MISSISSIPPI LEGISLATURE REGULAR SESSION 2023

By: Representatives Johnson, Anthony

To: Medicaid

HOUSE BILL NO. 324

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE THAT TELEHEALTH SERVICES PROVIDED BY FEDERALLY
3 QUALIFIED HEALTH CENTERS, RURAL HEALTH CLINICS AND COMMUNITY
4 MENTAL HEALTH CENTERS ARE CONSIDERED TO BE BILLABLE AT THE SAME
5 FACE-TO-FACE ENCOUNTER RATE USED FOR ALL OTHER MEDICAID
6 REIMBURSEMENTS TO THOSE CENTERS UNDER THE PROSPECTIVE PAYMENT
7 SYSTEM; AND FOR RELATED PURPOSES.

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

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

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

18 (1) Inpatient hospital services.

19 (a) The division is authorized to implement an All
20 Patient Refined Diagnosis Related Groups (APR-DRG) reimbursement
21 methodology for inpatient hospital services.
22 (b) No service benefits or reimbursement
23 limitations in this subsection (A)(1) shall apply to payments
24 under an APR-DRG or Ambulatory Payment Classification (APC) model
25 or a managed care program or similar model described in subsection
26 (H) of this section unless specifically authorized by the
27 division.
28 (2) Outpatient hospital services.
29 (a) Emergency services.
30 (b) Other outpatient hospital services. The
31 division shall allow benefits for other medically necessary
32 outpatient hospital services (such as chemotherapy, radiation,
33 surgery and therapy), including outpatient services in a clinic or
34 other facility that is not located inside the hospital, but that
35 has been designated as an outpatient facility by the hospital, and
36 that was in operation or under construction on July 1, 2009,
37 provided that the costs and charges associated with the operation
38 of the hospital clinic are included in the hospital's cost report.
39 In addition, the Medicare thirty-five-mile rule will apply to
40 those hospital clinics not located inside the hospital that are
41 constructed after July 1, 2009. Where the same services are
42 reimbursed as clinic services, the division may revise the rate or

43 methodology of outpatient reimbursement to maintain consistency,
44 efficiency, economy and quality of care.
45 (c) The division is authorized to implement an
46 Ambulatory Payment Classification (APC) methodology for outpatient
47 hospital services. The division shall give rural hospitals that
48 have fifty (50) or fewer licensed beds the option to not be
49 reimbursed for outpatient hospital services using the APC
50 methodology, but reimbursement for outpatient hospital services
51 provided by those hospitals shall be based on one hundred one
52 percent (101%) of the rate established under Medicare for
53 outpatient hospital services. Those hospitals choosing to not be
54 reimbursed under the APC methodology shall remain under cost-based
55 reimbursement for a two-year period.
56 (d) No service benefits or reimbursement
57 limitations in this subsection (A)(2) shall apply to payments
58 under an APR-DRG or APC model or a managed care program or similar
59 model described in subsection (H) of this section unless
60 specifically authorized by the division.
61 (3) Laboratory and x-ray services.
62 (4) Nursing facility services.
63 (a) The division shall make full payment to
64 nursing facilities for each day, not exceeding forty-two (42) days
65 per year, that a patient is absent from the facility on home
66 leave. Payment may be made for the following home leave days in
67 addition to the forty-two-day limitation: Christmas, the day

68 before Christmas, the day after Christmas, Thanksgiving, the day
69 before Thanksgiving and the day after Thanksgiving.
70 (b) From and after July 1, 1997, the division
71 shall implement the integrated case-mix payment and quality
72 monitoring system, which includes the fair rental system for
73 property costs and in which recapture of depreciation is
74 eliminated. The division may reduce the payment for hospital
75 leave and therapeutic home leave days to the lower of the case-mix
76 category as computed for the resident on leave using the
77 assessment being utilized for payment at that point in time, or a
78 case-mix score of 1.000 for nursing facilities, and shall compute
79 case-mix scores of residents so that only services provided at the
80 nursing facility are considered in calculating a facility's per
81 diem.
82 (c) From and after July 1, 1997, all state-owned
83 nursing facilities shall be reimbursed on a full reasonable cost
84 basis.
85 (d) On or after January 1, 2015, the division
86 shall update the case-mix payment system resource utilization
87 grouper and classifications and fair rental reimbursement system.
88 The division shall develop and implement a payment add-on to
89 reimburse nursing facilities for ventilator-dependent resident
90 services.
91 (e) The division shall develop and implement, not
92 later than January 1, 2001, a case-mix payment add-on determined

93 by time studies and other valid statistical data that will
94 reimburse a nursing facility for the additional cost of caring for
95 a resident who has a diagnosis of Alzheimer's or other related
96 dementia and exhibits symptoms that require special care. Any
97 such case-mix add-on payment shall be supported by a determination
98 of additional cost. The division shall also develop and implement
99 as part of the fair rental reimbursement system for nursing
100 facility beds, an Alzheimer's resident bed depreciation enhanced
101 reimbursement system that will provide an incentive to encourage
102 nursing facilities to convert or construct beds for residents with
103 Alzheimer's or other related dementia.

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

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

112 (5) Periodic screening and diagnostic services for
113 individuals under age twenty-one (21) years as are needed to
114 identify physical and mental defects and to provide health care
115 treatment and other measures designed to correct or ameliorate
116 defects and physical and mental illness and conditions discovered
117 by the screening services, regardless of whether these services

118 are included in the state plan. The division may include in its
119 periodic screening and diagnostic program those discretionary
120 services authorized under the federal regulations adopted to
121 implement Title XIX of the federal Social Security Act, as
122 amended. The division, in obtaining physical therapy services,
123 occupational therapy services, and services for individuals with
124 speech, hearing and language disorders, may enter into a
125 cooperative agreement with the State Department of Education for
126 the provision of those services to handicapped students by public
127 school districts using state funds that are provided from the
128 appropriation to the Department of Education to obtain federal
129 matching funds through the division. The division, in obtaining
130 medical and mental health assessments, treatment, care and
131 services for children who are in, or at risk of being put in, the
132 custody of the Mississippi Department of Human Services may enter
133 into a cooperative agreement with the Mississippi Department of
134 Human Services for the provision of those services using state
135 funds that are provided from the appropriation to the Department
136 of Human Services to obtain federal matching funds through the
137 division.
138 (6) Physician services. Fees for physician's services
139 that are covered only by Medicaid shall be reimbursed at ninety
140 percent (90%) of the rate established on January 1, 2018, and as
141 may be adjusted each July thereafter, under Medicare. The
142 division may provide for a reimbursement rate for physician's

143 services of up to one hundred percent (100%) of the rate
144 established under Medicare for physician's services that are
145 provided after the normal working hours of the physician, as
146 determined in accordance with regulations of the division. The
147 division may reimburse eligible providers, as determined by the
148 division, for certain primary care services at one hundred percent
149 (100%) of the rate established under Medicare. The division shall
150 reimburse obstetricians and gynecologists for certain primary care
151 services as defined by the division at one hundred percent (100%)
152 of the rate established under Medicare.

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

163 (b) [Repealed]

164 (8) Emergency medical transportation services as
165 determined by the division.

166 (9) Prescription drugs and other covered drugs and
167 services as determined by the division.

168 The division shall establish a mandatory preferred drug list.
169 Drugs not on the mandatory preferred drug list shall be made
170 available by utilizing prior authorization procedures established
171 by the division.
172 The division may seek to establish relationships with other
173 states in order to lower acquisition costs of prescription drugs
174 to include single-source and innovator multiple-source drugs or
175 generic drugs. In addition, if allowed by federal law or
176 regulation, the division may seek to establish relationships with
177 and negotiate with other countries to facilitate the acquisition
178 of prescription drugs to include single-source and innovator
179 multiple-source drugs or generic drugs, if that will lower the
180 acquisition costs of those prescription drugs.
181 The division may allow for a combination of prescriptions for
182 single-source and innovator multiple-source drugs and generic
183 drugs to meet the needs of the beneficiaries.
184 The executive director may approve specific maintenance drugs
185 for beneficiaries with certain medical conditions, which may be
186 prescribed and dispensed in three-month supply increments.
187 Drugs prescribed for a resident of a psychiatric residential
188 treatment facility must be provided in true unit doses when
189 available. The division may require that drugs not covered by
190 Medicare Part D for a resident of a long-term care facility be
191 provided in true unit doses when available. Those drugs that were
192 originally billed to the division but are not used by a resident

193 in any of those facilities shall be returned to the billing
194 pharmacy for credit to the division, in accordance with the
195 guidelines of the State Board of Pharmacy and any requirements of
196 federal law and regulation. Drugs shall be dispensed to a
197 recipient and only one (1) dispensing fee per month may be
198 charged. The division shall develop a methodology for reimbursing
199 for restocked drugs, which shall include a restock fee as
200 determined by the division not exceeding Seven Dollars and
201 Eighty-two Cents ($7.82).

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

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

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

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

218 The division shall develop and implement a method or methods
219 by which the division will provide on a regular basis to Medicaid
220 providers who are authorized to prescribe drugs, information about
221 the costs to the Medicaid program of single-source drugs and
222 innovator multiple-source drugs, and information about other drugs
223 that may be prescribed as alternatives to those single-source
224 drugs and innovator multiple-source drugs and the costs to the
225 Medicaid program of those alternative drugs.
226 Notwithstanding any law or regulation, information obtained
227 or maintained by the division regarding the prescription drug
228 program, including trade secrets and manufacturer or labeler
229 pricing, is confidential and not subject to disclosure except to
230 other state agencies.
231 The dispensing fee for each new or refill prescription,
232 including nonlegend or over-the-counter drugs covered by the
233 division, shall be not less than Three Dollars and Ninety-one
234 Cents ($3.91), as determined by the division.
235 The division shall not reimburse for single-source or
236 innovator multiple-source drugs if there are equally effective
237 generic equivalents available and if the generic equivalents are
238 the least expensive.
239 It is the intent of the Legislature that the pharmacists
240 providers be reimbursed for the reasonable costs of filling and
241 dispensing prescriptions for Medicaid beneficiaries.

242 The division shall allow certain drugs, including
243 physician-administered drugs, and implantable drug system devices,
244 and medical supplies, with limited distribution or limited access
245 for beneficiaries and administered in an appropriate clinical
246 setting, to be reimbursed as either a medical claim or pharmacy
247 claim, as determined by the division.

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

252 (10) Dental and orthodontic services to be determined
253 by the division.

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

267 The Medical Care Advisory Committee, assisted by the Division
268 of Medicaid, shall annually determine the effect of this incentive
269 by evaluating the number of dentists who are Medicaid providers,
270 the number who and the degree to which they are actively billing
271 Medicaid, the geographic trends of where dentists are offering
272 what types of Medicaid services and other statistics pertinent to
273 the goals of this legislative intent. This data shall annually be
274 presented to the Chair of the Senate Medicaid Committee and the
275 Chair of the House Medicaid Committee.

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

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

288 (12) Intermediate care facility services.

289 (a) The division shall make full payment to all
290 intermediate care facilities for individuals with intellectual
291 disabilities for each day, not exceeding sixty-three (63) days per

292 year, that a patient is absent from the facility on home leave.
293 Payment may be made for the following home leave days in addition
294 to the sixty-three-day limitation: Christmas, the day before
295 Christmas, the day after Christmas, Thanksgiving, the day before
296 Thanksgiving and the day after Thanksgiving.

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

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

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

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

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

313 (b) Dialysis center services.

314 (15) Home- and community-based services for the elderly
315 and disabled, as provided under Title XIX of the federal Social
316 Security Act, as amended, under waivers, subject to the

317 availability of funds specifically appropriated for that purpose
318 by the Legislature.
319 (16) Mental health services. Certain services provided
320 by a psychiatrist shall be reimbursed at up to one hundred percent
321 (100%) of the Medicare rate. Approved therapeutic and case
322 management services (a) provided by an approved regional mental
323 health/intellectual disability center established under Sections
324 41-19-31 through 41-19-39, or by another community mental health
325 service provider meeting the requirements of the Department of
326 Mental Health to be an approved mental health/intellectual
327 disability center if determined necessary by the Department of
328 Mental Health, using state funds that are provided in the
329 appropriation to the division to match federal funds, or (b)
330 provided by a facility that is certified by the State Department
331 of Mental Health to provide therapeutic and case management
332 services, to be reimbursed on a fee for service basis, or (c)
333 provided in the community by a facility or program operated by the
334 Department of Mental Health. Any such services provided by a
335 facility described in subparagraph (b) must have the prior
336 approval of the division to be reimbursable under this section.
337 (17) Durable medical equipment services and medical
338 supplies. Precertification of durable medical equipment and
339 medical supplies must be obtained as required by the division.
340 The Division of Medicaid may require durable medical equipment
341 providers to obtain a surety bond in the amount and to the

342 specifications as established by the Balanced Budget Act of 1997.
343 A maximum dollar amount of reimbursement for noninvasive
344 ventilators or ventilation treatments properly ordered and being
345 used in an appropriate care setting shall not be set by any health
346 maintenance organization, coordinated care organization,
347 provider-sponsored health plan, or other organization paid for
348 services on a capitated basis by the division under any managed
349 care program or coordinated care program implemented by the
350 division under this section. Reimbursement by these organizations
351 to durable medical equipment suppliers for home use of noninvasive
352 and invasive ventilators shall be on a continuous monthly payment
353 basis for the duration of medical need throughout a patient's
354 valid prescription period.
355 (18) (a) Notwithstanding any other provision of this
356 section to the contrary, as provided in the Medicaid state plan
357 amendment or amendments as defined in Section 43-13-145(10), the
358 division shall make additional reimbursement to hospitals that
359 serve a disproportionate share of low-income patients and that
360 meet the federal requirements for those payments as provided in
361 Section 1923 of the federal Social Security Act and any applicable
362 regulations. It is the intent of the Legislature that the
363 division shall draw down all available federal funds allotted to
364 the state for disproportionate share hospitals. However, from and
365 after January 1, 1999, public hospitals participating in the
366 Medicaid disproportionate share program may be required to

367 participate in an intergovernmental transfer program as provided
368 in Section 1903 of the federal Social Security Act and any
369 applicable regulations.

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

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

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

392 division, consistent with federal regulations. The assessments
393 will remain in effect as long as the state participates in the
394 Medicare Upper Payment Limits Program or other program(s)
395 authorized under this subsection (A)(18)(b). In addition to the
396 hospital assessment provided in Section 43-13-145(4)(a), hospitals
397 with physicians participating in the Medicare Upper Payment Limits
398 Program or other program(s) authorized under this subsection
399 (A)(18)(b) shall be required to participate in an
400 intergovernmental transfer or assessment, as determined by the
401 division, for the purpose of financing the state portion of the
402 physician UPL payments or other payment(s) authorized under this
403 subsection (A)(18)(b).
404 (iii) Subject to approval by the Centers for
405 Medicare and Medicaid Services (CMS) and the provisions of this
406 subsection (A)(18)(b), the division shall make additional
407 reimbursement to hospitals, nursing facilities, and emergency
408 ambulance transportation providers for the Medicare Upper Payment
409 Limits Program or other program(s) authorized under this
410 subsection (A)(18)(b), and, if the program is established for
411 physicians, shall make additional reimbursement for physicians, as
412 defined in Section 1902(a)(30) of the federal Social Security Act
413 and any applicable federal regulations, provided the assessment in
414 this subsection (A)(18)(b) is in effect.
415 (iv) Notwithstanding any other provision of
416 this article to the contrary, effective upon implementation of the

417 Mississippi Hospital Access Program (MHAP) provided in
418 subparagraph (c)(i) below, the hospital portion of the inpatient
419 Upper Payment Limits Program shall transition into and be replaced
420 by the MHAP program. However, the division is authorized to
421 develop and implement an alternative fee-for-service Upper Payment
422 Limits model in accordance with federal laws and regulations if
423 necessary to preserve supplemental funding. Further, the
424 division, in consultation with the hospital industry shall develop
425 alternative models for distribution of medical claims and
426 supplemental payments for inpatient and outpatient hospital
427 services, and such models may include, but shall not be limited to
428 the following: increasing rates for inpatient and outpatient
429 services; creating a low-income utilization pool of funds to
430 reimburse hospitals for the costs of uncompensated care, charity
431 care and bad debts as permitted and approved pursuant to federal
432 regulations and the Centers for Medicare and Medicaid Services;
433 supplemental payments based upon Medicaid utilization, quality,
434 service lines and/or costs of providing such services to Medicaid
435 beneficiaries and to uninsured patients. The goals of such
436 payment models shall be to ensure access to inpatient and
437 outpatient care and to maximize any federal funds that are
438 available to reimburse hospitals for services provided. Any such
439 documents required to achieve the goals described in this
440 paragraph shall be submitted to the Centers for Medicare and
441 Medicaid Services, with a proposed effective date of July 1, 2019,

442 to the extent possible, but in no event shall the effective date
443 of such payment models be later than July 1, 2020. The Chairmen
444 of the Senate and House Medicaid Committees shall be provided a
445 copy of the proposed payment model(s) prior to submission.
446 Effective July 1, 2018, and until such time as any payment
447 model(s) as described above become effective, the division, in
448 consultation with the hospital industry, is authorized to
449 implement a transitional program for inpatient and outpatient
450 payments and/or supplemental payments (including, but not limited
451 to, MHAP and directed payments), to redistribute available
452 supplemental funds among hospital providers, provided that when
453 compared to a hospital's prior year supplemental payments,
454 supplemental payments made pursuant to any such transitional
455 program shall not result in a decrease of more than five percent
456 (5%) and shall not increase by more than the amount needed to
457 maximize the distribution of the available funds.
458 (v) 1. To preserve and improve access to
459 ambulance transportation provider services, the division shall
460 seek CMS approval to make ambulance service access payments as set
461 forth in this subsection (A)(18)(b) for all covered emergency
462 ambulance services rendered on or after July 1, 2022, and shall
463 make such ambulance service access payments for all covered
464 services rendered on or after the effective date of CMS approval.
465 2. The division shall calculate the
466 ambulance service access payment amount as the balance of the

467 portion of the Medical Care Fund related to ambulance
468 transportation service provider assessments plus any federal
469 matching funds earned on the balance, up to, but not to exceed,
470 the upper payment limit gap for all emergency ambulance service
471 providers.

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

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

486 c. As used in this paragraph
487 (18)(b)(v), the term "upper payment limit gap" means the
488 difference between the total amount that the ambulance
489 transportation service provider received from Medicaid and the
490 average amount that the ambulance transportation service provider

491 would have received from commercial insurers for those services
492 reimbursed by Medicaid.
493 4. An ambulance service access payment
494 shall not be used to offset any other payment by the division for
495 emergency or nonemergency services to Medicaid beneficiaries.
496 (c) (i) Not later than December 1, 2015, the
497 division shall, subject to approval by the Centers for Medicare
498 and Medicaid Services (CMS), establish, implement and operate a
499 Mississippi Hospital Access Program (MHAP) for the purpose of
500 protecting patient access to hospital care through hospital
501 inpatient reimbursement programs provided in this section designed
502 to maintain total hospital reimbursement for inpatient services
503 rendered by in-state hospitals and the out-of-state hospital that
504 is authorized by federal law to submit intergovernmental transfers
505 (IGTs) to the State of Mississippi and is classified as Level I
506 trauma center located in a county contiguous to the state line at
507 the maximum levels permissible under applicable federal statutes
508 and regulations, at which time the current inpatient Medicare
509 Upper Payment Limits (UPL) Program for hospital inpatient services
510 shall transition to the MHAP.
511 (ii) Subject to approval by the Centers for
512 Medicare and Medicaid Services (CMS), the MHAP shall provide
513 increased inpatient capitation (PMPM) payments to managed care
514 entities contracting with the division pursuant to subsection (H)
515 of this section to support availability of hospital services or

516 such other payments permissible under federal law necessary to
517 accomplish the intent of this subsection.
518 (iii) The intent of this subparagraph (c) is
519 that effective for all inpatient hospital Medicaid services during
520 state fiscal year 2016, and so long as this provision shall remain
521 in effect hereafter, the division shall to the fullest extent
522 feasible replace the additional reimbursement for hospital
523 inpatient services under the inpatient Medicare Upper Payment
524 Limits (UPL) Program with additional reimbursement under the MHAP
525 and other payment programs for inpatient and/or outpatient
526 payments which may be developed under the authority of this
527 paragraph.
528 (iv) The division shall assess each hospital
529 as provided in Section 43-13-145(4)(a) for the purpose of
530 financing the state portion of the MHAP, supplemental payments and
531 such other purposes as specified in Section 43-13-145. The
532 assessment will remain in effect as long as the MHAP and
533 supplemental payments are in effect.
534 (19) (a) Perinatal risk management services. The
535 division shall promulgate regulations to be effective from and
536 after October 1, 1988, to establish a comprehensive perinatal
537 system for risk assessment of all pregnant and infant Medicaid
538 recipients and for management, education and follow-up for those
539 who are determined to be at risk. Services to be performed
540 include case management, nutrition assessment/counseling,

541 psychosocial assessment/counseling and health education. The
542 division shall contract with the State Department of Health to
543 provide services within this paragraph (Perinatal High Risk
544 Management/Infant Services System (PHRM/ISS)). The State
545 Department of Health shall be reimbursed on a full reasonable cost
546 basis for services provided under this subparagraph (a).
547 (b) Early intervention system services. The
548 division shall cooperate with the State Department of Health,
549 acting as lead agency, in the development and implementation of a
550 statewide system of delivery of early intervention services, under
551 Part C of the Individuals with Disabilities Education Act (IDEA).
552 The State Department of Health shall certify annually in writing
553 to the executive director of the division the dollar amount of
554 state early intervention funds available that will be utilized as
555 a certified match for Medicaid matching funds. Those funds then
556 shall be used to provide expanded targeted case management
557 services for Medicaid eligible children with special needs who are
558 eligible for the state's early intervention system.
559 Qualifications for persons providing service coordination shall be
560 determined by the State Department of Health and the Division of
561 Medicaid.
562 (20) Home- and community-based services for physically
563 disabled approved services as allowed by a waiver from the United
564 States Department of Health and Human Services for home- and
565 community-based services for physically disabled people using

566 state funds that are provided from the appropriation to the State
567 Department of Rehabilitation Services and used to match federal
568 funds under a cooperative agreement between the division and the
569 department, provided that funds for these services are
570 specifically appropriated to the Department of Rehabilitation
571 Services.

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

588 (22) Ambulatory services delivered in federally
589 qualified health centers, rural health centers and clinics of the
590 local health departments of the State Department of Health for

591 individuals eligible for Medicaid under this article based on
592 reasonable costs as determined by the division. Federally
593 qualified health centers shall be reimbursed by the Medicaid
594 prospective payment system as approved by the Centers for Medicare
595 and Medicaid Services. The division shall recognize federally
596 qualified health centers (FQHCs), rural health clinics (RHCs) and
597 community mental health centers (CMHCs) as both an originating and
598 distant site provider for the purposes of telehealth
599 reimbursement. The division is further authorized and directed to
600 reimburse FQHCs, RHCs and CMHCs the applicable Medicaid fee for
601 both distant site and originating site telehealth services when
602 such services are appropriately provided by the same organization.
603 Telehealth services provided by FQHCs, RHCs and CMHCs are
604 considered billable at the same face-to-face encounter rate used
605 for all other Medicaid reimbursements to FQHCs, RHCs and CMHCs
606 under the prospective payment system.
607 (23) Inpatient psychiatric services.
608 (a) Inpatient psychiatric services to be
609 determined by the division for recipients under age twenty-one
610 (21) that are provided under the direction of a physician in an
611 inpatient program in a licensed acute care psychiatric facility or
612 in a licensed psychiatric residential treatment facility, before
613 the recipient reaches age twenty-one (21) or, if the recipient was
614 receiving the services immediately before he or she reached age
615 twenty-one (21), before the earlier of the date he or she no

616 longer requires the services or the date he or she reaches age
617 twenty-two (22), as provided by federal regulations. From and
618 after January 1, 2015, the division shall update the fair rental
619 reimbursement system for psychiatric residential treatment
620 facilities. Precertification of inpatient days and residential
621 treatment days must be obtained as required by the division. From
622 and after July 1, 2009, all state-owned and state-operated
623 facilities that provide inpatient psychiatric services to persons
624 under age twenty-one (21) who are eligible for Medicaid
625 reimbursement shall be reimbursed for those services on a full
626 reasonable cost basis.
627 (b) The division may reimburse for services
628 provided by a licensed freestanding psychiatric hospital to
629 Medicaid recipients over the age of twenty-one (21) in a method
630 and manner consistent with the provisions of Section 43-13-117.5.
631 (24) [Deleted]
632 (25) [Deleted]
633 (26) Hospice care. As used in this paragraph, the term
634 "hospice care" means a coordinated program of active professional
635 medical attention within the home and outpatient and inpatient
636 care that treats the terminally ill patient and family as a unit,
637 employing a medically directed interdisciplinary team. The
638 program provides relief of severe pain or other physical symptoms
639 and supportive care to meet the special needs arising out of
640 physical, psychological, spiritual, social and economic stresses

641 that are experienced during the final stages of illness and during
642 dying and bereavement and meets the Medicare requirements for
643 participation as a hospice as provided in federal regulations.

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

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

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

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

665 (31) Targeted case management services for children
666 with special needs, under waivers from the United States
667 Department of Health and Human Services, using state funds that
668 are provided from the appropriation to the Mississippi Department
669 of Human Services and used to match federal funds under a
670 cooperative agreement between the division and the department.
671 (32) Care and services provided in Christian Science
672 Sanatoria listed and certified by the Commission for Accreditation
673 of Christian Science Nursing Organizations/Facilities, Inc.,
674 rendered in connection with treatment by prayer or spiritual means
675 to the extent that those services are subject to reimbursement
676 under Section 1903 of the federal Social Security Act.
677 (33) Podiatrist services.
678 (34) Assisted living services as provided through
679 home- and community-based services under Title XIX of the federal
680 Social Security Act, as amended, subject to the availability of
681 funds specifically appropriated for that purpose by the
682 Legislature.
683 (35) Services and activities authorized in Sections
684 43-27-101 and 43-27-103, using state funds that are provided from
685 the appropriation to the Mississippi Department of Human Services
686 and used to match federal funds under a cooperative agreement
687 between the division and the department.
688 (36) Nonemergency transportation services for
689 Medicaid-eligible persons as determined by the division. The PEER

690 Committee shall conduct a performance evaluation of the
691 nonemergency transportation program to evaluate the administration
692 of the program and the providers of transportation services to
693 determine the most cost-effective ways of providing nonemergency
694 transportation services to the patients served under the program.
695 The performance evaluation shall be completed and provided to the
696 members of the Senate Medicaid Committee and the House Medicaid
697 Committee not later than January 1, 2019, and every two (2) years
698 thereafter.
699 (37) [Deleted]
700 (38) Chiropractic services. A chiropractor's manual
701 manipulation of the spine to correct a subluxation, if x-ray
702 demonstrates that a subluxation exists and if the subluxation has
703 resulted in a neuromusculoskeletal condition for which
704 manipulation is appropriate treatment, and related spinal x-rays
705 performed to document these conditions. Reimbursement for
706 chiropractic services shall not exceed Seven Hundred Dollars
707 ($700.00) per year per beneficiary.
708 (39) Dually eligible Medicare/Medicaid beneficiaries.
709 The division shall pay the Medicare deductible and coinsurance
710 amounts for services available under Medicare, as determined by
711 the division. From and after July 1, 2009, the division shall
712 reimburse crossover claims for inpatient hospital services and
713 crossover claims covered under Medicare Part B in the same manner

714 that was in effect on January 1, 2008, unless specifically
715 authorized by the Legislature to change this method.
716 (40) [Deleted]
717 (41) Services provided by the State Department of
718 Rehabilitation Services for the care and rehabilitation of persons
719 with spinal cord injuries or traumatic brain injuries, as allowed
720 under waivers from the United States Department of Health and
721 Human Services, using up to seventy-five percent (75%) of the
722 funds that are appropriated to the Department of Rehabilitation
723 Services from the Spinal Cord and Head Injury Trust Fund
724 established under Section 37-33-261 and used to match federal
725 funds under a cooperative agreement between the division and the
726 department.
727 (42) [Deleted]
728 (43) The division shall provide reimbursement,
729 according to a payment schedule developed by the division, for
730 smoking cessation medications for pregnant women during their
731 pregnancy and other Medicaid-eligible women who are of
732 child-bearing age.
733 (44) Nursing facility services for the severely
734 disabled.
735 (a) Severe disabilities include, but are not
736 limited to, spinal cord injuries, closed-head injuries and
737 ventilator-dependent patients.

738 (b) Those services must be provided in a long-term
739 care nursing facility dedicated to the care and treatment of
740 persons with severe disabilities.
741 (45) Physician assistant services. Services furnished
742 by a physician assistant who is licensed by the State Board of
743 Medical Licensure and is practicing with physician supervision
744 under regulations adopted by the board, under regulations adopted
745 by the division. Reimbursement for those services shall not
746 exceed ninety percent (90%) of the reimbursement rate for
747 comparable services rendered by a physician. The division may
748 provide for a reimbursement rate for physician assistant services
749 of up to one hundred percent (100%) or the reimbursement rate for
750 comparable services rendered by a physician for physician
751 assistant services that are provided after the normal working
752 hours of the physician assistant, as determined in accordance with
753 regulations of the division.
754 (46) The division shall make application to the federal
755 Centers for Medicare and Medicaid Services (CMS) for a waiver to
756 develop and provide services for children with serious emotional
757 disturbances as defined in Section 43-14-1(1), which may include
758 home- and community-based services, case management services or
759 managed care services through mental health providers certified by
760 the Department of Mental Health. The division may implement and
761 provide services under this waivered program only if funds for
762 these services are specifically appropriated for this purpose by

763 the Legislature, or if funds are voluntarily provided by affected
764 agencies.

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

769 (b) Participation in any disease management
770 program implemented under this paragraph (47) is optional with the
771 individual. An individual must affirmatively elect to participate
772 in the disease management program in order to participate, and may
773 elect to discontinue participation in the program at any time.

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

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

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

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

787 (50) Services provided by the State Department of
788 Rehabilitation Services for the care and rehabilitation of persons
789 who are deaf and blind, as allowed under waivers from the United
790 States Department of Health and Human Services to provide home-
791 and community-based services using state funds that are provided
792 from the appropriation to the State Department of Rehabilitation
793 Services or if funds are voluntarily provided by another agency.
794 (51) Upon determination of Medicaid eligibility and in
795 association with annual redetermination of Medicaid eligibility,
796 beneficiaries shall be encouraged to undertake a physical
797 examination that will establish a base-line level of health and
798 identification of a usual and customary source of care (a medical
799 home) to aid utilization of disease management tools. This
800 physical examination and utilization of these disease management
801 tools shall be consistent with current United States Preventive
802 Services Task Force or other recognized authority recommendations.
803 For persons who are determined ineligible for Medicaid, the
804 division will provide information and direction for accessing
805 medical care and services in the area of their residence.
806 (52) Notwithstanding any provisions of this article,
807 the division may pay enhanced reimbursement fees related to trauma
808 care, as determined by the division in conjunction with the State
809 Department of Health, using funds appropriated to the State
810 Department of Health for trauma care and services and used to
811 match federal funds under a cooperative agreement between the

812 division and the State Department of Health. The division, in
813 conjunction with the State Department of Health, may use grants,
814 waivers, demonstrations, enhanced reimbursements, Upper Payment
815 Limits Programs, supplemental payments, or other projects as
816 necessary in the development and implementation of this
817 reimbursement program.

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

821 (54) [Deleted]

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

834 (56) Prescribed pediatric extended care centers
835 services for medically dependent or technologically dependent
836 children with complex medical conditions that require continual

837 care as prescribed by the child's attending physician, as
838 determined by the division.

839 (57) No Medicaid benefit shall restrict coverage for
840 medically appropriate treatment prescribed by a physician and
841 agreed to by a fully informed individual, or if the individual
842 lacks legal capacity to consent by a person who has legal
843 authority to consent on his or her behalf, based on an
844 individual's diagnosis with a terminal condition. As used in this
845 paragraph (57), "terminal condition" means any aggressive
846 malignancy, chronic end-stage cardiovascular or cerebral vascular
847 disease, or any other disease, illness or condition which a
848 physician diagnoses as terminal.

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

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

862 (60) Border city university-affiliated pediatric
863 teaching hospital.
864 (a) Payments may only be made to a border city
865 university-affiliated pediatric teaching hospital if the Centers
866 for Medicare and Medicaid Services (CMS) approve an increase in
867 the annual request for the provider payment initiative authorized
868 under 42 CFR Section 438.6(c) in an amount equal to or greater
869 than the estimated annual payment to be made to the border city
870 university-affiliated pediatric teaching hospital. The estimate
871 shall be based on the hospital's prior year Mississippi managed
872 care utilization.
873 (b) As used in this paragraph (60), the term
874 "border city university-affiliated pediatric teaching hospital"
875 means an out-of-state hospital located within a city bordering the
876 eastern bank of the Mississippi River and the State of Mississippi
877 that submits to the division a copy of a current and effective
878 affiliation agreement with an accredited university and other
879 documentation establishing that the hospital is
880 university-affiliated, is licensed and designated as a pediatric
881 hospital or pediatric primary hospital within its home state,
882 maintains at least five (5) different pediatric specialty training
883 programs, and maintains at least one hundred (100) operated beds
884 dedicated exclusively for the treatment of patients under the age
885 of twenty-one (21) years.

886 (c) The cost of providing services to Mississippi
887 Medicaid beneficiaries under the age of twenty-one (21) years who
888 are treated by a border city university-affiliated pediatric
889 teaching hospital shall not exceed the cost of providing the same
890 services to individuals in hospitals in the state.
891 (d) It is the intent of the Legislature that
892 payments shall not result in any in-state hospital receiving
893 payments lower than they would otherwise receive if not for the
894 payments made to any border city university-affiliated pediatric
895 teaching hospital.
896 (e) This paragraph (60) shall stand repealed on
897 July 1, 2024.
898 (B) Planning and development districts participating in the
899 home- and community-based services program for the elderly and
900 disabled as case management providers shall be reimbursed for case
901 management services at the maximum rate approved by the Centers
902 for Medicare and Medicaid Services (CMS).
903 (C) The division may pay to those providers who participate
904 in and accept patient referrals from the division's emergency room
905 redirection program a percentage, as determined by the division,
906 of savings achieved according to the performance measures and
907 reduction of costs required of that program. Federally qualified
908 health centers may participate in the emergency room redirection
909 program, and the division may pay those centers a percentage of
910 any savings to the Medicaid program achieved by the centers'

911 accepting patient referrals through the program, as provided in
912 this subsection (C).
913 (D) (1) As used in this subsection (D), the following terms
914 shall be defined as provided in this paragraph, except as
915 otherwise provided in this subsection:
916 (a) "Committees" means the Medicaid Committees of
917 the House of Representatives and the Senate, and "committee" means
918 either one of those committees.
919 (b) "Rate change" means an increase, decrease or
920 other change in the payments or rates of reimbursement, or a
921 change in any payment methodology that results in an increase,
922 decrease or other change in the payments or rates of
923 reimbursement, to any Medicaid provider that renders any services
924 authorized to be provided to Medicaid recipients under this
925 article.
926 (2) Whenever the Division of Medicaid proposes a rate
927 change, the division shall give notice to the chairmen of the
928 committees at least thirty (30) calendar days before the proposed
929 rate change is scheduled to take effect. The division shall
930 furnish the chairmen with a concise summary of each proposed rate
931 change along with the notice, and shall furnish the chairmen with
932 a copy of any proposed rate change upon request. The division
933 also shall provide a summary and copy of any proposed rate change
934 to any other member of the Legislature upon request.

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

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

952 (b) After the committee meeting, the committee or
953 committees may object to the proposed rate change or any part
954 thereof. The committee or committees shall notify the division
955 and the reasons for their objection in writing not later than
956 seven (7) calendar days after the meeting. The committee or
957 committees may make written recommendations to the division for
958 changes to be made to a proposed rate change.

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

966 (6) (a) If there are any objections to a proposed rate
967 change or any part thereof from either or both of the chairmen or
968 the committees, the division may withdraw the proposed rate
969 change, make any of the recommended changes to the proposed rate
970 change, or not make any changes to the proposed rate change.

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

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

980 (7) Nothing in this subsection (D) shall be construed
981 as giving the chairmen or the committees any authority to veto,
982 nullify or revise any rate change proposed by the division. The
983 authority of the chairmen or the committees under this subsection

984 shall be limited to reviewing, making objections to and making
985 recommendations for changes to rate changes proposed by the
986 division.

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

993 (F) The executive director shall keep the Governor advised
994 on a timely basis of the funds available for expenditure and the
995 projected expenditures. Notwithstanding any other provisions of
996 this article, if current or projected expenditures of the division
997 are reasonably anticipated to exceed the amount of funds
998 appropriated to the division for any fiscal year, the Governor,
999 after consultation with the executive director, shall take all
1000 appropriate measures to reduce costs, which may include, but are
1001 not limited to:

1002 (1) Reducing or discontinuing any or all services that
1003 are deemed to be optional under Title XIX of the Social Security
1004 Act;

1005 (2) Reducing reimbursement rates for any or all service
1006 types;

1007 (3) Imposing additional assessments on health care
1008 providers; or

1009 (4) Any additional cost-containment measures deemed
1010 appropriate by the Governor.

1011 To the extent allowed under federal law, any reduction to
1012 services or reimbursement rates under this subsection (F) shall be
1013 accompanied by a reduction, to the fullest allowable amount, to
1014 the profit margin and administrative fee portions of capitated
1015 payments to organizations described in paragraph (1) of subsection
1016 (H).

1017 Beginning in fiscal year 2010 and in fiscal years thereafter,
1018 when Medicaid expenditures are projected to exceed funds available
1019 for the fiscal year, the division shall submit the expected
1020 shortfall information to the PEER Committee not later than
1021 December 1 of the year in which the shortfall is projected to
1022 occur. PEER shall review the computations of the division and
1023 report its findings to the Legislative Budget Office not later
1024 than January 7 in any year.

1025 (G) Notwithstanding any other provision of this article, it
1026 shall be the duty of each provider participating in the Medicaid
1027 program to keep and maintain books, documents and other records as
1028 prescribed by the Division of Medicaid in accordance with federal
1029 laws and regulations.

1030 (H) (1) Notwithstanding any other provision of this
1031 article, the division is authorized to implement (a) a managed
1032 care program, (b) a coordinated care program, (c) a coordinated
1033 care organization program, (d) a health maintenance organization

1034 program, (e) a patient-centered medical home program, (f) an
1035 accountable care organization program, (g) provider-sponsored
1036 health plan, or (h) any combination of the above programs. As a
1037 condition for the approval of any program under this subsection
1038 (H)(1), the division shall require that no managed care program,
1039 coordinated care program, coordinated care organization program,
1040 health maintenance organization program, or provider-sponsored
1041 health plan may:

1042 (a) Pay providers at a rate that is less than the
1043 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
1044 reimbursement rate;

1045 (b) Override the medical decisions of hospital
1046 physicians or staff regarding patients admitted to a hospital for
1047 an emergency medical condition as defined by 42 US Code Section
1048 1395dd. This restriction (b) does not prohibit the retrospective
1049 review of the appropriateness of the determination that an
1050 emergency medical condition exists by chart review or coding
1051 algorithm, nor does it prohibit prior authorization for
1052 nonemergency hospital admissions;

1053 (c) Pay providers at a rate that is less than the
1054 normal Medicaid reimbursement rate. It is the intent of the
1055 Legislature that all managed care entities described in this
1056 subsection (H), in collaboration with the division, develop and
1057 implement innovative payment models that incentivize improvements
1058 in health care quality, outcomes, or value, as determined by the

1059 division. Participation in the provider network of any managed
1060 care, coordinated care, provider-sponsored health plan, or similar
1061 contractor shall not be conditioned on the provider's agreement to
1062 accept such alternative payment models;

1063 (d) Implement a prior authorization and
1064 utilization review program for medical services, transportation
1065 services and prescription drugs that is more stringent than the
1066 prior authorization processes used by the division in its
1067 administration of the Medicaid program. Not later than December
1068 2, 2021, the contractors that are receiving capitated payments
1069 under a managed care delivery system established under this
1070 subsection (H) shall submit a report to the Chairmen of the House
1071 and Senate Medicaid Committees on the status of the prior
1072 authorization and utilization review program for medical services,
1073 transportation services and prescription drugs that is required to
1074 be implemented under this subparagraph (d);

1075 (e) [Deleted]

1076 (f) Implement a preferred drug list that is more
1077 stringent than the mandatory preferred drug list established by
1078 the division under subsection (A)(9) of this section;

1079 (g) Implement a policy which denies beneficiaries
1080 with hemophilia access to the federally funded hemophilia
1081 treatment centers as part of the Medicaid Managed Care network of
1082 providers.

1083 Each health maintenance organization, coordinated care
1084 organization, provider-sponsored health plan, or other
1085 organization paid for services on a capitated basis by the
1086 division under any managed care program or coordinated care
1087 program implemented by the division under this section shall use a
1088 clear set of level of care guidelines in the determination of
1089 medical necessity and in all utilization management practices,
1090 including the prior authorization process, concurrent reviews,
1091 retrospective reviews and payments, that are consistent with
1092 widely accepted professional standards of care. Organizations
1093 participating in a managed care program or coordinated care
1094 program implemented by the division may not use any additional
1095 criteria that would result in denial of care that would be
1096 determined appropriate and, therefore, medically necessary under
1097 those levels of care guidelines.
1098 (2) Notwithstanding any provision of this section, the
1099 recipients eligible for enrollment into a Medicaid Managed Care
1100 Program authorized under this subsection (H) may include only
1101 those categories of recipients eligible for participation in the
1102 Medicaid Managed Care Program as of January 1, 2021, the
1103 Children's Health Insurance Program (CHIP), and the CMS-approved
1104 Section 1115 demonstration waivers in operation as of January 1,
1105 2021. No expansion of Medicaid Managed Care Program contracts may
1106 be implemented by the division without enabling legislation from
1107 the Mississippi Legislature.

1108 (3) (a) Any contractors receiving capitated payments
1109 under a managed care delivery system established in this section
1110 shall provide to the Legislature and the division statistical data
1111 to be shared with provider groups in order to improve patient
1112 access, appropriate utilization, cost savings and health outcomes
1113 not later than October 1 of each year. Additionally, each
1114 contractor shall disclose to the Chairmen of the Senate and House
1115 Medicaid Committees the administrative expenses costs for the
1116 prior calendar year, and the number of full-equivalent employees
1117 located in the State of Mississippi dedicated to the Medicaid and
1118 CHIP lines of business as of June 30 of the current year.
1119 (b) The division and the contractors participating
1120 in the managed care program, a coordinated care program or a
1121 provider-sponsored health plan shall be subject to annual program
1122 reviews or audits performed by the Office of the State Auditor,
1123 the PEER Committee, the Department of Insurance and/or independent
1124 third parties.
1125 (c) Those reviews shall include, but not be
1126 limited to, at least two (2) of the following items:
1127 (i) The financial benefit to the State of
1128 Mississippi of the managed care program,
1129 (ii) The difference between the premiums paid
1130 to the managed care contractors and the payments made by those
1131 contractors to health care providers,

1132 (iii) Compliance with performance measures
1133 required under the contracts,
1134 (iv) Administrative expense allocation
1135 methodologies,
1136 (v) Whether nonprovider payments assigned as
1137 medical expenses are appropriate,
1138 (vi) Capitated arrangements with related
1139 party subcontractors,
1140 (vii) Reasonableness of corporate
1141 allocations,
1142 (viii) Value-added benefits and the extent to
1143 which they are used,
1144 (ix) The effectiveness of subcontractor
1145 oversight, including subcontractor review,
1146 (x) Whether health care outcomes have been
1147 improved, and
1148 (xi) The most common claim denial codes to
1149 determine the reasons for the denials.
1150 The audit reports shall be considered public documents and
1151 shall be posted in their entirety on the division's website.
1152 (4) All health maintenance organizations, coordinated
1153 care organizations, provider-sponsored health plans, or other
1154 organizations paid for services on a capitated basis by the
1155 division under any managed care program or coordinated care
1156 program implemented by the division under this section shall

1157 reimburse all providers in those organizations at rates no lower
1158 than those provided under this section for beneficiaries who are
1159 not participating in those programs.

1160 (5) No health maintenance organization, coordinated
1161 care organization, provider-sponsored health plan, or other
1162 organization paid for services on a capitated basis by the
1163 division under any managed care program or coordinated care
1164 program implemented by the division under this section shall
1165 require its providers or beneficiaries to use any pharmacy that
1166 ships, mails or delivers prescription drugs or legend drugs or
1167 devices.

1168 (6) (a) Not later than December 1, 2021, the
1169 contractors who are receiving capitated payments under a managed
1170 care delivery system established under this subsection (H) shall
1171 develop and implement a uniform credentialing process for
1172 providers. Under that uniform credentialing process, a provider
1173 who meets the criteria for credentialing will be credentialed with
1174 all of those contractors and no such provider will have to be
1175 separately credentialed by any individual contractor in order to
1176 receive reimbursement from the contractor. Not later than
1177 December 2, 2021, those contractors shall submit a report to the
1178 Chairmen of the House and Senate Medicaid Committees on the status
1179 of the uniform credentialing process for providers that is
1180 required under this subparagraph (a).

1181 (b) If those contractors have not implemented a
1182 uniform credentialing process as described in subparagraph (a) by
1183 December 1, 2021, the division shall develop and implement, not
1184 later than July 1, 2022, a single, consolidated credentialing
1185 process by which all providers will be credentialed. Under the
1186 division's single, consolidated credentialing process, no such
1187 contractor shall require its providers to be separately
1188 credentialed by the contractor in order to receive reimbursement
1189 from the contractor, but those contractors shall recognize the
1190 credentialing of the providers by the division's credentialing
1191 process.

1192 (c) The division shall require a uniform provider
1193 credentialing application that shall be used in the credentialing
1194 process that is established under subparagraph (a) or (b). If the
1195 contractor or division, as applicable, has not approved or denied
1196 the provider credentialing application within sixty (60) days of
1197 receipt of the completed application that includes all required
1198 information necessary for credentialing, then the contractor or
1199 division, upon receipt of a written request from the applicant and
1200 within five (5) business days of its receipt, shall issue a
1201 temporary provider credential/enrollment to the applicant if the
1202 applicant has a valid Mississippi professional or occupational
1203 license to provide the health care services to which the
1204 credential/enrollment would apply. The contractor or the division
1205 shall not issue a temporary credential/enrollment if the applicant

1206 has reported on the application a history of medical or other
1207 professional or occupational malpractice claims, a history of
1208 substance abuse or mental health issues, a criminal record, or a
1209 history of medical or other licensing board, state or federal
1210 disciplinary action, including any suspension from participation
1211 in a federal or state program. The temporary
1212 credential/enrollment shall be effective upon issuance and shall
1213 remain in effect until the provider's credentialing/enrollment
1214 application is approved or denied by the contractor or division.
1215 The contractor or division shall render a final decision regarding
1216 credentialing/enrollment of the provider within sixty (60) days
1217 from the date that the temporary provider credential/enrollment is
1218 issued to the applicant.

1219 (d) If the contractor or division does not render
1220 a final decision regarding credentialing/enrollment of the
1221 provider within the time required in subparagraph (c), the
1222 provider shall be deemed to be credentialed by and enrolled with
1223 all of the contractors and eligible to receive reimbursement from
1224 the contractors.

1225 (7) (a) Each contractor that is receiving capitated
1226 payments under a managed care delivery system established under
1227 this subsection (H) shall provide to each provider for whom the
1228 contractor has denied the coverage of a procedure that was ordered
1229 or requested by the provider for or on behalf of a patient, a
1230 letter that provides a detailed explanation of the reasons for the

1231 denial of coverage of the procedure and the name and the
1232 credentials of the person who denied the coverage. The letter
1233 shall be sent to the provider in electronic format.
1234 (b) After a contractor that is receiving capitated
1235 payments under a managed care delivery system established under
1236 this subsection (H) has denied coverage for a claim submitted by a
1237 provider, the contractor shall issue to the provider within sixty
1238 (60) days a final ruling of denial of the claim that allows the
1239 provider to have a state fair hearing and/or agency appeal with
1240 the division. If a contractor does not issue a final ruling of
1241 denial within sixty (60) days as required by this subparagraph
1242 (b), the provider's claim shall be deemed to be automatically
1243 approved and the contractor shall pay the amount of the claim to
1244 the provider.
1245 (c) After a contractor has issued a final ruling
1246 of denial of a claim submitted by a provider, the division shall
1247 conduct a state fair hearing and/or agency appeal on the matter of
1248 the disputed claim between the contractor and the provider within
1249 sixty (60) days, and shall render a decision on the matter within
1250 thirty (30) days after the date of the hearing and/or appeal.
1251 (8) It is the intention of the Legislature that the
1252 division evaluate the feasibility of using a single vendor to
1253 administer pharmacy benefits provided under a managed care
1254 delivery system established under this subsection (H). Providers

1255 of pharmacy benefits shall cooperate with the division in any
1256 transition to a carve-out of pharmacy benefits under managed care.
1257 (9) The division shall evaluate the feasibility of
1258 using a single vendor to administer dental benefits provided under
1259 a managed care delivery system established in this subsection (H).
1260 Providers of dental benefits shall cooperate with the division in
1261 any transition to a carve-out of dental benefits under managed
1262 care.
1263 (10) It is the intent of the Legislature that any
1264 contractor receiving capitated payments under a managed care
1265 delivery system established in this section shall implement
1266 innovative programs to improve the health and well-being of
1267 members diagnosed with prediabetes and diabetes.
1268 (11) It is the intent of the Legislature that any
1269 contractors receiving capitated payments under a managed care
1270 delivery system established under this subsection (H) shall work
1271 with providers of Medicaid services to improve the utilization of
1272 long-acting reversible contraceptives (LARCs). Not later than
1273 December 1, 2021, any contractors receiving capitated payments
1274 under a managed care delivery system established under this
1275 subsection (H) shall provide to the Chairmen of the House and
1276 Senate Medicaid Committees and House and Senate Public Health
1277 Committees a report of LARC utilization for State Fiscal Years
1278 2018 through 2020 as well as any programs, initiatives, or efforts
1279 made by the contractors and providers to increase LARC

1280 utilization. This report shall be updated annually to include
1281 information for subsequent state fiscal years.
1282 (12) The division is authorized to make not more than
1283 one (1) emergency extension of the contracts that are in effect on
1284 July 1, 2021, with contractors who are receiving capitated
1285 payments under a managed care delivery system established under
1286 this subsection (H), as provided in this paragraph (12). The
1287 maximum period of any such extension shall be one (1) year, and
1288 under any such extensions, the contractors shall be subject to all
1289 of the provisions of this subsection (H). The extended contracts
1290 shall be revised to incorporate any provisions of this subsection
1291 (H).
1292 (I) [Deleted]
1293 (J) There shall be no cuts in inpatient and outpatient
1294 hospital payments, or allowable days or volumes, as long as the
1295 hospital assessment provided in Section 43-13-145 is in effect.
1296 This subsection (J) shall not apply to decreases in payments that
1297 are a result of: reduced hospital admissions, audits or payments
1298 under the APR-DRG or APC models, or a managed care program or
1299 similar model described in subsection (H) of this section.
1300 (K) In the negotiation and execution of such contracts
1301 involving services performed by actuarial firms, the Executive
1302 Director of the Division of Medicaid may negotiate a limitation on
1303 liability to the state of prospective contractors.

1304 (L) The Division of Medicaid shall reimburse for services
1305 provided to eligible Medicaid beneficiaries by a licensed birthing
1306 center in a method and manner to be determined by the division in
1307 accordance with federal laws and federal regulations. The
1308 division shall seek any necessary waivers, make any required
1309 amendments to its State Plan or revise any contracts authorized
1310 under subsection (H) of this section as necessary to provide the
1311 services authorized under this subsection. As used in this
1312 subsection, the term "birthing centers" shall have the meaning as
1313 defined in Section 41-77-1(a), which is a publicly or privately
1314 owned facility, place or institution constructed, renovated,
1315 leased or otherwise established where nonemergency births are
1316 planned to occur away from the mother's usual residence following
1317 a documented period of prenatal care for a normal uncomplicated
1318 pregnancy which has been determined to be low risk through a
1319 formal risk-scoring examination.

1320 (M) This section shall stand repealed on July 1, 2024.

1321 **SECTION 2.** This act shall take effect and be in force from
1322 and after July 1, 2023.