

By: Representative Creekmore IV

To: Medicaid; Appropriations  
A

HOUSE BILL NO. 1044

1 AN ACT TO PROVIDE FOR THE LICENSURE AND REGULATION OF ADULT  
 2 RESIDENTIAL TREATMENT FACILITIES AND ADULT SUPPORTIVE RESIDENTIAL  
 3 FACILITIES BY THE STATE DEPARTMENT OF MENTAL HEALTH; TO DIRECT THE  
 4 STATE BOARD OF MENTAL HEALTH TO ADOPT RULES PROVIDING FOR FACILITY  
 5 REQUIREMENTS AND MINIMUM PROGRAMMATIC, STAFFING AND OPERATIONAL  
 6 REQUIREMENTS OF SERVICES OFFERED AT THE FACILITIES; TO PROVIDE  
 7 THAT IT IS UNLAWFUL FOR ANY PERSON, PARTNERSHIP, ASSOCIATION,  
 8 CORPORATION OR OTHER ENTITY TO OWN OR OPERATE AN ADULT MENTAL  
 9 HEALTH FACILITY WITHOUT HAVING APPLIED FOR AND OBTAINED A LICENSE  
 10 FROM THE DEPARTMENT; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE  
 11 OF 1972, TO PROVIDE THAT MENTAL HEALTH SERVICES PROVIDED BY ADULT  
 12 RESIDENTIAL TREATMENT FACILITIES AND ADULT SUPPORTIVE RESIDENTIAL  
 13 FACILITIES SHALL BE COVERED UNDER THE MEDICAID PROGRAM; TO  
 14 PRESCRIBE THE INITIAL FEE SCHEDULES FOR THE FOUR LEVELS OF CARE  
 15 PROVIDED IN THOSE FACILITIES; TO DIRECT THE DIVISION OF MEDICAID  
 16 TO APPLY FOR A FEDERAL WAIVER AS NECESSARY TO ALLOW FOR THE  
 17 IMPLEMENTATION OF THE PROVISIONS OF THIS ACT; TO EXTEND THE DATE  
 18 OF THE REPEALER ON THAT SECTION; AND FOR RELATED PURPOSES.

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

20 **SECTION 1.** (1) As used in this section, the following terms  
 21 shall be defined as provided in this subsection:

22 (a) "Adult mental health facility" or "facility" means  
 23 an adult residential treatment facility or an adult supportive  
 24 residential facility.

25 (b) "Adult residential treatment facility" means a  
 26 mental health treatment program that offers twenty-four-hour



27 intensive, coordinated, and structured services for adult service  
28 recipients within a nonpermanent therapeutic milieu that focuses  
29 on enabling a service recipient to move to a less restrictive  
30 setting.

31 (c) "Adult supportive residential facility" means a  
32 mental health residential program that provides twenty-four-hour  
33 residential care with a treatment and rehabilitation component  
34 less intensive than required in an adult residential treatment  
35 facility. Coordinated and structured services are provided for  
36 adult service recipients that include personal care services,  
37 training in community living skills, vocational skills, and/or  
38 socialization. Access to medical services, social services, and  
39 mental health services are ensured and are usually provided  
40 off-site, although limited mental health treatment and  
41 rehabilitation may be provided on site.

42 (d) "Board" means the State Board of Mental Health.

43 (e) "Department" means the State Department of Mental  
44 Health.

45 (2) The department shall license and regulate adult mental  
46 health facilities, and the board shall adopt rules for the  
47 administration of a program for adult mental health facilities.  
48 Such rules shall provide for facility requirements and minimum  
49 programmatic, staffing and operational requirements of services  
50 offered at the facilities. At a minimum, the rules shall address  
51 the adequacy of services, qualifications of professional staff,



52 facility conditions, consideration of the adequacy of environment,  
53 life safety, treatment or habilitation services, educational and  
54 training requirements of the staff, fees for the issuance and  
55 renewal of licenses, and such other considerations as are deemed  
56 necessary by the board to determine the adequacy of providing  
57 services in adult mental health facilities.

58 (3) (a) Any person, partnership, association, corporation  
59 or other entity must obtain a license from the department in order  
60 to lawfully establish, conduct, operate or maintain an adult  
61 mental health facility.

62 (b) It is unlawful for any person, partnership,  
63 association, corporation or other entity to own or operate an  
64 adult mental health facility without having applied for and  
65 obtained a license from the department.

66 (c) The department may maintain an action to enjoin any  
67 person, partnership, association, corporation or other entity from  
68 establishing, conducting, managing or operating an adult mental  
69 health facility without having a license issued by the department.

70 (4) The department may suspend or revoke a license or impose  
71 fines on licensees for violation of any of the provisions of this  
72 section or the rules adopted by the board for the implementation  
73 of this section.

74 **SECTION 2.** Section 43-13-117, Mississippi Code of 1972, is  
75 amended as follows:



76           43-13-117. (A) Medicaid as authorized by this article shall  
77 include payment of part or all of the costs, at the discretion of  
78 the division, with approval of the Governor and the Centers for  
79 Medicare and Medicaid Services, of the following types of care and  
80 services rendered to eligible applicants who have been determined  
81 to be eligible for that care and services, within the limits of  
82 state appropriations and federal matching funds:

83                   (1) Inpatient hospital services.

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

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

93                   (2) Outpatient hospital services.

94                           (a) Emergency services.

95                           (b) Other outpatient hospital services. The  
96 division shall allow benefits for other medically necessary  
97 outpatient hospital services (such as chemotherapy, radiation,  
98 surgery and therapy), including outpatient services in a clinic or  
99 other facility that is not located inside the hospital, but that  
100 has been designated as an outpatient facility by the hospital, and



101 that was in operation or under construction on July 1, 2009,  
102 provided that the costs and charges associated with the operation  
103 of the hospital clinic are included in the hospital's cost report.  
104 In addition, the Medicare thirty-five-mile rule will apply to  
105 those hospital clinics not located inside the hospital that are  
106 constructed after July 1, 2009. Where the same services are  
107 reimbursed as clinic services, the division may revise the rate or  
108 methodology of outpatient reimbursement to maintain consistency,  
109 efficiency, economy and quality of care.

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

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



126 (3) Laboratory and x-ray services.

127 (4) Nursing facility services.

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

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

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



150                   (d) On or after January 1, 2015, the division  
151 shall update the case-mix payment system resource utilization  
152 grouper and classifications and fair rental reimbursement system.  
153 The division shall develop and implement a payment add-on to  
154 reimburse nursing facilities for ventilator-dependent resident  
155 services.

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

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

173                   The division shall apply for necessary federal waivers to  
174 assure that additional services providing alternatives to nursing



175 facility care are made available to applicants for nursing  
176 facility care.

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





200 funds that are provided from the appropriation to the Department  
201 of Human Services to obtain federal matching funds through the  
202 division.

203           (6) Physician services. Fees for physician's services  
204 that are covered only by Medicaid shall be reimbursed at ninety  
205 percent (90%) of the rate established on January 1, 2018, and as  
206 may be adjusted each July thereafter, under Medicare. The  
207 division may provide for a reimbursement rate for physician's  
208 services of up to one hundred percent (100%) of the rate  
209 established under Medicare for physician's services that are  
210 provided after the normal working hours of the physician, as  
211 determined in accordance with regulations of the division. The  
212 division may reimburse eligible providers, as determined by the  
213 division, for certain primary care services at one hundred percent  
214 (100%) of the rate established under Medicare. The division shall  
215 reimburse obstetricians and gynecologists for certain primary care  
216 services as defined by the division at one hundred percent (100%)  
217 of the rate established under Medicare.

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



225 certify and recertify eligibility for home health services and  
226 conduct the required initial face-to-face visit with the recipient  
227 of the services.

228 (b) [Repealed]

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

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

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

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

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



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

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

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

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



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

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

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

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

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



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

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

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

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

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

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

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



323 The division shall increase the amount of the reimbursement rate  
324 for restorative dental services for each of the fiscal years 2023,  
325 2024 and 2025 by five percent (5%) above the amount of the  
326 reimbursement rate for the previous fiscal year. It is the intent  
327 of the Legislature that the reimbursement rate revision for  
328 preventative dental services will be an incentive to increase the  
329 number of dentists who actively provide Medicaid services. This  
330 dental services reimbursement rate revision shall be known as the  
331 "James Russell Dumas Medicaid Dental Services Incentive Program."

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

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

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



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

353 (12) Intermediate care facility services.

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

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

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

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

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



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

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

378 (b) Dialysis center services.

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

384 (16) Mental health services. Certain services provided  
385 by a psychiatrist shall be reimbursed at up to one hundred percent  
386 (100%) of the Medicare rate. Approved therapeutic and case  
387 management services (a) provided by an approved regional mental  
388 health/intellectual disability center established under Sections  
389 41-19-31 through 41-19-39, or by another community mental health  
390 service provider meeting the requirements of the Department of  
391 Mental Health to be an approved mental health/intellectual  
392 disability center if determined necessary by the Department of  
393 Mental Health, using state funds that are provided in the  
394 appropriation to the division to match federal funds, or (b)  
395 provided by a facility that is certified by the State Department  
396 of Mental Health to provide therapeutic and case management  
397 services, to be reimbursed on a fee for service basis, or (c)





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

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

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



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

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

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



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

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



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

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



498 supplemental payments based upon Medicaid utilization, quality,  
499 service lines and/or costs of providing such services to Medicaid  
500 beneficiaries and to uninsured patients. The goals of such  
501 payment models shall be to ensure access to inpatient and  
502 outpatient care and to maximize any federal funds that are  
503 available to reimburse hospitals for services provided. Any such  
504 documents required to achieve the goals described in this  
505 paragraph shall be submitted to the Centers for Medicare and  
506 Medicaid Services, with a proposed effective date of July 1, 2019,  
507 to the extent possible, but in no event shall the effective date  
508 of such payment models be later than July 1, 2020. The Chairmen  
509 of the Senate and House Medicaid Committees shall be provided a  
510 copy of the proposed payment model(s) prior to submission.  
511 Effective July 1, 2018, and until such time as any payment  
512 model(s) as described above become effective, the division, in  
513 consultation with the hospital industry, is authorized to  
514 implement a transitional program for inpatient and outpatient  
515 payments and/or supplemental payments (including, but not limited  
516 to, MHAP and directed payments), to redistribute available  
517 supplemental funds among hospital providers, provided that when  
518 compared to a hospital's prior year supplemental payments,  
519 supplemental payments made pursuant to any such transitional  
520 program shall not result in a decrease of more than five percent  
521 (5%) and shall not increase by more than the amount needed to  
522 maximize the distribution of the available funds.



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

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

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

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



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

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

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

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



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

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

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

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





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

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

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



622 services for Medicaid eligible children with special needs who are  
623 eligible for the state's early intervention system.

624 Qualifications for persons providing service coordination shall be  
625 determined by the State Department of Health and the Division of  
626 Medicaid.

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

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



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

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

668           (23) Inpatient psychiatric services.

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



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

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

692 (24) [Deleted]

693 (25) [Deleted]

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



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

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

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

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



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

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

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

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

738 (33) Podiatrist services.

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

744 (35) Services and activities authorized in Sections  
745 43-27-101 and 43-27-103, using state funds that are provided from



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

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

760           (37) [Deleted]

761           (38) Chiropractic services. A chiropractor's manual  
762 manipulation of the spine to correct a subluxation, if x-ray  
763 demonstrates that a subluxation exists and if the subluxation has  
764 resulted in a neuromusculoskeletal condition for which  
765 manipulation is appropriate treatment, and related spinal x-rays  
766 performed to document these conditions. Reimbursement for  
767 chiropractic services shall not exceed Seven Hundred Dollars  
768 (\$700.00) per year per beneficiary.

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



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

777 (40) [Deleted]

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

788 (42) [Deleted]

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

794 (44) Nursing facility services for the severely  
795 disabled.





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

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

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

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



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

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

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

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

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

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



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

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

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

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

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



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

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

882 (54) [Deleted]

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



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

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

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

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



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

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

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

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



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

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

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

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

959 (61) Mental health services provided by licensed adult  
960 residential treatment facilities and adult supportive residential  
961 facilities licensed under Section 1 of this act. The initial fee  
962 schedules for the four (4) levels of care provided in those  
963 facilities shall be as follows: basic supportive living services  
964 - Eighty-eight Dollars (\$88.00) per day; enhanced supportive  
965 living services - One Hundred Sixty Dollars (\$160.00) per day;  
966 medically fragile services - Two Hundred Ninety Dollars (\$290.00)  
967 per day; and adult residential treatment services - Three Hundred  
968 Fourteen Dollars and Eighty-two Cents (\$314.82) per day.



969           The Division of Medicaid shall apply to the United States  
970 Secretary of Health and Human Services for a federal waiver of the  
971 applicable provisions of Title XIX of the federal Social Security  
972 Act, as amended, and any other applicable provisions of federal  
973 law as necessary to allow for the implementation of this paragraph  
974 (61). The provisions of this paragraph (61) shall be implemented  
975 from and after the date that the Division of Medicaid receives the  
976 federal waiver.

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

982           (C) The division may pay to those providers who participate  
983 in and accept patient referrals from the division's emergency room  
984 redirection program a percentage, as determined by the division,  
985 of savings achieved according to the performance measures and  
986 reduction of costs required of that program. Federally qualified  
987 health centers may participate in the emergency room redirection  
988 program, and the division may pay those centers a percentage of  
989 any savings to the Medicaid program achieved by the centers'  
990 accepting patient referrals through the program, as provided in  
991 this subsection (C).





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

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

998 (b) "Rate change" means an increase, decrease or  
999 other change in the payments or rates of reimbursement, or a  
1000 change in any payment methodology that results in an increase,  
1001 decrease or other change in the payments or rates of  
1002 reimbursement, to any Medicaid provider that renders any services  
1003 authorized to be provided to Medicaid recipients under this  
1004 article.

1005 (2) Whenever the Division of Medicaid proposes a rate  
1006 change, the division shall give notice to the chairmen of the  
1007 committees at least thirty (30) calendar days before the proposed  
1008 rate change is scheduled to take effect. The division shall  
1009 furnish the chairmen with a concise summary of each proposed rate  
1010 change along with the notice, and shall furnish the chairmen with  
1011 a copy of any proposed rate change upon request. The division  
1012 also shall provide a summary and copy of any proposed rate change  
1013 to any other member of the Legislature upon request.

1014 (3) If the chairman of either committee or both  
1015 chairmen jointly object to the proposed rate change or any part  
1016 thereof, the chairman or chairmen shall notify the division and



1017 provide the reasons for their objection in writing not later than  
1018 seven (7) calendar days after receipt of the notice from the  
1019 division. The chairman or chairmen may make written  
1020 recommendations to the division for changes to be made to a  
1021 proposed rate change.

1022 (4) (a) The chairman of either committee or both  
1023 chairmen jointly may hold a committee meeting to review a proposed  
1024 rate change. If either chairman or both chairmen decide to hold a  
1025 meeting, they shall notify the division of their intention in  
1026 writing within seven (7) calendar days after receipt of the notice  
1027 from the division, and shall set the date and time for the meeting  
1028 in their notice to the division, which shall not be later than  
1029 fourteen (14) calendar days after receipt of the notice from the  
1030 division.

1031 (b) After the committee meeting, the committee or  
1032 committees may object to the proposed rate change or any part  
1033 thereof. The committee or committees shall notify the division  
1034 and the reasons for their objection in writing not later than  
1035 seven (7) calendar days after the meeting. The committee or  
1036 committees may make written recommendations to the division for  
1037 changes to be made to a proposed rate change.

1038 (5) If both chairmen notify the division in writing  
1039 within seven (7) calendar days after receipt of the notice from  
1040 the division that they do not object to the proposed rate change  
1041 and will not be holding a meeting to review the proposed rate



1042 change, the proposed rate change will take effect on the original  
1043 date as scheduled by the division or on such other date as  
1044 specified by the division.

1045 (6) (a) If there are any objections to a proposed rate  
1046 change or any part thereof from either or both of the chairmen or  
1047 the committees, the division may withdraw the proposed rate  
1048 change, make any of the recommended changes to the proposed rate  
1049 change, or not make any changes to the proposed rate change.

1050 (b) If the division does not make any changes to  
1051 the proposed rate change, it shall notify the chairmen of that  
1052 fact in writing, and the proposed rate change shall take effect on  
1053 the original date as scheduled by the division or on such other  
1054 date as specified by the division.

1055 (c) If the division makes any changes to the  
1056 proposed rate change, the division shall notify the chairmen of  
1057 its actions in writing, and the revised proposed rate change shall  
1058 take effect on the date as specified by the division.

1059 (7) Nothing in this subsection (D) shall be construed  
1060 as giving the chairmen or the committees any authority to veto,  
1061 nullify or revise any rate change proposed by the division. The  
1062 authority of the chairmen or the committees under this subsection  
1063 shall be limited to reviewing, making objections to and making  
1064 recommendations for changes to rate changes proposed by the  
1065 division.



1066 (E) Notwithstanding any provision of this article, no new  
1067 groups or categories of recipients and new types of care and  
1068 services may be added without enabling legislation from the  
1069 Mississippi Legislature, except that the division may authorize  
1070 those changes without enabling legislation when the addition of  
1071 recipients or services is ordered by a court of proper authority.

1072 (F) The executive director shall keep the Governor advised  
1073 on a timely basis of the funds available for expenditure and the  
1074 projected expenditures. Notwithstanding any other provisions of  
1075 this article, if current or projected expenditures of the division  
1076 are reasonably anticipated to exceed the amount of funds  
1077 appropriated to the division for any fiscal year, the Governor,  
1078 after consultation with the executive director, shall take all  
1079 appropriate measures to reduce costs, which may include, but are  
1080 not limited to:

1081 (1) Reducing or discontinuing any or all services that  
1082 are deemed to be optional under Title XIX of the Social Security  
1083 Act;

1084 (2) Reducing reimbursement rates for any or all service  
1085 types;

1086 (3) Imposing additional assessments on health care  
1087 providers; or

1088 (4) Any additional cost-containment measures deemed  
1089 appropriate by the Governor.



1090 To the extent allowed under federal law, any reduction to  
1091 services or reimbursement rates under this subsection (F) shall be  
1092 accompanied by a reduction, to the fullest allowable amount, to  
1093 the profit margin and administrative fee portions of capitated  
1094 payments to organizations described in paragraph (1) of subsection  
1095 (H).

1096 Beginning in fiscal year 2010 and in fiscal years thereafter,  
1097 when Medicaid expenditures are projected to exceed funds available  
1098 for the fiscal year, the division shall submit the expected  
1099 shortfall information to the PEER Committee not later than  
1100 December 1 of the year in which the shortfall is projected to  
1101 occur. PEER shall review the computations of the division and  
1102 report its findings to the Legislative Budget Office not later  
1103 than January 7 in any year.

1104 (G) Notwithstanding any other provision of this article, it  
1105 shall be the duty of each provider participating in the Medicaid  
1106 program to keep and maintain books, documents and other records as  
1107 prescribed by the Division of Medicaid in accordance with federal  
1108 laws and regulations.

1109 (H) (1) Notwithstanding any other provision of this  
1110 article, the division is authorized to implement (a) a managed  
1111 care program, (b) a coordinated care program, (c) a coordinated  
1112 care organization program, (d) a health maintenance organization  
1113 program, (e) a patient-centered medical home program, (f) an  
1114 accountable care organization program, (g) provider-sponsored



1115 health plan, or (h) any combination of the above programs. As a  
1116 condition for the approval of any program under this subsection  
1117 (H)(1), the division shall require that no managed care program,  
1118 coordinated care program, coordinated care organization program,  
1119 health maintenance organization program, or provider-sponsored  
1120 health plan may:

1121                   (a) Pay providers at a rate that is less than the  
1122 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)  
1123 reimbursement rate;

1124                   (b) Override the medical decisions of hospital  
1125 physicians or staff regarding patients admitted to a hospital for  
1126 an emergency medical condition as defined by 42 US Code Section  
1127 1395dd. This restriction (b) does not prohibit the retrospective  
1128 review of the appropriateness of the determination that an  
1129 emergency medical condition exists by chart review or coding  
1130 algorithm, nor does it prohibit prior authorization for  
1131 nonemergency hospital admissions;

1132                   (c) Pay providers at a rate that is less than the  
1133 normal Medicaid reimbursement rate. It is the intent of the  
1134 Legislature that all managed care entities described in this  
1135 subsection (H), in collaboration with the division, develop and  
1136 implement innovative payment models that incentivize improvements  
1137 in health care quality, outcomes, or value, as determined by the  
1138 division. Participation in the provider network of any managed  
1139 care, coordinated care, provider-sponsored health plan, or similar



1140 contractor shall not be conditioned on the provider's agreement to  
1141 accept such alternative payment models;

1142 (d) Implement a prior authorization and  
1143 utilization review program for medical services, transportation  
1144 services and prescription drugs that is more stringent than the  
1145 prior authorization processes used by the division in its  
1146 administration of the Medicaid program. Not later than December  
1147 2, 2021, the contractors that are receiving capitated payments  
1148 under a managed care delivery system established under this  
1149 subsection (H) shall submit a report to the Chairmen of the House  
1150 and Senate Medicaid Committees on the status of the prior  
1151 authorization and utilization review program for medical services,  
1152 transportation services and prescription drugs that is required to  
1153 be implemented under this subparagraph (d);

1154 (e) [Deleted]

1155 (f) Implement a preferred drug list that is more  
1156 stringent than the mandatory preferred drug list established by  
1157 the division under subsection (A) (9) of this section;

1158 (g) Implement a policy which denies beneficiaries  
1159 with hemophilia access to the federally funded hemophilia  
1160 treatment centers as part of the Medicaid Managed Care network of  
1161 providers.

1162 Each health maintenance organization, coordinated care  
1163 organization, provider-sponsored health plan, or other  
1164 organization paid for services on a capitated basis by the



1165 division under any managed care program or coordinated care  
1166 program implemented by the division under this section shall use a  
1167 clear set of level of care guidelines in the determination of  
1168 medical necessity and in all utilization management practices,  
1169 including the prior authorization process, concurrent reviews,  
1170 retrospective reviews and payments, that are consistent with  
1171 widely accepted professional standards of care. Organizations  
1172 participating in a managed care program or coordinated care  
1173 program implemented by the division may not use any additional  
1174 criteria that would result in denial of care that would be  
1175 determined appropriate and, therefore, medically necessary under  
1176 those levels of care guidelines.

1177 (2) Notwithstanding any provision of this section, the  
1178 recipients eligible for enrollment into a Medicaid Managed Care  
1179 Program authorized under this subsection (H) may include only  
1180 those categories of recipients eligible for participation in the  
1181 Medicaid Managed Care Program as of January 1, 2021, the  
1182 Children's Health Insurance Program (CHIP), and the CMS-approved  
1183 Section 1115 demonstration waivers in operation as of January 1,  
1184 2021. No expansion of Medicaid Managed Care Program contracts may  
1185 be implemented by the division without enabling legislation from  
1186 the Mississippi Legislature.

1187 (3) (a) Any contractors receiving capitated payments  
1188 under a managed care delivery system established in this section  
1189 shall provide to the Legislature and the division statistical data





1190 to be shared with provider groups in order to improve patient  
1191 access, appropriate utilization, cost savings and health outcomes  
1192 not later than October 1 of each year. Additionally, each  
1193 contractor shall disclose to the Chairmen of the Senate and House  
1194 Medicaid Committees the administrative expenses costs for the  
1195 prior calendar year, and the number of full-equivalent employees  
1196 located in the State of Mississippi dedicated to the Medicaid and  
1197 CHIP lines of business as of June 30 of the current year.

1198 (b) The division and the contractors participating  
1199 in the managed care program, a coordinated care program or a  
1200 provider-sponsored health plan shall be subject to annual program  
1201 reviews or audits performed by the Office of the State Auditor,  
1202 the PEER Committee, the Department of Insurance and/or independent  
1203 third parties.

1204 (c) Those reviews shall include, but not be  
1205 limited to, at least two (2) of the following items:

1206 (i) The financial benefit to the State of  
1207 Mississippi of the managed care program,

1208 (ii) The difference between the premiums paid  
1209 to the managed care contractors and the payments made by those  
1210 contractors to health care providers,

1211 (iii) Compliance with performance measures  
1212 required under the contracts,

1213 (iv) Administrative expense allocation  
1214 methodologies,



1215 (v) Whether nonprovider payments assigned as  
1216 medical expenses are appropriate,  
1217 (vi) Capitated arrangements with related  
1218 party subcontractors,  
1219 (vii) Reasonableness of corporate  
1220 allocations,  
1221 (viii) Value-added benefits and the extent to  
1222 which they are used,  
1223 (ix) The effectiveness of subcontractor  
1224 oversight, including subcontractor review,  
1225 (x) Whether health care outcomes have been  
1226 improved, and  
1227 (xi) The most common claim denial codes to  
1228 determine the reasons for the denials.

1229 The audit reports shall be considered public documents and  
1230 shall be posted in their entirety on the division's website.

1231 (4) All health maintenance organizations, coordinated  
1232 care organizations, provider-sponsored health plans, or other  
1233 organizations paid for services on a capitated basis by the  
1234 division under any managed care program or coordinated care  
1235 program implemented by the division under this section shall  
1236 reimburse all providers in those organizations at rates no lower  
1237 than those provided under this section for beneficiaries who are  
1238 not participating in those programs.



1239           (5) No health maintenance organization, coordinated  
1240 care organization, provider-sponsored health plan, or other  
1241 organization paid for services on a capitated basis by the  
1242 division under any managed care program or coordinated care  
1243 program implemented by the division under this section shall  
1244 require its providers or beneficiaries to use any pharmacy that  
1245 ships, mails or delivers prescription drugs or legend drugs or  
1246 devices.

1247           (6) (a) Not later than December 1, 2021, the  
1248 contractors who are receiving capitated payments under a managed  
1249 care delivery system established under this subsection (H) shall  
1250 develop and implement a uniform credentialing process for  
1251 providers. Under that uniform credentialing process, a provider  
1252 who meets the criteria for credentialing will be credentialed with  
1253 all of those contractors and no such provider will have to be  
1254 separately credentialed by any individual contractor in order to  
1255 receive reimbursement from the contractor. Not later than  
1256 December 2, 2021, those contractors shall submit a report to the  
1257 Chairmen of the House and Senate Medicaid Committees on the status  
1258 of the uniform credentialing process for providers that is  
1259 required under this subparagraph (a).

1260           (b) If those contractors have not implemented a  
1261 uniform credentialing process as described in subparagraph (a) by  
1262 December 1, 2021, the division shall develop and implement, not  
1263 later than July 1, 2022, a single, consolidated credentialing



1264 process by which all providers will be credentialed. Under the  
1265 division's single, consolidated credentialing process, no such  
1266 contractor shall require its providers to be separately  
1267 credentialed by the contractor in order to receive reimbursement  
1268 from the contractor, but those contractors shall recognize the  
1269 credentialing of the providers by the division's credentialing  
1270 process.

1271 (c) The division shall require a uniform provider  
1272 credentialing application that shall be used in the credentialing  
1273 process that is established under subparagraph (a) or (b). If the  
1274 contractor or division, as applicable, has not approved or denied  
1275 the provider credentialing application within sixty (60) days of  
1276 receipt of the completed application that includes all required  
1277 information necessary for credentialing, then the contractor or  
1278 division, upon receipt of a written request from the applicant and  
1279 within five (5) business days of its receipt, shall issue a  
1280 temporary provider credential/enrollment to the applicant if the  
1281 applicant has a valid Mississippi professional or occupational  
1282 license to provide the health care services to which the  
1283 credential/enrollment would apply. The contractor or the division  
1284 shall not issue a temporary credential/enrollment if the applicant  
1285 has reported on the application a history of medical or other  
1286 professional or occupational malpractice claims, a history of  
1287 substance abuse or mental health issues, a criminal record, or a  
1288 history of medical or other licensing board, state or federal



1289 disciplinary action, including any suspension from participation  
1290 in a federal or state program. The temporary  
1291 credential/enrollment shall be effective upon issuance and shall  
1292 remain in effect until the provider's credentialing/enrollment  
1293 application is approved or denied by the contractor or division.  
1294 The contractor or division shall render a final decision regarding  
1295 credentialing/enrollment of the provider within sixty (60) days  
1296 from the date that the temporary provider credential/enrollment is  
1297 issued to the applicant.

1298 (d) If the contractor or division does not render  
1299 a final decision regarding credentialing/enrollment of the  
1300 provider within the time required in subparagraph (c), the  
1301 provider shall be deemed to be credentialed by and enrolled with  
1302 all of the contractors and eligible to receive reimbursement from  
1303 the contractors.

1304 (7) (a) Each contractor that is receiving capitated  
1305 payments under a managed care delivery system established under  
1306 this subsection (H) shall provide to each provider for whom the  
1307 contractor has denied the coverage of a procedure that was ordered  
1308 or requested by the provider for or on behalf of a patient, a  
1309 letter that provides a detailed explanation of the reasons for the  
1310 denial of coverage of the procedure and the name and the  
1311 credentials of the person who denied the coverage. The letter  
1312 shall be sent to the provider in electronic format.



1313                   (b) After a contractor that is receiving capitated  
1314 payments under a managed care delivery system established under  
1315 this subsection (H) has denied coverage for a claim submitted by a  
1316 provider, the contractor shall issue to the provider within sixty  
1317 (60) days a final ruling of denial of the claim that allows the  
1318 provider to have a state fair hearing and/or agency appeal with  
1319 the division. If a contractor does not issue a final ruling of  
1320 denial within sixty (60) days as required by this subparagraph  
1321 (b), the provider's claim shall be deemed to be automatically  
1322 approved and the contractor shall pay the amount of the claim to  
1323 the provider.

1324                   (c) After a contractor has issued a final ruling  
1325 of denial of a claim submitted by a provider, the division shall  
1326 conduct a state fair hearing and/or agency appeal on the matter of  
1327 the disputed claim between the contractor and the provider within  
1328 sixty (60) days, and shall render a decision on the matter within  
1329 thirty (30) days after the date of the hearing and/or appeal.

1330                   (8) It is the intention of the Legislature that the  
1331 division evaluate the feasibility of using a single vendor to  
1332 administer pharmacy benefits provided under a managed care  
1333 delivery system established under this subsection (H). Providers  
1334 of pharmacy benefits shall cooperate with the division in any  
1335 transition to a carve-out of pharmacy benefits under managed care.

1336                   (9) The division shall evaluate the feasibility of  
1337 using a single vendor to administer dental benefits provided under



1338 a managed care delivery system established in this subsection (H).  
1339 Providers of dental benefits shall cooperate with the division in  
1340 any transition to a carve-out of dental benefits under managed  
1341 care.

1342 (10) It is the intent of the Legislature that any  
1343 contractor receiving capitated payments under a managed care  
1344 delivery system established in this section shall implement  
1345 innovative programs to improve the health and well-being of  
1346 members diagnosed with prediabetes and diabetes.

1347 (11) It is the intent of the Legislature that any  
1348 contractors receiving capitated payments under a managed care  
1349 delivery system established under this subsection (H) shall work  
1350 with providers of Medicaid services to improve the utilization of  
1351 long-acting reversible contraceptives (LARCs). Not later than  
1352 December 1, 2021, any contractors receiving capitated payments  
1353 under a managed care delivery system established under this  
1354 subsection (H) shall provide to the Chairmen of the House and  
1355 Senate Medicaid Committees and House and Senate Public Health  
1356 Committees a report of LARC utilization for State Fiscal Years  
1357 2018 through 2020 as well as any programs, initiatives, or efforts  
1358 made by the contractors and providers to increase LARC  
1359 utilization. This report shall be updated annually to include  
1360 information for subsequent state fiscal years.

1361 (12) The division is authorized to make not more than  
1362 one (1) emergency extension of the contracts that are in effect on



1363 July 1, 2021, with contractors who are receiving capitated  
1364 payments under a managed care delivery system established under  
1365 this subsection (H), as provided in this paragraph (12). The  
1366 maximum period of any such extension shall be one (1) year, and  
1367 under any such extensions, the contractors shall be subject to all  
1368 of the provisions of this subsection (H). The extended contracts  
1369 shall be revised to incorporate any provisions of this subsection  
1370 (H).

1371 (I) [Deleted]

1372 (J) There shall be no cuts in inpatient and outpatient  
1373 hospital payments, or allowable days or volumes, as long as the  
1374 hospital assessment provided in Section 43-13-145 is in effect.  
1375 This subsection (J) shall not apply to decreases in payments that  
1376 are a result of: reduced hospital admissions, audits or payments  
1377 under the APR-DRG or APC models, or a managed care program or  
1378 similar model described in subsection (H) of this section.

1379 (K) In the negotiation and execution of such contracts  
1380 involving services performed by actuarial firms, the Executive  
1381 Director of the Division of Medicaid may negotiate a limitation on  
1382 liability to the state of prospective contractors.

1383 (L) The Division of Medicaid shall reimburse for services  
1384 provided to eligible Medicaid beneficiaries by a licensed birthing  
1385 center in a method and manner to be determined by the division in  
1386 accordance with federal laws and federal regulations. The  
1387 division shall seek any necessary waivers, make any required





1388 amendments to its State Plan or revise any contracts authorized  
1389 under subsection (H) of this section as necessary to provide the  
1390 services authorized under this subsection. As used in this  
1391 subsection, the term "birthing centers" shall have the meaning as  
1392 defined in Section 41-77-1(a), which is a publicly or privately  
1393 owned facility, place or institution constructed, renovated,  
1394 leased or otherwise established where nonemergency births are  
1395 planned to occur away from the mother's usual residence following  
1396 a documented period of prenatal care for a normal uncomplicated  
1397 pregnancy which has been determined to be low risk through a  
1398 formal risk-scoring examination.

1399 (M) This section shall stand repealed on July 1, \* \* \* 2028.

1400 **SECTION 3.** This act shall take effect and be in force from  
1401 and after July 1, 2024.

