

By: Representative Hines

To: Medicaid; Appropriations
A

HOUSE BILL NO. 102

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE FOR AN INCREASED RATE OF MEDICAID REIMBURSEMENT FOR
3 INPATIENT AND OUTPATIENT HOSPITAL SERVICES FOR HOSPITALS THAT ARE
4 LOCATED IN A COUNTY THAT HAD AN AVERAGE MONTHLY UNEMPLOYMENT RATE
5 OF EIGHT PERCENT OR HIGHER FOR THE TWELVE MONTHS OF THE PREVIOUS
6 STATE FISCAL YEAR AND HAS A CRITICAL SHORTAGE OF PHYSICIANS AND
7 NURSES; TO EXTEND THE DATE OF THE REPEALER ON THIS SECTION; AND
8 FOR RELATED PURPOSES.

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

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

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

19 (1) Inpatient hospital services.



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

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

29 (c) The division shall provide an increased rate
30 of reimbursement for inpatient hospital services that is not less
31 than eighty percent (80%) of the Medicare reimbursement rate for
32 the same services, for hospitals that are located in a county
33 that:

34 (i) Had an average monthly unemployment rate
35 of eight percent (8%) or higher, as determined by the United
36 States Bureau of Labor Statistics, for the twelve (12) months of
37 the previous state fiscal year; and

38 (ii) Has an critical shortage of physicians
39 and nurses, as determined by a committee composed of
40 representatives from the Mississippi Hospital Association,
41 Mississippi Nurses Association and Mississippi Primary Care
42 Association, and the Chairs of the House and Senate Medicaid
43 Committees.



44 The increased rate of reimbursement provided for under this
45 subparagraph (c) shall be implemented by the division not later
46 than September 1, 2024, and shall be adjusted each year thereafter
47 not later than September 1 of the year. The increased rate of
48 reimbursement established each year shall remain in effect until
49 it is adjusted the next year.

50 (2) Outpatient hospital services.

51 (a) Emergency services.

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

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



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

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

83 (e) The division shall provide an increased rate
84 of reimbursement for outpatient hospital services that is not less
85 than eighty percent (80%) of the Medicare reimbursement rate for
86 the same services, for hospitals that meet the criteria for an
87 increased rate of reimbursement for inpatient hospital services as
88 provided in paragraph (1) (c) of this subsection (A).

89 (3) Laboratory and x-ray services.

90 (4) Nursing facility services.

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



94 leave. Payment may be made for the following home leave days in
95 addition to the forty-two-day limitation: Christmas, the day
96 before Christmas, the day after Christmas, Thanksgiving, the day
97 before Thanksgiving and the day after Thanksgiving.

98 (b) From and after July 1, 1997, the division
99 shall implement the integrated case-mix payment and quality
100 monitoring system, which includes the fair rental system for
101 property costs and in which recapture of depreciation is
102 eliminated. The division may reduce the payment for hospital
103 leave and therapeutic home leave days to the lower of the case-mix
104 category as computed for the resident on leave using the
105 assessment being utilized for payment at that point in time, or a
106 case-mix score of 1.000 for nursing facilities, and shall compute
107 case-mix scores of residents so that only services provided at the
108 nursing facility are considered in calculating a facility's per
109 diem.

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

113 (d) On or after January 1, 2015, the division
114 shall update the case-mix payment system resource utilization
115 grouper and classifications and fair rental reimbursement system.
116 The division shall develop and implement a payment add-on to
117 reimburse nursing facilities for ventilator-dependent resident
118 services.



119 (e) The division shall develop and implement, not
120 later than January 1, 2001, a case-mix payment add-on determined
121 by time studies and other valid statistical data that will
122 reimburse a nursing facility for the additional cost of caring for
123 a resident who has a diagnosis of Alzheimer's or other related
124 dementia and exhibits symptoms that require special care. Any
125 such case-mix add-on payment shall be supported by a determination
126 of additional cost. The division shall also develop and implement
127 as part of the fair rental reimbursement system for nursing
128 facility beds, an Alzheimer's resident bed depreciation enhanced
129 reimbursement system that will provide an incentive to encourage
130 nursing facilities to convert or construct beds for residents with
131 Alzheimer's or other related dementia.

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

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

140 (5) Periodic screening and diagnostic services for
141 individuals under age twenty-one (21) years as are needed to
142 identify physical and mental defects and to provide health care
143 treatment and other measures designed to correct or ameliorate



144 defects and physical and mental illness and conditions discovered
145 by the screening services, regardless of whether these services
146 are included in the state plan. The division may include in its
147 periodic screening and diagnostic program those discretionary
148 services authorized under the federal regulations adopted to
149 implement Title XIX of the federal Social Security Act, as
150 amended. The division, in obtaining physical therapy services,
151 occupational therapy services, and services for individuals with
152 speech, hearing and language disorders, may enter into a
153 cooperative agreement with the State Department of Education for
154 the provision of those services to handicapped students by public
155 school districts using state funds that are provided from the
156 appropriation to the Department of Education to obtain federal
157 matching funds through the division. The division, in obtaining
158 medical and mental health assessments, treatment, care and
159 services for children who are in, or at risk of being put in, the
160 custody of the Mississippi Department of Human Services may enter
161 into a cooperative agreement with the Mississippi Department of
162 Human Services for the provision of those services using state
163 funds that are provided from the appropriation to the Department
164 of Human Services to obtain federal matching funds through the
165 division.

166 (6) Physician services. Fees for physician's services
167 that are covered only by Medicaid shall be reimbursed at ninety
168 percent (90%) of the rate established on January 1, 2018, and as



169 may be adjusted each July thereafter, under Medicare. The
170 division may provide for a reimbursement rate for physician's
171 services of up to one hundred percent (100%) of the rate
172 established under Medicare for physician's services that are
173 provided after the normal working hours of the physician, as
174 determined in accordance with regulations of the division. The
175 division may reimburse eligible providers, as determined by the
176 division, for certain primary care services at one hundred percent
177 (100%) of the rate established under Medicare. The division shall
178 reimburse obstetricians and gynecologists for certain primary care
179 services as defined by the division at one hundred percent (100%)
180 of the rate established under Medicare.

181 (7) (a) Home health services for eligible persons, not
182 to exceed in cost the prevailing cost of nursing facility
183 services. All home health visits must be precertified as required
184 by the division. In addition to physicians, certified registered
185 nurse practitioners, physician assistants and clinical nurse
186 specialists are authorized to prescribe or order home health
187 services and plans of care, sign home health plans of care,
188 certify and recertify eligibility for home health services and
189 conduct the required initial face-to-face visit with the recipient
190 of the services.

191 (b) [Repealed]

192 (8) Emergency medical transportation services as
193 determined by the division.



194 (9) Prescription drugs and other covered drugs and
195 services as determined by the division.

196 The division shall establish a mandatory preferred drug list.
197 Drugs not on the mandatory preferred drug list shall be made
198 available by utilizing prior authorization procedures established
199 by the division.

200 The division may seek to establish relationships with other
201 states in order to lower acquisition costs of prescription drugs
202 to include single-source and innovator multiple-source drugs or
203 generic drugs. In addition, if allowed by federal law or
204 regulation, the division may seek to establish relationships with
205 and negotiate with other countries to facilitate the acquisition
206 of prescription drugs to include single-source and innovator
207 multiple-source drugs or generic drugs, if that will lower the
208 acquisition costs of those prescription drugs.

209 The division may allow for a combination of prescriptions for
210 single-source and innovator multiple-source drugs and generic
211 drugs to meet the needs of the beneficiaries.

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

215 Drugs prescribed for a resident of a psychiatric residential
216 treatment facility must be provided in true unit doses when
217 available. The division may require that drugs not covered by
218 Medicare Part D for a resident of a long-term care facility be



219 provided in true unit doses when available. Those drugs that were
220 originally billed to the division but are not used by a resident
221 in any of those facilities shall be returned to the billing
222 pharmacy for credit to the division, in accordance with the
223 guidelines of the State Board of Pharmacy and any requirements of
224 federal law and regulation. Drugs shall be dispensed to a
225 recipient and only one (1) dispensing fee per month may be
226 charged. The division shall develop a methodology for reimbursing
227 for restocked drugs, which shall include a restock fee as
228 determined by the division not exceeding Seven Dollars and
229 Eighty-two Cents (\$7.82).

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

234 The division is authorized to develop and implement a program
235 of payment for additional pharmacist services as determined by the
236 division.

237 All claims for drugs for dually eligible Medicare/Medicaid
238 beneficiaries that are paid for by Medicare must be submitted to
239 Medicare for payment before they may be processed by the
240 division's online payment system.

241 The division shall develop a pharmacy policy in which drugs
242 in tamper-resistant packaging that are prescribed for a resident
243 of a nursing facility but are not dispensed to the resident shall



244 be returned to the pharmacy and not billed to Medicaid, in
245 accordance with guidelines of the State Board of Pharmacy.

246 The division shall develop and implement a method or methods
247 by which the division will provide on a regular basis to Medicaid
248 providers who are authorized to prescribe drugs, information about
249 the costs to the Medicaid program of single-source drugs and
250 innovator multiple-source drugs, and information about other drugs
251 that may be prescribed as alternatives to those single-source
252 drugs and innovator multiple-source drugs and the costs to the
253 Medicaid program of those alternative drugs.

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

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

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



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

270 The division shall allow certain drugs, including
271 physician-administered drugs, and implantable drug system devices,
272 and medical supplies, with limited distribution or limited access
273 for beneficiaries and administered in an appropriate clinical
274 setting, to be reimbursed as either a medical claim or pharmacy
275 claim, as determined by the division.

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

280 (10) Dental and orthodontic services to be determined
281 by the division.

282 The division shall increase the amount of the reimbursement
283 rate for diagnostic and preventative dental services for each of
284 the fiscal years 2022, 2023 and 2024 by five percent (5%) above
285 the amount of the reimbursement rate for the previous fiscal year.
286 The division shall increase the amount of the reimbursement rate
287 for restorative dental services for each of the fiscal years 2023,
288 2024 and 2025 by five percent (5%) above the amount of the
289 reimbursement rate for the previous fiscal year. It is the intent
290 of the Legislature that the reimbursement rate revision for
291 preventative dental services will be an incentive to increase the



292 number of dentists who actively provide Medicaid services. This
293 dental services reimbursement rate revision shall be known as the
294 "James Russell Dumas Medicaid Dental Services Incentive Program."

295 The Medical Care Advisory Committee, assisted by the Division
296 of Medicaid, shall annually determine the effect of this incentive
297 by evaluating the number of dentists who are Medicaid providers,
298 the number who and the degree to which they are actively billing
299 Medicaid, the geographic trends of where dentists are offering
300 what types of Medicaid services and other statistics pertinent to
301 the goals of this legislative intent. This data shall annually be
302 presented to the Chair of the Senate Medicaid Committee and the
303 Chair of the House Medicaid Committee.

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

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

316 (12) Intermediate care facility services.



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

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

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

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

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

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

341 (b) Dialysis center services.



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

347 (16) Mental health services. Certain services provided
348 by a psychiatrist shall be reimbursed at up to one hundred percent
349 (100%) of the Medicare rate. Approved therapeutic and case
350 management services (a) provided by an approved regional mental
351 health/intellectual disability center established under Sections
352 41-19-31 through 41-19-39, or by another community mental health
353 service provider meeting the requirements of the Department of
354 Mental Health to be an approved mental health/intellectual
355 disability center if determined necessary by the Department of
356 Mental Health, using state funds that are provided in the
357 appropriation to the division to match federal funds, or (b)
358 provided by a facility that is certified by the State Department
359 of Mental Health to provide therapeutic and case management
360 services, to be reimbursed on a fee for service basis, or (c)
361 provided in the community by a facility or program operated by the
362 Department of Mental Health. Any such services provided by a
363 facility described in subparagraph (b) must have the prior
364 approval of the division to be reimbursable under this section.

365 (17) Durable medical equipment services and medical
366 supplies. Precertification of durable medical equipment and



367 medical supplies must be obtained as required by the division.
368 The Division of Medicaid may require durable medical equipment
369 providers to obtain a surety bond in the amount and to the
370 specifications as established by the Balanced Budget Act of 1997.
371 A maximum dollar amount of reimbursement for noninvasive
372 ventilators or ventilation treatments properly ordered and being
373 used in an appropriate care setting shall not be set by any health
374 maintenance organization, coordinated care organization,
375 provider-sponsored health plan, or other organization paid for
376 services on a capitated basis by the division under any managed
377 care program or coordinated care program implemented by the
378 division under this section. Reimbursement by these organizations
379 to durable medical equipment suppliers for home use of noninvasive
380 and invasive ventilators shall be on a continuous monthly payment
381 basis for the duration of medical need throughout a patient's
382 valid prescription period.

383 (18) (a) Notwithstanding any other provision of this
384 section to the contrary, as provided in the Medicaid state plan
385 amendment or amendments as defined in Section 43-13-145(10), the
386 division shall make additional reimbursement to hospitals that
387 serve a disproportionate share of low-income patients and that
388 meet the federal requirements for those payments as provided in
389 Section 1923 of the federal Social Security Act and any applicable
390 regulations. It is the intent of the Legislature that the
391 division shall draw down all available federal funds allotted to



392 the state for disproportionate share hospitals. However, from and
393 after January 1, 1999, public hospitals participating in the
394 Medicaid disproportionate share program may be required to
395 participate in an intergovernmental transfer program as provided
396 in Section 1903 of the federal Social Security Act and any
397 applicable regulations.

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

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

411 (ii) The division shall assess each hospital,
412 nursing facility, and emergency ambulance transportation provider
413 for the sole purpose of financing the state portion of the
414 Medicare Upper Payment Limits Program or other program(s)
415 authorized under this subsection (A)(18)(b). The hospital
416 assessment shall be as provided in Section 43-13-145(4)(a), and



417 the nursing facility and the emergency ambulance transportation
418 assessments, if established, shall be based on Medicaid
419 utilization or other appropriate method, as determined by the
420 division, consistent with federal regulations. The assessments
421 will remain in effect as long as the state participates in the
422 Medicare Upper Payment Limits Program or other program(s)
423 authorized under this subsection (A) (18) (b). In addition to the
424 hospital assessment provided in Section 43-13-145(4) (a), hospitals
425 with physicians participating in the Medicare Upper Payment Limits
426 Program or other program(s) authorized under this subsection
427 (A) (18) (b) shall be required to participate in an
428 intergovernmental transfer or assessment, as determined by the
429 division, for the purpose of financing the state portion of the
430 physician UPL payments or other payment(s) authorized under this
431 subsection (A) (18) (b).

432 (iii) Subject to approval by the Centers for
433 Medicare and Medicaid Services (CMS) and the provisions of this
434 subsection (A) (18) (b), the division shall make additional
435 reimbursement to hospitals, nursing facilities, and emergency
436 ambulance transportation providers for the Medicare Upper Payment
437 Limits Program or other program(s) authorized under this
438 subsection (A) (18) (b), and, if the program is established for
439 physicians, shall make additional reimbursement for physicians, as
440 defined in Section 1902(a) (30) of the federal Social Security Act



441 and any applicable federal regulations, provided the assessment in
442 this subsection (A) (18) (b) is in effect.

443 (iv) Notwithstanding any other provision of
444 this article to the contrary, effective upon implementation of the
445 Mississippi Hospital Access Program (MHAP) provided in
446 subparagraph (c) (i) below, the hospital portion of the inpatient
447 Upper Payment Limits Program shall transition into and be replaced
448 by the MHAP program. However, the division is authorized to
449 develop and implement an alternative fee-for-service Upper Payment
450 Limits model in accordance with federal laws and regulations if
451 necessary to preserve supplemental funding. Further, the
452 division, in consultation with the hospital industry shall develop
453 alternative models for distribution of medical claims and
454 supplemental payments for inpatient and outpatient hospital
455 services, and such models may include, but shall not be limited to
456 the following: increasing rates for inpatient and outpatient
457 services; creating a low-income utilization pool of funds to
458 reimburse hospitals for the costs of uncompensated care, charity
459 care and bad debts as permitted and approved pursuant to federal
460 regulations and the Centers for Medicare and Medicaid Services;
461 supplemental payments based upon Medicaid utilization, quality,
462 service lines and/or costs of providing such services to Medicaid
463 beneficiaries and to uninsured patients. The goals of such
464 payment models shall be to ensure access to inpatient and
465 outpatient care and to maximize any federal funds that are



466 available to reimburse hospitals for services provided. Any such
467 documents required to achieve the goals described in this
468 paragraph shall be submitted to the Centers for Medicare and
469 Medicaid Services, with a proposed effective date of July 1, 2019,
470 to the extent possible, but in no event shall the effective date
471 of such payment models be later than July 1, 2020. The Chairmen
472 of the Senate and House Medicaid Committees shall be provided a
473 copy of the proposed payment model(s) prior to submission.
474 Effective July 1, 2018, and until such time as any payment
475 model(s) as described above become effective, the division, in
476 consultation with the hospital industry, is authorized to
477 implement a transitional program for inpatient and outpatient
478 payments and/or supplemental payments (including, but not limited
479 to, MHAP and directed payments), to redistribute available
480 supplemental funds among hospital providers, provided that when
481 compared to a hospital's prior year supplemental payments,
482 supplemental payments made pursuant to any such transitional
483 program shall not result in a decrease of more than five percent
484 (5%) and shall not increase by more than the amount needed to
485 maximize the distribution of the available funds.

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



491 make such ambulance service access payments for all covered
492 services rendered on or after the effective date of CMS approval.

493 2. The division shall calculate the
494 ambulance service access payment amount as the balance of the
495 portion of the Medical Care Fund related to ambulance
496 transportation service provider assessments plus any federal
497 matching funds earned on the balance, up to, but not to exceed,
498 the upper payment limit gap for all emergency ambulance service
499 providers.

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

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

514 c. As used in this paragraph
515 (18)(b)(v), the term "upper payment limit gap" means the



516 difference between the total amount that the ambulance
517 transportation service provider received from Medicaid and the
518 average amount that the ambulance transportation service provider
519 would have received from commercial insurers for those services
520 reimbursed by Medicaid.

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

524 (c) (i) Not later than December 1, 2015, the
525 division shall, subject to approval by the Centers for Medicare
526 and Medicaid Services (CMS), establish, implement and operate a
527 Mississippi Hospital Access Program (MHAP) for the purpose of
528 protecting patient access to hospital care through hospital
529 inpatient reimbursement programs provided in this section designed
530 to maintain total hospital reimbursement for inpatient services
531 rendered by in-state hospitals and the out-of-state hospital that
532 is authorized by federal law to submit intergovernmental transfers
533 (IGTs) to the State of Mississippi and is classified as Level I
534 trauma center located in a county contiguous to the state line at
535 the maximum levels permissible under applicable federal statutes
536 and regulations, at which time the current inpatient Medicare
537 Upper Payment Limits (UPL) Program for hospital inpatient services
538 shall transition to the MHAP.

539 (ii) Subject to approval by the Centers for
540 Medicare and Medicaid Services (CMS), the MHAP shall provide



541 increased inpatient capitation (PMPM) payments to managed care
542 entities contracting with the division pursuant to subsection (H)
543 of this section to support availability of hospital services or
544 such other payments permissible under federal law necessary to
545 accomplish the intent of this subsection.

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

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

562 (19) (a) Perinatal risk management services. The
563 division shall promulgate regulations to be effective from and
564 after October 1, 1988, to establish a comprehensive perinatal
565 system for risk assessment of all pregnant and infant Medicaid



566 recipients and for management, education and follow-up for those
567 who are determined to be at risk. Services to be performed
568 include case management, nutrition assessment/counseling,
569 psychosocial assessment/counseling and health education. The
570 division shall contract with the State Department of Health to
571 provide services within this paragraph (Perinatal High Risk
572 Management/Infant Services System (PHRM/ISS)). The State
573 Department of Health shall be reimbursed on a full reasonable cost
574 basis for services provided under this subparagraph (a).

575 (b) Early intervention system services. The
576 division shall cooperate with the State Department of Health,
577 acting as lead agency, in the development and implementation of a
578 statewide system of delivery of early intervention services, under
579 Part C of the Individuals with Disabilities Education Act (IDEA).
580 The State Department of Health shall certify annually in writing
581 to the executive director of the division the dollar amount of
582 state early intervention funds available that will be utilized as
583 a certified match for Medicaid matching funds. Those funds then
584 shall be used to provide expanded targeted case management
585 services for Medicaid eligible children with special needs who are
586 eligible for the state's early intervention system.
587 Qualifications for persons providing service coordination shall be
588 determined by the State Department of Health and the Division of
589 Medicaid.



590 (20) Home- and community-based services for physically
591 disabled approved services as allowed by a waiver from the United
592 States Department of Health and Human Services for home- and
593 community-based services for physically disabled people using
594 state funds that are provided from the appropriation to the State
595 Department of Rehabilitation Services and used to match federal
596 funds under a cooperative agreement between the division and the
597 department, provided that funds for these services are
598 specifically appropriated to the Department of Rehabilitation
599 Services.

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



614 nurse practitioner, as determined in accordance with regulations
615 of the division.

616 (22) Ambulatory services delivered in federally
617 qualified health centers, rural health centers and clinics of the
618 local health departments of the State Department of Health for
619 individuals eligible for Medicaid under this article based on
620 reasonable costs as determined by the division. Federally
621 qualified health centers shall be reimbursed by the Medicaid
622 prospective payment system as approved by the Centers for Medicare
623 and Medicaid Services. The division shall recognize federally
624 qualified health centers (FQHCs), rural health clinics (RHCs) and
625 community mental health centers (CMHCs) as both an originating and
626 distant site provider for the purposes of telehealth
627 reimbursement. The division is further authorized and directed to
628 reimburse FQHCs, RHCs and CMHCs for both distant site and
629 originating site services when such services are appropriately
630 provided by the same organization.

631 (23) Inpatient psychiatric services.

632 (a) Inpatient psychiatric services to be
633 determined by the division for recipients under age twenty-one
634 (21) that are provided under the direction of a physician in an
635 inpatient program in a licensed acute care psychiatric facility or
636 in a licensed psychiatric residential treatment facility, before
637 the recipient reaches age twenty-one (21) or, if the recipient was
638 receiving the services immediately before he or she reached age



639 twenty-one (21), before the earlier of the date he or she no
640 longer requires the services or the date he or she reaches age
641 twenty-two (22), as provided by federal regulations. From and
642 after January 1, 2015, the division shall update the fair rental
643 reimbursement system for psychiatric residential treatment
644 facilities. Precertification of inpatient days and residential
645 treatment days must be obtained as required by the division. From
646 and after July 1, 2009, all state-owned and state-operated
647 facilities that provide inpatient psychiatric services to persons
648 under age twenty-one (21) who are eligible for Medicaid
649 reimbursement shall be reimbursed for those services on a full
650 reasonable cost basis.

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

655 (24) [Deleted]

656 (25) [Deleted]

657 (26) Hospice care. As used in this paragraph, the term
658 "hospice care" means a coordinated program of active professional
659 medical attention within the home and outpatient and inpatient
660 care that treats the terminally ill patient and family as a unit,
661 employing a medically directed interdisciplinary team. The
662 program provides relief of severe pain or other physical symptoms
663 and supportive care to meet the special needs arising out of



664 physical, psychological, spiritual, social and economic stresses
665 that are experienced during the final stages of illness and during
666 dying and bereavement and meets the Medicare requirements for
667 participation as a hospice as provided in federal regulations.

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

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

675 (29) The Division of Medicaid may apply for a waiver
676 from the United States Department of Health and Human Services for
677 home- and community-based services for developmentally disabled
678 people using state funds that are provided from the appropriation
679 to the State Department of Mental Health and/or funds transferred
680 to the department by a political subdivision or instrumentality of
681 the state and used to match federal funds under a cooperative
682 agreement between the division and the department, provided that
683 funds for these services are specifically appropriated to the
684 Department of Mental Health and/or transferred to the department
685 by a political subdivision or instrumentality of the state.

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



689 (31) Targeted case management services for children
690 with special needs, under waivers from the United States
691 Department of Health and Human Services, using state funds that
692 are provided from the appropriation to the Mississippi Department
693 of Human Services and used to match federal funds under a
694 cooperative agreement between the division and the department.

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

701 (33) Podiatrist services.

702 (34) Assisted living services as provided through
703 home- and community-based services under Title XIX of the federal
704 Social Security Act, as amended, subject to the availability of
705 funds specifically appropriated for that purpose by the
706 Legislature.

707 (35) Services and activities authorized in Sections
708 43-27-101 and 43-27-103, using state funds that are provided from
709 the appropriation to the Mississippi Department of Human Services
710 and used to match federal funds under a cooperative agreement
711 between the division and the department.

712 (36) Nonemergency transportation services for
713 Medicaid-eligible persons as determined by the division. The PEER



714 Committee shall conduct a performance evaluation of the
715 nonemergency transportation program to evaluate the administration
716 of the program and the providers of transportation services to
717 determine the most cost-effective ways of providing nonemergency
718 transportation services to the patients served under the program.
719 The performance evaluation shall be completed and provided to the
720 members of the Senate Medicaid Committee and the House Medicaid
721 Committee not later than January 1, 2019, and every two (2) years
722 thereafter.

723 (37) [Deleted]

724 (38) Chiropractic services. A chiropractor's manual
725 manipulation of the spine to correct a subluxation, if x-ray
726 demonstrates that a subluxation exists and if the subluxation has
727 resulted in a neuromusculoskeletal condition for which
728 manipulation is appropriate treatment, and related spinal x-rays
729 performed to document these conditions. Reimbursement for
730 chiropractic services shall not exceed Seven Hundred Dollars
731 (\$700.00) per year per beneficiary.

732 (39) Dually eligible Medicare/Medicaid beneficiaries.
733 The division shall pay the Medicare deductible and coinsurance
734 amounts for services available under Medicare, as determined by
735 the division. From and after July 1, 2009, the division shall
736 reimburse crossover claims for inpatient hospital services and
737 crossover claims covered under Medicare Part B in the same manner



738 that was in effect on January 1, 2008, unless specifically
739 authorized by the Legislature to change this method.

740 (40) [Deleted]

741 (41) Services provided by the State Department of
742 Rehabilitation Services for the care and rehabilitation of persons
743 with spinal cord injuries or traumatic brain injuries, as allowed
744 under waivers from the United States Department of Health and
745 Human Services, using up to seventy-five percent (75%) of the
746 funds that are appropriated to the Department of Rehabilitation
747 Services from the Spinal Cord and Head Injury Trust Fund
748 established under Section 37-33-261 and used to match federal
749 funds under a cooperative agreement between the division and the
750 department.

751 (42) [Deleted]

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

757 (44) Nursing facility services for the severely
758 disabled.

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



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

765 (45) Physician assistant services. Services furnished
766 by a physician assistant who is licensed by the State Board of
767 Medical Licensure and is practicing with physician supervision
768 under regulations adopted by the board, under regulations adopted
769 by the division. Reimbursement for those services shall not
770 exceed ninety percent (90%) of the reimbursement rate for
771 comparable services rendered by a physician. The division may
772 provide for a reimbursement rate for physician assistant services
773 of up to one hundred percent (100%) or the reimbursement rate for
774 comparable services rendered by a physician for physician
775 assistant services that are provided after the normal working
776 hours of the physician assistant, as determined in accordance with
777 regulations of the division.

778 (46) The division shall make application to the federal
779 Centers for Medicare and Medicaid Services (CMS) for a waiver to
780 develop and provide services for children with serious emotional
781 disturbances as defined in Section 43-14-1(1), which may include
782 home- and community-based services, case management services or
783 managed care services through mental health providers certified by
784 the Department of Mental Health. The division may implement and
785 provide services under this waived program only if funds for
786 these services are specifically appropriated for this purpose by



787 the Legislature, or if funds are voluntarily provided by affected
788 agencies.

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

793 (b) Participation in any disease management
794 program implemented under this paragraph (47) is optional with the
795 individual. An individual must affirmatively elect to participate
796 in the disease management program in order to participate, and may
797 elect to discontinue participation in the program at any time.

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

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

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

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



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

818 (51) Upon determination of Medicaid eligibility and in
819 association with annual redetermination of Medicaid eligibility,
820 beneficiaries shall be encouraged to undertake a physical
821 examination that will establish a base-line level of health and
822 identification of a usual and customary source of care (a medical
823 home) to aid utilization of disease management tools. This
824 physical examination and utilization of these disease management
825 tools shall be consistent with current United States Preventive
826 Services Task Force or other recognized authority recommendations.

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

830 (52) Notwithstanding any provisions of this article,
831 the division may pay enhanced reimbursement fees related to trauma
832 care, as determined by the division in conjunction with the State
833 Department of Health, using funds appropriated to the State
834 Department of Health for trauma care and services and used to
835 match federal funds under a cooperative agreement between the



836 division and the State Department of Health. The division, in
837 conjunction with the State Department of Health, may use grants,
838 waivers, demonstrations, enhanced reimbursements, Upper Payment
839 Limits Programs, supplemental payments, or other projects as
840 necessary in the development and implementation of this
841 reimbursement program.

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

845 (54) [Deleted]

846 (55) Therapy services. The plan of care for therapy
847 services may be developed to cover a period of treatment for up to
848 six (6) months, but in no event shall the plan of care exceed a
849 six-month period of treatment. The projected period of treatment
850 must be indicated on the initial plan of care and must be updated
851 with each subsequent revised plan of care. Based on medical
852 necessity, the division shall approve certification periods for
853 less than or up to six (6) months, but in no event shall the
854 certification period exceed the period of treatment indicated on
855 the plan of care. The appeal process for any reduction in therapy
856 services shall be consistent with the appeal process in federal
857 regulations.

858 (56) Prescribed pediatric extended care centers
859 services for medically dependent or technologically dependent
860 children with complex medical conditions that require continual



861 care as prescribed by the child's attending physician, as
862 determined by the division.

863 (57) No Medicaid benefit shall restrict coverage for
864 medically appropriate treatment prescribed by a physician and
865 agreed to by a fully informed individual, or if the individual
866 lacks legal capacity to consent by a person who has legal
867 authority to consent on his or her behalf, based on an
868 individual's diagnosis with a terminal condition. As used in this
869 paragraph (57), "terminal condition" means any aggressive
870 malignancy, chronic end-stage cardiovascular or cerebral vascular
871 disease, or any other disease, illness or condition which a
872 physician diagnoses as terminal.

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

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



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

888 (a) Payments may only be made to a border city
889 university-affiliated pediatric teaching hospital if the Centers
890 for Medicare and Medicaid Services (CMS) approve an increase in
891 the annual request for the provider payment initiative authorized
892 under 42 CFR Section 438.6(c) in an amount equal to or greater
893 than the estimated annual payment to be made to the border city
894 university-affiliated pediatric teaching hospital. The estimate
895 shall be based on the hospital's prior year Mississippi managed
896 care utilization.

897 (b) As used in this paragraph (60), the term
898 "border city university-affiliated pediatric teaching hospital"
899 means an out-of-state hospital located within a city bordering the
900 eastern bank of the Mississippi River and the State of Mississippi
901 that submits to the division a copy of a current and effective
902 affiliation agreement with an accredited university and other
903 documentation establishing that the hospital is
904 university-affiliated, is licensed and designated as a pediatric
905 hospital or pediatric primary hospital within its home state,
906 maintains at least five (5) different pediatric specialty training
907 programs, and maintains at least one hundred (100) operated beds
908 dedicated exclusively for the treatment of patients under the age
909 of twenty-one (21) years.



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

915 (d) It is the intent of the Legislature that
916 payments shall not result in any in-state hospital receiving
917 payments lower than they would otherwise receive if not for the
918 payments made to any border city university-affiliated pediatric
919 teaching hospital.

920 (e) This paragraph (60) shall stand repealed on
921 July 1, 2024.

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

927 (C) The division may pay to those providers who participate
928 in and accept patient referrals from the division's emergency room
929 redirection program a percentage, as determined by the division,
930 of savings achieved according to the performance measures and
931 reduction of costs required of that program. Federally qualified
932 health centers may participate in the emergency room redirection
933 program, and the division may pay those centers a percentage of
934 any savings to the Medicaid program achieved by the centers'



935 accepting patient referrals through the program, as provided in
936 this subsection (C).

937 (D) (1) As used in this subsection (D), the following terms
938 shall be defined as provided in this paragraph, except as
939 otherwise provided in this subsection:

940 (a) "Committees" means the Medicaid Committees of
941 the House of Representatives and the Senate, and "committee" means
942 either one of those committees.

943 (b) "Rate change" means an increase, decrease or
944 other change in the payments or rates of reimbursement, or a
945 change in any payment methodology that results in an increase,
946 decrease or other change in the payments or rates of
947 reimbursement, to any Medicaid provider that renders any services
948 authorized to be provided to Medicaid recipients under this
949 article.

950 (2) Whenever the Division of Medicaid proposes a rate
951 change, the division shall give notice to the chairmen of the
952 committees at least thirty (30) calendar days before the proposed
953 rate change is scheduled to take effect. The division shall
954 furnish the chairmen with a concise summary of each proposed rate
955 change along with the notice, and shall furnish the chairmen with
956 a copy of any proposed rate change upon request. The division
957 also shall provide a summary and copy of any proposed rate change
958 to any other member of the Legislature upon request.



959 (3) If the chairman of either committee or both
960 chairmen jointly object to the proposed rate change or any part
961 thereof, the chairman or chairmen shall notify the division and
962 provide the reasons for their objection in writing not later than
963 seven (7) calendar days after receipt of the notice from the
964 division. The chairman or chairmen may make written
965 recommendations to the division for changes to be made to a
966 proposed rate change.

967 (4) (a) The chairman of either committee or both
968 chairmen jointly may hold a committee meeting to review a proposed
969 rate change. If either chairman or both chairmen decide to hold a
970 meeting, they shall notify the division of their intention in
971 writing within seven (7) calendar days after receipt of the notice
972 from the division, and shall set the date and time for the meeting
973 in their notice to the division, which shall not be later than
974 fourteen (14) calendar days after receipt of the notice from the
975 division.

976 (b) After the committee meeting, the committee or
977 committees may object to the proposed rate change or any part
978 thereof. The committee or committees shall notify the division
979 and the reasons for their objection in writing not later than
980 seven (7) calendar days after the meeting. The committee or
981 committees may make written recommendations to the division for
982 changes to be made to a proposed rate change.



983 (5) If both chairmen notify the division in writing
984 within seven (7) calendar days after receipt of the notice from
985 the division that they do not object to the proposed rate change
986 and will not be holding a meeting to review the proposed rate
987 change, the proposed rate change will take effect on the original
988 date as scheduled by the division or on such other date as
989 specified by the division.

990 (6) (a) If there are any objections to a proposed rate
991 change or any part thereof from either or both of the chairmen or
992 the committees, the division may withdraw the proposed rate
993 change, make any of the recommended changes to the proposed rate
994 change, or not make any changes to the proposed rate change.

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

1000 (c) If the division makes any changes to the
1001 proposed rate change, the division shall notify the chairmen of
1002 its actions in writing, and the revised proposed rate change shall
1003 take effect on the date as specified by the division.

1004 (7) Nothing in this subsection (D) shall be construed
1005 as giving the chairmen or the committees any authority to veto,
1006 nullify or revise any rate change proposed by the division. The
1007 authority of the chairmen or the committees under this subsection



1008 shall be limited to reviewing, making objections to and making
1009 recommendations for changes to rate changes proposed by the
1010 division.

1011 (E) Notwithstanding any provision of this article, no new
1012 groups or categories of recipients and new types of care and
1013 services may be added without enabling legislation from the
1014 Mississippi Legislature, except that the division may authorize
1015 those changes without enabling legislation when the addition of
1016 recipients or services is ordered by a court of proper authority.

1017 (F) The executive director shall keep the Governor advised
1018 on a timely basis of the funds available for expenditure and the
1019 projected expenditures. Notwithstanding any other provisions of
1020 this article, if current or projected expenditures of the division
1021 are reasonably anticipated to exceed the amount of funds
1022 appropriated to the division for any fiscal year, the Governor,
1023 after consultation with the executive director, shall take all
1024 appropriate measures to reduce costs, which may include, but are
1025 not limited to:

1026 (1) Reducing or discontinuing any or all services that
1027 are deemed to be optional under Title XIX of the Social Security
1028 Act;

1029 (2) Reducing reimbursement rates for any or all service
1030 types;

1031 (3) Imposing additional assessments on health care
1032 providers; or



1033 (4) Any additional cost-containment measures deemed
1034 appropriate by the Governor.

1035 To the extent allowed under federal law, any reduction to
1036 services or reimbursement rates under this subsection (F) shall be
1037 accompanied by a reduction, to the fullest allowable amount, to
1038 the profit margin and administrative fee portions of capitated
1039 payments to organizations described in paragraph (1) of subsection
1040 (H).

1041 Beginning in fiscal year 2010 and in fiscal years thereafter,
1042 when Medicaid expenditures are projected to exceed funds available
1043 for the fiscal year, the division shall submit the expected
1044 shortfall information to the PEER Committee not later than
1045 December 1 of the year in which the shortfall is projected to
1046 occur. PEER shall review the computations of the division and
1047 report its findings to the Legislative Budget Office not later
1048 than January 7 in any year.

1049 (G) Notwithstanding any other provision of this article, it
1050 shall be the duty of each provider participating in the Medicaid
1051 program to keep and maintain books, documents and other records as
1052 prescribed by the Division of Medicaid in accordance with federal
1053 laws and regulations.

1054 (H) (1) Notwithstanding any other provision of this
1055 article, the division is authorized to implement (a) a managed
1056 care program, (b) a coordinated care program, (c) a coordinated
1057 care organization program, (d) a health maintenance organization



1058 program, (e) a patient-centered medical home program, (f) an
1059 accountable care organization program, (g) provider-sponsored
1060 health plan, or (h) any combination of the above programs. As a
1061 condition for the approval of any program under this subsection
1062 (H)(1), the division shall require that no managed care program,
1063 coordinated care program, coordinated care organization program,
1064 health maintenance organization program, or provider-sponsored
1065 health plan may:

1066 (a) Pay providers at a rate that is less than the
1067 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
1068 reimbursement rate;

1069 (b) Override the medical decisions of hospital
1070 physicians or staff regarding patients admitted to a hospital for
1071 an emergency medical condition as defined by 42 US Code Section
1072 1395dd. This restriction (b) does not prohibit the retrospective
1073 review of the appropriateness of the determination that an
1074 emergency medical condition exists by chart review or coding
1075 algorithm, nor does it prohibit prior authorization for
1076 nonemergency hospital admissions;

1077 (c) Pay providers at a rate that is less than the
1078 normal Medicaid reimbursement rate. It is the intent of the
1079 Legislature that all managed care entities described in this
1080 subsection (H), in collaboration with the division, develop and
1081 implement innovative payment models that incentivize improvements
1082 in health care quality, outcomes, or value, as determined by the



1083 division. Participation in the provider network of any managed
1084 care, coordinated care, provider-sponsored health plan, or similar
1085 contractor shall not be conditioned on the provider's agreement to
1086 accept such alternative payment models;

1087 (d) Implement a prior authorization and
1088 utilization review program for medical services, transportation
1089 services and prescription drugs that is more stringent than the
1090 prior authorization processes used by the division in its
1091 administration of the Medicaid program. Not later than December
1092 2, 2021, the contractors that are receiving capitated payments
1093 under a managed care delivery system established under this
1094 subsection (H) shall submit a report to the Chairmen of the House
1095 and Senate Medicaid Committees on the status of the prior
1096 authorization and utilization review program for medical services,
1097 transportation services and prescription drugs that is required to
1098 be implemented under this subparagraph (d);

1099 (e) [Deleted]

1100 (f) Implement a preferred drug list that is more
1101 stringent than the mandatory preferred drug list established by
1102 the division under subsection (A) (9) of this section;

1103 (g) Implement a policy which denies beneficiaries
1104 with hemophilia access to the federally funded hemophilia
1105 treatment centers as part of the Medicaid Managed Care network of
1106 providers.



1107 Each health maintenance organization, coordinated care
1108 organization, provider-sponsored health plan, or other
1109 organization paid for services on a capitated basis by the
1110 division under any managed care program or coordinated care
1111 program implemented by the division under this section shall use a
1112 clear set of level of care guidelines in the determination of
1113 medical necessity and in all utilization management practices,
1114 including the prior authorization process, concurrent reviews,
1115 retrospective reviews and payments, that are consistent with
1116 widely accepted professional standards of care. Organizations
1117 participating in a managed care program or coordinated care
1118 program implemented by the division may not use any additional
1119 criteria that would result in denial of care that would be
1120 determined appropriate and, therefore, medically necessary under
1121 those levels of care guidelines.

1122 (2) Notwithstanding any provision of this section, the
1123 recipients eligible for enrollment into a Medicaid Managed Care
1124 Program authorized under this subsection (H) may include only
1125 those categories of recipients eligible for participation in the
1126 Medicaid Managed Care Program as of January 1, 2021, the
1127 Children's Health Insurance Program (CHIP), and the CMS-approved
1128 Section 1115 demonstration waivers in operation as of January 1,
1129 2021. No expansion of Medicaid Managed Care Program contracts may
1130 be implemented by the division without enabling legislation from
1131 the Mississippi Legislature.



1132 (3) (a) Any contractors receiving capitated payments
1133 under a managed care delivery system established in this section
1134 shall provide to the Legislature and the division statistical data
1135 to be shared with provider groups in order to improve patient
1136 access, appropriate utilization, cost savings and health outcomes
1137 not later than October 1 of each year. Additionally, each
1138 contractor shall disclose to the Chairmen of the Senate and House
1139 Medicaid Committees the administrative expenses costs for the
1140 prior calendar year, and the number of full-equivalent employees
1141 located in the State of Mississippi dedicated to the Medicaid and
1142 CHIP lines of business as of June 30 of the current year.

1143 (b) The division and the contractors participating
1144 in the managed care program, a coordinated care program or a
1145 provider-sponsored health plan shall be subject to annual program
1146 reviews or audits performed by the Office of the State Auditor,
1147 the PEER Committee, the Department of Insurance and/or independent
1148 third parties.

1149 (c) Those reviews shall include, but not be
1150 limited to, at least two (2) of the following items:

1151 (i) The financial benefit to the State of
1152 Mississippi of the managed care program,

1153 (ii) The difference between the premiums paid
1154 to the managed care contractors and the payments made by those
1155 contractors to health care providers,



1156 (iii) Compliance with performance measures
1157 required under the contracts,
1158 (iv) Administrative expense allocation
1159 methodologies,
1160 (v) Whether nonprovider payments assigned as
1161 medical expenses are appropriate,
1162 (vi) Capitated arrangements with related
1163 party subcontractors,
1164 (vii) Reasonableness of corporate
1165 allocations,
1166 (viii) Value-added benefits and the extent to
1167 which they are used,
1168 (ix) The effectiveness of subcontractor
1169 oversight, including subcontractor review,
1170 (x) Whether health care outcomes have been
1171 improved, and
1172 (xi) The most common claim denial codes to
1173 determine the reasons for the denials.

1174 The audit reports shall be considered public documents and
1175 shall be posted in their entirety on the division's website.

1176 (4) All health maintenance organizations, coordinated
1177 care organizations, provider-sponsored health plans, or other
1178 organizations paid for services on a capitated basis by the
1179 division under any managed care program or coordinated care
1180 program implemented by the division under this section shall



1181 reimburse all providers in those organizations at rates no lower
1182 than those provided under this section for beneficiaries who are
1183 not participating in those programs.

1184 (5) No health maintenance organization, coordinated
1185 care organization, provider-sponsored health plan, or other
1186 organization paid for services on a capitated basis by the
1187 division under any managed care program or coordinated care
1188 program implemented by the division under this section shall
1189 require its providers or beneficiaries to use any pharmacy that
1190 ships, mails or delivers prescription drugs or legend drugs or
1191 devices.

1192 (6) (a) Not later than December 1, 2021, the
1193 contractors who are receiving capitated payments under a managed
1194 care delivery system established under this subsection (H) shall
1195 develop and implement a uniform credentialing process for
1196 providers. Under that uniform credentialing process, a provider
1197 who meets the criteria for credentialing will be credentialed with
1198 all of those contractors and no such provider will have to be
1199 separately credentialed by any individual contractor in order to
1200 receive reimbursement from the contractor. Not later than
1201 December 2, 2021, those contractors shall submit a report to the
1202 Chairmen of the House and Senate Medicaid Committees on the status
1203 of the uniform credentialing process for providers that is
1204 required under this subparagraph (a).



1205 (b) If those contractors have not implemented a
1206 uniform credentialing process as described in subparagraph (a) by
1207 December 1, 2021, the division shall develop and implement, not
1208 later than July 1, 2022, a single, consolidated credentialing
1209 process by which all providers will be credentialed. Under the
1210 division's single, consolidated credentialing process, no such
1211 contractor shall require its providers to be separately
1212 credentialed by the contractor in order to receive reimbursement
1213 from the contractor, but those contractors shall recognize the
1214 credentialing of the providers by the division's credentialing
1215 process.

1216 (c) The division shall require a uniform provider
1217 credentialing application that shall be used in the credentialing
1218 process that is established under subparagraph (a) or (b). If the
1219 contractor or division, as applicable, has not approved or denied
1220 the provider credentialing application within sixty (60) days of
1221 receipt of the completed application that includes all required
1222 information necessary for credentialing, then the contractor or
1223 division, upon receipt of a written request from the applicant and
1224 within five (5) business days of its receipt, shall issue a
1225 temporary provider credential/enrollment to the applicant if the
1226 applicant has a valid Mississippi professional or occupational
1227 license to provide the health care services to which the
1228 credential/enrollment would apply. The contractor or the division
1229 shall not issue a temporary credential/enrollment if the applicant



1230 has reported on the application a history of medical or other
1231 professional or occupational malpractice claims, a history of
1232 substance abuse or mental health issues, a criminal record, or a
1233 history of medical or other licensing board, state or federal
1234 disciplinary action, including any suspension from participation
1235 in a federal or state program. The temporary
1236 credential/enrollment shall be effective upon issuance and shall
1237 remain in effect until the provider's credentialing/enrollment
1238 application is approved or denied by the contractor or division.
1239 The contractor or division shall render a final decision regarding
1240 credentialing/enrollment of the provider within sixty (60) days
1241 from the date that the temporary provider credential/enrollment is
1242 issued to the applicant.

1243 (d) If the contractor or division does not render
1244 a final decision regarding credentialing/enrollment of the
1245 provider within the time required in subparagraph (c), the
1246 provider shall be deemed to be credentialed by and enrolled with
1247 all of the contractors and eligible to receive reimbursement from
1248 the contractors.

1249 (7) (a) Each contractor that is receiving capitated
1250 payments under a managed care delivery system established under
1251 this subsection (H) shall provide to each provider for whom the
1252 contractor has denied the coverage of a procedure that was ordered
1253 or requested by the provider for or on behalf of a patient, a
1254 letter that provides a detailed explanation of the reasons for the



1255 denial of coverage of the procedure and the name and the
1256 credentials of the person who denied the coverage. The letter
1257 shall be sent to the provider in electronic format.

1258 (b) After a contractor that is receiving capitated
1259 payments under a managed care delivery system established under
1260 this subsection (H) has denied coverage for a claim submitted by a
1261 provider, the contractor shall issue to the provider within sixty
1262 (60) days a final ruling of denial of the claim that allows the
1263 provider to have a state fair hearing and/or agency appeal with
1264 the division. If a contractor does not issue a final ruling of
1265 denial within sixty (60) days as required by this subparagraph
1266 (b), the provider's claim shall be deemed to be automatically
1267 approved and the contractor shall pay the amount of the claim to
1268 the provider.

1269 (c) After a contractor has issued a final ruling
1270 of denial of a claim submitted by a provider, the division shall
1271 conduct a state fair hearing and/or agency appeal on the matter of
1272 the disputed claim between the contractor and the provider within
1273 sixty (60) days, and shall render a decision on the matter within
1274 thirty (30) days after the date of the hearing and/or appeal.

1275 (8) It is the intention of the Legislature that the
1276 division evaluate the feasibility of using a single vendor to
1277 administer pharmacy benefits provided under a managed care
1278 delivery system established under this subsection (H). Providers



1279 of pharmacy benefits shall cooperate with the division in any
1280 transition to a carve-out of pharmacy benefits under managed care.

1281 (9) The division shall evaluate the feasibility of
1282 using a single vendor to administer dental benefits provided under
1283 a managed care delivery system established in this subsection (H).
1284 Providers of dental benefits shall cooperate with the division in
1285 any transition to a carve-out of dental benefits under managed
1286 care.

1287 (10) It is the intent of the Legislature that any
1288 contractor receiving capitated payments under a managed care
1289 delivery system established in this section shall implement
1290 innovative programs to improve the health and well-being of
1291 members diagnosed with prediabetes and diabetes.

1292 (11) It is the intent of the Legislature that any
1293 contractors receiving capitated payments under a managed care
1294 delivery system established under this subsection (H) shall work
1295 with providers of Medicaid services to improve the utilization of
1296 long-acting reversible contraceptives (LARCs). Not later than
1297 December 1, 2021, any contractors receiving capitated payments
1298 under a managed care delivery system established under this
1299 subsection (H) shall provide to the Chairmen of the House and
1300 Senate Medicaid Committees and House and Senate Public Health
1301 Committees a report of LARC utilization for State Fiscal Years
1302 2018 through 2020 as well as any programs, initiatives, or efforts
1303 made by the contractors and providers to increase LARC



1304 utilization. This report shall be updated annually to include
1305 information for subsequent state fiscal years.

1306 (12) The division is authorized to make not more than
1307 one (1) emergency extension of the contracts that are in effect on
1308 July 1, 2021, with contractors who are receiving capitated
1309 payments under a managed care delivery system established under
1310 this subsection (H), as provided in this paragraph (12). The
1311 maximum period of any such extension shall be one (1) year, and
1312 under any such extensions, the contractors shall be subject to all
1313 of the provisions of this subsection (H). The extended contracts
1314 shall be revised to incorporate any provisions of this subsection
1315 (H).

1316 (I) [Deleted]

1317 (J) There shall be no cuts in inpatient and outpatient
1318 hospital payments, or allowable days or volumes, as long as the
1319 hospital assessment provided in Section 43-13-145 is in effect.
1320 This subsection (J) shall not apply to decreases in payments that
1321 are a result of: reduced hospital admissions, audits or payments
1322 under the APR-DRG or APC models, or a managed care program or
1323 similar model described in subsection (H) of this section.

1324 (K) In the negotiation and execution of such contracts
1325 involving services performed by actuarial firms, the Executive
1326 Director of the Division of Medicaid may negotiate a limitation on
1327 liability to the state of prospective contractors.



1328 (L) The Division of Medicaid shall reimburse for services
1329 provided to eligible Medicaid beneficiaries by a licensed birthing
1330 center in a method and manner to be determined by the division in
1331 accordance with federal laws and federal regulations. The
1332 division shall seek any necessary waivers, make any required
1333 amendments to its State Plan or revise any contracts authorized
1334 under subsection (H) of this section as necessary to provide the
1335 services authorized under this subsection. As used in this
1336 subsection, the term "birthing centers" shall have the meaning as
1337 defined in Section 41-77-1(a), which is a publicly or privately
1338 owned facility, place or institution constructed, renovated,
1339 leased or otherwise established where nonemergency births are
1340 planned to occur away from the mother's usual residence following
1341 a documented period of prenatal care for a normal uncomplicated
1342 pregnancy which has been determined to be low risk through a
1343 formal risk-scoring examination.

1344 (M) This section shall stand repealed on July 1, 2025.

1345 **SECTION 2.** This act shall take effect and be in force from
1346 and after July 1, 2024.

