MISSISSIPPI LEGISLATURE REGULAR SESSION 2024

By: Representative Zuber

To: Public Health and Human Services

HOUSE BILL NO. 421

AN ACT TO BRING FORWARD SECTIONS 83-51-15, 83-9-6.3, 83-9-32, 83-9-353, 43-13-117, 43-13-107, 73-23-101, 41-83-9, 41-83-31, 73-23-35, 41-10-3, 41-63-1, 41-63-4, 41-83-1, 41-83-3, 41-83-5, 41-83-13, 41-83-15, 41-83-17, 41-83-21, 41-83-25, 41-83-27, 41-83-29, 71-3-15, 73-21-73, 73-21-161, 83-9-39, 83-9-213, 83-41-403 AND 83-41-409, MISSISSIPPI CODE OF 1972, WHICH RELATE TO PRIOR AUTHORIZATIONS, FOR THE PURPOSE OF POSSIBLE AMENDMENT; AND FOR RELATED PURPOSES.

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

SECTION 1. Section 83-51-15, Mississippi Code of 1972, is brought forward as follows:

83-51-15. (1) (a) A dental service contractor or a contract of dental insurance shall establish and maintain appeal procedures for any claim by a dentist or a subscriber that is denied based upon lack of medical necessity.

(b) Any denial shall be based upon a determination by a dentist who holds a nonrestricted license issued in the United States in the same or an appropriate specialty that typically manages the dental condition, procedure, or treatment under review.

(c) Subsequent to an initial denial, the licensed dentist making the adverse determination shall not be an employee of the dental service contractor or dental insurer.

(d) Any written communication to an insured or a dentist that includes or pertains to a denial of benefits for all or part of a claim on the basis of a lack of medical necessity shall include the name, applicable specialty designation, license number together with state of issuance, and the email address of the licensed dentist making the adverse determination.

(2) (a) For the purposes of this subsection, a "prior authorization" shall mean any predetermination, prior authorization or similar authorization that is verifiable, whether through issuance of letter, facsimile, e-mail or similar means, indicating that a specific procedure is, or multiple procedures are, covered under the patient's plan and reimbursable at a specific amount, subject to applicable coinsurance and deductibles, and issued in response to a request submitted by a dentist using a prescribed format.

(b) A dental service contractor shall not deny any claim subsequently submitted for procedures specifically included in a prior authorization unless at least one (1) of the following circumstances applies for each procedure denied:

(i) Benefit limitations such as annual maximums and frequency limitations not applicable at the time of prior

authorization are reached due to utilization subsequent to issuance of the prior authorization;

(ii) The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;

(iii) If, subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care;

(iv) If, subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would at that time require disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was issued; or

(v) The dental service contractor's denial is because of one (1) of the following:

1. Another payor is responsible for the payment;

2. The dentist has already been paid for the procedures identified on the claim;

3. The claim was submitted fraudulently or the prior authorization was based in whole or material part on

erroneous information provided to the dental service contractor by the dentist, patient, or other person not related to the carrier; or

4. The person receiving the procedure was not eligible to receive the procedure on the date of service and the dental service contractor did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status.

(c) A dental service contractor shall not require any information be submitted for a prior authorization request that would not be required for submission of a claim.

(d) A dental service contractor shall issue a prior authorization within thirty (30) days of the date a request is submitted by a dentist.

(e) The provisions of subsection (1) of this section shall apply to any denial of a claim pursuant to paragraph (b) of this subsection for a procedure included in a prior authorization.

(3) A contractor shall not recoup a claim solely due to a patient's loss of coverage or ineligibility if, at the time of treatment, the contractor erroneously confirms coverage and eligibility, but had sufficient information available to it indicating that the patient was no longer covered or was ineligible for coverage.

SECTION 2. Section 83-9-6.3, Mississippi Code of 1972, is brought forward as follows:

83-9-6.3. (1) As used in this section:

(a) "Health benefit plan" means services consisting of medical care, provided directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization, or health maintenance organization contract offered by a health insurance issuer. The term "health benefit plan" includes the Medicaid fee-for-service program and any managed care program, coordinated care program, coordinated care organization program or health maintenance organization program implemented by the Division of Medicaid.

(b) "Health insurance issuer" means any entity that offers health insurance coverage through a health benefit plan, policy, or certificate of insurance subject to state law that regulates the business of insurance. "Health insurance issuer" also includes a health maintenance organization, as defined and regulated under Section 83-41-301 et seq., and includes the Division of Medicaid for the services provided by fee-for-service and through any managed care program, coordinated care program, coordinated care organization program or health maintenance organization program implemented by the division.

(c) "Prior authorization" means a utilization management criterion used to seek permission or waiver of a drug

to be covered under a health benefit plan that provides prescription drug benefits.

(d) "Prior authorization form" means a standardized, uniform application developed by a health insurance issuer for the purpose of obtaining prior authorization.

(2) Notwithstanding any other provision of law to the contrary, in order to establish uniformity in the submission of prior authorization forms, on or after January 1, 2014, a health insurance issuer shall use only a single, standardized prior authorization form for obtaining any prior authorization for prescription drug benefits. The form shall not exceed two (2) pages in length, excluding any instructions or guiding documentation. The form shall also be made available electronically, and the prescribing provider may submit the completed form electronically to the health benefit plan. Additionally, the health insurance issuer shall submit its prior authorization forms to the Mississippi Department of Insurance to be kept on file on or after January 1, 2014. A copy of any subsequent replacements or modifications of a health insurance issuer's prior authorization form shall be filed with the Mississippi Department of Insurance within fifteen (15) days prior to use or implementation of such replacements or modifications.

(3) A health insurance issuer shall respond within two (2) business days upon receipt of a completed prior authorization request from a prescribing provider that was submitted using the

standardized prior authorization form required by subsection (2) of this section.

SECTION 3. Section 83-9-32, Mississippi Code of 1972, is brought forward as follows:

83-9-32. Every hospital, health or medical expenses insurance policy, hospital or medical service contract, health maintenance organization and preferred provider organization that is delivered or issued for delivery in this state and otherwise provides anesthesia benefits shall offer benefits for anesthesia and for associated facility charges when the mental or physical condition of the child or mentally handicapped adult requires dental treatment to be rendered under physician-supervised general anesthesia in a hospital setting, surgical center or dental office. This coverage shall be offered on an optional basis, and each primary insured must accept or reject such coverage in writing and accept responsibility for premium payment.

An insurer may require prior authorization for the anesthesia and associated facility charges for dental care procedures in the same manner that prior authorization is required for treatment of other medical conditions under general anesthesia. An insurer may require review for medical necessity and may limit payment of facility charges to certified facilities in the same manner that medical review is required and payment of facility charges is limited for other services. The benefit provided by this coverage shall be subject to the same annual deductibles or coinsurance

established for all other covered benefits within a given policy, plan or contract. Private third-party payers may not reduce or eliminate coverage due to these requirements.

A dentist shall consider the Indications for General Anesthesia as published in the reference manual of the American Academy of Pediatric Dentistry as utilization standards for determining whether performing dental procedures necessary to treat the particular condition or conditions of the patient under general anesthesia constitutes appropriate treatment.

The provisions of this section shall apply to anesthesia services provided by oral and maxillofacial surgeons as permitted by the Mississippi State Board of Dental Examiners.

The provisions of this section shall not apply to treatment rendered for temporal mandibular joint (TMJ) disorders.

SECTION 4. Section 83-9-353, Mississippi Code of 1972, is brought forward as follows:

83-9-353. (1) As used in this section:

(a) "Employee benefit plan" means any plan, fund or program established or maintained by an employer or by an employee organization, or both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, hospital care or other benefits.

(b) "Health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, and includes the State and School Employees Health Insurance Plan and any other public health care assistance program offered or administered by the state or any political subdivision or instrumentality of the state. The term does not include policies or plans providing coverage for specified disease or other limited benefit coverage.

(c) "Health insurer" means any health insurance company, nonprofit hospital and medical service corporation, health maintenance organization, preferred provider organization, managed care organization, pharmacy benefit manager, and, to the extent permitted under federal law, any administrator of an insured, self-insured or publicly funded health care benefit plan offered by public and private entities, and other parties that are by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

(d) "Store-and-forward telemedicine services" means the use of asynchronous computer-based communication between a patient and a consulting provider or a referring health care provider and a medical specialist at a distant site for the purpose of diagnostic and therapeutic assistance in the care of patients who otherwise have no access to specialty care. Store-and-forward telemedicine services involve the transferring of medical data from one (1) site to another through the use of a camera or

similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation.

(e) "Remote patient monitoring services" means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including:

(i) Monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry and other condition-specific data, such as blood glucose;

(ii) Medication adherence monitoring; and

(iii) Interactive video conferencing with or without digital image upload as needed.

(f) "Mediation adherence management services" means the monitoring of a patient's conformance with the clinician's medication plan with respect to timing, dosing and frequency of medication-taking through electronic transmission of data in a home telemonitoring program.

(2) Store-and-forward telemedicine services allow a health care provider trained and licensed in his or her given specialty to review forwarded images and patient history in order to provide diagnostic and therapeutic assistance in the care of the patient without the patient being present in real time. Treatment recommendations made via electronic means shall be held to the same standards of appropriate practice as those in traditional provider-patient setting.

(3) Any patient receiving medical care by store-and-forward telemedicine services shall be notified of the right to receive interactive communication with the distant specialist health care provider and shall receive an interactive communication with the distant specialist upon request. If requested, communication with the distant specialist may occur at the time of the consultation or within thirty (30) days of the patient's notification of the request of the consultation. Telemedicine networks unable to offer the interactive consultation shall not be reimbursed for store-and-forward telemedicine services.

(4) Remote patient monitoring services aim to allow more people to remain at home or in other residential settings and to improve the quality and cost of their care, including prevention of more costly care. Remote patient monitoring services via telehealth aim to coordinate primary, acute, behavioral and long-term social service needs for high-need, high-cost patients. Specific patient criteria must be met in order for reimbursement to occur.

(5) Qualifying patients for remote patient monitoring services must meet all the following criteria:

(a) Be diagnosed, in the last eighteen (18) months, with one or more chronic conditions, as defined by the Centers for Medicare and Medicaid Services (CMS), which include, but are not limited to, sickle cell, mental health, asthma, diabetes, and heart disease; and

(b) The patient's health care provider recommends disease management services via remote patient monitoring.

(6) A remote patient monitoring prior authorization request form may be required for approval of telemonitoring services. If prior authorization is required, the request form must include the following:

(a) An order for home telemonitoring services, signed and dated by the prescribing physician;

(b) A plan of care, signed and dated by the prescribing physician, that includes telemonitoring transmission frequency and duration of monitoring requested;

(c) The client's diagnosis and risk factors that qualify the client for home telemonitoring services;

(d) Attestation that the client is sufficiently cognitively intact and able to operate the equipment or has a willing and able person to assist in completing electronic transmission of data; and

(e) Attestation that the client is not receiving duplicative services via disease management services.

(7) The entity that will provide the remote monitoring must be a Mississippi-based entity and have protocols in place to address all of the following:

(a) Authentication and authorization of users;

(b) A mechanism for monitoring, tracking and responding to changes in a client's clinical condition;

(c) A standard of acceptable and unacceptable parameters for client's clinical parameters, which can be adjusted based on the client's condition;

(d) How monitoring staff will respond to abnormal parameters for client's vital signs, symptoms and/or lab results;

(e) The monitoring, tracking and responding to changes in client's clinical condition;

(f) The process for notifying the prescribing physician for significant changes in the client's clinical signs and symptoms;

(g) The prevention of unauthorized access to the system or information;

(h) System security, including the integrity of information that is collected, program integrity and system integrity;

(i) Information storage, maintenance and transmission;

(j) Synchronization and verification of patient profile data; and

(k) Notification of the client's discharge from remote patient monitoring services or the de-installation of the remote patient monitoring unit.

(8) The telemonitoring equipment must:

(a) Be capable of monitoring any data parameters in the plan of care; and

(b) Be a FDA Class II hospital-grade medical device.

(9) Monitoring of the client's data shall not be duplicated by another provider.

(10) To receive payment for the delivery of remote patient monitoring services via telehealth, the service must involve:

(a) An assessment, problem identification, and evaluation that includes:

(i) Assessment and monitoring of clinical data including, but not limited to, appropriate vital signs, pain levels and other biometric measures specified in the plan of care, and also includes assessment of response to previous changes in the plan of care; and

(ii) Detection of condition changes based on the telemedicine encounter that may indicate the need for a change in the plan of care.

(b) Implementation of a management plan through one or more of the following:

(i) Teaching regarding medication management as appropriate based on the telemedicine findings for that encounter;

(ii) Teaching regarding other interventions as appropriate to both the patient and the caregiver;

(iii) Management and evaluation of the plan of care including changes in visit frequency or addition of other skilled services;

(iv) Coordination of care with the ordering health care provider regarding telemedicine findings;

(v) Coordination and referral to other medical providers as needed; and

(vi) Referral for an in-person visit or the emergency room as needed.

(11) The telemedicine equipment and network used for remote patient monitoring services should meet the following requirements:

(a) Comply with applicable standards of the United States Food and Drug Administration;

(b) Telehealth equipment be maintained in good repair and free from safety hazards;

(c) Telehealth equipment be new or sanitized before installation in the patient's home setting;

(d) Accommodate non-English language options; and

(e) Have 24/7 technical and clinical support services available for the patient user.

(12) All health insurance and employee benefit plans in this state must provide coverage and reimbursement for the asynchronous telemedicine services of store-and-forward telemedicine services and remote patient monitoring services based on the criteria set out in this section. Store-and-forward telemedicine services shall be reimbursed to the same extent that the services would be covered if they were provided through in-person consultation.

(13) Remote patient monitoring services shall include reimbursement for a daily monitoring rate at a minimum of Ten

Dollars ($10.00) per day each month and Sixteen Dollars ($16.00) per day when medication adherence management services are included, not to exceed thirty-one (31) days per month. These reimbursement rates are only eligible to Mississippi-based telehealth programs affiliated with a Mississippi health care facility.

(14) A one-time telehealth installation/training fee for remote patient monitoring services will also be reimbursed at a minimum rate of Fifty Dollars ($50.00) per patient, with a maximum of two (2) installation/training fees/calendar year. These reimbursement rates are only eligible to Mississippi-based telehealth programs affiliated with a Mississippi health care facility.

(15) No geographic restrictions shall be placed on the delivery of telemedicine services in the home setting other than requiring the patient reside within the State of Mississippi.

(16) Health care providers seeking reimbursement for store-and-forward telemedicine services must be licensed Mississippi providers that are affiliated with an established Mississippi health care facility in order to qualify for reimbursement of telemedicine services in the state. If a service is not available in Mississippi, then a health insurance or employee benefit plan may decide to allow a non-Mississippi-based provider who is licensed to practice in Mississippi reimbursement for those services.

(17) A health insurance or employee benefit plan may charge a deductible, co-payment, or coinsurance for a health care service provided through store-and-forward telemedicine services or remote patient monitoring services so long as it does not exceed the deductible, co-payment, or coinsurance applicable to an in-person consultation.

(18) A health insurance or employee benefit plan may limit coverage to health care providers in a telemedicine network approved by the plan.

(19) Nothing in this section shall be construed to prohibit a health insurance or employee benefit plan from providing coverage for only those services that are medically necessary, subject to the terms and conditions of the covered person's policy.

(20) In a claim for the services provided, the appropriate procedure code for the covered service shall be included with the appropriate modifier indicating telemedicine services were used. A "GQ" modifier is required for asynchronous telemedicine services such as store-and-forward and remote patient monitoring.

(21) The originating site is eligible to receive a facility fee, but facility fees are not payable to the distant site.

SECTION 5. Section 43-13-117, Mississippi Code of 1972, is brought forward as follows:

43-13-117. (A) Medicaid as authorized by this article shall include payment of part or all of the costs, at the discretion of

the division, with approval of the Governor and the Centers for Medicare and Medicaid Services, of the following types of care and services rendered to eligible applicants who have been determined to be eligible for that care and services, within the limits of state appropriations and federal matching funds:

(1) Inpatient hospital services.

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

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

(2) Outpatient hospital services.

(a) Emergency services.

(b) Other outpatient hospital services. The division shall allow benefits for other medically necessary outpatient hospital services (such as chemotherapy, radiation, surgery and therapy), including outpatient services in a clinic or other facility that is not located inside the hospital, but that has been designated as an outpatient facility by the hospital, and that was in operation or under construction on July 1, 2009, provided that the costs and charges associated with the operation

of the hospital clinic are included in the hospital's cost report. In addition, the Medicare thirty-five-mile rule will apply to those hospital clinics not located inside the hospital that are constructed after July 1, 2009. Where the same services are reimbursed as clinic services, the division may revise the rate or methodology of outpatient reimbursement to maintain consistency, efficiency, economy and quality of care.

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

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

(3) Laboratory and x-ray services.

(4) Nursing facility services.

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

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

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

(d) On or after January 1, 2015, the division shall update the case-mix payment system resource utilization grouper and classifications and fair rental reimbursement system.

The division shall develop and implement a payment add-on to reimburse nursing facilities for ventilator-dependent resident services.

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

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

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

(5) Periodic screening and diagnostic services for individuals under age twenty-one (21) years as are needed to identify physical and mental defects and to provide health care treatment and other measures designed to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services, regardless of whether these services are included in the state plan. The division may include in its periodic screening and diagnostic program those discretionary services authorized under the federal regulations adopted to implement Title XIX of the federal Social Security Act, as amended. The division, in obtaining physical therapy services, occupational therapy services, and services for individuals with speech, hearing and language disorders, may enter into a cooperative agreement with the State Department of Education for the provision of those services to handicapped students by public school districts using state funds that are provided from the appropriation to the Department of Education to obtain federal matching funds through the division. The division, in obtaining medical and mental health assessments, treatment, care and services for children who are in, or at risk of being put in, the custody of the Mississippi Department of Human Services may enter into a cooperative agreement with the Mississippi Department of Human Services for the provision of those services using state funds that are provided from the appropriation to the Department

of Human Services to obtain federal matching funds through the division.

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

(7) (a) Home health services for eligible persons, not to exceed in cost the prevailing cost of nursing facility services. All home health visits must be precertified as required by the division. In addition to physicians, certified registered nurse practitioners, physician assistants and clinical nurse specialists are authorized to prescribe or order home health services and plans of care, sign home health plans of care, certify and recertify eligibility for home health services and

conduct the required initial face-to-face visit with the recipient of the services.

(b) [Repealed]

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

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

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

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

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

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

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

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

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

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

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

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

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

The dispensing fee for each new or refill prescription, including nonlegend or over-the-counter drugs covered by the

division, shall be not less than Three Dollars and Ninety-one Cents ($3.91), as determined by the division.

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

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

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

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

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

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

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

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

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

(11) Eyeglasses for all Medicaid beneficiaries who have (a) had surgery on the eyeball or ocular muscle that results in a vision change for which eyeglasses or a change in eyeglasses is medically indicated within six (6) months of the surgery and is in

accordance with policies established by the division, or (b) one (1) pair every five (5) years and in accordance with policies established by the division. In either instance, the eyeglasses must be prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the beneficiary may select.

(12) Intermediate care facility services.

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

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

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

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

(14) Clinic services. Preventive, diagnostic, therapeutic, rehabilitative or palliative services that are

furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Clinic services include, but are not limited to:

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

(b) Dialysis center services.

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

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

provided in the community by a facility or program operated by the Department of Mental Health. Any such services provided by a facility described in subparagraph (b) must have the prior approval of the division to be reimbursable under this section.

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

(18) (a) Notwithstanding any other provision of this section to the contrary, as provided in the Medicaid state plan amendment or amendments as defined in Section 43-13-145(10), the

division shall make additional reimbursement to hospitals that serve a disproportionate share of low-income patients and that meet the federal requirements for those payments as provided in Section 1923 of the federal Social Security Act and any applicable regulations. It is the intent of the Legislature that the division shall draw down all available federal funds allotted to the state for disproportionate share hospitals. However, from and after January 1, 1999, public hospitals participating in the Medicaid disproportionate share program may be required to participate in an intergovernmental transfer program as provided in Section 1903 of the federal Social Security Act and any applicable regulations.

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

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

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

(iii) Subject to approval by the Centers for Medicare and Medicaid Services (CMS) and the provisions of this subsection (A)(18)(b), the division shall make additional reimbursement to hospitals, nursing facilities, and emergency

ambulance transportation providers for the Medicare Upper Payment Limits Program or other program(s) authorized under this subsection (A)(18)(b), and, if the program is established for physicians, shall make additional reimbursement for physicians, as defined in Section 1902(a)(30) of the federal Social Security Act and any applicable federal regulations, provided the assessment in this subsection (A)(18)(b) is in effect.

(iv) Notwithstanding any other provision of this article to the contrary, effective upon implementation of the Mississippi Hospital Access Program (MHAP) provided in subparagraph (c)(i) below, the hospital portion of the inpatient Upper Payment Limits Program shall transition into and be replaced by the MHAP program. However, the division is authorized to develop and implement an alternative fee-for-service Upper Payment Limits model in accordance with federal laws and regulations if necessary to preserve supplemental funding. Further, the division, in consultation with the hospital industry shall develop alternative models for distribution of medical claims and supplemental payments for inpatient and outpatient hospital services, and such models may include, but shall not be limited to the following: increasing rates for inpatient and outpatient services; creating a low-income utilization pool of funds to reimburse hospitals for the costs of uncompensated care, charity care and bad debts as permitted and approved pursuant to federal regulations and the Centers for Medicare and Medicaid Services;

supplemental payments based upon Medicaid utilization, quality, service lines and/or costs of providing such services to Medicaid beneficiaries and to uninsured patients. The goals of such payment models shall be to ensure access to inpatient and outpatient care and to maximize any federal funds that are available to reimburse hospitals for services provided. Any such documents required to achieve the goals described in this paragraph shall be submitted to the Centers for Medicare and Medicaid Services, with a proposed effective date of July 1, 2019, to the extent possible, but in no event shall the effective date of such payment models be later than July 1, 2020. The Chairmen of the Senate and House Medicaid Committees shall be provided a copy of the proposed payment model(s) prior to submission. Effective July 1, 2018, and until such time as any payment model(s) as described above become effective, the division, in consultation with the hospital industry, is authorized to implement a transitional program for inpatient and outpatient payments and/or supplemental payments (including, but not limited to, MHAP and directed payments), to redistribute available supplemental funds among hospital providers, provided that when compared to a hospital's prior year supplemental payments, supplemental payments made pursuant to any such transitional program shall not result in a decrease of more than five percent (5%) and shall not increase by more than the amount needed to maximize the distribution of the available funds.

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

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

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

b. In addition to any other funds paid to ambulance transportation service providers for emergency medical services provided to Medicaid beneficiaries, each eligible ambulance transportation service provider shall receive ambulance service access payments each state fiscal year equal to the ambulance transportation service provider's upper payment limit

gap. Subject to approval by the Centers for Medicare and Medicaid Services, ambulance service access payments shall be made no less than on a quarterly basis.

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

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

(c) (i) Not later than December 1, 2015, the division shall, subject to approval by the Centers for Medicare and Medicaid Services (CMS), establish, implement and operate a Mississippi Hospital Access Program (MHAP) for the purpose of protecting patient access to hospital care through hospital inpatient reimbursement programs provided in this section designed to maintain total hospital reimbursement for inpatient services rendered by in-state hospitals and the out-of-state hospital that is authorized by federal law to submit intergovernmental transfers (IGTs) to the State of Mississippi and is classified as Level I trauma center located in a county contiguous to the state line at the maximum levels permissible under applicable federal statutes

and regulations, at which time the current inpatient Medicare Upper Payment Limits (UPL) Program for hospital inpatient services shall transition to the MHAP.

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

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

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

assessment will remain in effect as long as the MHAP and supplemental payments are in effect.

(19) (a) Perinatal risk management services. The division shall promulgate regulations to be effective from and after October 1, 1988, to establish a comprehensive perinatal system for risk assessment of all pregnant and infant Medicaid recipients and for management, education and follow-up for those who are determined to be at risk. Services to be performed include case management, nutrition assessment/counseling, psychosocial assessment/counseling and health education. The division shall contract with the State Department of Health to provide services within this paragraph (Perinatal High Risk Management/Infant Services System (PHRM/ISS)). The State Department of Health shall be reimbursed on a full reasonable cost basis for services provided under this subparagraph (a).

(b) Early intervention system services. The division shall cooperate with the State Department of Health, acting as lead agency, in the development and implementation of a statewide system of delivery of early intervention services, under Part C of the Individuals with Disabilities Education Act (IDEA). The State Department of Health shall certify annually in writing to the executive director of the division the dollar amount of state early intervention funds available that will be utilized as a certified match for Medicaid matching funds. Those funds then shall be used to provide expanded targeted case management

services for Medicaid eligible children with special needs who are eligible for the state's early intervention system. Qualifications for persons providing service coordination shall be determined by the State Department of Health and the Division of Medicaid.

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

(21) Nurse practitioner services. Services furnished by a registered nurse who is licensed and certified by the Mississippi Board of Nursing as a nurse practitioner, including, but not limited to, nurse anesthetists, nurse midwives, family nurse practitioners, family planning nurse practitioners, pediatric nurse practitioners, obstetrics-gynecology nurse practitioners and neonatal nurse practitioners, under regulations adopted by the division. Reimbursement for those services shall not exceed ninety percent (90%) of the reimbursement rate for comparable services rendered by a physician. The division may

provide for a reimbursement rate for nurse practitioner services of up to one hundred percent (100%) of the reimbursement rate for comparable services rendered by a physician for nurse practitioner services that are provided after the normal working hours of the nurse practitioner, as determined in accordance with regulations of the division.

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

(23) Inpatient psychiatric services.

(a) Inpatient psychiatric services to be determined by the division for recipients under age twenty-one (21) that are provided under the direction of a physician in an

inpatient program in a licensed acute care psychiatric facility or in a licensed psychiatric residential treatment facility, before the recipient reaches age twenty-one (21) or, if the recipient was receiving the services immediately before he or she reached age twenty-one (21), before the earlier of the date he or she no longer requires the services or the date he or she reaches age twenty-two (22), as provided by federal regulations. From and after January 1, 2015, the division shall update the fair rental reimbursement system for psychiatric residential treatment facilities. Precertification of inpatient days and residential treatment days must be obtained as required by the division. From and after July 1, 2009, all state-owned and state-operated facilities that provide inpatient psychiatric services to persons under age twenty-one (21) who are eligible for Medicaid reimbursement shall be reimbursed for those services on a full reasonable cost basis.

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

(24) [Deleted]

(25) [Deleted]

(26) Hospice care. As used in this paragraph, the term "hospice care" means a coordinated program of active professional medical attention within the home and outpatient and inpatient

care that treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses that are experienced during the final stages of illness and during dying and bereavement and meets the Medicare requirements for participation as a hospice as provided in federal regulations.

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

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

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

Department of Mental Health and/or transferred to the department by a political subdivision or instrumentality of the state.

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

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

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

(33) Podiatrist services.

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

(35) Services and activities authorized in Sections 43-27-101 and 43-27-103, using state funds that are provided from

the appropriation to the Mississippi Department of Human Services and used to match federal funds under a cooperative agreement between the division and the department.

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

(37) [Deleted]

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

(39) Dually eligible Medicare/Medicaid beneficiaries. The division shall pay the Medicare deductible and coinsurance

amounts for services available under Medicare, as determined by the division. From and after July 1, 2009, the division shall reimburse crossover claims for inpatient hospital services and crossover claims covered under Medicare Part B in the same manner that was in effect on January 1, 2008, unless specifically authorized by the Legislature to change this method.

(40) [Deleted]

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

(42) [Deleted]

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

(44) Nursing facility services for the severely disabled.

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

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

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

(46) The division shall make application to the federal Centers for Medicare and Medicaid Services (CMS) for a waiver to develop and provide services for children with serious emotional disturbances as defined in Section 43-14-1(1), which may include home- and community-based services, case management services or managed care services through mental health providers certified by

the Department of Mental Health. The division may implement and provide services under this waivered program only if funds for these services are specifically appropriated for this purpose by the Legislature, or if funds are voluntarily provided by affected agencies.

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

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

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

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

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

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

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

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

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

(52) Notwithstanding any provisions of this article, the division may pay enhanced reimbursement fees related to trauma care, as determined by the division in conjunction with the State

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

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

(54) [Deleted]

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

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

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

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

(59) The division shall allow beneficiaries between the ages of ten (10) and eighteen (18) years to receive vaccines through a pharmacy venue. The division and the State Department

of Health shall coordinate and notify OB-GYN providers that the Vaccines for Children program is available to providers free of charge.

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

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

(b) As used in this paragraph (60), the term "border city university-affiliated pediatric teaching hospital" means an out-of-state hospital located within a city bordering the eastern bank of the Mississippi River and the State of Mississippi that submits to the division a copy of a current and effective affiliation agreement with an accredited university and other documentation establishing that the hospital is university-affiliated, is licensed and designated as a pediatric hospital or pediatric primary hospital within its home state, maintains at least five (5) different pediatric specialty training programs, and maintains at least one hundred (100) operated beds

dedicated exclusively for the treatment of patients under the age of twenty-one (21) years.

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

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

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

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

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

program, and the division may pay those centers a percentage of any savings to the Medicaid program achieved by the centers' accepting patient referrals through the program, as provided in this subsection (C).

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

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

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

(2) Whenever the Division of Medicaid proposes a rate change, the division shall give notice to the chairmen of the committees at least thirty (30) calendar days before the proposed rate change is scheduled to take effect. The division shall furnish the chairmen with a concise summary of each proposed rate change along with the notice, and shall furnish the chairmen with a copy of any proposed rate change upon request. The division

also shall provide a summary and copy of any proposed rate change to any other member of the Legislature upon request.

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

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

(b) After the committee meeting, the committee or committees may object to the proposed rate change or any part thereof. The committee or committees shall notify the division and the reasons for their objection in writing not later than seven (7) calendar days after the meeting. The committee or

committees may make written recommendations to the division for changes to be made to a proposed rate change.

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

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

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

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

(7) Nothing in this subsection (D) shall be construed as giving the chairmen or the committees any authority to veto,

nullify or revise any rate change proposed by the division. The authority of the chairmen or the committees under this subsection shall be limited to reviewing, making objections to and making recommendations for changes to rate changes proposed by the division.

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

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

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

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

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

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

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

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

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

(H) (1) Notwithstanding any other provision of this article, the division is authorized to implement (a) a managed

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

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

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

(c) Pay providers at a rate that is less than the normal Medicaid reimbursement rate. It is the intent of the Legislature that all managed care entities described in this subsection (H), in collaboration with the division, develop and

implement innovative payment models that incentivize improvements in health care quality, outcomes, or value, as determined by the division. Participation in the provider network of any managed care, coordinated care, provider-sponsored health plan, or similar contractor shall not be conditioned on the provider's agreement to accept such alternative payment models;

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

(e) [Deleted]

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

(g) Implement a policy which denies beneficiaries with hemophilia access to the federally funded hemophilia

treatment centers as part of the Medicaid Managed Care network of providers.

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

(2) Notwithstanding any provision of this section, the recipients eligible for enrollment into a Medicaid Managed Care Program authorized under this subsection (H) may include only those categories of recipients eligible for participation in the Medicaid Managed Care Program as of January 1, 2021, the Children's Health Insurance Program (CHIP), and the CMS-approved Section 1115 demonstration waivers in operation as of January 1, 2021. No expansion of Medicaid Managed Care Program contracts may

be implemented by the division without enabling legislation from the Mississippi Legislature.

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

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

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

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

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

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

(iv) Administrative expense allocation methodologies,

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

(vi) Capitated arrangements with related party subcontractors,

(vii) Reasonableness of corporate allocations,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) [Deleted]

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

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

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

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

SECTION 6. Section 43-13-107, Mississippi Code of 1972, is brought forward as follows:

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

(2) (a) The Governor shall appoint a full-time executive director, with the advice and consent of the Senate, who shall be either (i) a physician with administrative experience in a medical

care or health program, or (ii) a person holding a graduate degree in medical care administration, public health, hospital administration, or the equivalent, or (iii) a person holding a bachelor's degree with at least three (3) years' experience in management-level administration of, or policy development for, Medicaid programs. Provided, however, no one who has been a member of the Mississippi Legislature during the previous three (3) years may be executive director. The executive director shall be the official secretary and legal custodian of the records of the division; shall be the agent of the division for the purpose of receiving all service of process, summons and notices directed to the division; shall perform such other duties as the Governor may prescribe from time to time; and shall perform all other duties that are now or may be imposed upon him or her by law.

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

(c) The executive director shall, before entering upon the discharge of the duties of the office, take and subscribe to the oath of office prescribed by the Mississippi Constitution and shall file the same in the Office of the Secretary of State, and shall execute a bond in some surety company authorized to do business in the state in the penal sum of One Hundred Thousand Dollars ($100,000.00), conditioned for the faithful and impartial discharge of the duties of the office. The premium on the bond

shall be paid as provided by law out of funds appropriated to the Division of Medicaid for contractual services.

(d) The executive director, with the approval of the Governor and subject to the rules and regulations of the State Personnel Board, shall employ such professional, administrative, stenographic, secretarial, clerical and technical assistance as may be necessary to perform the duties required in administering this article and fix the compensation for those persons, all in accordance with a state merit system meeting federal requirements. When the salary of the executive director is not set by law, that salary shall be set by the State Personnel Board. No employees of the Division of Medicaid shall be considered to be staff members of the immediate Office of the Governor; however, Section 25-9-107(c)(xv) shall apply to the executive director and other administrative heads of the division.

(3) (a) There is established a Medical Care Advisory Committee, which shall be the committee that is required by federal regulation to advise the Division of Medicaid about health and medical care services.

(b) The advisory committee shall consist of not less than eleven (11) members, as follows:

(i) The Governor shall appoint five (5) members, one (1) from each congressional district and one (1) from the state at large;

(ii) The Lieutenant Governor shall appoint three (3) members, one (1) from each Supreme Court district;

(iii) The Speaker of the House of Representatives shall appoint three (3) members, one (1) from each Supreme Court district.

All members appointed under this paragraph shall either be health care providers or consumers of health care services. One (1) member appointed by each of the appointing authorities shall be a board-certified physician.

(c) The respective Chairmen of the House Medicaid Committee, the House Public Health and Human Services Committee, the House Appropriations Committee, the Senate Medicaid Committee, the Senate Public Health and Welfare Committee and the Senate Appropriations Committee, or their designees, one (1) member of the State Senate appointed by the Lieutenant Governor and one (1) member of the House of Representatives appointed by the Speaker of the House, shall serve as ex officio nonvoting members of the advisory committee.

(d) In addition to the committee members required by paragraph (b), the advisory committee shall consist of such other members as are necessary to meet the requirements of the federal regulation applicable to the advisory committee, who shall be appointed as provided in the federal regulation.

(e) The chairmanship of the advisory committee shall be elected by the voting members of the committee annually and shall not serve more than two (2) consecutive years as chairman.

(f) The members of the advisory committee specified in paragraph (b) shall serve for terms that are concurrent with the terms of members of the Legislature, and any member appointed under paragraph (b) may be reappointed to the advisory committee. The members of the advisory committee specified in paragraph (b) shall serve without compensation, but shall receive reimbursement to defray actual expenses incurred in the performance of committee business as authorized by law. Legislators shall receive per diem and expenses, which may be paid from the contingent expense funds of their respective houses in the same amounts as provided for committee meetings when the Legislature is not in session.

(g) The advisory committee shall meet not less than quarterly, and advisory committee members shall be furnished written notice of the meetings at least ten (10) days before the date of the meeting.

(h) The executive director shall submit to the advisory committee all amendments, modifications and changes to the state plan for the operation of the Medicaid program, for review by the advisory committee before the amendments, modifications or changes may be implemented by the division.

(i) The advisory committee, among its duties and responsibilities, shall:

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

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

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

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

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

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

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

(i) Review and initiate retrospective drug use, review including ongoing periodic examination of claims data and

other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists and individuals receiving Medicaid benefits or associated with specific drugs or groups of drugs.

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

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

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

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

(d) The board meetings shall be open to the public, members of the press, legislators and consumers. Additionally, all documents provided to board members shall be available to members of the Legislature in the same manner, and shall be made available to others for a reasonable fee for copying. However, patient confidentiality and provider confidentiality shall be protected by blinding patient names and provider names with numerical or other anonymous identifiers. The board meetings shall be subject to the Open Meetings Act (Sections 25-41-1

through 25-41-17). Board meetings conducted in violation of this section shall be deemed unlawful.

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

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

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

(d) After a thirty-day public notice, the executive director, or his or her designee, shall present the division's recommendation regarding prior approval for a therapeutic class of drugs to the committee. However, in circumstances where the

division deems it necessary for the health and safety of Medicaid beneficiaries, the division may present to the committee its recommendations regarding a particular drug without a thirty-day public notice. In making that presentation, the division shall state to the committee the circumstances that precipitate the need for the committee to review the status of a particular drug without a thirty-day public notice. The committee may determine whether or not to review the particular drug under the circumstances stated by the division without a thirty-day public notice. If the committee determines to review the status of the particular drug, it shall make its recommendations to the division, after which the division shall file those recommendations for a thirty-day public comment under Section 25-43-7(1).

(e) Upon reviewing the information and recommendations, the committee shall forward a written recommendation approved by a majority of the committee to the executive director, or his or her designee. The decisions of the committee regarding any limitations to be imposed on any drug or its use for a specified indication shall be based on sound clinical evidence found in labeling, drug compendia, and peer reviewed clinical literature pertaining to use of the drug in the relevant population.

(f) Upon reviewing and considering all recommendations including recommendations of the committee, comments, and data, the executive director shall make a final determination whether to

require prior approval of a therapeutic class of drugs, or modify existing prior approval requirements for a therapeutic class of drugs.

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

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

SECTION 7. Section 73-23-101, Mississippi Code of 1972, is brought forward as follows:

73-23-101. The Physical Therapy Licensure Compact is enacted into law and entered into by this state with any and all states legally joining in the Compact in accordance with its terms, in the form substantially as follows:

PHYSICAL THERAPY LICENSURE COMPACT

Section 1.

PURPOSE

The purpose of this Compact is to facilitate interstate practice of physical therapy with the goal of improving public access to physical therapy services. The practice of physical therapy occurs in the state where the patient/client is located at the time of the patient/client encounter. The Compact preserves the regulatory authority of states to protect public health and safety through the current system of state licensure.

This Compact is designed to achieve the following objectives:

1. Increase public access to physical therapy services by providing for the mutual recognition of other member state licenses;

2. Enhance the states' ability to protect the public's health and safety;

3. Encourage the cooperation of member states in regulating multi-state physical therapy practice;

4. Support spouses of relocating military members;

5. Enhance the exchange of licensure, investigative, and disciplinary information between member states; and

6. Allow a remote state to hold a provider of services with a compact privilege in that state accountable to that state's practice standards.

Section 2.

DEFINITIONS

As used in this Compact, and except as otherwise provided, the following definitions shall apply:

1. "Active duty military" means full-time duty status in the active uniformed service of the United States, including members of the National Guard and Reserve on active duty orders pursuant to 10 U.S.C. Section 1209 and 1211.

2. "Adverse action" means disciplinary action taken by a physical therapy licensing board based upon misconduct, unacceptable performance, or a combination of both.

3. "Alternative program" means a nondisciplinary monitoring or practice remediation process approved by a physical therapy licensing board. This includes, but is not limited to, substance abuse issues.

4. "Compact privilege" means the authorization granted by a remote state to allow a licensee from another member state to practice as a physical therapist or work as a physical therapist assistant in the remote state under its laws and rules. The practice of physical therapy occurs in the member state where the patient/client is located at the time of the patient/client encounter.

5. "Continuing competence" means a requirement, as a condition of license renewal, to provide evidence of participation in, and/or completion of, educational and professional activities relevant to practice or area of work.

6. "Data system" means a repository of information about licensees, including examination, licensure, investigative, compact privilege, and adverse action.

7. "Encumbered license" means a license that a physical therapy licensing board has limited in any way.

8. "Executive Board" means a group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the Commission.

9. "Home state" means the member state that is the licensee's primary state of residence.

10. "Investigative information" means information, records, and documents received or generated by a physical therapy licensing board pursuant to an investigation.

11. "Jurisprudence requirement" means the assessment of an individual's knowledge of the laws and rules governing the practice of physical therapy in a state.

12. "Licensee" means an individual who currently holds an authorization from the state to practice as a physical therapist or to work as a physical therapist assistant.

13. "Member state" means a state that has enacted the Compact.

14. "Party state" means any member state in which a licensee holds a current license or compact privilege or is applying for a license or compact privilege.

15. "Physical therapist" means an individual who is licensed by a state to practice physical therapy.

16. "Physical therapist assistant" means an individual who is licensed/certified by a state and who assists the physical therapist in selected components of physical therapy.

17. "Physical therapy," "physical therapy practice," and "the practice of physical therapy" mean the care and services provided by or under the direction and supervision of a licensed physical therapist.

18. "Physical Therapy Compact Commission" or "Commission" means the national administrative body whose membership consists of all states that have enacted the Compact.

19. "Physical therapy licensing board" or "licensing board" means the agency of a state that is responsible for the licensing and regulation of physical therapists and physical therapist assistants.

20. "Remote state" means a member state other than the home state, where a licensee is exercising or seeking to exercise the compact privilege.

21. "Rule" means a regulation, principle, or directive promulgated by the Commission that has the force of law.

22. "State" means any state, commonwealth, district, or territory of the United States of America that regulates the practice of physical therapy.

Section 3.

STATE PARTICIPATION IN THE COMPACT

A. To participate in the Compact, a state must:

1. Participate fully in the Commission's data system, including using the Commission's unique identifier as defined in rules;

2. Have a mechanism in place for receiving and investigating complaints about licensees;

3. Notify the Commission, in compliance with the terms of the Compact and rules, of any adverse action or the availability of investigative information regarding a licensee;

4. Fully implement a criminal background check requirement, within a time frame established by rule, by receiving the results of the Federal Bureau of Investigation record search on criminal background checks and use the results in making licensure decisions in accordance with Section 3.B.;

5. Comply with the rules of the Commission;

6. Utilize a recognized national examination as a requirement for licensure pursuant to the rules of the Commission; and

7. Have continuing competence requirements as a condition for license renewal.

B. Upon adoption of this Compact, the member state shall have the authority to obtain biometric-based information from each physical therapy licensure applicant and submit this information to the Federal Bureau of Investigation for a criminal background

check in accordance with 28 U.S.C. Section 534 and 42 U.S.C. Section 14616.

C. A member state shall grant the compact privilege to a licensee holding a valid unencumbered license in another member state in accordance with the terms of the Compact and rules.

D. Member states may charge a fee for granting a compact privilege.

Section 4.

COMPACT PRIVILEGE

A. To exercise the compact privilege under the terms and provisions of the Compact, the licensee shall:

1. Hold a license in the home state;

2. Have no encumbrance on any state license;

3. Be eligible for a compact privilege in any member state in accordance with Section 4.D, G and H;

4. Have not had any adverse action against any license or compact privilege within the previous two (2) years;

5. Notify the Commission that the licensee is seeking the compact privilege within a remote state(s);

6. Pay any applicable fees, including any state fee, for the compact privilege;

7. Meet any jurisprudence requirements established by the remote state(s) in which the licensee is seeking a compact privilege; and

8. Report to the Commission adverse action taken by any nonmember state within thirty (30) days from the date the adverse action is taken.

B. The compact privilege is valid until the expiration date of the home license. The licensee must comply with the requirements of Section 4.A to maintain the compact privilege in the remote state.

C. A licensee providing physical therapy in a remote state under the compact privilege shall function within the laws and regulations of the remote state.

D. A licensee providing physical therapy in a remote state is subject to that state's regulatory authority. A remote state may, in accordance with due process and that state's laws, remove a licensee's compact privilege in the remote state for a specific period of time, impose fines, and/or take any other necessary actions to protect the health and safety of its citizens. The licensee is not eligible for a compact privilege in any state until the specific time for removal has passed and all fines are paid.

E. If a home state license is encumbered, the licensee shall lose the compact privilege in any remote state until the following occur:

1. The home state license is no longer encumbered; and

2. Two (2) years have elapsed from the date of the adverse action.

F. Once an encumbered license in the home state is restored to good standing, the licensee must meet the requirements of Section 4.A to obtain a compact privilege in any remote state.

G. If a licensee's compact privilege in any remote state is removed, the individual shall lose the compact privilege in any remote state until the following occur:

1. The specific period of time for which the compact privilege was removed has ended;

2. All fines have been paid; and

3. Two (2) years have elapsed from the date of the adverse action.

H. Once the requirements of Section 4.G have been met, the licensee must meet the requirements in Section 4.A to obtain a compact privilege in a remote state.

Section 5.

ACTIVE DUTY MILITARY PERSONNEL OR THEIR SPOUSES

A licensee who is active duty military or is the spouse of an individual who is active duty military may designate one (1) of the following as the home state:

A. Home of record;

B. Permanent Change of Station (PCS); or

C. State of current residence if it is different than the PCS state or home of record.

Section 6.

ADVERSE ACTIONS

A. A home state shall have exclusive power to impose adverse action against a license issued by the home state.

B. A home state may take adverse action based on the investigative information of a remote state, so long as the home state follows its own procedures for imposing adverse action.

C. Nothing in this Compact shall override a member state's decision that participation in an alternative program may be used in lieu of adverse action and that such participation shall remain nonpublic if required by the member state's laws. Member states must require licensees who enter any alternative programs in lieu of discipline to agree not to practice in any other member state during the term of the alternative program without prior authorization from such other member state.

D. Any member state may investigate actual or alleged violations of the statutes and rules authorizing the practice of physical therapy in any other member state in which a physical therapist or physical therapist assistant holds a license or compact privilege.

E. A remote state shall have the authority to:

1. Take adverse actions as set forth in Section 4.D against a licensee's compact privilege in the state;

2. Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses, and the production of evidence. Subpoenas issued by a physical therapy licensing board in a party state for the attendance and testimony

of witnesses, and/or the production of evidence from another party state, shall be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state where the witnesses and/or evidence are located; and

3. If otherwise permitted by state law, recover from the licensee the costs of investigations and disposition of cases resulting from any adverse action taken against that licensee.

F. Joint Investigations.

1. In addition to the authority granted to a member state by its respective physical therapy practice act or other applicable state law, a member state may participate with other member states in joint investigations of licensees.

2. Member states shall share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the Compact.

Section 7.

ESTABLISHMENT OF THE PHYSICAL THERAPY COMPACT COMMISSION

A. The Compact member states hereby create and establish a joint public agency known as the Physical Therapy Compact Commission:

1. The Commission is an instrumentality of the Compact states.

2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

B. Membership, Voting, and Meetings.

1. Each member state shall have and be limited to one (1) delegate selected by that member state's licensing board.

2. The delegate shall be a current member of the licensing board, who is a physical therapist, physical therapist assistant, public member, or the board administrator.

3. Any delegate may be removed or suspended from office as provided by the law of the state from which the delegate is appointed.

4. The member state board shall fill any vacancy occurring in the Commission.

5. Each delegate shall be entitled to one (1) vote with regard to the promulgation of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission.

6. A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other means of communication.

7. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

C. The Commission shall have the following powers and duties:

1. Establish the fiscal year of the Commission;

2. Establish bylaws;

3. Maintain its financial records in accordance with the bylaws;

4. Meet and take such actions as are consistent with the provisions of this Compact and the bylaws;

5. Promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rules shall have the force and effect of law and shall be binding in all member states;

6. Bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any state physical therapy licensing board to sue or be sued under applicable law shall not be affected;

7. Purchase and maintain insurance and bonds;

8. Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a member state;

9. Hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and to establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

10. Accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the Commission shall avoid any appearance of impropriety and/or conflict of interest;

11. Lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or mixed; provided that at all times the Commission shall avoid any appearance of impropriety;

12. Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property real, personal, or mixed;

13. Establish a budget and make expenditures;

14. Borrow money;

15. Appoint committees, including standing committees comprised of members, state regulators, state legislators or their

representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the bylaws;

16. Provide and receive information from, and cooperate with, law enforcement agencies;

17. Establish and elect an Executive Board; and

18. Perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of physical therapy licensure and practice.

D. The Executive Board.

The Executive Board shall have the power to act on behalf of the Commission according to the terms of this Compact.

1. The Executive Board shall be comprised of nine (9) members:

a. Seven (7) voting members who are elected by the Commission from the current membership of the Commission;

b. One (1) ex-officio, nonvoting member from the recognized national physical therapy professional association; and

c. One (1) ex-officio, nonvoting member from the recognized membership organization of the physical therapy licensing boards.

2. The ex-officio members will be selected by their respective organizations.

3. The Commission may remove any member of the Executive Board as provided in bylaws.

4. The Executive Board shall meet at least annually.

5. The Executive Board shall have the following duties and responsibilities:

a. Recommend to the entire Commission changes to the rules or bylaws, changes to this Compact legislation, fees paid by Compact member states such as annual dues, and any commission Compact fee charged to licensees for the compact privilege;

b. Ensure Compact administration services are appropriately provided, contractual or otherwise;

c. Prepare and recommend the budget;

d. Maintain financial records on behalf of the Commission;

e. Monitor Compact compliance of member states and provide compliance reports to the Commission;

f. Establish additional committees as necessary; and

g. Other duties as provided in rules or bylaws.

E. Meetings of the Commission.

1. All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in Section 9.

2. The Commission or the Executive Board or other committees of the Commission may convene in a closed, nonpublic meeting if the Commission or Executive Board or other committees of the Commission must discuss:

a. Noncompliance of a member state with its obligations under the Compact;

b. The employment, compensation, discipline or other matters, practices or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

c. Current, threatened, or reasonably anticipated litigation;

d. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate;

e. Accusing any person of a crime or formally censuring any person;

f. Disclosure of trade secrets or commercial or financial information that is privileged or confidential;

g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

h. Disclosure of investigative records compiled for law enforcement purposes;

i. Disclosure of information related to any investigative reports prepared by or on behalf of or for use of

the Commission or other committee charged with responsibility of investigation or determination of compliance issues pursuant to the Compact; or

j. Matters specifically exempted from disclosure by federal or member state statute.

3. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision.

4. The Commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the Commission or order of a court of competent jurisdiction.

F. Financing of the Commission.

1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

2. The Commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

3. The Commission may levy on and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission, which shall promulgate a rule binding upon all member states.

4. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any of the member states, except by and with the authority of the member state.

5. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant, and the report of the audit shall be included in and become part of the annual report of the Commission.

G. Qualified Immunity, Defense, and Indemnification.

1. The members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity,

for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

2. The Commission shall defend any member, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

3. The Commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged

act, error or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

Section 8.

DATA SYSTEM

A. The Commission shall provide for the development, maintenance, and utilization of a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensed individuals in member states.

B. Notwithstanding any other provision of state law to the contrary, a member state shall submit a uniform data set to the data system on all individuals to whom this Compact is applicable as required by the rules of the Commission, including:

1. Identifying information;

2. Licensure data;

3. Adverse actions against a license or compact privilege;

4. Nonconfidential information related to alternative program participation;

5. Any denial of application for licensure, and the reason(s) for such denial; and

6. Other information that may facilitate the administration of this Compact, as determined by the rules of the Commission.

C. Investigative information pertaining to a licensee in any member state will only be available to other party states.

D. The Commission shall promptly notify all member states of any adverse action taken against a licensee or an individual applying for a license. Adverse action information pertaining to a licensee in any member state will be available to any other member state.

E. Member states contributing information to the data system may designate information that may not be shared with the public without the express permission of the contributing state.

F. Any information submitted to the data system that is subsequently required to be expunged by the laws of the member state contributing the information shall be removed from the data system.

Section 9.

RULEMAKING

A. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in this section and the rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

B. If a majority of the legislatures of the member states rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact within four (4) years of the date of adoption of the rule, then such rule shall have no further force and effect in any member state.

C. Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

D. Prior to promulgation and adoption of a final rule or rules by the Commission, and at least thirty (30) days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a Notice of Proposed Rulemaking:

1. On the website of the Commission or other publicly accessible platform; and

2. On the website of each member state physical therapy licensing board or other publicly accessible platform or the publication in which each state would otherwise publish proposed rules.

E. The Notice of Proposed Rulemaking shall include:

1. The proposed time, date, and location of the meeting in which the rule will be considered and voted upon;

2. The text of the proposed rule or amendment and the reason for the proposed rule;

3. A request for comments on the proposed rule from any interested person; and

4. The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

F. Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

G. The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

1. At least twenty-five (25) persons;

2. A state or federal governmental subdivision or agency; or

3. An association having at least twenty-five (25) members.

H. If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing. If the hearing is held via electronic means, the Commission shall publish the mechanism for access to the electronic hearing.

1. All persons wishing to be heard at the hearing shall notify the executive director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five (5) business days before the scheduled date of the hearing.

2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

3. All hearings will be recorded. A copy of the recording will be made available on request.

4. Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

I. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

J. If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

K. The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

L. Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the Compact and in this

section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety, or welfare;

2. Prevent a loss of Commission or member state funds;

3. Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or

4. Protect public health and safety.

M. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing, and delivered to the chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

Section 10.

OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT

A. Oversight.

1. The executive, legislative, and judicial branches of state government in each member state shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of this Compact and the rules promulgated hereunder shall have standing as statutory law.

2. All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of this Compact which may affect the powers, responsibilities or actions of the Commission.

3. The Commission shall be entitled to receive service of process in any such proceeding, and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact, or promulgated rules.

B. Default, Technical Assistance, and Termination.

1. If the Commission determines that a member state has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:

a. Provide written notice to the defaulting state and other member states of the nature of the default, the proposed means of curing the default and/or any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

2. If a state in default fails to cure the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the member states, and all rights, privileges and benefits conferred by this Compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

3. Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the Commission to the governor, the majority and minority leaders of the defaulting state's legislature, and each of the member states.

4. A state that has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

5. The Commission shall not bear any costs related to a state that is found to be in default or that has been terminated

from the Compact, unless agreed upon in writing between the Commission and the defaulting state.

6. The defaulting state may appeal the action of the Commission by petitioning the United States District Court for the District of Columbia or the federal district where the Commission has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorney's fees.

C. Dispute Resolution.

1. Upon request by a member state, the Commission shall attempt to resolve disputes related to the Compact that arise among member states and between member and nonmember states.

2. The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes as appropriate.

D. Enforcement.

1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of this Compact.

2. By majority vote, the Commission may initiate legal action in the United States District Court for the District of Columbia or the federal district where the Commission has its principal offices against a member state in default to enforce compliance with the provisions of the Compact and its promulgated rules and bylaws. The relief sought may include both injunctive

relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorney's fees.

3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

Section 11.

DATE OF IMPLEMENTATION OF THE INTERSTATE COMMISSION FOR PHYSICAL THERAPY PRACTICE AND ASSOCIATED RULES, WITHDRAWAL, AND AMENDMENT

A. The Compact shall come into effect on the date on which the Compact is enacted into law in the tenth member state. The provisions, which become effective at that time, shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rulemaking powers necessary to the implementation and administration of the Compact.

B. Any state that joins the Compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the Compact becomes law in that state. Any rule that has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.

C. Any member state may withdraw from this Compact by enacting a statute repealing the same.

1. A member state's withdrawal shall not take effect until six (6) months after enactment of the repealing statute.

2. Withdrawal shall not affect the continuing requirement of the withdrawing state's physical therapy licensing board to comply with the investigative and adverse action reporting requirements of this Compact prior to the effective date of withdrawal.

D. Nothing contained in this Compact shall be construed to invalidate or prevent any physical therapy licensure agreement or other cooperative arrangement between a member state and a nonmember state that does not conflict with the provisions of this Compact.

E. This Compact may be amended by the member states. No amendment to this Compact shall become effective and binding upon any member state until it is enacted into the laws of all member states.

Section 12.

CONSTRUCTION AND SEVERABILITY

This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this Compact and the

applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this Compact shall be held contrary to the constitution of any party state, the Compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters.

SECTION 8. Section 41-83-9, Mississippi Code of 1972, is brought forward as follows:

41-83-9. In conjunction with the application, the private review agent shall submit information that the department requires including:

(a) A utilization review plan that includes a description of review criteria, standards and procedures to be used in evaluating proposed or delivered hospital and medical care and the provisions by which patients, physicians or hospitals may seek reconsideration or appeal of adverse decisions by the private review agent;

(b) The type and qualifications of the personnel either employed or under contract to perform the utilization review;

(c) The procedures and policies to insure that a representative of the private review agent is reasonably accessible to patients and providers at all times in this state;

(d) The policies and procedures to insure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;

(e) A copy of the materials designed to inform applicable patients and providers of the requirements of the utilization review plan; and

(f) A list of the third party payors for which the private review agent is performing utilization review in this state.

SECTION 9. Section 41-83-31, Mississippi Code of 1972, is brought forward as follows:

41-83-31. Any program of utilization review with regard to hospital, medical or other health care services provided in this state shall comply with the following:

(a) No determination adverse to a patient or to any affected health care provider shall be made on any question relating to the necessity or justification for any form of hospital, medical or other health care services without prior evaluation and concurrence in the adverse determination by a physician licensed to practice in Mississippi. The physician who made the adverse determination shall discuss the reasons for any adverse determination with the affected health care provider, if the provider so requests. The physician shall comply with this request within fourteen (14) calendar days of being notified of a request. Adverse determination by a physician shall not be grounds for any disciplinary action against the physician by the State Board of Medical Licensure.

(b) Any determination regarding hospital, medical or other health care services rendered or to be rendered to a patient which may result in a denial of third-party reimbursement or a denial of precertification for that service shall include the evaluation, findings and concurrence of a physician trained in the relevant specialty or subspecialty, if requested by the patient's physician, to make a final determination that care rendered or to be rendered was, is, or may be medically inappropriate.

(c) The requirement in this section that the physician who makes the evaluation and concurrence in the adverse determination must be licensed to practice in Mississippi shall not apply to the Comprehensive Health Insurance Risk Pool Association or its policyholders and shall not apply to any utilization review company which reviews fewer than ten (10) persons residing in the State of Mississippi.

SECTION 10. Section 73-23-35, Mississippi Code of 1972, is brought forward as follows:

73-23-35. (1) A person, corporation, association or business entity shall not use in connection with that person's or party's name or the name or activity of the business the words "physical therapy," "physical therapist," "physiotherapy," "physiotherapist," "registered physical therapist," "doctor of physical therapy," "physical therapist assistant," the letters "PT," "DPT," "LPT," "RPT," "PTA," "LPTA," and/or any other words, abbreviations, or insignia indicating or implying directly or

indirectly that physical therapy is provided or supplied unless such services are provided by or under the direction of a physical therapist or physical therapist assistant, as the case may be, with a valid and current license issued pursuant to this chapter or with the privilege to practice. It shall be unlawful to employ an unlicensed physical therapist or physical therapist assistant to provide physical therapy services.

(2) The board shall aid the state's attorneys of the various counties in the enforcement of the provisions of this chapter and the prosecution of any violations thereof. In addition to the criminal penalties provided by this chapter, the civil remedy of injunction shall be available to restrain and enjoin violations of any provisions of this chapter without proof of actual damages sustained by any person. For purposes of this chapter, the board, in seeking an injunction, need only show that the defendant violated subsection (1) of this section to establish irreparable injury or a likelihood of a continuation of the violation.

(3) A physical therapist licensed under this chapter or privileged to practice shall not perform physical therapy services without a prescription or referral from a person licensed as a physician, dentist, osteopath, podiatrist, chiropractor, physician assistant or nurse practitioner. However, a physical therapist licensed under this chapter or privileged to practice may perform physical therapy services without a prescription or referral under the following circumstances:

(a) To children with a diagnosed developmental disability pursuant to the patient's plan of care.

(b) As part of a home health care agency pursuant to the patient's plan of care.

(c) To a patient in a nursing home pursuant to the patient's plan of care.

(d) Related to conditioning or to providing education or activities in a wellness setting for the purpose of injury prevention, reduction of stress or promotion of fitness.

(e) (i) To an individual for a previously diagnosed condition or conditions for which physical therapy services are appropriate after informing the health care provider rendering the diagnosis. The diagnosis must have been made within the previous one hundred eighty (180) days. The physical therapist shall provide the health care provider who rendered the diagnosis with a plan of care for physical therapy services within the first fifteen (15) days of physical therapy intervention.

(ii) Nothing in this chapter shall create liability of any kind for the health care provider rendering the diagnosis under this paragraph (e) for a condition, illness or injury that manifested itself after the diagnosis, or for any alleged damages as a result of physical therapy services performed without a prescription or referral from a person licensed as a physician, dentist, osteopath, podiatrist, chiropractor, physician assistant or nurse practitioner, the diagnosis and/or prescription

for physical therapy services having been rendered with reasonable care.

(4) Physical therapy services performed without a prescription or referral from a person licensed as a physician, dentist, osteopath, podiatrist, chiropractor, physician assistant or nurse practitioner shall not be construed to mandate coverage for physical therapy services under any health care plan, insurance policy, or workers' compensation or circumvent any requirement for preauthorization of services in accordance with any health care plan, insurance policy or workers' compensation.

(5) Nothing in this section shall restrict the Division of Medicaid from setting rules and regulations regarding the coverage of physical therapy services and nothing in this section shall amend or change the Division of Medicaid's schedule of benefits, exclusions and/or limitations related to physical therapy services as determined by state or federal regulations and state and federal law.

SECTION 11. Section 41-10-3, Mississippi Code of 1972, is brought forward as follows:

41-10-3. (1) The following words and phrases shall have the meanings ascribed in this section unless the context clearly indicates otherwise:

(a) "Heir" means any person who is entitled to a distribution from the estate of an intestate decedent, or a person

who would be entitled to a distribution from the estate of a testate decedent if that decedent had died intestate.

(b) "Medical records" means any communications related to a patient's physical or mental health or condition that are recorded in any form or medium and that are maintained for purposes of patient diagnosis or treatment, including communications that are prepared by a health care provider or by other providers. The term does not include (i) materials that are prepared in connection with utilization review, peer review or quality assurance activities, or (ii) recorded telephone and radio communications to and from a publicly operated emergency dispatch office relating to requests for emergency services or reports of suspected criminal activity; however, the term includes communications that are recorded in any form or medium between emergency medical personnel and medical personnel concerning the diagnosis or treatment of a patient.

(2) Where no executor or administrator has been appointed by a chancery court of competent jurisdiction regarding the probate or administration of the estate of a decedent, any heir of the decedent shall be authorized to act on behalf of the decedent solely for the purpose of obtaining a copy of the decedent's medical records. The authority shall not extend to any other property rights relating to the decedent's estate.

(3) A custodian of medical records may provide a copy of the decedent's medical records to an heir upon receipt of an affidavit

by the heir stating that he or she meets the requirements of this section and that no executor or administrator has been appointed by a chancery court with respect to the estate of the decedent.

(4) The authority of the heir to act on behalf of the decedent shall terminate upon the appointment of an executor or administrator to act on behalf of the estate of the decedent. However, the custodian of medical records shall be entitled to rely upon the affidavit of the heir until the custodian of medical records receives written notice of the appointment of an executor or administrator.

(5) A custodian of medical records shall not be required to provide more than three (3) heirs with a copy of the decedent's medical records before the appointment of an executor or administrator.

(6) The provisions of this section shall not prohibit an executor or administrator from requesting and receiving the medical records of a decedent after his or her appointment.

(7) The Mississippi State Asylum Records shall not be considered medical records for purposes of this section. In accordance with Section 41-21-51, the Asylum Hill Oversight Committee shall establish procedures by which descendants of a decedent who was the subject of specific Mississippi State Asylum Records may access such records.

SECTION 12. Section 41-63-1, Mississippi Code of 1972, is brought forward as follows:

41-63-1. (1) The terms "medical or dental review committee" or "committee," when used in this chapter, shall mean a committee of a state or local professional medical, nursing, pharmacy or dental society or a licensed hospital, nursing home or other health care facility, or of a medical, nursing, pharmacy or dental staff or a licensed hospital, nursing home or other health care facility or of a medical care foundation or health maintenance organization, preferred provider organization, individual practice association, any ambulance service or other prehospital emergency response agency, or any trauma improvement committee established at a licensed hospital designated as a trauma care facility by the Mississippi State Department of Health, Emergency Medical Services program, or any regional or state committee designated by the Mississippi State Department of Health, Emergency Medical Services program, and which participates in the trauma care system, or similar entity, the function of which, or one (1) of the functions of which, is to evaluate and improve the quality of health care rendered by providers of health care service, to evaluate the competence or practice of physicians or other health care practitioners, or to determine that health care services rendered were professionally indicated or were performed in compliance with the applicable standard of care or that the cost of health care rendered was considered reasonable by the providers of professional health care services in the area and includes a committee functioning as a utilization review committee, a

utilization or quality control peer review organization, or a similar committee or a committee of similar purpose, and the governing body of any licensed hospital while considering a recommendation or decision concerning a physician's competence, conduct, staff membership or clinical privileges.

(2) The term "proceedings" means all reviews, meetings, conversations, and communications of any medical or dental review committee.

(3) The term "records" shall mean any and all committee minutes, transcripts, applications, correspondence, incident reports, and other documents created, received or reviewed by or for any medical or dental review committee.

SECTION 13. Section 41-63-4, Mississippi Code of 1972, is brought forward as follows:

41-63-4. (1) In order to improve the quality and efficiency of medical care, the State Department of Health shall design and establish a registry program of the condition and treatment of persons seeking medical care that will provide the following:

(a) Information in a central data bank system of accurate, precise and current information regarding the diagnostic services and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons, or rehabilitation services for the rehabilitation of injured, disabled or sick persons provided by licensed health care providers designated by the State Board of Health;

(b) Collection of that data;

(c) Dissemination of that data; and

(d) Analysis of that data for the purposes of the evaluation and improvement of the quality and efficiency of medical care provided in a health care facility.

(2) The State Board of Health shall adopt rules, regulations and procedures to govern the operation of the registry program and to carry out the intent of this section.

(3) At a minimum, the board shall require that each hospital, free-standing ambulatory surgical facility and outpatient diagnostic imaging center shall submit patient data as defined by the board to the Mississippi Hospital Association or the department within sixty (60) days after the close of each calendar quarter for all patients that were discharged or died during that quarter.

(4) (a) There is created a State Health Data Advisory Committee to advise and make recommendations to the board regarding rules and regulations promulgated under this section. The committee shall consist of the following members:

(i) A representative of the Mississippi Hospital Association appointed by the association;

(ii) A representative of the Mississippi State Medical Association appointed by the association;

(iii) A representative of the Mississippi Nurses Association appointed by the association;

(iv) A representative of the Mississippi Health Care Association appointed by the association;

(v) A health researcher appointed by the Board of Trustees of State Institutions of Higher Learning;

(vi) A representative of the State Department of Health appointed by the State Health Officer;

(vii) A consumer representative who is not professionally involved in the purchase, provision, administration, or utilization review of health care or insurance appointed by the Governor;

(viii) A representative of a third-party payer appointed by the Governor;

(ix) A member who is not professionally involved in the purchase, provision, administration, or utilization review of health care or insurance and who has expertise in health planning, health economics, health policy, or health information systems appointed by the Governor; and

(x) A member of the business community appointed by the Governor.

(b) Committee members shall serve until a successor is appointed.

(c) Committee members shall elect a chairman and vice chairman and adopt bylaws.

(d) The department shall provide staff assistance as needed to the committee.

(5) (a) The department shall specify the types of information to be provided to the registry. The State Health Data Advisory Committee shall advise the department on the content, format, frequency and transmission of the data to be provided.

(b) Data elements required to be submitted must comply with current national standards recommended by the National Uniform Billing Committee, the National Committee on Vital Health Statistics, or similar national standards setting body.

(6) The department shall accept data submitted by the Mississippi Hospital Association on behalf of hospitals by entering into a binding agreement negotiated with the association to obtain data required under this section. A health care provider shall submit the required information to the department:

(a) If the provider does not submit the required data through the Mississippi Hospital Association;

(b) If no binding agreement has been reached within ninety (90) days from July 1, 2008, between the department and the Mississippi Hospital Association; or

(c) If a binding agreement has expired for more than ninety (90) days.

(7) The information, data and records shall not divulge the identity of any patient.

(8) Submission of information to and use of information by the department in accordance with this section shall be considered a permitted disclosure for uses and disclosures required by law

and for public health activities under the Health Insurance Portability and Accountability Act and the Privacy Rules promulgated thereunder at 45 CFR Sections 164.512(a) and (b).

(9) Notwithstanding any conflicting statute, court rule or other law, the data maintained in the registry shall be confidential and shall not be subject to discovery or introduction into evidence in any civil action. However, information and data otherwise discoverable or admissible from original sources are not to be construed as immune from discovery or use in any civil action merely because they were provided to the registry.

(10) The department shall assure that public use data are made available and accessible to interested persons in accordance with the rules and regulations promulgated by the board.

(11) Notwithstanding other actions or remedies afforded to persons about whom data is released, a person who knowingly or negligently releases data in violation of this section is liable for a civil penalty of not more than Ten Thousand Dollars ($10,000.00).

(12) A person or organization who fails to supply data required under this section is liable for a civil penalty of Five Cents (5¢) for each record for each day the submission is delinquent. A submission is delinquent if the department does not receive it within thirty (30) days after the date the submission was due. If the department receives the submission in incomplete form, the department shall notify the provider and allow fifteen

(15) additional days to correct the error. The notice shall provide the provider an additional fifteen (15) days to submit the data before the imposition of any civil penalty. The maximum civil penalty for a delinquent submission is Ten Dollars ($10.00) for each record. The department shall issue an assessment of the civil penalty to the provider. The provider has a right to an informal conference with the department, if the provider requests the conference within thirty (30) days of receipt of the assessment. After the informal conference or, if no conference is requested, after the time for requesting the informal conference has expired, the department may proceed to collect the penalty. In its request for an informal conference, the provider may request the department to waive the penalty. The department may waive the penalty in cases of an act of God or other acts beyond the control of the provider. Waiver of the penalty is in the sole discretion of the department.

(13) The board shall have the authority to set fees and charges with regard to the collection and compilation of data requested for special reports and for the dissemination of data. The revenue derived from the fees imposed in this section shall be deposited by the Department of Health in a special fund that is created in the State Treasury, which is earmarked for use by the department in conducting its activities under this section.

SECTION 14. Section 41-83-1, Mississippi Code of 1972, is brought forward as follows:

41-83-1. As used in this chapter, the following terms shall be defined as follows:

(a) "Utilization review" means a system for reviewing the appropriate and efficient allocation of hospital resources and medical services given or proposed to be given to a patient or group of patients as to necessity for the purpose of determining whether such service should be covered or provided by an insurer, plan or other entity.

(b) "Private review agent" means a nonhospital-affiliated person or entity performing utilization review on behalf of:

(i) An employer or employees in the State of Mississippi; or

(ii) A third party that provides or administers hospital and medical benefits to citizens of this state, including: a health maintenance organization issued a certificate of authority under and by virtue of the laws of the State of Mississippi; or a health insurer, nonprofit health service plan, health insurance service organization, or preferred provider organization or other entity offering health insurance policies, contracts or benefits in this state.

(c) "Utilization review plan" means a description of the utilization review procedures of a private review agent.

(d) "Department" means the Mississippi State Department of Health.

(e) "Certificate" means a certificate of registration granted by the Mississippi State Department of Health to a private review agent.

SECTION 15. Section 41-83-3, Mississippi Code of 1972, is brought forward as follows:

41-83-3. (1) A private review agent who approves or denies payment or who recommends approval or denial of payment for hospital or medical services or whose review results in approval or denial of payment for hospital or medical services on a case by case basis, may not conduct utilization review in this state unless the Mississippi State Department of Health has granted the private review agent a certificate.

(2) The Mississippi State Department of Health shall issue a certificate to an applicant that has met all the requirements of this chapter and all applicable regulations of the department.

(3) A certificate issued under this chapter is not transferable.

(4) The State Department of Health shall adopt regulations to implement the provisions of this chapter. Any information required by the department with respect to customers or patients shall be held in confidence and not disclosed to the public.

SECTION 16. Section 41-83-5, Mississippi Code of 1972, is brought forward as follows:

41-83-5. No certificate is required for those private review agents conducting general in-house utilization review for

hospitals, home health agencies, preferred provider organizations or other managed care entities, clinics, private physician offices or any other health facility or entity, so long as the review does not result in the approval or denial of payment for hospital or medical services for a particular case. Such general in-house utilization review is completely exempt from the provisions of this chapter.

SECTION 17. Section 41-83-13, Mississippi Code of 1972, is brought forward as follows:

41-83-13. (1) The department shall deny a certificate to any applicant if, upon review of the application, the department finds that the applicant proposing to conduct utilization review does not:

(a) Have available the services of a physician to carry out its utilization review activities;

(b) Meet any applicable regulations the department adopted under this chapter relating to the qualifications of private review agents or the performance of utilization review; and

(c) Provide assurances satisfactory to the department that the procedure and policies of the private review agent will protect the confidentiality of medical records and the private review agent will be reasonably accessible to patients and providers for five (5) working days a week during normal business hours in this state.

(2) The department may revoke or deny a certificate if the holder does not comply with the performance assurances under this section, violates any provision of this chapter, or violates any regulation adopted pursuant to this chapter.

(3) Before denying or revoking a certificate under this section, the department shall provide the applicant or certificate holder with reasonable time to supply additional information demonstrating compliance with the requirements of this chapter and the opportunity to request a hearing. If an applicant or certificate holder requests a hearing, the department shall send a hearing notice and conduct a hearing in accordance with the Mississippi Administrative Procedure Law, Section 25-43-17, Mississippi Code of 1972.

SECTION 18. Section 41-83-15, Mississippi Code of 1972, is brought forward as follows:

41-83-15. The department shall establish reporting requirements to:

(a) Evaluate the effectiveness of private review agents; and

(b) Determine if the utilization review programs are in compliance with the provisions of this section and applicable regulations.

SECTION 19. Section 41-83-17, Mississippi Code of 1972, is brought forward as follows:

41-83-17. A private review agent may not disclose or publish individual medical records or any other confidential medical information obtained in the performance of utilization review activities without the patient's authorization or an order of a county, circuit or chancery court of Mississippi or a United States district court. Provided, however, that nothing in this chapter shall prohibit private review agents from providing information to a third party with whom the private review agent is under contract or acting on behalf of.

SECTION 20. Section 41-83-21, Mississippi Code of 1972, is brought forward as follows:

41-83-21. Notwithstanding language to the contrary elsewhere contained herein, if a licensed physician certifies in writing to an insurer within seventy-two (72) hours of an admission that the insured person admitted was in need of immediate hospital care, such shall constitute a prima facie case of the medical necessity of the admission. To overcome this, the entity requesting the utilization review and/or the private review agent must show by clear and convincing evidence that the admitted person was not in need of immediate hospital care.

SECTION 21. Section 41-83-25, Mississippi Code of 1972, is brought forward as follows:

41-83-25. (1) Every health insurance plan proposing to issue or deliver a health insurance policy or contract or administer a health benefit program which provides for the

coverage of hospital and medical benefits and the utilization review of those benefits shall:

(a) Have a certificate in accordance with this chapter; or

(b) Contract with a private review agent who has a certificate in accordance with this chapter.

(2) Notwithstanding any other provisions of this chapter, for claims where the medical necessity of the provision of a covered benefit is disputed, a health service plan that does not meet the requirements of subsection (1) of this section shall pay any person or hospital entitled to reimbursement under the policy or contract.

SECTION 22. Section 41-83-27, Mississippi Code of 1972, is brought forward as follows:

41-83-27. (1) Every insurer proposing to issue or deliver a health insurance policy or contract or administer a health benefit program which provides for the coverage of hospital and medical benefits and the utilization review of such benefits shall:

(a) Have a certificate in accordance with this chapter; or

(b) Contract with a private review agent that has a certificate in accordance with this chapter.

(2) Notwithstanding any provision of this chapter, for claims where the medical necessity of the provision of a covered benefit is disputed, an insurer that does not meet the

requirements of subsection (1) of this section shall pay any person or hospital entitled to reimbursement under the policy or contract.

SECTION 23. Section 41-83-29, Mississippi Code of 1972, is brought forward as follows:

41-83-29. Any health insurer proposing to issue or deliver in this state a group or blanket health insurance policy or administer a health benefit program which provides for the coverage of hospital and medical benefits and the utilization review of such benefits shall:

(a) Have a certificate in accordance with this chapter; or

(b) Contract with a private review agent that has a certificate in accordance with this chapter.

SECTION 24. Section 71-3-15, Mississippi Code of 1972, is brought forward as follows:

71-3-15. (1) The employer shall furnish such medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, artificial members, and other apparatus for such period as the nature of the injury or the process of recovery may require. The injured employee shall have the right to accept the services furnished by the employer or, in his discretion, to select one (1) competent physician of his choosing and such other specialists to whom he is referred by his chosen physician to administer medical treatment. Referrals by

the chosen physician shall be limited to one (1) physician within a specialty or subspecialty area. Except in an emergency requiring immediate medical attention, any additional selection of physicians by the injured employee or further referrals must be approved by the employer, if self-insured, or the carrier prior to obtaining the services of the physician at the expense of the employer or carrier. If denied, the injured employee may apply to the commission for approval of the additional selection or referral, and if the commission determines that such request is reasonable, the employee may be authorized to obtain such treatment at the expense of the employer or carrier. Approval by the employer or carrier does not require approval by the commission. A physician to whom the employee is referred by his employer shall not constitute the employee's selection, unless the employee, in writing, accepts the employer's referral as his own selection. However, if the employee is treated for his alleged work-related injury or occupational disease by a physician for six (6) months or longer, or if the employee has surgery for the alleged work-related injury or occupational disease performed by a physician, then that physician shall be deemed the employee's selection. Should the employer desire, he may have the employee examined by a physician other than of the employee's choosing for the purpose of evaluating temporary or permanent disability or medical treatment being rendered under such reasonable terms and conditions as may be prescribed by the commission. If at any time

during such period the employee unreasonably refuses to submit to medical or surgical treatment, the commission shall, by order, suspend the payment of further compensation during such time as such refusal continues, and no compensation shall be paid at any time during the period of such suspension; provided, that no claim for medical or surgical treatment shall be valid and enforceable, as against such employer, unless within twenty (20) days following the first treatment the physician or provider giving such treatment shall furnish to the employer, if self-insured, or its carrier, a preliminary report of such injury and treatment, on a form or in a format approved by the commission. Subsequent reports of such injury and treatment must be submitted at least every thirty (30) days thereafter until such time as a final report shall have been made. Reports which are required to be filed hereunder shall be furnished by the medical provider to the employer or carrier, and it shall be the responsibility of the employer or carrier receiving such reports to promptly furnish copies to the commission. The commission may, in its discretion, excuse the failure to furnish such reports within the time prescribed herein if it finds good cause to do so, and may, upon request of any party in interest, order or direct the employer or carrier to pay the reasonable value of medical services rendered to the employee.

(2) Whenever in the opinion of the commission a physician has not correctly estimated the degree of permanent disability or

the extent of the temporary disability of an injured employee, the commission shall have the power to cause such employee to be examined by a physician selected by the commission, and to obtain from such physician a report containing his estimate of such disabilities. The commission shall have the power in its discretion to charge the cost of such examination to the employer, if he is a self-insurer, or to the insurance company which is carrying the risk.

(3) In carrying out this section, the commission shall establish an appropriate medical provider fee schedule, medical cost containment system and utilization review which incorporates one or more medical review panels to determine the reasonableness of charges and the necessity for the services, and limitations on fees to be charged by medical providers for testimony and copying or completion of records and reports and other provisions which, at the discretion of the commission, are necessary to encompass a complete medical cost containment program. The commission may contract with a private organization or organizations to establish and implement such a medical cost containment system and fee schedule with the cost for administering such a system to be paid out of the administrative expense fund as provided in this chapter. All fees and other charges for such treatment or service shall be limited to such charges as prevail in the same community for similar treatment and shall be subject to regulation by the commission. No medical bill shall be paid to any doctor until all

forms and reports required by the commission have been filed. Any employee receiving treatment or service under the provisions of this chapter may not be held responsible for any charge for such treatment or service, and no doctor, hospital or other recognized medical provider shall attempt to bill, charge or otherwise collect from the employee any amount greater than or in excess of the amount paid by the employer, if self-insured, or its workers' compensation carrier. Any dispute over the amount charged for service rendered under the provisions of this chapter, or over the amount of reimbursement for services rendered under the provisions of this chapter, shall be limited to and resolved between the provider and the employer or carrier in accordance with the fee dispute resolution procedures adopted by the commission.

(4) The liability of an employer for medical treatment as herein provided shall not be affected by the fact that his employee was injured through the fault or negligence of a third party, not in the same employ, provided the injured employee was engaged in the scope of his employment when injured. The employer shall, however, have a cause of action against such third party to recover any amounts paid by him for such medical treatment.

(5) An injured worker who believes that his best interest has been prejudiced by the findings of the physician designated by the employer or carrier shall have the privilege of a medical examination by a physician of his own choosing, at the expense of the carrier or employer. Such examination may be had at any time

after injury and prior to the closing of the case, provided that the charge shall not exceed One Hundred Dollars ($100.00) and shall be paid by the carrier or employer where the previous medical findings are upset, but paid by the employee if previous medical findings are confirmed.

(6) Medical and surgical treatment as provided in this section shall not be deemed to be privileged insofar as carrying out the provisions of this chapter is concerned. All findings pertaining to a second opinion medical examination, at the instance of the employer shall be reported as herein required within fourteen (14) days of the examination, except that copies thereof shall also be furnished by the employer or carrier to the employee. All findings pertaining to an independent medical examination by order of the commission shall be reported as provided in the order for such examination.

(7) Any medical benefits paid by reason of any accident or health insurance policy or plan paid for by the employer, which were for expenses of medical treatment under this section, are, upon notice to the carrier prior to payment by it, subject to subrogation in favor of the accident or health insurance company to the extent of its payment for medical treatment under this section. Reimbursement to the accident or health insurance company by the carrier or employer, to the extent of such reimbursement, shall constitute payment by the employer or carrier of medical expenses under this section. Under no circumstances,

shall any subrogation be had by any insurance company against any compensation benefits paid under this chapter.

SECTION 25. Section 73-21-73, Mississippi Code of 1972, is brought forward as follows:

73-21-73. As used in this chapter, unless the context requires otherwise:

(a) "Administer" means the direct application of a prescription drug pursuant to a lawful order of a practitioner to the body of a patient by injection, inhalation, ingestion or any other means.

(b) "Biological product" means the same as that term is defined in 42 USC Section 262.

(c) "Board of Pharmacy," "Pharmacy Board," "MSBP" or "board" means the State Board of Pharmacy.

(d) "Compounding" means (i) the production, preparation, propagation, conversion or processing of a sterile or nonsterile drug or device either directly or indirectly by extraction from substances of natural origin or independently by means of chemical or biological synthesis or from bulk chemicals or the preparation, mixing, measuring, assembling, packaging or labeling of a drug or device as a result of a practitioner's prescription drug order or initiative based on the practitioner/patient/pharmacist relationship in the course of professional practice, or (ii) for the purpose of, as an incident to, research, teaching or chemical analysis and not for sale or

dispensing. Compounding also includes the preparation of drugs or devices in anticipation of prescription drug orders based on routine regularly observed prescribing patterns.

(e) "Continuing education unit" means ten (10) clock hours of study or other such activity as may be approved by the board, including, but not limited to, all programs which have been approved by the American Council on Pharmaceutical Education.

(f) "Deliver" or "delivery" means the actual, constructive or attempted transfer in any manner of a drug or device from one (1) person to another, whether or not for a consideration, including, but not limited to, delivery by mailing or shipping.

(g) "Device" means an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent or other similar or related article, including any component part or accessory which is required under federal or state law to be prescribed by a practitioner and dispensed by a pharmacist.

(h) "Dispense" or "dispensing" means the interpretation of a valid prescription of a practitioner by a pharmacist and the subsequent preparation of the drug or device for administration to or use by a patient or other individual entitled to receive the drug.

(i) "Distribute" means the delivery of a drug or device other than by administering or dispensing to persons other than the ultimate consumer.

(j) "Drug" means:

(i) Articles recognized as drugs in the official United States Pharmacopeia, official National Formulary, official Homeopathic Pharmacopeia, other drug compendium or any supplement to any of them;

(ii) Articles intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in man or other animals;

(iii) Articles other than food intended to affect the structure or any function of the body of man or other animals; and

(iv) Articles intended for use as a component of any articles specified in subparagraph (i), (ii) or (iii) of this paragraph.

(k) "Drugroom" means a business, which does not require the services of a pharmacist, where prescription drugs or prescription devices are bought, sold, maintained or provided to consumers.

(l) "Extern" means a student in the professional program of a school of pharmacy accredited by the American Council on Pharmaceutical Education who is making normal progress toward completion of a professional degree in pharmacy.

(m) "Foreign pharmacy graduate" means a person whose undergraduate pharmacy degree was conferred by a recognized school of pharmacy outside of the United States, the District of Columbia

and Puerto Rico. Recognized schools of pharmacy are those colleges and universities listed in the World Health Organization's World Directory of Schools of Pharmacy, or otherwise approved by the Foreign Pharmacy Graduate Examination Committee (FPGEC) certification program as established by the National Association of Boards of Pharmacy.

(n) "Generic equivalent drug product" means a drug product which (i) contains the identical active chemical ingredient of the same strength, quantity and dosage form; (ii) is of the same generic drug name as determined by the United States Adoptive Names and accepted by the United States Food and Drug Administration; and (iii) conforms to such rules and regulations as may be adopted by the board for the protection of the public to assure that such drug product is therapeutically equivalent.

(o) "Interchangeable biological product" or "I.B." means a biological product that the federal Food and Drug Administration:

(i) Has licensed and determined as meeting the standards for interchangeability under 42 USC Section 262(k)(4); or

(ii) Has determined is therapeutically equivalent as set forth in the latest edition of or supplement to the federal Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations.

(p) "Internet" means collectively the myriad of computer and telecommunications facilities, including equipment and operating software, which comprise the interconnected worldwide network of networks that employ the Transmission Control Protocol/Internet Protocol, or any predecessor or successor protocol to such protocol, to communicate information of all kinds by wire or radio.

(q) "Interested directly" means being employed by, having full or partial ownership of, or control of, any facility permitted or licensed by the Mississippi State Board of Pharmacy.

(r) "Interested indirectly" means having a spouse who is employed by any facility permitted or licensed by the Mississippi State Board of Pharmacy.

(s) "Intern" means a person who has graduated from a school of pharmacy but has not yet become licensed as a pharmacist.

(t) "Manufacturer" means a person, business or other entity engaged in the production, preparation, propagation, conversion or processing of a prescription drug or device, if such actions are associated with promotion and marketing of such drugs or devices.

(u) "Manufacturer's distributor" means any person or business who is not an employee of a manufacturer, but who distributes sample drugs or devices, as defined under subsection

(i) of this section, under contract or business arrangement for a manufacturer to practitioners.

(v) "Manufacturing" of prescription products means the production, preparation, propagation, conversion or processing of a drug or device, either directly or indirectly, by extraction from substances from natural origin or independently by means of chemical or biological synthesis, or from bulk chemicals and includes any packaging or repackaging of the substance(s) or labeling or relabeling of its container, if such actions are associated with promotion and marketing of such drug or devices.

(w) "Misappropriation of a prescription drug" means to illegally or unlawfully convert a drug, as defined in subsection (i) of this section, to one's own use or to the use of another.

(x) "Nonprescription drugs" means nonnarcotic medicines or drugs that may be sold without a prescription and are prepackaged and labeled for use by the consumer in accordance with the requirements of the statutes and regulations of this state and the federal government.

(y) "Person" means an individual, corporation, partnership, association or any other legal entity.

(z) "Pharmacist" means an individual health care provider licensed by this state to engage in the practice of pharmacy. This recognizes a pharmacist as a learned professional who is authorized to provide patient services.

(aa) "Pharmacy" means any location for which a pharmacy permit is required and in which prescription drugs are maintained, compounded and dispensed for patients by a pharmacist. This definition includes any location where pharmacy-related services are provided by a pharmacist.

(bb) "Prepackaging" means the act of placing small precounted quantities of drug products in containers suitable for dispensing or administering in anticipation of prescriptions or orders.

(cc) "Unlawful or unauthorized possession" means physical holding or control by a pharmacist of a controlled substance outside the usual and lawful course of employment.

(dd) "Practice of pharmacy" means a health care service that includes, but is not limited to, the compounding, dispensing, and labeling of drugs or devices; interpreting and evaluating prescriptions; administering and distributing drugs and devices; the compounding, dispensing and labeling of drugs and devices; maintaining prescription drug records; advising and consulting concerning therapeutic values, content, hazards and uses of drugs and devices; initiating or modifying of drug therapy in accordance with written guidelines or protocols previously established and approved by the board; selecting drugs; participating in drug utilization reviews; storing prescription drugs and devices; ordering lab work in accordance with written guidelines or protocols as defined by paragraph (nn) of this section; providing

pharmacotherapeutic consultations; supervising supportive personnel and such other acts, services, operations or transactions necessary or incidental to the conduct of the foregoing.

(ee) "Practitioner" means a physician, dentist, veterinarian, or other health care provider authorized by law to diagnose and prescribe drugs.

(ff) "Prescription" means a written, verbal or electronically transmitted order issued by a practitioner for a drug or device to be dispensed for a patient by a pharmacist. "Prescription" includes a standing order issued by a practitioner to an individual pharmacy that authorizes the pharmacy to dispense an opioid antagonist to certain persons without the person to whom the opioid antagonist is dispensed needing to have an individual prescription, as authorized by Section 41-29-319(3).

(gg) "Prescription drug" or "legend drug" means a drug which is required under federal law to be labeled with either of the following statements prior to being dispensed or delivered:

(i) "Caution: Federal law prohibits dispensing without prescription," or

(ii) "Caution: Federal law restricts this drug to use by or on the order of a licensed veterinarian"; or a drug which is required by any applicable federal or state law or regulation to be dispensed on prescription only or is restricted to use by practitioners only.

(hh) "Product selection" means the dispensing of a generic equivalent drug product or an interchangeable biological product in lieu of the drug product ordered by the prescriber.

(ii) "Provider" or "primary health care provider" includes a pharmacist who provides health care services within his or her scope of practice pursuant to state law and regulation.

(jj) "Registrant" means a pharmacy or other entity which is registered with the Mississippi State Board of Pharmacy to buy, sell or maintain controlled substances.

(kk) "Repackager" means a person registered by the federal Food and Drug Administration as a repackager who removes a prescription drug product from its marketed container and places it into another, usually of smaller size, to be distributed to persons other than the consumer.

(ll) "Reverse distributor" means a business operator that is responsible for the receipt and appropriate return or disposal of unwanted, unneeded or outdated stocks of controlled or uncontrolled drugs from a pharmacy.

(mm) "Supportive personnel" or "pharmacist technician" means those individuals utilized in pharmacies whose responsibilities are to provide nonjudgmental technical services concerned with the preparation and distribution of drugs under the direct supervision and responsibility of a pharmacist.

(nn) "Written guideline or protocol" means an agreement in which any practitioner authorized to prescribe drugs delegates

to a pharmacist authority to conduct specific prescribing functions in an institutional setting, or with the practitioner's individual patients, provided that a specific protocol agreement between the practitioner and the pharmacist is signed and filed as required by law or by rule or regulation of the board.

(oo) "Wholesaler" means a person who buys or otherwise acquires prescription drugs or prescription devices for resale or distribution, or for repackaging for resale or distribution, to persons other than consumers.

(pp) "Pharmacy benefit manager" has the same meaning as defined in Section 73-21-153.

SECTION 26. Section 73-21-161, Mississippi Code of 1972, is brought forward as follows:

73-21-161. (1) As used in this section, the term "referral" means:

(a) Ordering of a patient to a pharmacy by a pharmacy benefit manager affiliate either orally or in writing, including online messaging;

(b) Offering or implementing plan designs that require patients to use affiliated pharmacies; or

(c) Patient or prospective patient specific advertising, marketing, or promotion of a pharmacy by an affiliate.

The term "referral" does not include a pharmacy's inclusion by a pharmacy benefit manager affiliate in communications to

patients, including patient and prospective patient specific communications, regarding network pharmacies and prices, provided that the affiliate includes information regarding eligible nonaffiliate pharmacies in those communications and the information provided is accurate.

(2) A pharmacy, pharmacy benefit manager, or pharmacy benefit manager affiliate licensed or operating in Mississippi shall be prohibited from:

(a) Making referrals;

(b) Transferring or sharing records relative to prescription information containing patient identifiable and prescriber identifiable data to or from a pharmacy benefit manager affiliate for any commercial purpose; however, nothing in this section shall be construed to prohibit the exchange of prescription information between a pharmacy and its affiliate for the limited purposes of pharmacy reimbursement; formulary compliance; pharmacy care; public health activities otherwise authorized by law; or utilization review by a health care provider; or

(c) Presenting a claim for payment to any individual, third-party payor, affiliate, or other entity for a service furnished pursuant to a referral from an affiliate.

(3) This section shall not be construed to prohibit a pharmacy from entering into an agreement with a pharmacy benefit manager affiliate to provide pharmacy care to patients, provided

that the pharmacy does not receive referrals in violation of subsection (2) of this section and the pharmacy provides the disclosures required in subsection (1) of this section.

(4) If a pharmacy licensed or holding a nonresident pharmacy permit in this state has an affiliate, it shall annually file with the board a disclosure statement identifying all such affiliates.

(5) In addition to any other remedy provided by law, a violation of this section by a pharmacy shall be grounds for disciplinary action by the board under its authority granted in this chapter.

(6) A pharmacist who fills a prescription that violates subsection (2) of this section shall not be liable under this section.

SECTION 27. Section 83-9-39, Mississippi Code of 1972, is brought forward as follows:

83-9-39. (1) (a) Except as otherwise provided herein, all alternative delivery systems and all group health insurance policies, plans or programs regulated by the State of Mississippi shall provide covered benefits for the treatment of mental illness, except for policies which only provide coverage for specified diseases and other limited benefit health insurance policies and negotiated labor contracts.

(b) Health insurance policies, plans or programs of any employer of one hundred (100) or fewer eligible employees and all individual health insurance policies which are regulated by the

State of Mississippi which do not currently offer benefits for treatment of mental illness shall offer covered benefits for the treatment of mental illness, which must include the treatment of mental illness by community mental health centers operated by a regional commission established under Section 41-19-33 or by a public or private entity under contract with a regional commission to operate the center, except for policies which only provide coverage for specified diseases and other limited benefit health insurance policies and negotiated labor contracts.

(c) Alternative delivery systems and group health insurance policies, plans or programs regulated by the State of Mississippi shall not deny any community mental health center or contract entity described in paragraph (b) of this subsection the right to participate as a contract provider if the community mental health center or contract entity agrees to provide the mental health services that meet the terms of requirements set forth by the insurer under the policy or plan and agrees to the terms of reimbursement set forth by the insurer. Certification/licensure of all mental health providers by the Board of Mental Health in accordance with Section 41-4-7(r) shall be recognized by the insurer and shall not be used as a reason to deny any mental health provider the right to participate as a contract provider.

(2) Covered benefits for inpatient treatment of mental illness in insurance policies and other contracts subject to

Sections 83-9-37 through 83-9-43 shall be limited to inpatient services certified as necessary by a health service provider.

(3) Covered benefits for outpatient treatment of mental illness in insurance policies and other contracts subject to Sections 83-9-37 through 83-9-43 shall be limited to outpatient services certified as necessary by a health service provider.

(4) Before an insured party may qualify to receive benefits under Sections 83-9-37 through 83-9-43, a health service provider shall certify that the individual is suffering from mental illness and refer the individual for the appropriate treatment.

(5) All mental illness, treatment or services with respect to such treatment eligible for health insurance coverage shall be subject to professional utilization and peer review procedures.

(6) The provisions of this section shall apply only to alternative delivery systems and individual and group health insurance policies, plans or programs issued or renewed after July 1, 1991.

(7) The exclusion period for coverage of a preexisting mental condition shall be the same period of time as that for other medical illnesses covered under the same plan, program or contract.

SECTION 28. Section 83-9-213, Mississippi Code of 1972, is brought forward as follows:

83-9-213. (1) The association shall:

(a) Establish administrative and accounting procedures for the operation of the association.

(b) Establish procedures under which applicants and participants in the plan may have grievances reviewed by an impartial body and reported to the board.

(c) Select an administering insurer in accordance with Section 83-9-215.

(d) Collect the assessments provided in Section 83-9-217 from insurers and third-party administrators for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board. Assessments shall be collected pursuant to the plan of operation approved by the board. In addition to the collection of such assessments, the association shall collect an organizational assessment or assessments from all insurers as necessary to provide for expenses which have been incurred or are estimated to be incurred prior to receipt of the first calendar year assessments. Organizational assessments shall be equal in amount for all insurers, but shall not exceed One Hundred Dollars ($100.00) per insurer for all such assessments. Assessments are due and payable within thirty (30) days of receipt of the assessment notice by the insurer.

(e) Require that all policy forms issued by the association conform to standard forms developed by the

association. The forms shall be approved by the State Department of Insurance.

(f) Develop and implement a program to publicize the existence of the plan, the eligibility requirements for the plan, and the procedures for enrollment in the plan and to maintain public awareness of the plan.

(2) The association may:

(a) Exercise powers granted to insurers under the laws of this state.

(b) Take any legal actions necessary or proper for the recovery of any monies due the association under Sections 83-9-201 through 83-9-222. There shall be no liability on the part of and no cause of action of any nature shall arise against the Commissioner of Insurance or any of his staff, the administrator, the board or its directors, agents or employees, or against any participating insurer for any actions performed in accordance with Sections 83-9-201 through 83-9-222.

(c) Enter into contracts as are necessary or proper to carry out the provisions and purposes of Sections 83-9-201 through 83-9-222, including the authority, with the approval of the commissioner, to enter into contracts with similar organizations of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions.

(d) Sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the association.

(e) Take any legal actions necessary to:

(i) Avoid the payment of improper claims against the association or the coverage provided by or through the association.

(ii) Recover any amounts erroneously or improperly paid by the association.

(iii) Recover any amounts paid by the association as a result of mistake of fact or law.

(iv) Recover other amounts due the association.

(f) Establish, and modify from time to time as appropriate, rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas and any other actuarial function appropriate to the operation of the association. Rates and rate schedules may be adjusted for appropriate factors such as age, sex and geographic variation in claim cost and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices.

(g) Issue policies of insurance in accordance with the requirements of Sections 83-9-201 through 83-9-222.

(h) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the

operation of the plan, policy and other contract design, and any other function within the authority of the association.

(i) Borrow money to effect the purposes of the association. Any notes or other evidence of indebtedness of the association not in default shall be legal investments for insurers and may be carried as admitted assets.

(j) Establish rules, conditions and procedures for reinsuring risks of member insurers desiring to issue plan coverages to individuals otherwise eligible for plan coverages in their own name. Provision of reinsurance shall not subject the association to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers.

(k) Prepare and distribute application forms and enrollment instruction forms to insurance producers and to the general public.

(l) Provide for reinsurance of risks incurred by the association.

(m) Issue additional types of health insurance policies to provide optional coverages, including Medicare supplemental health insurance.

(n) Provide for and employ cost containment measures and requirements including, but not limited to, disease management programs and incentives for participation therein, preadmission screening, second surgical opinion, concurrent utilization review

and individual case management for the purpose of making the benefit plan more cost-effective.

(o) Design, utilize, contract or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations and other limited network provider arrangements.

(p) Serve as a mechanism to provide health and accident insurance coverage to citizens of this state under any state or federal program designed to enable persons to obtain or maintain health insurance coverage.

(3) The commissioner may, by rule, establish additional powers and duties of the board and may adopt such rules as are necessary and proper to implement Sections 83-9-201 through 83-9-222.

(4) The State Department of Insurance shall examine and investigate the association and make an annual report to the Legislature thereon. Upon such investigation, the Commissioner of Insurance, if he deems necessary, shall require the board: (a) to contract with an outside independent actuarial firm to assess the solvency of the association and for consultation as to the sufficiency and means of the funding of the association, and the enrollment in and the eligibility, benefits and rate structure of the benefits plan to ensure the solvency of the association; and (b) to close enrollment in the benefits plan at any time upon a

determination by the outside independent actuarial firm that funds of the association are insufficient to support the enrollment of additional persons. In no case shall the commissioner require such actuarial study any less than once every two (2) years.

SECTION 29. Section 83-41-403, Mississippi Code of 1972, is brought forward as follows:

83-41-403. As used in this article:

(a) "Department" means the Mississippi Department of Insurance.

(b) "Managed care plan" means a plan operated by a managed care entity as described in paragraph (c) of this section that provides for the financing and delivery of health care services to persons enrolled in such plan through:

(i) Arrangements with selected providers to furnish health care services;

(ii) Explicit standards for the selection of participating providers;

(iii) Organizational arrangements for ongoing quality assurance, utilization review programs and dispute resolution; and

(iv) Financial incentives for persons enrolled in the plan to use the participating providers, products and procedures provided for by the plan.

(c) "Managed care entity" includes a licensed insurance company, hospital or medical service plan, health maintenance

organization (HMO), an employer or employee organization, or a managed care contractor as described in paragraph (d) of this section that operates a managed care plan.

(d) "Managed care contractor" means a person or corporation that:

(i) Establishes, operates or maintains a network of participating providers;

(ii) Conducts or arranges for utilization review activities; and

(iii) Contracts with an insurance company, a hospital or medical service plan, an employer or employee organization, or any other entity providing coverage for health care services to operate a managed care plan.

(e) "Participating provider" means a physician, hospital, pharmacy, pharmacist, dentist, nurse, chiropractor, optometrist, or other provider of health care services licensed or certified by the state, that has entered into an agreement with a managed care entity to provide services, products or supplies to a patient enrolled in a managed care plan.

SECTION 30. Section 83-41-409, Mississippi Code of 1972, is brought forward as follows:

83-41-409. In order to be certified and recertified under this article, a managed care plan shall:

(a) Provide enrollees or other applicants with written information on the terms and conditions of coverage in easily

understandable language including, but not limited to, information on the following:

(i) Coverage provisions, benefits, limitations, exclusions and restrictions on the use of any providers of care;

(ii) Summary of utilization review and quality assurance policies; and

(iii) Enrollee financial responsibility for copayments, deductibles and payments for out-of-plan services or supplies;

(b) Demonstrate that its provider network has providers of sufficient number throughout the service area to assure reasonable access to care with minimum inconvenience by plan enrollees;

(c) File a summary of the plan credentialing criteria and process and policies with the State Department of Insurance to be available upon request;

(d) Provide a participating provider with a copy of his/her individual profile if economic or practice profiles, or both, are used in the credentialing process upon request;

(e) When any provider application for participation is denied or contract is terminated, the reasons for denial or termination shall be reviewed by the managed care plan upon the request of the provider; and

(f) Establish procedures to ensure that all applicable state and federal laws designed to protect the confidentiality of medical records are followed.

SECTION 31. This act shall take effect and be in force from and after July 1, 2024.