

By: Representatives Johnson, Hines, Harness, Porter, Clark To: Medicaid

HOUSE BILL NO. 586

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

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

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

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

18 (1) Inpatient hospital services.



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

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

28                   (2) Outpatient hospital services.

29                   (a) Emergency services.

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



43 methodology of outpatient reimbursement to maintain consistency,  
44 efficiency, economy and quality of care.

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

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

61 (3) Laboratory and x-ray services.

62 (4) Nursing facility services.

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



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

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

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

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

91 (e) The division shall develop and implement, not  
92 later than January 1, 2001, a case-mix payment add-on determined



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

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

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

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



118 are included in the state plan. The division may include in its  
119 periodic screening and diagnostic program those discretionary  
120 services authorized under the federal regulations adopted to  
121 implement Title XIX of the federal Social Security Act, as  
122 amended. The division, in obtaining physical therapy services,  
123 occupational therapy services, and services for individuals with  
124 speech, hearing and language disorders, may enter into a  
125 cooperative agreement with the State Department of Education for  
126 the provision of those services to handicapped students by public  
127 school districts using state funds that are provided from the  
128 appropriation to the Department of Education to obtain federal  
129 matching funds through the division. The division, in obtaining  
130 medical and mental health assessments, treatment, care and  
131 services for children who are in, or at risk of being put in, the  
132 custody of the Mississippi Department of Human Services may enter  
133 into a cooperative agreement with the Mississippi Department of  
134 Human Services for the provision of those services using state  
135 funds that are provided from the appropriation to the Department  
136 of Human Services to obtain federal matching funds through the  
137 division.

138 (6) Physician services. Fees for physician's services  
139 that are covered only by Medicaid shall be reimbursed at ninety  
140 percent (90%) of the rate established on January 1, 2018, and as  
141 may be adjusted each July thereafter, under Medicare. The  
142 division may provide for a reimbursement rate for physician's



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

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

163 (b) [Repealed]

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

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



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

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

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

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

187           Drugs prescribed for a resident of a psychiatric residential  
188   treatment facility must be provided in true unit doses when  
189   available. The division may require that drugs not covered by  
190   Medicare Part D for a resident of a long-term care facility be  
191   provided in true unit doses when available. Those drugs that were  
192   originally billed to the division but are not used by a resident





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

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

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

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

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



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

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

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

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

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



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

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

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

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



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

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

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

288           (12) Intermediate care facility services.

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



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

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

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

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

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

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

313 (b) Dialysis center services.

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



317 availability of funds specifically appropriated for that purpose  
318 by the Legislature.

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

337 (17) Durable medical equipment services and medical  
338 supplies. Precertification of durable medical equipment and  
339 medical supplies must be obtained as required by the division.  
340 The Division of Medicaid may require durable medical equipment  
341 providers to obtain a surety bond in the amount and to the



342 specifications as established by the Balanced Budget Act of 1997.  
343 A maximum dollar amount of reimbursement for noninvasive  
344 ventilators or ventilation treatments properly ordered and being  
345 used in an appropriate care setting shall not be set by any health  
346 maintenance organization, coordinated care organization,  
347 provider-sponsored health plan, or other organization paid for  
348 services on a capitated basis by the division under any managed  
349 care program or coordinated care program implemented by the  
350 division under this section. Reimbursement by these organizations  
351 to durable medical equipment suppliers for home use of noninvasive  
352 and invasive ventilators shall be on a continuous monthly payment  
353 basis for the duration of medical need throughout a patient's  
354 valid prescription period.

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



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

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

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

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





392 division, consistent with federal regulations. The assessments  
393 will remain in effect as long as the state participates in the  
394 Medicare Upper Payment Limits Program or other program(s)  
395 authorized under this subsection (A) (18) (b). In addition to the  
396 hospital assessment provided in Section 43-13-145(4) (a), hospitals  
397 with physicians participating in the Medicare Upper Payment Limits  
398 Program or other program(s) authorized under this subsection  
399 (A) (18) (b) shall be required to participate in an  
400 intergovernmental transfer or assessment, as determined by the  
401 division, for the purpose of financing the state portion of the  
402 physician UPL payments or other payment(s) authorized under this  
403 subsection (A) (18) (b).

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

415 (iv) Notwithstanding any other provision of  
416 this article to the contrary, effective upon implementation of the



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



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

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

465 2. The division shall calculate the  
466 ambulance service access payment amount as the balance of the



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

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

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

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



491 would have received from commercial insurers for those services  
492 reimbursed by Medicaid.

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

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

511                   (ii) Subject to approval by the Centers for  
512 Medicare and Medicaid Services (CMS), the MHAP shall provide  
513 increased inpatient capitation (PMPM) payments to managed care  
514 entities contracting with the division pursuant to subsection (H)  
515 of this section to support availability of hospital services or



516 such other payments permissible under federal law necessary to  
517 accomplish the intent of this subsection.

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

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

534 (19) (a) Perinatal risk management services. The  
535 division shall promulgate regulations to be effective from and  
536 after October 1, 1988, to establish a comprehensive perinatal  
537 system for risk assessment of all pregnant and infant Medicaid  
538 recipients and for management, education and follow-up for those  
539 who are determined to be at risk. Services to be performed  
540 include case management, nutrition assessment/counseling,



541 psychosocial assessment/counseling and health education. The  
542 division shall contract with the State Department of Health to  
543 provide services within this paragraph (Perinatal High Risk  
544 Management/Infant Services System (PHRM/ISS)). The State  
545 Department of Health shall be reimbursed on a full reasonable cost  
546 basis for services provided under this subparagraph (a).

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

559 Qualifications for persons providing service coordination shall be  
560 determined by the State Department of Health and the Division of  
561 Medicaid.

562 (20) Home- and community-based services for physically  
563 disabled approved services as allowed by a waiver from the United  
564 States Department of Health and Human Services for home- and  
565 community-based services for physically disabled people using



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

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

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





591 individuals eligible for Medicaid under this article based on  
592 reasonable costs as determined by the division. Federally  
593 qualified health centers shall be reimbursed by the Medicaid  
594 prospective payment system as approved by the Centers for Medicare  
595 and Medicaid Services. The division shall recognize federally  
596 qualified health centers (FQHCs), rural health clinics (RHCs) and  
597 community mental health centers (CMHCs) as both an originating and  
598 distant site provider for the purposes of telehealth  
599 reimbursement. The division is further authorized and directed to  
600 reimburse FQHCs, RHCs and CMHCs the applicable Medicaid fee for  
601 both distant site and originating site telehealth services when  
602 such services are appropriately provided by the same organization.  
603 Telehealth services provided by FQHCs, RHCs and CMHCs are  
604 considered billable at the same face-to-face encounter rate used  
605 for all other Medicaid reimbursements to FQHCs, RHCs and CMHCs  
606 under the prospective payment system.

607 (23) Inpatient psychiatric services.

608 (a) Inpatient psychiatric services to be  
609 determined by the division for recipients under age twenty-one  
610 (21) that are provided under the direction of a physician in an  
611 inpatient program in a licensed acute care psychiatric facility or  
612 in a licensed psychiatric residential treatment facility, before  
613 the recipient reaches age twenty-one (21) or, if the recipient was  
614 receiving the services immediately before he or she reached age  
615 twenty-one (21), before the earlier of the date he or she no



616 longer requires the services or the date he or she reaches age  
617 twenty-two (22), as provided by federal regulations. From and  
618 after January 1, 2015, the division shall update the fair rental  
619 reimbursement system for psychiatric residential treatment  
620 facilities. Precertification of inpatient days and residential  
621 treatment days must be obtained as required by the division. From  
622 and after July 1, 2009, all state-owned and state-operated  
623 facilities that provide inpatient psychiatric services to persons  
624 under age twenty-one (21) who are eligible for Medicaid  
625 reimbursement shall be reimbursed for those services on a full  
626 reasonable cost basis.

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

631 (24) [Deleted]

632 (25) [Deleted]

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



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

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

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

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

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



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

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

677           (33) Podiatrist services.

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

683           (35) Services and activities authorized in Sections  
684 43-27-101 and 43-27-103, using state funds that are provided from  
685 the appropriation to the Mississippi Department of Human Services  
686 and used to match federal funds under a cooperative agreement  
687 between the division and the department.

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



690 Committee shall conduct a performance evaluation of the  
691 nonemergency transportation program to evaluate the administration  
692 of the program and the providers of transportation services to  
693 determine the most cost-effective ways of providing nonemergency  
694 transportation services to the patients served under the program.  
695 The performance evaluation shall be completed and provided to the  
696 members of the Senate Medicaid Committee and the House Medicaid  
697 Committee not later than January 1, 2019, and every two (2) years  
698 thereafter.

699 (37) [Deleted]

700 (38) Chiropractic services. A chiropractor's manual  
701 manipulation of the spine to correct a subluxation, if x-ray  
702 demonstrates that a subluxation exists and if the subluxation has  
703 resulted in a neuromusculoskeletal condition for which  
704 manipulation is appropriate treatment, and related spinal x-rays  
705 performed to document these conditions. Reimbursement for  
706 chiropractic services shall not exceed Seven Hundred Dollars  
707 (\$700.00) per year per beneficiary.

708 (39) Dually eligible Medicare/Medicaid beneficiaries.  
709 The division shall pay the Medicare deductible and coinsurance  
710 amounts for services available under Medicare, as determined by  
711 the division. From and after July 1, 2009, the division shall  
712 reimburse crossover claims for inpatient hospital services and  
713 crossover claims covered under Medicare Part B in the same manner



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

716 (40) [Deleted]

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

727 (42) [Deleted]

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

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

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



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

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

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



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

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

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

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

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

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

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





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

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

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

806 (52) Notwithstanding any provisions of this article,  
807 the division may pay enhanced reimbursement fees related to trauma  
808 care, as determined by the division in conjunction with the State  
809 Department of Health, using funds appropriated to the State  
810 Department of Health for trauma care and services and used to  
811 match federal funds under a cooperative agreement between the



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

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

821 (54) [Deleted]

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

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



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

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

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

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



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

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

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



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

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

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

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

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



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

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

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

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

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



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

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

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



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

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

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

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

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





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

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

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

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

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

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



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

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

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

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

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



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

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

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

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



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

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

1075 (e) [Deleted]

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

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



1083           Each health maintenance organization, coordinated care  
1084 organization, provider-sponsored health plan, or other  
1085 organization paid for services on a capitated basis by the  
1086 division under any managed care program or coordinated care  
1087 program implemented by the division under this section shall use a  
1088 clear set of level of care guidelines in the determination of  
1089 medical necessity and in all utilization management practices,  
1090 including the prior authorization process, concurrent reviews,  
1091 retrospective reviews and payments, that are consistent with  
1092 widely accepted professional standards of care. Organizations  
1093 participating in a managed care program or coordinated care  
1094 program implemented by the division may not use any additional  
1095 criteria that would result in denial of care that would be  
1096 determined appropriate and, therefore, medically necessary under  
1097 those levels of care guidelines.

1098           (2) Notwithstanding any provision of this section, the  
1099 recipients eligible for enrollment into a Medicaid Managed Care  
1100 Program authorized under this subsection (H) may include only  
1101 those categories of recipients eligible for participation in the  
1102 Medicaid Managed Care Program as of January 1, 2021, the  
1103 Children's Health Insurance Program (CHIP), and the CMS-approved  
1104 Section 1115 demonstration waivers in operation as of January 1,  
1105 2021. No expansion of Medicaid Managed Care Program contracts may  
1106 be implemented by the division without enabling legislation from  
1107 the Mississippi Legislature.



1108           (3) (a) Any contractors receiving capitated payments  
1109 under a managed care delivery system established in this section  
1110 shall provide to the Legislature and the division statistical data  
1111 to be shared with provider groups in order to improve patient  
1112 access, appropriate utilization, cost savings and health outcomes  
1113 not later than October 1 of each year. Additionally, each  
1114 contractor shall disclose to the Chairmen of the Senate and House  
1115 Medicaid Committees the administrative expenses costs for the  
1116 prior calendar year, and the number of full-equivalent employees  
1117 located in the State of Mississippi dedicated to the Medicaid and  
1118 CHIP lines of business as of June 30 of the current year.

1119           (b) The division and the contractors participating  
1120 in the managed care program, a coordinated care program or a  
1121 provider-sponsored health plan shall be subject to annual program  
1122 reviews or audits performed by the Office of the State Auditor,  
1123 the PEER Committee, the Department of Insurance and/or independent  
1124 third parties.

1125           (c) Those reviews shall include, but not be  
1126 limited to, at least two (2) of the following items:

1127           (i) The financial benefit to the State of  
1128 Mississippi of the managed care program,

1129           (ii) The difference between the premiums paid  
1130 to the managed care contractors and the payments made by those  
1131 contractors to health care providers,



1132 (iii) Compliance with performance measures  
1133 required under the contracts,  
1134 (iv) Administrative expense allocation  
1135 methodologies,  
1136 (v) Whether nonprovider payments assigned as  
1137 medical expenses are appropriate,  
1138 (vi) Capitated arrangements with related  
1139 party subcontractors,  
1140 (vii) Reasonableness of corporate  
1141 allocations,  
1142 (viii) Value-added benefits and the extent to  
1143 which they are used,  
1144 (ix) The effectiveness of subcontractor  
1145 oversight, including subcontractor review,  
1146 (x) Whether health care outcomes have been  
1147 improved, and  
1148 (xi) The most common claim denial codes to  
1149 determine the reasons for the denials.

1150 The audit reports shall be considered public documents and  
1151 shall be posted in their entirety on the division's website.

1152 (4) All health maintenance organizations, coordinated  
1153 care organizations, provider-sponsored health plans, or other  
1154 organizations paid for services on a capitated basis by the  
1155 division under any managed care program or coordinated care  
1156 program implemented by the division under this section shall



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

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

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





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

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



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

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

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



1231 denial of coverage of the procedure and the name and the  
1232 credentials of the person who denied the coverage. The letter  
1233 shall be sent to the provider in electronic format.

1234 (b) After a contractor that is receiving capitated  
1235 payments under a managed care delivery system established under  
1236 this subsection (H) has denied coverage for a claim submitted by a  
1237 provider, the contractor shall issue to the provider within sixty  
1238 (60) days a final ruling of denial of the claim that allows the  
1239 provider to have a state fair hearing and/or agency appeal with  
1240 the division. If a contractor does not issue a final ruling of  
1241 denial within sixty (60) days as required by this subparagraph  
1242 (b), the provider's claim shall be deemed to be automatically  
1243 approved and the contractor shall pay the amount of the claim to  
1244 the provider.

1245 (c) After a contractor has issued a final ruling  
1246 of denial of a claim submitted by a provider, the division shall  
1247 conduct a state fair hearing and/or agency appeal on the matter of  
1248 the disputed claim between the contractor and the provider within  
1249 sixty (60) days, and shall render a decision on the matter within  
1250 thirty (30) days after the date of the hearing and/or appeal.

1251 (8) It is the intention of the Legislature that the  
1252 division evaluate the feasibility of using a single vendor to  
1253 administer pharmacy benefits provided under a managed care  
1254 delivery system established under this subsection (H). Providers



1255 of pharmacy benefits shall cooperate with the division in any  
1256 transition to a carve-out of pharmacy benefits under managed care.

1257 (9) The division shall evaluate the feasibility of  
1258 using a single vendor to administer dental benefits provided under  
1259 a managed care delivery system established in this subsection (H).  
1260 Providers of dental benefits shall cooperate with the division in  
1261 any transition to a carve-out of dental benefits under managed  
1262 care.

1263 (10) It is the intent of the Legislature that any  
1264 contractor receiving capitated payments under a managed care  
1265 delivery system established in this section shall implement  
1266 innovative programs to improve the health and well-being of  
1267 members diagnosed with prediabetes and diabetes.

1268 (11) It is the intent of the Legislature that any  
1269 contractors receiving capitated payments under a managed care  
1270 delivery system established under this subsection (H) shall work  
1271 with providers of Medicaid services to improve the utilization of  
1272 long-acting reversible contraceptives (LARCs). Not later than  
1273 December 1, 2021, any contractors receiving capitated payments  
1274 under a managed care delivery system established under this  
1275 subsection (H) shall provide to the Chairmen of the House and  
1276 Senate Medicaid Committees and House and Senate Public Health  
1277 Committees a report of LARC utilization for State Fiscal Years  
1278 2018 through 2020 as well as any programs, initiatives, or efforts  
1279 made by the contractors and providers to increase LARC



1280 utilization. This report shall be updated annually to include  
1281 information for subsequent state fiscal years.

1282 (12) The division is authorized to make not more than  
1283 one (1) emergency extension of the contracts that are in effect on  
1284 July 1, 2021, with contractors who are receiving capitated  
1285 payments under a managed care delivery system established under  
1286 this subsection (H), as provided in this paragraph (12). The  
1287 maximum period of any such extension shall be one (1) year, and  
1288 under any such extensions, the contractors shall be subject to all  
1289 of the provisions of this subsection (H). The extended contracts  
1290 shall be revised to incorporate any provisions of this subsection  
1291 (H).

1292 (I) [Deleted]

1293 (J) There shall be no cuts in inpatient and outpatient  
1294 hospital payments, or allowable days or volumes, as long as the  
1295 hospital assessment provided in Section 43-13-145 is in effect.  
1296 This subsection (J) shall not apply to decreases in payments that  
1297 are a result of: reduced hospital admissions, audits or payments  
1298 under the APR-DRG or APC models, or a managed care program or  
1299 similar model described in subsection (H) of this section.

1300 (K) In the negotiation and execution of such contracts  
1301 involving services performed by actuarial firms, the Executive  
1302 Director of the Division of Medicaid may negotiate a limitation on  
1303 liability to the state of prospective contractors.



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

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

1321 **SECTION 2.** This act shall take effect and be in force from  
1322 and after July 1, 2024.

