021. No expansion of Medicaid Managed Care Program contracts may
1100 be implemented by the division without enabling legislation from
1101 the Mississippi Legislature.

1102 (3) (a) Any contractors receiving capitated payments
1103 under a managed care delivery system established in this section
1104 shall provide to the Legislature and the division statistical data
1105 to be shared with provider groups in order to improve patient
1106 access, appropriate utilization, cost savings and health outcomes
1107 not later than October 1 of each year. Additionally, each
1108 contractor shall disclose to the Chairmen of the Senate and House
1109 Medicaid Committees the administrative expenses costs for the
1110 prior calendar year, and the number of full-equivalent employees
1111 located in the State of Mississippi dedicated to the Medicaid and
1112 CHIP lines of business as of June 30 of the current year.



1113 (b) The division and the contractors participating
1114 in the managed care program, a coordinated care program or a
1115 provider-sponsored health plan shall be subject to annual program
1116 reviews or audits performed by the Office of the State Auditor,
1117 the PEER Committee, the Department of Insurance and/or independent
1118 third parties.

1119 (c) Those reviews shall include, but not be
1120 limited to, at least two (2) of the following items:

1121 (i) The financial benefit to the State of
1122 Mississippi of the managed care program,

1123 (ii) The difference between the premiums paid
1124 to the managed care contractors and the payments made by those
1125 contractors to health care providers,

1126 (iii) Compliance with performance measures
1127 required under the contracts,

1128 (iv) Administrative expense allocation
1129 methodologies,

1130 (v) Whether nonprovider payments assigned as
1131 medical expenses are appropriate,

1132 (vi) Capitated arrangements with related
1133 party subcontractors,

1134 (vii) Reasonableness of corporate
1135 allocations,

1136 (viii) Value-added benefits and the extent to
1137 which they are used,



1138 (ix) The effectiveness of subcontractor
1139 oversight, including subcontractor review,
1140 (x) Whether health care outcomes have been
1141 improved, and
1142 (xi) The most common claim denial codes to
1143 determine the reasons for the denials.

1144 The audit reports shall be considered public documents and
1145 shall be posted in their entirety on the division's website.

1146 (4) All health maintenance organizations, coordinated
1147 care organizations, provider-sponsored health plans, or other
1148 organizations paid for services on a capitated basis by the
1149 division under any managed care program or coordinated care
1150 program implemented by the division under this section shall
1151 reimburse all providers in those organizations at rates no lower
1152 than those provided under this section for beneficiaries who are
1153 not participating in those programs.

1154 (5) No health maintenance organization, coordinated
1155 care organization, provider-sponsored health plan, or other
1156 organization paid for services on a capitated basis by the
1157 division under any managed care program or coordinated care
1158 program implemented by the division under this section shall
1159 require its providers or beneficiaries to use any pharmacy that
1160 ships, mails or delivers prescription drugs or legend drugs or
1161 devices.



1162 (6) (a) Not later than December 1, 2021, the
1163 contractors who are receiving capitated payments under a managed
1164 care delivery system established under this subsection (H) shall
1165 develop and implement a uniform credentialing process for
1166 providers. Under that uniform credentialing process, a provider
1167 who meets the criteria for credentialing will be credentialed with
1168 all of those contractors and no such provider will have to be
1169 separately credentialed by any individual contractor in order to
1170 receive reimbursement from the contractor. Not later than
1171 December 2, 2021, those contractors shall submit a report to the
1172 Chairmen of the House and Senate Medicaid Committees on the status
1173 of the uniform credentialing process for providers that is
1174 required under this subparagraph (a).

1175 (b) If those contractors have not implemented a
1176 uniform credentialing process as described in subparagraph (a) by
1177 December 1, 2021, the division shall develop and implement, not
1178 later than July 1, 2022, a single, consolidated credentialing
1179 process by which all providers will be credentialed. Under the
1180 division's single, consolidated credentialing process, no such
1181 contractor shall require its providers to be separately
1182 credentialed by the contractor in order to receive reimbursement
1183 from the contractor, but those contractors shall recognize the
1184 credentialing of the providers by the division's credentialing
1185 process.



1186 (c) The division shall require a uniform provider
1187 credentialing application that shall be used in the credentialing
1188 process that is established under subparagraph (a) or (b). If the
1189 contractor or division, as applicable, has not approved or denied
1190 the provider credentialing application within sixty (60) days of
1191 receipt of the completed application that includes all required
1192 information necessary for credentialing, then the contractor or
1193 division, upon receipt of a written request from the applicant and
1194 within five (5) business days of its receipt, shall issue a
1195 temporary provider credential/enrollment to the applicant if the
1196 applicant has a valid Mississippi professional or occupational
1197 license to provide the health care services to which the
1198 credential/enrollment would apply. The contractor or the division
1199 shall not issue a temporary credential/enrollment if the applicant
1200 has reported on the application a history of medical or other
1201 professional or occupational malpractice claims, a history of
1202 substance abuse or mental health issues, a criminal record, or a
1203 history of medical or other licensing board, state or federal
1204 disciplinary action, including any suspension from participation
1205 in a federal or state program. The temporary
1206 credential/enrollment shall be effective upon issuance and shall
1207 remain in effect until the provider's credentialing/enrollment
1208 application is approved or denied by the contractor or division.
1209 The contractor or division shall render a final decision regarding
1210 credentialing/enrollment of the provider within sixty (60) days



1211 from the date that the temporary provider credential/enrollment is
1212 issued to the applicant.

1213 (d) If the contractor or division does not render
1214 a final decision regarding credentialing/enrollment of the
1215 provider within the time required in subparagraph (c), the
1216 provider shall be deemed to be credentialed by and enrolled with
1217 all of the contractors and eligible to receive reimbursement from
1218 the contractors.

1219 (7) (a) Each contractor that is receiving capitated
1220 payments under a managed care delivery system established under
1221 this subsection (H) shall provide to each provider for whom the
1222 contractor has denied the coverage of a procedure that was ordered
1223 or requested by the provider for or on behalf of a patient, a
1224 letter that provides a detailed explanation of the reasons for the
1225 denial of coverage of the procedure and the name and the
1226 credentials of the person who denied the coverage. The letter
1227 shall be sent to the provider in electronic format.

1228 (b) After a contractor that is receiving capitated
1229 payments under a managed care delivery system established under
1230 this subsection (H) has denied coverage for a claim submitted by a
1231 provider, the contractor shall issue to the provider within sixty
1232 (60) days a final ruling of denial of the claim that allows the
1233 provider to have a state fair hearing and/or agency appeal with
1234 the division. If a contractor does not issue a final ruling of
1235 denial within sixty (60) days as required by this subparagraph



1236 (b), the provider's claim shall be deemed to be automatically
1237 approved and the contractor shall pay the amount of the claim to
1238 the provider.

1239 (c) After a contractor has issued a final ruling
1240 of denial of a claim submitted by a provider, the division shall
1241 conduct a state fair hearing and/or agency appeal on the matter of
1242 the disputed claim between the contractor and the provider within
1243 sixty (60) days, and shall render a decision on the matter within
1244 thirty (30) days after the date of the hearing and/or appeal.

1245 (8) It is the intention of the Legislature that the
1246 division evaluate the feasibility of using a single vendor to
1247 administer pharmacy benefits provided under a managed care
1248 delivery system established under this subsection (H). Providers
1249 of pharmacy benefits shall cooperate with the division in any
1250 transition to a carve-out of pharmacy benefits under managed care.

1251 (9) The division shall evaluate the feasibility of
1252 using a single vendor to administer dental benefits provided under
1253 a managed care delivery system established in this subsection (H).
1254 Providers of dental benefits shall cooperate with the division in
1255 any transition to a carve-out of dental benefits under managed
1256 care.

1257 (10) It is the intent of the Legislature that any
1258 contractor receiving capitated payments under a managed care
1259 delivery system established in this section shall implement



1260 innovative programs to improve the health and well-being of
1261 members diagnosed with prediabetes and diabetes.

1262 (11) It is the intent of the Legislature that any
1263 contractors receiving capitated payments under a managed care
1264 delivery system established under this subsection (H) shall work
1265 with providers of Medicaid services to improve the utilization of
1266 long-acting reversible contraceptives (LARCs). Not later than
1267 December 1, 2021, any contractors receiving capitated payments
1268 under a managed care delivery system established under this
1269 subsection (H) shall provide to the Chairmen of the House and
1270 Senate Medicaid Committees and House and Senate Public Health
1271 Committees a report of LARC utilization for State Fiscal Years
1272 2018 through 2020 as well as any programs, initiatives, or efforts
1273 made by the contractors and providers to increase LARC
1274 utilization. This report shall be updated annually to include
1275 information for subsequent state fiscal years.

1276 (12) The division is authorized to make not more than
1277 one (1) emergency extension of the contracts that are in effect on
1278 July 1, 2021, with contractors who are receiving capitated
1279 payments under a managed care delivery system established under
1280 this subsection (H), as provided in this paragraph (12). The
1281 maximum period of any such extension shall be one (1) year, and
1282 under any such extensions, the contractors shall be subject to all
1283 of the provisions of this subsection (H). The extended contracts



1284 shall be revised to incorporate any provisions of this subsection
1285 (H) .

1286 (I) [Deleted]

1287 (J) There shall be no cuts in inpatient and outpatient
1288 hospital payments, or allowable days or volumes, as long as the
1289 hospital assessment provided in Section 43-13-145 is in effect.
1290 This subsection (J) shall not apply to decreases in payments that
1291 are a result of: reduced hospital admissions, audits or payments
1292 under the APR-DRG or APC models, or a managed care program or
1293 similar model described in subsection (H) of this section.

1294 (K) In the negotiation and execution of such contracts
1295 involving services performed by actuarial firms, the Executive
1296 Director of the Division of Medicaid may negotiate a limitation on
1297 liability to the state of prospective contractors.

1298 (L) The Division of Medicaid shall reimburse for services
1299 provided to eligible Medicaid beneficiaries by a licensed birthing
1300 center in a method and manner to be determined by the division in
1301 accordance with federal laws and federal regulations. The
1302 division shall seek any necessary waivers, make any required
1303 amendments to its State Plan or revise any contracts authorized
1304 under subsection (H) of this section as necessary to provide the
1305 services authorized under this subsection. As used in this
1306 subsection, the term "birthing centers" shall have the meaning as
1307 defined in Section 41-77-1(a), which is a publicly or privately
1308 owned facility, place or institution constructed, renovated,



1309 leased or otherwise established where nonemergency births are
1310 planned to occur away from the mother's usual residence following
1311 a documented period of prenatal care for a normal uncomplicated
1312 pregnancy which has been determined to be low risk through a
1313 formal risk-scoring examination.

1314 (M) This section shall stand repealed on July 1, 2028.

1315 **SECTION 2.** This act shall take effect and be in force from
1316 and after July 1, 2025.

