MISSISSIPPI LEGISLATURE REGULAR SESSION 2024

By: Representative Clark

To: Medicaid; Appropriations A

HOUSE BILL NO. 477

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO REVISE THE CALCULATION OF MEDICAID REIMBURSEMENT FOR DURABLE
3 MEDICAL EQUIPMENT; TO EXTEND THE DATE OF THE REPEALER ON THAT
4 SECTION; AND FOR RELATED PURPOSES.

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

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

8 43-13-117. (A) Medicaid as authorized by this article shall
9 include payment of part or all of the costs, at the discretion of
10 the division, with approval of the Governor and the Centers for
11 Medicare and Medicaid Services, of the following types of care and
12 services rendered to eligible applicants who have been determined
13 to be eligible for that care and services, within the limits of
14 state appropriations and federal matching funds:

15 (1) Inpatient hospital services.

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

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

44 hospital services. The division shall give rural hospitals that
45 have fifty (50) or fewer licensed beds the option to not be
46 reimbursed for outpatient hospital services using the APC
47 methodology, but reimbursement for outpatient hospital services
48 provided by those hospitals shall be based on one hundred one
49 percent (101%) of the rate established under Medicare for
50 outpatient hospital services. Those hospitals choosing to not be
51 reimbursed under the APC methodology shall remain under cost-based
52 reimbursement for a two-year period.
53 (d) No service benefits or reimbursement
54 limitations in this subsection (A)(2) shall apply to payments
55 under an APR-DRG or APC model or a managed care program or similar
56 model described in subsection (H) of this section unless
57 specifically authorized by the division.
58 (3) Laboratory and x-ray services.
59 (4) Nursing facility services.
60 (a) The division shall make full payment to
61 nursing facilities for each day, not exceeding forty-two (42) days
62 per year, that a patient is absent from the facility on home
63 leave. Payment may be made for the following home leave days in
64 addition to the forty-two-day limitation: Christmas, the day
65 before Christmas, the day after Christmas, Thanksgiving, the day
66 before Thanksgiving and the day after Thanksgiving.
67 (b) From and after July 1, 1997, the division
68 shall implement the integrated case-mix payment and quality

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

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

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

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

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

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

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

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

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

160 (b) [Repealed]

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

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

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

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

194 recipient and only one (1) dispensing fee per month may be
195 charged. The division shall develop a methodology for reimbursing
196 for restocked drugs, which shall include a restock fee as
197 determined by the division not exceeding Seven Dollars and
198 Eighty-two Cents ($7.82).
199 Except for those specific maintenance drugs approved by the
200 executive director, the division shall not reimburse for any
201 portion of a prescription that exceeds a thirty-one-day supply of
202 the drug based on the daily dosage.
203 The division is authorized to develop and implement a program
204 of payment for additional pharmacist services as determined by the
205 division.
206 All claims for drugs for dually eligible Medicare/Medicaid
207 beneficiaries that are paid for by Medicare must be submitted to
208 Medicare for payment before they may be processed by the
209 division's online payment system.
210 The division shall develop a pharmacy policy in which drugs
211 in tamper-resistant packaging that are prescribed for a resident
212 of a nursing facility but are not dispensed to the resident shall
213 be returned to the pharmacy and not billed to Medicaid, in
214 accordance with guidelines of the State Board of Pharmacy.
215 The division shall develop and implement a method or methods
216 by which the division will provide on a regular basis to Medicaid
217 providers who are authorized to prescribe drugs, information about
218 the costs to the Medicaid program of single-source drugs and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

285 (12) Intermediate care facility services.

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

292 Christmas, the day after Christmas, Thanksgiving, the day before
293 Thanksgiving and the day after Thanksgiving.
294 (b) All state-owned intermediate care facilities
295 for individuals with intellectual disabilities shall be reimbursed
296 on a full reasonable cost basis.
297 (c) Effective January 1, 2015, the division shall
298 update the fair rental reimbursement system for intermediate care
299 facilities for individuals with intellectual disabilities.
300 (13) Family planning services, including drugs,
301 supplies and devices, when those services are under the
302 supervision of a physician or nurse practitioner.
303 (14) Clinic services. Preventive, diagnostic,
304 therapeutic, rehabilitative or palliative services that are
305 furnished by a facility that is not part of a hospital but is
306 organized and operated to provide medical care to outpatients.
307 Clinic services include, but are not limited to:
308 (a) Services provided by ambulatory surgical
309 centers (ACSs) as defined in Section 41-75-1(a); and
310 (b) Dialysis center services.
311 (15) Home- and community-based services for the elderly
312 and disabled, as provided under Title XIX of the federal Social
313 Security Act, as amended, under waivers, subject to the
314 availability of funds specifically appropriated for that purpose
315 by the Legislature.

316 (16) Mental health services. Certain services provided
317 by a psychiatrist shall be reimbursed at up to one hundred percent
318 (100%) of the Medicare rate. Approved therapeutic and case
319 management services (a) provided by an approved regional mental
320 health/intellectual disability center established under Sections
321 41-19-31 through 41-19-39, or by another community mental health
322 service provider meeting the requirements of the Department of
323 Mental Health to be an approved mental health/intellectual
324 disability center if determined necessary by the Department of
325 Mental Health, using state funds that are provided in the
326 appropriation to the division to match federal funds, or (b)
327 provided by a facility that is certified by the State Department
328 of Mental Health to provide therapeutic and case management
329 services, to be reimbursed on a fee for service basis, or (c)
330 provided in the community by a facility or program operated by the
331 Department of Mental Health. Any such services provided by a
332 facility described in subparagraph (b) must have the prior
333 approval of the division to be reimbursable under this section.
334 (17) Durable medical equipment services and medical
335 supplies. Precertification of durable medical equipment and
336 medical supplies must be obtained as required by the division.
337 The Division of Medicaid may require durable medical equipment
338 providers to obtain a surety bond in the amount and to the
339 specifications as established by the Balanced Budget Act of 1997.
340 A maximum dollar amount of reimbursement for noninvasive

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

352 Payment for the purchase of new durable medical equipment is
353 the lesser of the provider's usual and customary charge or a fee
354 from the statewide uniform fee schedule updated on January 1 of
355 each year and effective for services provided on or after January
356 1. The statewide uniform fee schedule will be calculated using
357 one hundred percent (100%) of the Medicare Durable Medical
358 Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Rural Fee
359 Schedule in effect on January 1 of each year.

360 (18) (a) Notwithstanding any other provision of this
361 section to the contrary, as provided in the Medicaid state plan
362 amendment or amendments as defined in Section 43-13-145(10), the
363 division shall make additional reimbursement to hospitals that
364 serve a disproportionate share of low-income patients and that
365 meet the federal requirements for those payments as provided in

ST: Medicaid; revise calculation of reimbursement for durable medical equipment (DME).

366 Section 1923 of the federal Social Security Act and any applicable
367 regulations. It is the intent of the Legislature that the
368 division shall draw down all available federal funds allotted to
369 the state for disproportionate share hospitals. However, from and
370 after January 1, 1999, public hospitals participating in the
371 Medicaid disproportionate share program may be required to
372 participate in an intergovernmental transfer program as provided
373 in Section 1903 of the federal Social Security Act and any
374 applicable regulations.

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

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

388 (ii) The division shall assess each hospital,
389 nursing facility, and emergency ambulance transportation provider
390 for the sole purpose of financing the state portion of the

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

416 physicians, shall make additional reimbursement for physicians, as
417 defined in Section 1902(a)(30) of the federal Social Security Act
418 and any applicable federal regulations, provided the assessment in
419 this subsection (A)(18)(b) is in effect.

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

441 payment models shall be to ensure access to inpatient and
442 outpatient care and to maximize any federal funds that are
443 available to reimburse hospitals for services provided. Any such
444 documents required to achieve the goals described in this
445 paragraph shall be submitted to the Centers for Medicare and
446 Medicaid Services, with a proposed effective date of July 1, 2019,
447 to the extent possible, but in no event shall the effective date
448 of such payment models be later than July 1, 2020. The Chairmen
449 of the Senate and House Medicaid Committees shall be provided a
450 copy of the proposed payment model(s) prior to submission.
451 Effective July 1, 2018, and until such time as any payment
452 model(s) as described above become effective, the division, in
453 consultation with the hospital industry, is authorized to
454 implement a transitional program for inpatient and outpatient
455 payments and/or supplemental payments (including, but not limited
456 to, MHAP and directed payments), to redistribute available
457 supplemental funds among hospital providers, provided that when
458 compared to a hospital's prior year supplemental payments,
459 supplemental payments made pursuant to any such transitional
460 program shall not result in a decrease of more than five percent
461 (5%) and shall not increase by more than the amount needed to
462 maximize the distribution of the available funds.

463 (v) 1. To preserve and improve access to
464 ambulance transportation provider services, the division shall
465 seek CMS approval to make ambulance service access payments as set

ST: Medicaid; revise calculation of reimbursement for durable medical equipment (DME).

466 forth in this subsection (A)(18)(b) for all covered emergency
467 ambulance services rendered on or after July 1, 2022, and shall
468 make such ambulance service access payments for all covered
469 services rendered on or after the effective date of CMS approval.
470 2. The division shall calculate the
471 ambulance service access payment amount as the balance of the
472 portion of the Medical Care Fund related to ambulance
473 transportation service provider assessments plus any federal
474 matching funds earned on the balance, up to, but not to exceed,
475 the upper payment limit gap for all emergency ambulance service
476 providers.
477 3. a. Except for ambulance services
478 exempt from the assessment provided in this paragraph (18)(b), all
479 ambulance transportation service providers shall be eligible for
480 ambulance service access payments each state fiscal year as set
481 forth in this paragraph (18)(b).
482 b. In addition to any other funds
483 paid to ambulance transportation service providers for emergency
484 medical services provided to Medicaid beneficiaries, each eligible
485 ambulance transportation service provider shall receive ambulance
486 service access payments each state fiscal year equal to the
487 ambulance transportation service provider's upper payment limit
488 gap. Subject to approval by the Centers for Medicare and Medicaid
489 Services, ambulance service access payments shall be made no less
490 than on a quarterly basis.

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

516 (ii) Subject to approval by the Centers for
517 Medicare and Medicaid Services (CMS), the MHAP shall provide
518 increased inpatient capitation (PMPM) payments to managed care
519 entities contracting with the division pursuant to subsection (H)
520 of this section to support availability of hospital services or
521 such other payments permissible under federal law necessary to
522 accomplish the intent of this subsection.
523 (iii) The intent of this subparagraph (c) is
524 that effective for all inpatient hospital Medicaid services during
525 state fiscal year 2016, and so long as this provision shall remain
526 in effect hereafter, the division shall to the fullest extent
527 feasible replace the additional reimbursement for hospital
528 inpatient services under the inpatient Medicare Upper Payment
529 Limits (UPL) Program with additional reimbursement under the MHAP
530 and other payment programs for inpatient and/or outpatient
531 payments which may be developed under the authority of this
532 paragraph.
533 (iv) The division shall assess each hospital
534 as provided in Section 43-13-145(4)(a) for the purpose of
535 financing the state portion of the MHAP, supplemental payments and
536 such other purposes as specified in Section 43-13-145. The
537 assessment will remain in effect as long as the MHAP and
538 supplemental payments are in effect.
539 (19) (a) Perinatal risk management services. The
540 division shall promulgate regulations to be effective from and

541 after October 1, 1988, to establish a comprehensive perinatal
542 system for risk assessment of all pregnant and infant Medicaid
543 recipients and for management, education and follow-up for those
544 who are determined to be at risk. Services to be performed
545 include case management, nutrition assessment/counseling,
546 psychosocial assessment/counseling and health education. The
547 division shall contract with the State Department of Health to
548 provide services within this paragraph (Perinatal High Risk
549 Management/Infant Services System (PHRM/ISS)). The State
550 Department of Health shall be reimbursed on a full reasonable cost
551 basis for services provided under this subparagraph (a).
552 (b) Early intervention system services. The
553 division shall cooperate with the State Department of Health,
554 acting as lead agency, in the development and implementation of a
555 statewide system of delivery of early intervention services, under
556 Part C of the Individuals with Disabilities Education Act (IDEA).
557 The State Department of Health shall certify annually in writing
558 to the executive director of the division the dollar amount of
559 state early intervention funds available that will be utilized as
560 a certified match for Medicaid matching funds. Those funds then
561 shall be used to provide expanded targeted case management
562 services for Medicaid eligible children with special needs who are
563 eligible for the state's early intervention system.
564 Qualifications for persons providing service coordination shall be

565 determined by the State Department of Health and the Division of
566 Medicaid.
567 (20) Home- and community-based services for physically
568 disabled approved services as allowed by a waiver from the United
569 States Department of Health and Human Services for home- and
570 community-based services for physically disabled people using
571 state funds that are provided from the appropriation to the State
572 Department of Rehabilitation Services and used to match federal
573 funds under a cooperative agreement between the division and the
574 department, provided that funds for these services are
575 specifically appropriated to the Department of Rehabilitation
576 Services.
577 (21) Nurse practitioner services. Services furnished
578 by a registered nurse who is licensed and certified by the
579 Mississippi Board of Nursing as a nurse practitioner, including,
580 but not limited to, nurse anesthetists, nurse midwives, family
581 nurse practitioners, family planning nurse practitioners,
582 pediatric nurse practitioners, obstetrics-gynecology nurse
583 practitioners and neonatal nurse practitioners, under regulations
584 adopted by the division. Reimbursement for those services shall
585 not exceed ninety percent (90%) of the reimbursement rate for
586 comparable services rendered by a physician. The division may
587 provide for a reimbursement rate for nurse practitioner services
588 of up to one hundred percent (100%) of the reimbursement rate for
589 comparable services rendered by a physician for nurse practitioner

590 services that are provided after the normal working hours of the
591 nurse practitioner, as determined in accordance with regulations
592 of the division.
593 (22) Ambulatory services delivered in federally
594 qualified health centers, rural health centers and clinics of the
595 local health departments of the State Department of Health for
596 individuals eligible for Medicaid under this article based on
597 reasonable costs as determined by the division. Federally
598 qualified health centers shall be reimbursed by the Medicaid
599 prospective payment system as approved by the Centers for Medicare
600 and Medicaid Services. The division shall recognize federally
601 qualified health centers (FQHCs), rural health clinics (RHCs) and
602 community mental health centers (CMHCs) as both an originating and
603 distant site provider for the purposes of telehealth
604 reimbursement. The division is further authorized and directed to
605 reimburse FQHCs, RHCs and CMHCs for both distant site and
606 originating site services when such services are appropriately
607 provided by the same organization.
608 (23) Inpatient psychiatric services.
609 (a) Inpatient psychiatric services to be
610 determined by the division for recipients under age twenty-one
611 (21) that are provided under the direction of a physician in an
612 inpatient program in a licensed acute care psychiatric facility or
613 in a licensed psychiatric residential treatment facility, before
614 the recipient reaches age twenty-one (21) or, if the recipient was

615 receiving the services immediately before he or she reached age
616 twenty-one (21), before the earlier of the date he or she no
617 longer requires the services or the date he or she reaches age
618 twenty-two (22), as provided by federal regulations. From and
619 after January 1, 2015, the division shall update the fair rental
620 reimbursement system for psychiatric residential treatment
621 facilities. Precertification of inpatient days and residential
622 treatment days must be obtained as required by the division. From
623 and after July 1, 2009, all state-owned and state-operated
624 facilities that provide inpatient psychiatric services to persons
625 under age twenty-one (21) who are eligible for Medicaid
626 reimbursement shall be reimbursed for those services on a full
627 reasonable cost basis.

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

632 (24) [Deleted]

633 (25) [Deleted]

634 (26) Hospice care. As used in this paragraph, the term
635 "hospice care" means a coordinated program of active professional
636 medical attention within the home and outpatient and inpatient
637 care that treats the terminally ill patient and family as a unit,
638 employing a medically directed interdisciplinary team. The
639 program provides relief of severe pain or other physical symptoms

640 and supportive care to meet the special needs arising out of
641 physical, psychological, spiritual, social and economic stresses
642 that are experienced during the final stages of illness and during
643 dying and bereavement and meets the Medicare requirements for
644 participation as a hospice as provided in federal regulations.

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

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

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

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

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

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

717 (40) [Deleted]

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

728 (42) [Deleted]

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

734 (44) Nursing facility services for the severely
735 disabled.

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

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

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

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

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

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

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

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

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

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

822 (54) [Deleted]

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

835 (56) Prescribed pediatric extended care centers
836 services for medically dependent or technologically dependent
837 children with complex medical conditions that require continual
838 care as prescribed by the child's attending physician, as
839 determined by the division.
840 (57) No Medicaid benefit shall restrict coverage for
841 medically appropriate treatment prescribed by a physician and
842 agreed to by a fully informed individual, or if the individual
843 lacks legal capacity to consent by a person who has legal
844 authority to consent on his or her behalf, based on an
845 individual's diagnosis with a terminal condition. As used in this
846 paragraph (57), "terminal condition" means any aggressive
847 malignancy, chronic end-stage cardiovascular or cerebral vascular
848 disease, or any other disease, illness or condition which a
849 physician diagnoses as terminal.
850 (58) Treatment services for persons with opioid
851 dependency or other highly addictive substance use disorders. The
852 division is authorized to reimburse eligible providers for
853 treatment of opioid dependency and other highly addictive
854 substance use disorders, as determined by the division. Treatment
855 related to these conditions shall not count against any physician
856 visit limit imposed under this section.
857 (59) The division shall allow beneficiaries between the
858 ages of ten (10) and eighteen (18) years to receive vaccines
859 through a pharmacy venue. The division and the State Department

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

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

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

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

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

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

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

934 also shall provide a summary and copy of any proposed rate change
935 to any other member of the Legislature upon request.
936 (3) If the chairman of either committee or both
937 chairmen jointly object to the proposed rate change or any part
938 thereof, the chairman or chairmen shall notify the division and
939 provide the reasons for their objection in writing not later than
940 seven (7) calendar days after receipt of the notice from the
941 division. The chairman or chairmen may make written
942 recommendations to the division for changes to be made to a
943 proposed rate change.
944 (4) (a) The chairman of either committee or both
945 chairmen jointly may hold a committee meeting to review a proposed
946 rate change. If either chairman or both chairmen decide to hold a
947 meeting, they shall notify the division of their intention in
948 writing within seven (7) calendar days after receipt of the notice
949 from the division, and shall set the date and time for the meeting
950 in their notice to the division, which shall not be later than
951 fourteen (14) calendar days after receipt of the notice from the
952 division.
953 (b) After the committee meeting, the committee or
954 committees may object to the proposed rate change or any part
955 thereof. The committee or committees shall notify the division
956 and the reasons for their objection in writing not later than
957 seven (7) calendar days after the meeting. The committee or

958 committees may make written recommendations to the division for
959 changes to be made to a proposed rate change.
960 (5) If both chairmen notify the division in writing
961 within seven (7) calendar days after receipt of the notice from
962 the division that they do not object to the proposed rate change
963 and will not be holding a meeting to review the proposed rate
964 change, the proposed rate change will take effect on the original
965 date as scheduled by the division or on such other date as
966 specified by the division.
967 (6) (a) If there are any objections to a proposed rate
968 change or any part thereof from either or both of the chairmen or
969 the committees, the division may withdraw the proposed rate
970 change, make any of the recommended changes to the proposed rate
971 change, or not make any changes to the proposed rate change.
972 (b) If the division does not make any changes to
973 the proposed rate change, it shall notify the chairmen of that
974 fact in writing, and the proposed rate change shall take effect on
975 the original date as scheduled by the division or on such other
976 date as specified by the division.
977 (c) If the division makes any changes to the
978 proposed rate change, the division shall notify the chairmen of
979 its actions in writing, and the revised proposed rate change shall
980 take effect on the date as specified by the division.
981 (7) Nothing in this subsection (D) shall be construed
982 as giving the chairmen or the committees any authority to veto,

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

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

994 (F) The executive director shall keep the Governor advised
995 on a timely basis of the funds available for expenditure and the
996 projected expenditures. Notwithstanding any other provisions of
997 this article, if current or projected expenditures of the division
998 are reasonably anticipated to exceed the amount of funds
999 appropriated to the division for any fiscal year, the Governor,
1000 after consultation with the executive director, shall take all
1001 appropriate measures to reduce costs, which may include, but are
1002 not limited to:

1003 (1) Reducing or discontinuing any or all services that
1004 are deemed to be optional under Title XIX of the Social Security
1005 Act;

1006 (2) Reducing reimbursement rates for any or all service
1007 types;

1008 (3) Imposing additional assessments on health care
1009 providers; or
1010 (4) Any additional cost-containment measures deemed
1011 appropriate by the Governor.
1012 To the extent allowed under federal law, any reduction to
1013 services or reimbursement rates under this subsection (F) shall be
1014 accompanied by a reduction, to the fullest allowable amount, to
1015 the profit margin and administrative fee portions of capitated
1016 payments to organizations described in paragraph (1) of subsection
1017 (H).
1018 Beginning in fiscal year 2010 and in fiscal years thereafter,
1019 when Medicaid expenditures are projected to exceed funds available
1020 for the fiscal year, the division shall submit the expected
1021 shortfall information to the PEER Committee not later than
1022 December 1 of the year in which the shortfall is projected to
1023 occur. PEER shall review the computations of the division and
1024 report its findings to the Legislative Budget Office not later
1025 than January 7 in any year.
1026 (G) Notwithstanding any other provision of this article, it
1027 shall be the duty of each provider participating in the Medicaid
1028 program to keep and maintain books, documents and other records as
1029 prescribed by the Division of Medicaid in accordance with federal
1030 laws and regulations.
1031 (H) (1) Notwithstanding any other provision of this
1032 article, the division is authorized to implement (a) a managed

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1033 care program, (b) a coordinated care program, (c) a coordinated
1034 care organization program, (d) a health maintenance organization
1035 program, (e) a patient-centered medical home program, (f) an
1036 accountable care organization program, (g) provider-sponsored
1037 health plan, or (h) any combination of the above programs. As a
1038 condition for the approval of any program under this subsection
1039 (H)(1), the division shall require that no managed care program,
1040 coordinated care program, coordinated care organization program,
1041 health maintenance organization program, or provider-sponsored
1042 health plan may:

1043 (a) Pay providers at a rate that is less than the
1044 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
1045 reimbursement rate;

1046 (b) Override the medical decisions of hospital
1047 physicians or staff regarding patients admitted to a hospital for
1048 an emergency medical condition as defined by 42 US Code Section
1049 1395dd. This restriction (b) does not prohibit the retrospective
1050 review of the appropriateness of the determination that an
1051 emergency medical condition exists by chart review or coding
1052 algorithm, nor does it prohibit prior authorization for
1053 nonemergency hospital admissions;

1054 (c) Pay providers at a rate that is less than the
1055 normal Medicaid reimbursement rate. It is the intent of the
1056 Legislature that all managed care entities described in this
1057 subsection (H), in collaboration with the division, develop and

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1058 implement innovative payment models that incentivize improvements
1059 in health care quality, outcomes, or value, as determined by the
1060 division. Participation in the provider network of any managed
1061 care, coordinated care, provider-sponsored health plan, or similar
1062 contractor shall not be conditioned on the provider's agreement to
1063 accept such alternative payment models;

1064 (d) Implement a prior authorization and
1065 utilization review program for medical services, transportation
1066 services and prescription drugs that is more stringent than the
1067 prior authorization processes used by the division in its
1068 administration of the Medicaid program. Not later than December
1069 2, 2021, the contractors that are receiving capitated payments
1070 under a managed care delivery system established under this
1071 subsection (H) shall submit a report to the Chairmen of the House
1072 and Senate Medicaid Committees on the status of the prior
1073 authorization and utilization review program for medical services,
1074 transportation services and prescription drugs that is required to
1075 be implemented under this subparagraph (d);

1076 (e) [Deleted]

1077 (f) Implement a preferred drug list that is more
1078 stringent than the mandatory preferred drug list established by
1079 the division under subsection (A)(9) of this section;

1080 (g) Implement a policy which denies beneficiaries
1081 with hemophilia access to the federally funded hemophilia

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1082 treatment centers as part of the Medicaid Managed Care network of
1083 providers.

1084 Each health maintenance organization, coordinated care
1085 organization, provider-sponsored health plan, or other
1086 organization paid for services on a capitated basis by the
1087 division under any managed care program or coordinated care
1088 program implemented by the division under this section shall use a
1089 clear set of level of care guidelines in the determination of
1090 medical necessity and in all utilization management practices,
1091 including the prior authorization process, concurrent reviews,
1092 retrospective reviews and payments, that are consistent with
1093 widely accepted professional standards of care. Organizations
1094 participating in a managed care program or coordinated care
1095 program implemented by the division may not use any additional
1096 criteria that would result in denial of care that would be
1097 determined appropriate and, therefore, medically necessary under
1098 those levels of care guidelines.

1099 (2) Notwithstanding any provision of this section, the
1100 recipients eligible for enrollment into a Medicaid Managed Care
1101 Program authorized under this subsection (H) may include only
1102 those categories of recipients eligible for participation in the
1103 Medicaid Managed Care Program as of January 1, 2021, the
1104 Children's Health Insurance Program (CHIP), and the CMS-approved
1105 Section 1115 demonstration waivers in operation as of January 1,
1106 2021. No expansion of Medicaid Managed Care Program contracts may

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1107 be implemented by the division without enabling legislation from
1108 the Mississippi Legislature.

1109 (3) (a) Any contractors receiving capitated payments
1110 under a managed care delivery system established in this section
1111 shall provide to the Legislature and the division statistical data
1112 to be shared with provider groups in order to improve patient
1113 access, appropriate utilization, cost savings and health outcomes
1114 not later than October 1 of each year. Additionally, each
1115 contractor shall disclose to the Chairmen of the Senate and House
1116 Medicaid Committees the administrative expenses costs for the
1117 prior calendar year, and the number of full-equivalent employees
1118 located in the State of Mississippi dedicated to the Medicaid and
1119 CHIP lines of business as of June 30 of the current year.

1120 (b) The division and the contractors participating
1121 in the managed care program, a coordinated care program or a
1122 provider-sponsored health plan shall be subject to annual program
1123 reviews or audits performed by the Office of the State Auditor,
1124 the PEER Committee, the Department of Insurance and/or independent
1125 third parties.

1126 (c) Those reviews shall include, but not be
1127 limited to, at least two (2) of the following items:

1128 (i) The financial benefit to the State of
1129 Mississippi of the managed care program,

1130 (ii) The difference between the premiums paid
1131 to the managed care contractors and the payments made by those
1132 contractors to health care providers,
1133 (iii) Compliance with performance measures
1134 required under the contracts,
1135 (iv) Administrative expense allocation
1136 methodologies,
1137 (v) Whether nonprovider payments assigned as
1138 medical expenses are appropriate,
1139 (vi) Capitated arrangements with related
1140 party subcontractors,
1141 (vii) Reasonableness of corporate
1142 allocations,
1143 (viii) Value-added benefits and the extent to
1144 which they are used,
1145 (ix) The effectiveness of subcontractor
1146 oversight, including subcontractor review,
1147 (x) Whether health care outcomes have been
1148 improved, and
1149 (xi) The most common claim denial codes to
1150 determine the reasons for the denials.
1151 The audit reports shall be considered public documents and
1152 shall be posted in their entirety on the division's website.
1153 (4) All health maintenance organizations, coordinated
1154 care organizations, provider-sponsored health plans, or other

1155 organizations paid for services on a capitated basis by the
1156 division under any managed care program or coordinated care
1157 program implemented by the division under this section shall
1158 reimburse all providers in those organizations at rates no lower
1159 than those provided under this section for beneficiaries who are
1160 not participating in those programs.

1161 (5) No health maintenance organization, coordinated
1162 care organization, provider-sponsored health plan, or other
1163 organization paid for services on a capitated basis by the
1164 division under any managed care program or coordinated care
1165 program implemented by the division under this section shall
1166 require its providers or beneficiaries to use any pharmacy that
1167 ships, mails or delivers prescription drugs or legend drugs or
1168 devices.

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

1180 of the uniform credentialing process for providers that is
1181 required under this subparagraph (a).
1182 (b) If those contractors have not implemented a
1183 uniform credentialing process as described in subparagraph (a) by
1184 December 1, 2021, the division shall develop and implement, not
1185 later than July 1, 2022, a single, consolidated credentialing
1186 process by which all providers will be credentialed. Under the
1187 division's single, consolidated credentialing process, no such
1188 contractor shall require its providers to be separately
1189 credentialed by the contractor in order to receive reimbursement
1190 from the contractor, but those contractors shall recognize the
1191 credentialing of the providers by the division's credentialing
1192 process.
1193 (c) The division shall require a uniform provider
1194 credentialing application that shall be used in the credentialing
1195 process that is established under subparagraph (a) or (b). If the
1196 contractor or division, as applicable, has not approved or denied
1197 the provider credentialing application within sixty (60) days of
1198 receipt of the completed application that includes all required
1199 information necessary for credentialing, then the contractor or
1200 division, upon receipt of a written request from the applicant and
1201 within five (5) business days of its receipt, shall issue a
1202 temporary provider credential/enrollment to the applicant if the
1203 applicant has a valid Mississippi professional or occupational
1204 license to provide the health care services to which the

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1205 credential/enrollment would apply. The contractor or the division
1206 shall not issue a temporary credential/enrollment if the applicant
1207 has reported on the application a history of medical or other
1208 professional or occupational malpractice claims, a history of
1209 substance abuse or mental health issues, a criminal record, or a
1210 history of medical or other licensing board, state or federal
1211 disciplinary action, including any suspension from participation
1212 in a federal or state program. The temporary
1213 credential/enrollment shall be effective upon issuance and shall
1214 remain in effect until the provider's credentialing/enrollment
1215 application is approved or denied by the contractor or division.
1216 The contractor or division shall render a final decision regarding
1217 credentialing/enrollment of the provider within sixty (60) days
1218 from the date that the temporary provider credential/enrollment is
1219 issued to the applicant.
1220 (d) If the contractor or division does not render
1221 a final decision regarding credentialing/enrollment of the
1222 provider within the time required in subparagraph (c), the
1223 provider shall be deemed to be credentialed by and enrolled with
1224 all of the contractors and eligible to receive reimbursement from
1225 the contractors.
1226 (7) (a) Each contractor that is receiving capitated
1227 payments under a managed care delivery system established under
1228 this subsection (H) shall provide to each provider for whom the
1229 contractor has denied the coverage of a procedure that was ordered

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1230 or requested by the provider for or on behalf of a patient, a
1231 letter that provides a detailed explanation of the reasons for the
1232 denial of coverage of the procedure and the name and the
1233 credentials of the person who denied the coverage. The letter
1234 shall be sent to the provider in electronic format.

1235 (b) After a contractor that is receiving capitated
1236 payments under a managed care delivery system established under
1237 this subsection (H) has denied coverage for a claim submitted by a
1238 provider, the contractor shall issue to the provider within sixty
1239 (60) days a final ruling of denial of the claim that allows the
1240 provider to have a state fair hearing and/or agency appeal with
1241 the division. If a contractor does not issue a final ruling of
1242 denial within sixty (60) days as required by this subparagraph
1243 (b), the provider's claim shall be deemed to be automatically
1244 approved and the contractor shall pay the amount of the claim to
1245 the provider.

1246 (c) After a contractor has issued a final ruling
1247 of denial of a claim submitted by a provider, the division shall
1248 conduct a state fair hearing and/or agency appeal on the matter of
1249 the disputed claim between the contractor and the provider within
1250 sixty (60) days, and shall render a decision on the matter within
1251 thirty (30) days after the date of the hearing and/or appeal.

1252 (8) It is the intention of the Legislature that the
1253 division evaluate the feasibility of using a single vendor to
1254 administer pharmacy benefits provided under a managed care

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

1280 made by the contractors and providers to increase LARC
1281 utilization. This report shall be updated annually to include
1282 information for subsequent state fiscal years.
1283 (12) The division is authorized to make not more than
1284 one (1) emergency extension of the contracts that are in effect on
1285 July 1, 2021, with contractors who are receiving capitated
1286 payments under a managed care delivery system established under
1287 this subsection (H), as provided in this paragraph (12). The
1288 maximum period of any such extension shall be one (1) year, and
1289 under any such extensions, the contractors shall be subject to all
1290 of the provisions of this subsection (H). The extended contracts
1291 shall be revised to incorporate any provisions of this subsection
1292 (H).
1293 (I) [Deleted]
1294 (J) There shall be no cuts in inpatient and outpatient
1295 hospital payments, or allowable days or volumes, as long as the
1296 hospital assessment provided in Section 43-13-145 is in effect.
1297 This subsection (J) shall not apply to decreases in payments that
1298 are a result of: reduced hospital admissions, audits or payments
1299 under the APR-DRG or APC models, or a managed care program or
1300 similar model described in subsection (H) of this section.
1301 (K) In the negotiation and execution of such contracts
1302 involving services performed by actuarial firms, the Executive
1303 Director of the Division of Medicaid may negotiate a limitation on
1304 liability to the state of prospective contractors.

1305 (L) The Division of Medicaid shall reimburse for services
1306 provided to eligible Medicaid beneficiaries by a licensed birthing
1307 center in a method and manner to be determined by the division in
1308 accordance with federal laws and federal regulations. The
1309 division shall seek any necessary waivers, make any required
1310 amendments to its State Plan or revise any contracts authorized
1311 under subsection (H) of this section as necessary to provide the
1312 services authorized under this subsection. As used in this
1313 subsection, the term "birthing centers" shall have the meaning as
1314 defined in Section 41-77-1(a), which is a publicly or privately
1315 owned facility, place or institution constructed, renovated,
1316 leased or otherwise established where nonemergency births are
1317 planned to occur away from the mother's usual residence following
1318 a documented period of prenatal care for a normal uncomplicated
1319 pregnancy which has been determined to be low risk through a
1320 formal risk-scoring examination.
1321 (M) This section shall stand repealed on July 1, *** * *** <u>2025</u>.
1322 **SECTION 2.** This act shall take effect and be in force from
1323 and after July 1, 2024.