MISSISSIPPI LEGISLATURE REGULAR SESSION 2024

By: Representative Hobgood-Wilkes To: Medicaid

HOUSE BILL NO. 1468

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO REQUIRE THE DIVISION OF MEDICAID, IN ESTABLISHING AND
3 MAINTAINING A MANDATORY PREFERRED DRUG LIST, TO ENSURE THAT NO
4 NONOPIOID DRUG APPROVED BY THE UNITED STATES FOOD AND DRUG
5 ADMINISTRATION FOR THE TREATMENT OR MANAGEMENT OF PAIN WILL BE
6 DISADVANTAGED OR DISCOURAGED WITH RESPECT TO COVERAGE RELATIVE TO
7 ANY OPIOID OR NARCOTIC DRUG FOR THE TREATMENT OR MANAGEMENT OF
8 PAIN ON SUCH PREFERRED DRUG LIST; TO EXTEND THE DATE OF THE
9 REPEALER ON THE SECTION; AND FOR RELATED PURPOSES.

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

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

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

20 (1) Inpatient hospital services.

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

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

70 before Christmas, the day after Christmas, Thanksgiving, the day
71 before Thanksgiving and the day after Thanksgiving.

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

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

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

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

95 by time studies and other valid statistical data that will
96 reimburse a nursing facility for the additional cost of caring for
97 a resident who has a diagnosis of Alzheimer's or other related
98 dementia and exhibits symptoms that require special care. Any
99 such case-mix add-on payment shall be supported by a determination
100 of additional cost. The division shall also develop and implement
101 as part of the fair rental reimbursement system for nursing
102 facility beds, an Alzheimer's resident bed depreciation enhanced
103 reimbursement system that will provide an incentive to encourage
104 nursing facilities to convert or construct beds for residents with
105 Alzheimer's or other related dementia.
106 (f) The division shall develop and implement an
107 assessment process for long-term care services. The division may
108 provide the assessment and related functions directly or through
109 contract with the area agencies on aging.
110 The division shall apply for necessary federal waivers to
111 assure that additional services providing alternatives to nursing
112 facility care are made available to applicants for nursing
113 facility care.
114 (5) Periodic screening and diagnostic services for
115 individuals under age twenty-one (21) years as are needed to
116 identify physical and mental defects and to provide health care
117 treatment and other measures designed to correct or ameliorate
118 defects and physical and mental illness and conditions discovered
119 by the screening services, regardless of whether these services

120 are included in the state plan. The division may include in its
121 periodic screening and diagnostic program those discretionary
122 services authorized under the federal regulations adopted to
123 implement Title XIX of the federal Social Security Act, as
124 amended. The division, in obtaining physical therapy services,
125 occupational therapy services, and services for individuals with
126 speech, hearing and language disorders, may enter into a
127 cooperative agreement with the State Department of Education for
128 the provision of those services to handicapped students by public
129 school districts using state funds that are provided from the
130 appropriation to the Department of Education to obtain federal
131 matching funds through the division. The division, in obtaining
132 medical and mental health assessments, treatment, care and
133 services for children who are in, or at risk of being put in, the
134 custody of the Mississippi Department of Human Services may enter
135 into a cooperative agreement with the Mississippi Department of
136 Human Services for the provision of those services using state
137 funds that are provided from the appropriation to the Department
138 of Human Services to obtain federal matching funds through the
139 division.
140 (6) Physician services. Fees for physician's services
141 that are covered only by Medicaid shall be reimbursed at ninety
142 percent (90%) of the rate established on January 1, 2018, and as
143 may be adjusted each July thereafter, under Medicare. The
144 division may provide for a reimbursement rate for physician's

145 services of up to one hundred percent (100%) of the rate
146 established under Medicare for physician's services that are
147 provided after the normal working hours of the physician, as
148 determined in accordance with regulations of the division. The
149 division may reimburse eligible providers, as determined by the
150 division, for certain primary care services at one hundred percent
151 (100%) of the rate established under Medicare. The division shall
152 reimburse obstetricians and gynecologists for certain primary care
153 services as defined by the division at one hundred percent (100%)
154 of the rate established under Medicare.
155 (7) (a) Home health services for eligible persons, not
156 to exceed in cost the prevailing cost of nursing facility
157 services. All home health visits must be precertified as required
158 by the division. In addition to physicians, certified registered
159 nurse practitioners, physician assistants and clinical nurse
160 specialists are authorized to prescribe or order home health
161 services and plans of care, sign home health plans of care,
162 certify and recertify eligibility for home health services and
163 conduct the required initial face-to-face visit with the recipient
164 of the services.
165 (b) [Repealed]
166 (8) Emergency medical transportation services as
167 determined by the division.
168 (9) Prescription drugs and other covered drugs and
169 services as determined by the division.

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

174 In establishing and maintaining the mandatory preferred drug
175 list, the division shall ensure that no nonopioid drug approved by
176 the United States Food and Drug Administration for the treatment
177 or management of pain will be disadvantaged or discouraged with
178 respect to coverage relative to any opioid or narcotic drug for
179 the treatment or management of pain on such preferred drug list.
180 Impermissible disadvantaging or discouragement includes, without
181 limitation, designating any such nonopioid drug as a nonpreferred
182 drug if any opioid or narcotic drug is designated as a preferred
183 drug; or establishing more restrictive or more extensive
184 utilization controls, including, but not limited to, more
185 restrictive or more extensive prior authorization or step therapy
186 requirements, for such nonopioid drug than the least restrictive
187 or extensive utilization controls applicable to any such opioid or
188 narcotic drug. This paragraph shall apply to a nonopioid drug
189 immediately upon its approval by the United States Food and Drug
190 Administration for the treatment or management of pain, regardless
191 of whether such drug has been reviewed by the division for
192 inclusion on the preferred drug list. This paragraph also applies
193 to drugs being provided under a contract between the

194 division and any managed care organization or other organization
195 or entity administering a program or plan described in subsection
196 (H)(1) of this section.
197 The division may seek to establish relationships with other
198 states in order to lower acquisition costs of prescription drugs
199 to include single-source and innovator multiple-source drugs or
200 generic drugs. In addition, if allowed by federal law or
201 regulation, the division may seek to establish relationships with
202 and negotiate with other countries to facilitate the acquisition
203 of prescription drugs to include single-source and innovator
204 multiple-source drugs or generic drugs, if that will lower the
205 acquisition costs of those prescription drugs.
206 The division may allow for a combination of prescriptions for
207 single-source and innovator multiple-source drugs and generic
208 drugs to meet the needs of the beneficiaries.
209 The executive director may approve specific maintenance drugs
210 for beneficiaries with certain medical conditions, which may be
211 prescribed and dispensed in three-month supply increments.
212 Drugs prescribed for a resident of a psychiatric residential
213 treatment facility must be provided in true unit doses when
214 available. The division may require that drugs not covered by
215 Medicare Part D for a resident of a long-term care facility be
216 provided in true unit doses when available. Those drugs that were
217 originally billed to the division but are not used by a resident
218 in any of those facilities shall be returned to the billing

219 pharmacy for credit to the division, in accordance with the
220 guidelines of the State Board of Pharmacy and any requirements of
221 federal law and regulation. Drugs shall be dispensed to a
222 recipient and only one (1) dispensing fee per month may be
223 charged. The division shall develop a methodology for reimbursing
224 for restocked drugs, which shall include a restock fee as
225 determined by the division not exceeding Seven Dollars and
226 Eighty-two Cents ($7.82).

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

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

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

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

243 The division shall develop and implement a method or methods
244 by which the division will provide on a regular basis to Medicaid
245 providers who are authorized to prescribe drugs, information about
246 the costs to the Medicaid program of single-source drugs and
247 innovator multiple-source drugs, and information about other drugs
248 that may be prescribed as alternatives to those single-source
249 drugs and innovator multiple-source drugs and the costs to the
250 Medicaid program of those alternative drugs.
251 Notwithstanding any law or regulation, information obtained
252 or maintained by the division regarding the prescription drug
253 program, including trade secrets and manufacturer or labeler
254 pricing, is confidential and not subject to disclosure except to
255 other state agencies.
256 The dispensing fee for each new or refill prescription,
257 including nonlegend or over-the-counter drugs covered by the
258 division, shall be not less than Three Dollars and Ninety-one
259 Cents ($3.91), as determined by the division.
260 The division shall not reimburse for single-source or
261 innovator multiple-source drugs if there are equally effective
262 generic equivalents available and if the generic equivalents are
263 the least expensive.
264 It is the intent of the Legislature that the pharmacists
265 providers be reimbursed for the reasonable costs of filling and
266 dispensing prescriptions for Medicaid beneficiaries.

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

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

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

279 The division shall increase the amount of the reimbursement
280 rate for diagnostic and preventative dental services for each of
281 the fiscal years 2022, 2023 and 2024 by five percent (5%) above
282 the amount of the reimbursement rate for the previous fiscal year.
283 The division shall increase the amount of the reimbursement rate
284 for restorative dental services for each of the fiscal years 2023,
285 2024 and 2025 by five percent (5%) above the amount of the
286 reimbursement rate for the previous fiscal year. It is the intent
287 of the Legislature that the reimbursement rate revision for
288 preventative dental services will be an incentive to increase the
289 number of dentists who actively provide Medicaid services. This
290 dental services reimbursement rate revision shall be known as the
291 "James Russell Dumas Medicaid Dental Services Incentive Program."

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

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

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

313 (12) Intermediate care facility services.

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

317 year, that a patient is absent from the facility on home leave.
318 Payment may be made for the following home leave days in addition
319 to the sixty-three-day limitation: Christmas, the day before
320 Christmas, the day after Christmas, Thanksgiving, the day before
321 Thanksgiving and the day after Thanksgiving.
322 (b) All state-owned intermediate care facilities
323 for individuals with intellectual disabilities shall be reimbursed
324 on a full reasonable cost basis.
325 (c) Effective January 1, 2015, the division shall
326 update the fair rental reimbursement system for intermediate care
327 facilities for individuals with intellectual disabilities.
328 (13) Family planning services, including drugs,
329 supplies and devices, when those services are under the
330 supervision of a physician or nurse practitioner.
331 (14) Clinic services. Preventive, diagnostic,
332 therapeutic, rehabilitative or palliative services that are
333 furnished by a facility that is not part of a hospital but is
334 organized and operated to provide medical care to outpatients.
335 Clinic services include, but are not limited to:
336 (a) Services provided by ambulatory surgical
337 centers (ACSs) as defined in Section 41-75-1(a); and
338 (b) Dialysis center services.
339 (15) Home- and community-based services for the elderly
340 and disabled, as provided under Title XIX of the federal Social
341 Security Act, as amended, under waivers, subject to the

342 availability of funds specifically appropriated for that purpose
343 by the Legislature.
344 (16) Mental health services. Certain services provided
345 by a psychiatrist shall be reimbursed at up to one hundred percent
346 (100%) of the Medicare rate. Approved therapeutic and case
347 management services (a) provided by an approved regional mental
348 health/intellectual disability center established under Sections
349 41-19-31 through 41-19-39, or by another community mental health
350 service provider meeting the requirements of the Department of
351 Mental Health to be an approved mental health/intellectual
352 disability center if determined necessary by the Department of
353 Mental Health, using state funds that are provided in the
354 appropriation to the division to match federal funds, or (b)
355 provided by a facility that is certified by the State Department
356 of Mental Health to provide therapeutic and case management
357 services, to be reimbursed on a fee for service basis, or (c)
358 provided in the community by a facility or program operated by the
359 Department of Mental Health. Any such services provided by a
360 facility described in subparagraph (b) must have the prior
361 approval of the division to be reimbursable under this section.
362 (17) Durable medical equipment services and medical
363 supplies. Precertification of durable medical equipment and
364 medical supplies must be obtained as required by the division.
365 The Division of Medicaid may require durable medical equipment
366 providers to obtain a surety bond in the amount and to the

367 specifications as established by the Balanced Budget Act of 1997.
368 A maximum dollar amount of reimbursement for noninvasive
369 ventilators or ventilation treatments properly ordered and being
370 used in an appropriate care setting shall not be set by any health
371 maintenance organization, coordinated care organization,
372 provider-sponsored health plan, or other organization paid for
373 services on a capitated basis by the division under any managed
374 care program or coordinated care program implemented by the
375 division under this section. Reimbursement by these organizations
376 to durable medical equipment suppliers for home use of noninvasive
377 and invasive ventilators shall be on a continuous monthly payment
378 basis for the duration of medical need throughout a patient's
379 valid prescription period.
380 (18) (a) Notwithstanding any other provision of this
381 section to the contrary, as provided in the Medicaid state plan
382 amendment or amendments as defined in Section 43-13-145(10), the
383 division shall make additional reimbursement to hospitals that
384 serve a disproportionate share of low-income patients and that
385 meet the federal requirements for those payments as provided in
386 Section 1923 of the federal Social Security Act and any applicable
387 regulations. It is the intent of the Legislature that the
388 division shall draw down all available federal funds allotted to
389 the state for disproportionate share hospitals. However, from and
390 after January 1, 1999, public hospitals participating in the
391 Medicaid disproportionate share program may be required to

392 participate in an intergovernmental transfer program as provided
393 in Section 1903 of the federal Social Security Act and any
394 applicable regulations.

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

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

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

417 division, consistent with federal regulations. The assessments
418 will remain in effect as long as the state participates in the
419 Medicare Upper Payment Limits Program or other program(s)
420 authorized under this subsection (A)(18)(b). In addition to the
421 hospital assessment provided in Section 43-13-145(4)(a), hospitals
422 with physicians participating in the Medicare Upper Payment Limits
423 Program or other program(s) authorized under this subsection
424 (A)(18)(b) shall be required to participate in an
425 intergovernmental transfer or assessment, as determined by the
426 division, for the purpose of financing the state portion of the
427 physician UPL payments or other payment(s) authorized under this
428 subsection (A)(18)(b).
429 (iii) Subject to approval by the Centers for
430 Medicare and Medicaid Services (CMS) and the provisions of this
431 subsection (A)(18)(b), the division shall make additional
432 reimbursement to hospitals, nursing facilities, and emergency
433 ambulance transportation providers for the Medicare Upper Payment
434 Limits Program or other program(s) authorized under this
435 subsection (A)(18)(b), and, if the program is established for
436 physicians, shall make additional reimbursement for physicians, as
437 defined in Section 1902(a)(30) of the federal Social Security Act
438 and any applicable federal regulations, provided the assessment in
439 this subsection (A)(18)(b) is in effect.
440 (iv) Notwithstanding any other provision of
441 this article to the contrary, effective upon implementation of the

442 Mississippi Hospital Access Program (MHAP) provided in
443 subparagraph (c)(i) below, the hospital portion of the inpatient
444 Upper Payment Limits Program shall transition into and be replaced
445 by the MHAP program. However, the division is authorized to
446 develop and implement an alternative fee-for-service Upper Payment
447 Limits model in accordance with federal laws and regulations if
448 necessary to preserve supplemental funding. Further, the
449 division, in consultation with the hospital industry shall develop
450 alternative models for distribution of medical claims and
451 supplemental payments for inpatient and outpatient hospital
452 services, and such models may include, but shall not be limited to
453 the following: increasing rates for inpatient and outpatient
454 services; creating a low-income utilization pool of funds to
455 reimburse hospitals for the costs of uncompensated care, charity
456 care and bad debts as permitted and approved pursuant to federal
457 regulations and the Centers for Medicare and Medicaid Services;
458 supplemental payments based upon Medicaid utilization, quality,
459 service lines and/or costs of providing such services to Medicaid
460 beneficiaries and to uninsured patients. The goals of such
461 payment models shall be to ensure access to inpatient and
462 outpatient care and to maximize any federal funds that are
463 available to reimburse hospitals for services provided. Any such
464 documents required to achieve the goals described in this
465 paragraph shall be submitted to the Centers for Medicare and
466 Medicaid Services, with a proposed effective date of July 1, 2019,

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

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

490 2. The division shall calculate the
491 ambulance service access payment amount as the balance of the

492 portion of the Medical Care Fund related to ambulance
493 transportation service provider assessments plus any federal
494 matching funds earned on the balance, up to, but not to exceed,
495 the upper payment limit gap for all emergency ambulance service
496 providers.

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

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

511 c. As used in this paragraph
512 (18)(b)(v), the term "upper payment limit gap" means the
513 difference between the total amount that the ambulance
514 transportation service provider received from Medicaid and the
515 average amount that the ambulance transportation service provider

516 would have received from commercial insurers for those services
517 reimbursed by Medicaid.

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

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

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

541 such other payments permissible under federal law necessary to
542 accomplish the intent of this subsection.
543 (iii) The intent of this subparagraph (c) is
544 that effective for all inpatient hospital Medicaid services during
545 state fiscal year 2016, and so long as this provision shall remain
546 in effect hereafter, the division shall to the fullest extent
547 feasible replace the additional reimbursement for hospital
548 inpatient services under the inpatient Medicare Upper Payment
549 Limits (UPL) Program with additional reimbursement under the MHAP
550 and other payment programs for inpatient and/or outpatient
551 payments which may be developed under the authority of this
552 paragraph.
553 (iv) The division shall assess each hospital
554 as provided in Section 43-13-145(4)(a) for the purpose of
555 financing the state portion of the MHAP, supplemental payments and
556 such other purposes as specified in Section 43-13-145. The
557 assessment will remain in effect as long as the MHAP and
558 supplemental payments are in effect.
559 (19) (a) Perinatal risk management services. The
560 division shall promulgate regulations to be effective from and
561 after October 1, 1988, to establish a comprehensive perinatal
562 system for risk assessment of all pregnant and infant Medicaid
563 recipients and for management, education and follow-up for those
564 who are determined to be at risk. Services to be performed
565 include case management, nutrition assessment/counseling,

566 psychosocial assessment/counseling and health education. The
567 division shall contract with the State Department of Health to
568 provide services within this paragraph (Perinatal High Risk
569 Management/Infant Services System (PHRM/ISS)). The State
570 Department of Health shall be reimbursed on a full reasonable cost
571 basis for services provided under this subparagraph (a).
572 (b) Early intervention system services. The
573 division shall cooperate with the State Department of Health,
574 acting as lead agency, in the development and implementation of a
575 statewide system of delivery of early intervention services, under
576 Part C of the Individuals with Disabilities Education Act (IDEA).
577 The State Department of Health shall certify annually in writing
578 to the executive director of the division the dollar amount of
579 state early intervention funds available that will be utilized as
580 a certified match for Medicaid matching funds. Those funds then
581 shall be used to provide expanded targeted case management
582 services for Medicaid eligible children with special needs who are
583 eligible for the state's early intervention system.
584 Qualifications for persons providing service coordination shall be
585 determined by the State Department of Health and the Division of
586 Medicaid.
587 (20) Home- and community-based services for physically
588 disabled approved services as allowed by a waiver from the United
589 States Department of Health and Human Services for home- and
590 community-based services for physically disabled people using

591 state funds that are provided from the appropriation to the State
592 Department of Rehabilitation Services and used to match federal
593 funds under a cooperative agreement between the division and the
594 department, provided that funds for these services are
595 specifically appropriated to the Department of Rehabilitation
596 Services.

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

613 (22) Ambulatory services delivered in federally
614 qualified health centers, rural health centers and clinics of the
615 local health departments of the State Department of Health for

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

628 (23) Inpatient psychiatric services.

629 (a) Inpatient psychiatric services to be
630 determined by the division for recipients under age twenty-one
631 (21) that are provided under the direction of a physician in an
632 inpatient program in a licensed acute care psychiatric facility or
633 in a licensed psychiatric residential treatment facility, before
634 the recipient reaches age twenty-one (21) or, if the recipient was
635 receiving the services immediately before he or she reached age
636 twenty-one (21), before the earlier of the date he or she no
637 longer requires the services or the date he or she reaches age
638 twenty-two (22), as provided by federal regulations. From and
639 after January 1, 2015, the division shall update the fair rental
640 reimbursement system for psychiatric residential treatment

641 facilities. Precertification of inpatient days and residential
642 treatment days must be obtained as required by the division. From
643 and after July 1, 2009, all state-owned and state-operated
644 facilities that provide inpatient psychiatric services to persons
645 under age twenty-one (21) who are eligible for Medicaid
646 reimbursement shall be reimbursed for those services on a full
647 reasonable cost basis.

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

652 (24) [Deleted]

653 (25) [Deleted]

654 (26) Hospice care. As used in this paragraph, the term
655 "hospice care" means a coordinated program of active professional
656 medical attention within the home and outpatient and inpatient
657 care that treats the terminally ill patient and family as a unit,
658 employing a medically directed interdisciplinary team. The
659 program provides relief of severe pain or other physical symptoms
660 and supportive care to meet the special needs arising out of
661 physical, psychological, spiritual, social and economic stresses
662 that are experienced during the final stages of illness and during
663 dying and bereavement and meets the Medicare requirements for
664 participation as a hospice as provided in federal regulations.

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

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

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

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

686 (31) Targeted case management services for children
687 with special needs, under waivers from the United States
688 Department of Health and Human Services, using state funds that
689 are provided from the appropriation to the Mississippi Department

690 of Human Services and used to match federal funds under a
691 cooperative agreement between the division and the department.
692 (32) Care and services provided in Christian Science
693 Sanatoria listed and certified by the Commission for Accreditation
694 of Christian Science Nursing Organizations/Facilities, Inc.,
695 rendered in connection with treatment by prayer or spiritual means
696 to the extent that those services are subject to reimbursement
697 under Section 1903 of the federal Social Security Act.
698 (33) Podiatrist services.
699 (34) Assisted living services as provided through
700 home- and community-based services under Title XIX of the federal
701 Social Security Act, as amended, subject to the availability of
702 funds specifically appropriated for that purpose by the
703 Legislature.
704 (35) Services and activities authorized in Sections
705 43-27-101 and 43-27-103, using state funds that are provided from
706 the appropriation to the Mississippi Department of Human Services
707 and used to match federal funds under a cooperative agreement
708 between the division and the department.
709 (36) Nonemergency transportation services for
710 Medicaid-eligible persons as determined by the division. The PEER
711 Committee shall conduct a performance evaluation of the
712 nonemergency transportation program to evaluate the administration
713 of the program and the providers of transportation services to
714 determine the most cost-effective ways of providing nonemergency

715 transportation services to the patients served under the program.
716 The performance evaluation shall be completed and provided to the
717 members of the Senate Medicaid Committee and the House Medicaid
718 Committee not later than January 1, 2019, and every two (2) years
719 thereafter.

720 (37) [Deleted]

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

729 (39) Dually eligible Medicare/Medicaid beneficiaries.
730 The division shall pay the Medicare deductible and coinsurance
731 amounts for services available under Medicare, as determined by
732 the division. From and after July 1, 2009, the division shall
733 reimburse crossover claims for inpatient hospital services and
734 crossover claims covered under Medicare Part B in the same manner
735 that was in effect on January 1, 2008, unless specifically
736 authorized by the Legislature to change this method.

737 (40) [Deleted]

738 (41) Services provided by the State Department of
739 Rehabilitation Services for the care and rehabilitation of persons

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

748 (42) [Deleted]

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

754 (44) Nursing facility services for the severely
755 disabled.

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

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

762 (45) Physician assistant services. Services furnished
763 by a physician assistant who is licensed by the State Board of
764 Medical Licensure and is practicing with physician supervision

765 under regulations adopted by the board, under regulations adopted
766 by the division. Reimbursement for those services shall not
767 exceed ninety percent (90%) of the reimbursement rate for
768 comparable services rendered by a physician. The division may
769 provide for a reimbursement rate for physician assistant services
770 of up to one hundred percent (100%) or the reimbursement rate for
771 comparable services rendered by a physician for physician
772 assistant services that are provided after the normal working
773 hours of the physician assistant, as determined in accordance with
774 regulations of the division.
775 (46) The division shall make application to the federal
776 Centers for Medicare and Medicaid Services (CMS) for a waiver to
777 develop and provide services for children with serious emotional
778 disturbances as defined in Section 43-14-1(1), which may include
779 home- and community-based services, case management services or
780 managed care services through mental health providers certified by
781 the Department of Mental Health. The division may implement and
782 provide services under this waivered program only if funds for
783 these services are specifically appropriated for this purpose by
784 the Legislature, or if funds are voluntarily provided by affected
785 agencies.
786 (47) (a) The division may develop and implement
787 disease management programs for individuals with high-cost chronic
788 diseases and conditions, including the use of grants, waivers,
789 demonstrations or other projects as necessary.

790 (b) Participation in any disease management
791 program implemented under this paragraph (47) is optional with the
792 individual. An individual must affirmatively elect to participate
793 in the disease management program in order to participate, and may
794 elect to discontinue participation in the program at any time.
795 (48) Pediatric long-term acute care hospital services.
796 (a) Pediatric long-term acute care hospital
797 services means services provided to eligible persons under
798 twenty-one (21) years of age by a freestanding Medicare-certified
799 hospital that has an average length of inpatient stay greater than
800 twenty-five (25) days and that is primarily engaged in providing
801 chronic or long-term medical care to persons under twenty-one (21)
802 years of age.
803 (b) The services under this paragraph (48) shall
804 be reimbursed as a separate category of hospital services.
805 (49) The division may establish copayments and/or
806 coinsurance for any Medicaid services for which copayments and/or
807 coinsurance are allowable under federal law or regulation.
808 (50) Services provided by the State Department of
809 Rehabilitation Services for the care and rehabilitation of persons
810 who are deaf and blind, as allowed under waivers from the United
811 States Department of Health and Human Services to provide home-
812 and community-based services using state funds that are provided
813 from the appropriation to the State Department of Rehabilitation
814 Services or if funds are voluntarily provided by another agency.

815 (51) Upon determination of Medicaid eligibility and in
816 association with annual redetermination of Medicaid eligibility,
817 beneficiaries shall be encouraged to undertake a physical
818 examination that will establish a base-line level of health and
819 identification of a usual and customary source of care (a medical
820 home) to aid utilization of disease management tools. This
821 physical examination and utilization of these disease management
822 tools shall be consistent with current United States Preventive
823 Services Task Force or other recognized authority recommendations.
824 For persons who are determined ineligible for Medicaid, the
825 division will provide information and direction for accessing
826 medical care and services in the area of their residence.
827 (52) Notwithstanding any provisions of this article,
828 the division may pay enhanced reimbursement fees related to trauma
829 care, as determined by the division in conjunction with the State
830 Department of Health, using funds appropriated to the State
831 Department of Health for trauma care and services and used to
832 match federal funds under a cooperative agreement between the
833 division and the State Department of Health. The division, in
834 conjunction with the State Department of Health, may use grants,
835 waivers, demonstrations, enhanced reimbursements, Upper Payment
836 Limits Programs, supplemental payments, or other projects as
837 necessary in the development and implementation of this
838 reimbursement program.

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

842 (54) [Deleted]

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

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

860 (57) No Medicaid benefit shall restrict coverage for
861 medically appropriate treatment prescribed by a physician and
862 agreed to by a fully informed individual, or if the individual
863 lacks legal capacity to consent by a person who has legal

864 authority to consent on his or her behalf, based on an
865 individual's diagnosis with a terminal condition. As used in this
866 paragraph (57), "terminal condition" means any aggressive
867 malignancy, chronic end-stage cardiovascular or cerebral vascular
868 disease, or any other disease, illness or condition which a
869 physician diagnoses as terminal.
870 (58) Treatment services for persons with opioid
871 dependency or other highly addictive substance use disorders. The
872 division is authorized to reimburse eligible providers for
873 treatment of opioid dependency and other highly addictive
874 substance use disorders, as determined by the division. Treatment
875 related to these conditions shall not count against any physician
876 visit limit imposed under this section.
877 (59) The division shall allow beneficiaries between the
878 ages of ten (10) and eighteen (18) years to receive vaccines
879 through a pharmacy venue. The division and the State Department
880 of Health shall coordinate and notify OB-GYN providers that the
881 Vaccines for Children program is available to providers free of
882 charge.
883 (60) Border city university-affiliated pediatric
884 teaching hospital.
885 (a) Payments may only be made to a border city
886 university-affiliated pediatric teaching hospital if the Centers
887 for Medicare and Medicaid Services (CMS) approve an increase in
888 the annual request for the provider payment initiative authorized

889 under 42 CFR Section 438.6(c) in an amount equal to or greater
890 than the estimated annual payment to be made to the border city
891 university-affiliated pediatric teaching hospital. The estimate
892 shall be based on the hospital's prior year Mississippi managed
893 care utilization.

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

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

912 (d) It is the intent of the Legislature that
913 payments shall not result in any in-state hospital receiving

914 payments lower than they would otherwise receive if not for the
915 payments made to any border city university-affiliated pediatric
916 teaching hospital.

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

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

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

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

937 (a) "Committees" means the Medicaid Committees of
938 the House of Representatives and the Senate, and "committee" means
939 either one of those committees.
940 (b) "Rate change" means an increase, decrease or
941 other change in the payments or rates of reimbursement, or a
942 change in any payment methodology that results in an increase,
943 decrease or other change in the payments or rates of
944 reimbursement, to any Medicaid provider that renders any services
945 authorized to be provided to Medicaid recipients under this
946 article.
947 (2) Whenever the Division of Medicaid proposes a rate
948 change, the division shall give notice to the chairmen of the
949 committees at least thirty (30) calendar days before the proposed
950 rate change is scheduled to take effect. The division shall
951 furnish the chairmen with a concise summary of each proposed rate
952 change along with the notice, and shall furnish the chairmen with
953 a copy of any proposed rate change upon request. The division
954 also shall provide a summary and copy of any proposed rate change
955 to any other member of the Legislature upon request.
956 (3) If the chairman of either committee or both
957 chairmen jointly object to the proposed rate change or any part
958 thereof, the chairman or chairmen shall notify the division and
959 provide the reasons for their objection in writing not later than
960 seven (7) calendar days after receipt of the notice from the
961 division. The chairman or chairmen may make written

962 recommendations to the division for changes to be made to a
963 proposed rate change.

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

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

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

987 (6) (a) If there are any objections to a proposed rate
988 change or any part thereof from either or both of the chairmen or
989 the committees, the division may withdraw the proposed rate
990 change, make any of the recommended changes to the proposed rate
991 change, or not make any changes to the proposed rate change.
992 (b) If the division does not make any changes to
993 the proposed rate change, it shall notify the chairmen of that
994 fact in writing, and the proposed rate change shall take effect on
995 the original date as scheduled by the division or on such other
996 date as specified by the division.
997 (c) If the division makes any changes to the
998 proposed rate change, the division shall notify the chairmen of
999 its actions in writing, and the revised proposed rate change shall
1000 take effect on the date as specified by the division.
1001 (7) Nothing in this subsection (D) shall be construed
1002 as giving the chairmen or the committees any authority to veto,
1003 nullify or revise any rate change proposed by the division. The
1004 authority of the chairmen or the committees under this subsection
1005 shall be limited to reviewing, making objections to and making
1006 recommendations for changes to rate changes proposed by the
1007 division.
1008 (E) Notwithstanding any provision of this article, no new
1009 groups or categories of recipients and new types of care and
1010 services may be added without enabling legislation from the
1011 Mississippi Legislature, except that the division may authorize

1012 those changes without enabling legislation when the addition of
1013 recipients or services is ordered by a court of proper authority.
1014 (F) The executive director shall keep the Governor advised
1015 on a timely basis of the funds available for expenditure and the
1016 projected expenditures. Notwithstanding any other provisions of
1017 this article, if current or projected expenditures of the division
1018 are reasonably anticipated to exceed the amount of funds
1019 appropriated to the division for any fiscal year, the Governor,
1020 after consultation with the executive director, shall take all
1021 appropriate measures to reduce costs, which may include, but are
1022 not limited to:
1023 (1) Reducing or discontinuing any or all services that
1024 are deemed to be optional under Title XIX of the Social Security
1025 Act;
1026 (2) Reducing reimbursement rates for any or all service
1027 types;
1028 (3) Imposing additional assessments on health care
1029 providers; or
1030 (4) Any additional cost-containment measures deemed
1031 appropriate by the Governor.
1032 To the extent allowed under federal law, any reduction to
1033 services or reimbursement rates under this subsection (F) shall be
1034 accompanied by a reduction, to the fullest allowable amount, to
1035 the profit margin and administrative fee portions of capitated

1036 payments to organizations described in paragraph (1) of subsection
1037 (H).

1038 Beginning in fiscal year 2010 and in fiscal years thereafter,
1039 when Medicaid expenditures are projected to exceed funds available
1040 for the fiscal year, the division shall submit the expected
1041 shortfall information to the PEER Committee not later than
1042 December 1 of the year in which the shortfall is projected to
1043 occur. PEER shall review the computations of the division and
1044 report its findings to the Legislative Budget Office not later
1045 than January 7 in any year.

1046 (G) Notwithstanding any other provision of this article, it
1047 shall be the duty of each provider participating in the Medicaid
1048 program to keep and maintain books, documents and other records as
1049 prescribed by the Division of Medicaid in accordance with federal
1050 laws and regulations.

1051 (H) (1) Notwithstanding any other provision of this
1052 article, the division is authorized to implement (a) a managed
1053 care program, (b) a coordinated care program, (c) a coordinated
1054 care organization program, (d) a health maintenance organization
1055 program, (e) a patient-centered medical home program, (f) an
1056 accountable care organization program, (g) provider-sponsored
1057 health plan, or (h) any combination of the above programs. As a
1058 condition for the approval of any program under this subsection
1059 (H)(1), the division shall require that no managed care program,
1060 coordinated care program, coordinated care organization program,

1061 health maintenance organization program, or provider-sponsored
1062 health plan may:
1063 (a) Pay providers at a rate that is less than the
1064 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
1065 reimbursement rate;
1066 (b) Override the medical decisions of hospital
1067 physicians or staff regarding patients admitted to a hospital for
1068 an emergency medical condition as defined by 42 US Code Section
1069 1395dd. This restriction (b) does not prohibit the retrospective
1070 review of the appropriateness of the determination that an
1071 emergency medical condition exists by chart review or coding
1072 algorithm, nor does it prohibit prior authorization for
1073 nonemergency hospital admissions;
1074 (c) Pay providers at a rate that is less than the
1075 normal Medicaid reimbursement rate. It is the intent of the
1076 Legislature that all managed care entities described in this
1077 subsection (H), in collaboration with the division, develop and
1078 implement innovative payment models that incentivize improvements
1079 in health care quality, outcomes, or value, as determined by the
1080 division. Participation in the provider network of any managed
1081 care, coordinated care, provider-sponsored health plan, or similar
1082 contractor shall not be conditioned on the provider's agreement to
1083 accept such alternative payment models;
1084 (d) Implement a prior authorization and
1085 utilization review program for medical services, transportation

1086 services and prescription drugs that is more stringent than the
1087 prior authorization processes used by the division in its
1088 administration of the Medicaid program. Not later than December
1089 2, 2021, the contractors that are receiving capitated payments
1090 under a managed care delivery system established under this
1091 subsection (H) shall submit a report to the Chairmen of the House
1092 and Senate Medicaid Committees on the status of the prior
1093 authorization and utilization review program for medical services,
1094 transportation services and prescription drugs that is required to
1095 be implemented under this subparagraph (d);
1096 (e) [Deleted]
1097 (f) Implement a preferred drug list that is more
1098 stringent than the mandatory preferred drug list established by
1099 the division under subsection (A)(9) of this section. Such
1100 preferred drug list shall be subject to the provisions in
1101 subsection (A)(9) of this section applicable to any nonopioid drug
1102 approved by the United States Food and Drug Administration for the
1103 treatment or management of pain;
1104 (g) Implement a policy which denies beneficiaries
1105 with hemophilia access to the federally funded hemophilia
1106 treatment centers as part of the Medicaid Managed Care network of
1107 providers.
1108 Each health maintenance organization, coordinated care
1109 organization, provider-sponsored health plan, or other
1110 organization paid for services on a capitated basis by the

1111 division under any managed care program or coordinated care
1112 program implemented by the division under this section shall use a
1113 clear set of level of care guidelines in the determination of
1114 medical necessity and in all utilization management practices,
1115 including the prior authorization process, concurrent reviews,
1116 retrospective reviews and payments, that are consistent with
1117 widely accepted professional standards of care. Organizations
1118 participating in a managed care program or coordinated care
1119 program implemented by the division may not use any additional
1120 criteria that would result in denial of care that would be
1121 determined appropriate and, therefore, medically necessary under
1122 those levels of care guidelines.

1123 (2) Notwithstanding any provision of this section, the
1124 recipients eligible for enrollment into a Medicaid Managed Care
1125 Program authorized under this subsection (H) may include only
1126 those categories of recipients eligible for participation in the
1127 Medicaid Managed Care Program as of January 1, 2021, the
1128 Children's Health Insurance Program (CHIP), and the CMS-approved
1129 Section 1115 demonstration waivers in operation as of January 1,
1130 2021. No expansion of Medicaid Managed Care Program contracts may
1131 be implemented by the division without enabling legislation from
1132 the Mississippi Legislature.

1133 (3) (a) Any contractors receiving capitated payments
1134 under a managed care delivery system established in this section
1135 shall provide to the Legislature and the division statistical data

1136 to be shared with provider groups in order to improve patient
1137 access, appropriate utilization, cost savings and health outcomes
1138 not later than October 1 of each year. Additionally, each
1139 contractor shall disclose to the Chairmen of the Senate and House
1140 Medicaid Committees the administrative expenses costs for the
1141 prior calendar year, and the number of full-equivalent employees
1142 located in the State of Mississippi dedicated to the Medicaid and
1143 CHIP lines of business as of June 30 of the current year.
1144 (b) The division and the contractors participating
1145 in the managed care program, a coordinated care program or a
1146 provider-sponsored health plan shall be subject to annual program
1147 reviews or audits performed by the Office of the State Auditor,
1148 the PEER Committee, the Department of Insurance and/or independent
1149 third parties.
1150 (c) Those reviews shall include, but not be
1151 limited to, at least two (2) of the following items:
1152 (i) The financial benefit to the State of
1153 Mississippi of the managed care program,
1154 (ii) The difference between the premiums paid
1155 to the managed care contractors and the payments made by those
1156 contractors to health care providers,
1157 (iii) Compliance with performance measures
1158 required under the contracts,
1159 (iv) Administrative expense allocation
1160 methodologies,

1161 (v) Whether nonprovider payments assigned as
1162 medical expenses are appropriate,
1163 (vi) Capitated arrangements with related
1164 party subcontractors,
1165 (vii) Reasonableness of corporate
1166 allocations,
1167 (viii) Value-added benefits and the extent to
1168 which they are used,
1169 (ix) The effectiveness of subcontractor
1170 oversight, including subcontractor review,
1171 (x) Whether health care outcomes have been
1172 improved, and
1173 (xi) The most common claim denial codes to
1174 determine the reasons for the denials.
1175 The audit reports shall be considered public documents and
1176 shall be posted in their entirety on the division's website.
1177 (4) All health maintenance organizations, coordinated
1178 care organizations, provider-sponsored health plans, or other
1179 organizations paid for services on a capitated basis by the
1180 division under any managed care program or coordinated care
1181 program implemented by the division under this section shall
1182 reimburse all providers in those organizations at rates no lower
1183 than those provided under this section for beneficiaries who are
1184 not participating in those programs.

1185 (5) No health maintenance organization, coordinated
1186 care organization, provider-sponsored health plan, or other
1187 organization paid for services on a capitated basis by the
1188 division under any managed care program or coordinated care
1189 program implemented by the division under this section shall
1190 require its providers or beneficiaries to use any pharmacy that
1191 ships, mails or delivers prescription drugs or legend drugs or
1192 devices.

1193 (6) (a) Not later than December 1, 2021, the
1194 contractors who are receiving capitated payments under a managed
1195 care delivery system established under this subsection (H) shall
1196 develop and implement a uniform credentialing process for
1197 providers. Under that uniform credentialing process, a provider
1198 who meets the criteria for credentialing will be credentialed with
1199 all of those contractors and no such provider will have to be
1200 separately credentialed by any individual contractor in order to
1201 receive reimbursement from the contractor. Not later than
1202 December 2, 2021, those contractors shall submit a report to the
1203 Chairmen of the House and Senate Medicaid Committees on the status
1204 of the uniform credentialing process for providers that is
1205 required under this subparagraph (a).

1206 (b) If those contractors have not implemented a
1207 uniform credentialing process as described in subparagraph (a) by
1208 December 1, 2021, the division shall develop and implement, not
1209 later than July 1, 2022, a single, consolidated credentialing

1210 process by which all providers will be credentialed. Under the
1211 division's single, consolidated credentialing process, no such
1212 contractor shall require its providers to be separately
1213 credentialed by the contractor in order to receive reimbursement
1214 from the contractor, but those contractors shall recognize the
1215 credentialing of the providers by the division's credentialing
1216 process.
1217 (c) The division shall require a uniform provider
1218 credentialing application that shall be used in the credentialing
1219 process that is established under subparagraph (a) or (b). If the
1220 contractor or division, as applicable, has not approved or denied
1221 the provider credentialing application within sixty (60) days of
1222 receipt of the completed application that includes all required
1223 information necessary for credentialing, then the contractor or
1224 division, upon receipt of a written request from the applicant and
1225 within five (5) business days of its receipt, shall issue a
1226 temporary provider credential/enrollment to the applicant if the
1227 applicant has a valid Mississippi professional or occupational
1228 license to provide the health care services to which the
1229 credential/enrollment would apply. The contractor or the division
1230 shall not issue a temporary credential/enrollment if the applicant
1231 has reported on the application a history of medical or other
1232 professional or occupational malpractice claims, a history of
1233 substance abuse or mental health issues, a criminal record, or a
1234 history of medical or other licensing board, state or federal

1235 disciplinary action, including any suspension from participation
1236 in a federal or state program. The temporary
1237 credential/enrollment shall be effective upon issuance and shall
1238 remain in effect until the provider's credentialing/enrollment
1239 application is approved or denied by the contractor or division.
1240 The contractor or division shall render a final decision regarding
1241 credentialing/enrollment of the provider within sixty (60) days
1242 from the date that the temporary provider credential/enrollment is
1243 issued to the applicant.
1244 (d) If the contractor or division does not render
1245 a final decision regarding credentialing/enrollment of the
1246 provider within the time required in subparagraph (c), the
1247 provider shall be deemed to be credentialed by and enrolled with
1248 all of the contractors and eligible to receive reimbursement from
1249 the contractors.
1250 (7) (a) Each contractor that is receiving capitated
1251 payments under a managed care delivery system established under
1252 this subsection (H) shall provide to each provider for whom the
1253 contractor has denied the coverage of a procedure that was ordered
1254 or requested by the provider for or on behalf of a patient, a
1255 letter that provides a detailed explanation of the reasons for the
1256 denial of coverage of the procedure and the name and the
1257 credentials of the person who denied the coverage. The letter
1258 shall be sent to the provider in electronic format.

1259 (b) After a contractor that is receiving capitated
1260 payments under a managed care delivery system established under
1261 this subsection (H) has denied coverage for a claim submitted by a
1262 provider, the contractor shall issue to the provider within sixty
1263 (60) days a final ruling of denial of the claim that allows the
1264 provider to have a state fair hearing and/or agency appeal with
1265 the division. If a contractor does not issue a final ruling of
1266 denial within sixty (60) days as required by this subparagraph
1267 (b), the provider's claim shall be deemed to be automatically
1268 approved and the contractor shall pay the amount of the claim to
1269 the provider.
1270 (c) After a contractor has issued a final ruling
1271 of denial of a claim submitted by a provider, the division shall
1272 conduct a state fair hearing and/or agency appeal on the matter of
1273 the disputed claim between the contractor and the provider within
1274 sixty (60) days, and shall render a decision on the matter within
1275 thirty (30) days after the date of the hearing and/or appeal.
1276 (8) It is the intention of the Legislature that the
1277 division evaluate the feasibility of using a single vendor to
1278 administer pharmacy benefits provided under a managed care
1279 delivery system established under this subsection (H). Providers
1280 of pharmacy benefits shall cooperate with the division in any
1281 transition to a carve-out of pharmacy benefits under managed care.
1282 (9) The division shall evaluate the feasibility of
1283 using a single vendor to administer dental benefits provided under

1284 a managed care delivery system established in this subsection (H).
1285 Providers of dental benefits shall cooperate with the division in
1286 any transition to a carve-out of dental benefits under managed
1287 care.

1288 (10) It is the intent of the Legislature that any
1289 contractor receiving capitated payments under a managed care
1290 delivery system established in this section shall implement
1291 innovative programs to improve the health and well-being of
1292 members diagnosed with prediabetes and diabetes.

1293 (11) It is the intent of the Legislature that any
1294 contractors receiving capitated payments under a managed care
1295 delivery system established under this subsection (H) shall work
1296 with providers of Medicaid services to improve the utilization of
1297 long-acting reversible contraceptives (LARCs). Not later than
1298 December 1, 2021, any contractors receiving capitated payments
1299 under a managed care delivery system established under this
1300 subsection (H) shall provide to the Chairmen of the House and
1301 Senate Medicaid Committees and House and Senate Public Health
1302 Committees a report of LARC utilization for State Fiscal Years
1303 2018 through 2020 as well as any programs, initiatives, or efforts
1304 made by the contractors and providers to increase LARC
1305 utilization. This report shall be updated annually to include
1306 information for subsequent state fiscal years.

1307 (12) The division is authorized to make not more than
1308 one (1) emergency extension of the contracts that are in effect on

1309 July 1, 2021, with contractors who are receiving capitated
1310 payments under a managed care delivery system established under
1311 this subsection (H), as provided in this paragraph (12). The
1312 maximum period of any such extension shall be one (1) year, and
1313 under any such extensions, the contractors shall be subject to all
1314 of the provisions of this subsection (H). The extended contracts
1315 shall be revised to incorporate any provisions of this subsection
1316 (H).

1317 (I) [Deleted]

1318 (J) There shall be no cuts in inpatient and outpatient
1319 hospital payments, or allowable days or volumes, as long as the
1320 hospital assessment provided in Section 43-13-145 is in effect.
1321 This subsection (J) shall not apply to decreases in payments that
1322 are a result of: reduced hospital admissions, audits or payments
1323 under the APR-DRG or APC models, or a managed care program or
1324 similar model described in subsection (H) of this section.

1325 (K) In the negotiation and execution of such contracts
1326 involving services performed by actuarial firms, the Executive
1327 Director of the Division of Medicaid may negotiate a limitation on
1328 liability to the state of prospective contractors.

1329 (L) The Division of Medicaid shall reimburse for services
1330 provided to eligible Medicaid beneficiaries by a licensed birthing
1331 center in a method and manner to be determined by the division in
1332 accordance with federal laws and federal regulations. The
1333 division shall seek any necessary waivers, make any required

1334 amendments to its State Plan or revise any contracts authorized
1335 under subsection (H) of this section as necessary to provide the
1336 services authorized under this subsection. As used in this
1337 subsection, the term "birthing centers" shall have the meaning as
1338 defined in Section 41-77-1(a), which is a publicly or privately
1339 owned facility, place or institution constructed, renovated,
1340 leased or otherwise established where nonemergency births are
1341 planned to occur away from the mother's usual residence following
1342 a documented period of prenatal care for a normal uncomplicated
1343 pregnancy which has been determined to be low risk through a
1344 formal risk-scoring examination.

1345 (M) This section shall stand repealed on July 1, *** * *** 2028.

1346 **SECTION 2.** This act shall take effect and be in force from
1347 and after July 1, 2024.