By: Senator(s) Turner-Ford To: Medicaid; Appropriations

SENATE BILL NO. 2045

1 AN ACT TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972,
2 TO REVISE MEDICAID ELIGIBILITY TO INCLUDE THOSE INDIVIDUALS WHO
3 ARE ENTITLED TO BENEFITS UNDER THE FEDERAL PATIENT PROTECTION AND
4 AFFORDABLE CARE ACT OF 2010 (ACA), AS AMENDED; TO AMEND SECTION
5 43-13-117, MISSISSIPPI CODE OF 1972, TO INCLUDE ESSENTIAL HEALTH
6 BENEFITS FOR INDIVIDUALS ELIGIBLE FOR MEDICAID UNDER THE FEDERAL
7 PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 (ACA), AS
8 AMENDED; AND FOR RELATED PURPOSES.

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

10 **SECTION 1.** Section 43-13-115, Mississippi Code of 1972, is
11 amended as follows:

12 43-13-115. Recipients of Medicaid shall be the following
13 persons only:

14 (1) Those who are qualified for public assistance
15 grants under provisions of Title IV-A and E of the federal Social
16 Security Act, as amended, including those statutorily deemed to be
17 IV-A and low income families and children under Section 1931 of
18 the federal Social Security Act. For the purposes of this
19 paragraph (1) and paragraphs (8), (17) and (18) of this section,
20 any reference to Title IV-A or to Part A of Title IV of the
21 federal Social Security Act, as amended, or the state plan under

22 Title IV-A or Part A of Title IV, shall be considered as a
23 reference to Title IV-A of the federal Social Security Act, as
24 amended, and the state plan under Title IV-A, including the income
25 and resource standards and methodologies under Title IV-A and the
26 state plan, as they existed on July 16, 1996. The Department of
27 Human Services shall determine Medicaid eligibility for children
28 receiving public assistance grants under Title IV-E. The division
29 shall determine eligibility for low income families under Section
30 1931 of the federal Social Security Act and shall redetermine
31 eligibility for those continuing under Title IV-A grants.

32 (2) Those qualified for Supplemental Security Income
33 (SSI) benefits under Title XVI of the federal Social Security Act,
34 as amended, and those who are deemed SSI eligible as contained in
35 federal statute. The eligibility of individuals covered in this
36 paragraph shall be determined by the Social Security
37 Administration and certified to the Division of Medicaid.

38 (3) Qualified pregnant women who would be eligible for
39 Medicaid as a low income family member under Section 1931 of the
40 federal Social Security Act if her child were born. The
41 eligibility of the individuals covered under this paragraph shall
42 be determined by the division.

43 (4) [Deleted]

44 (5) A child born on or after October 1, 1984, to a
45 woman eligible for and receiving Medicaid under the state plan on
46 the date of the child's birth shall be deemed to have applied for

47 Medicaid and to have been found eligible for Medicaid under the
48 plan on the date of that birth, and will remain eligible for
49 Medicaid for a period of one (1) year so long as the child is a
50 member of the woman's household and the woman remains eligible for
51 Medicaid or would be eligible for Medicaid if pregnant. The
52 eligibility of individuals covered in this paragraph shall be
53 determined by the Division of Medicaid.

54 (6) Children certified by the State Department of Human
55 Services to the Division of Medicaid of whom the state and county
56 departments of human services have custody and financial
57 responsibility, and children who are in adoptions subsidized in
58 full or part by the Department of Human Services, including
59 special needs children in non-Title IV-E adoption assistance, who
60 are approvable under Title XIX of the Medicaid program. The
61 eligibility of the children covered under this paragraph shall be
62 determined by the State Department of Human Services.

63 (7) Persons certified by the Division of Medicaid who
64 are patients in a medical facility (nursing home, hospital,
65 tuberculosis sanatorium or institution for treatment of mental
66 diseases), and who, except for the fact that they are patients in
67 that medical facility, would qualify for grants under Title IV,
68 Supplementary Security Income (SSI) benefits under Title XVI or
69 state supplements, and those aged, blind and disabled persons who
70 would not be eligible for Supplemental Security Income (SSI)
71 benefits under Title XVI or state supplements if they were not

72 institutionalized in a medical facility but whose income is below
73 the maximum standard set by the Division of Medicaid, which
74 standard shall not exceed that prescribed by federal regulation.
75 (8) Children under eighteen (18) years of age and
76 pregnant women (including those in intact families) who meet the
77 financial standards of the state plan approved under Title IV-A of
78 the federal Social Security Act, as amended. The eligibility of
79 children covered under this paragraph shall be determined by the
80 Division of Medicaid.
81 (9) Individuals who are:
82 (a) Children born after September 30, 1983, who
83 have not attained the age of nineteen (19), with family income
84 that does not exceed one hundred percent (100%) of the nonfarm
85 official poverty level;
86 (b) Pregnant women, infants and children who have
87 not attained the age of six (6), with family income that does not
88 exceed one hundred thirty-three percent (133%) of the federal
89 poverty level; and
90 (c) Pregnant women and infants who have not
91 attained the age of one (1), with family income that does not
92 exceed one hundred eighty-five percent (185%) of the federal
93 poverty level.
94 The eligibility of individuals covered in (a), (b) and (c) of
95 this paragraph shall be determined by the division.

96 (10) Certain disabled children age eighteen (18) or
97 under who are living at home, who would be eligible, if in a
98 medical institution, for SSI or a state supplemental payment under
99 Title XVI of the federal Social Security Act, as amended, and
100 therefore for Medicaid under the plan, and for whom the state has
101 made a determination as required under Section 1902(e)(3)(b) of
102 the federal Social Security Act, as amended. The eligibility of
103 individuals under this paragraph shall be determined by the
104 Division of Medicaid.
105 (11) Until the end of the day on December 31, 2005,
106 individuals who are sixty-five (65) years of age or older or are
107 disabled as determined under Section 1614(a)(3) of the federal
108 Social Security Act, as amended, and whose income does not exceed
109 one hundred thirty-five percent (135%) of the nonfarm official
110 poverty level as defined by the Office of Management and Budget
111 and revised annually, and whose resources do not exceed those
112 established by the Division of Medicaid. The eligibility of
113 individuals covered under this paragraph shall be determined by
114 the Division of Medicaid. After December 31, 2005, only those
115 individuals covered under the 1115(c) Healthier Mississippi waiver
116 will be covered under this category.
117 Any individual who applied for Medicaid during the period
118 from July 1, 2004, through March 31, 2005, who otherwise would
119 have been eligible for coverage under this paragraph (11) if it
120 had been in effect at the time the individual submitted his or her

121 application and is still eligible for coverage under this
122 paragraph (11) on March 31, 2005, shall be eligible for Medicaid
123 coverage under this paragraph (11) from March 31, 2005, through
124 December 31, 2005. The division shall give priority in processing
125 the applications for those individuals to determine their
126 eligibility under this paragraph (11).

127 (12) Individuals who are qualified Medicare
128 beneficiaries (QMB) entitled to Part A Medicare as defined under
129 Section 301, Public Law 100-360, known as the Medicare
130 Catastrophic Coverage Act of 1988, and whose income does not
131 exceed one hundred percent (100%) of the nonfarm official poverty
132 level as defined by the Office of Management and Budget and
133 revised annually.

134 The eligibility of individuals covered under this paragraph
135 shall be determined by the Division of Medicaid, and those
136 individuals determined eligible shall receive Medicare
137 cost-sharing expenses only as more fully defined by the Medicare
138 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
139 1997.

140 (13) (a) Individuals who are entitled to Medicare Part
141 A as defined in Section 4501 of the Omnibus Budget Reconciliation
142 Act of 1990, and whose income does not exceed one hundred twenty
143 percent (120%) of the nonfarm official poverty level as defined by
144 the Office of Management and Budget and revised annually.

145 Eligibility for Medicaid benefits is limited to full payment of
146 Medicare Part B premiums.
147 (b) Individuals entitled to Part A of Medicare,
148 with income above one hundred twenty percent (120%), but less than
149 one hundred thirty-five percent (135%) of the federal poverty
150 level, and not otherwise eligible for Medicaid. Eligibility for
151 Medicaid benefits is limited to full payment of Medicare Part B
152 premiums. The number of eligible individuals is limited by the
153 availability of the federal capped allocation at one hundred
154 percent (100%) of federal matching funds, as more fully defined in
155 the Balanced Budget Act of 1997.
156 The eligibility of individuals covered under this paragraph
157 shall be determined by the Division of Medicaid.
158 (14) [Deleted]
159 (15) Disabled workers who are eligible to enroll in
160 Part A Medicare as required by Public Law 101-239, known as the
161 Omnibus Budget Reconciliation Act of 1989, and whose income does
162 not exceed two hundred percent (200%) of the federal poverty level
163 as determined in accordance with the Supplemental Security Income
164 (SSI) program. The eligibility of individuals covered under this
165 paragraph shall be determined by the Division of Medicaid and
166 those individuals shall be entitled to buy-in coverage of Medicare
167 Part A premiums only under the provisions of this paragraph (15).
168 (16) In accordance with the terms and conditions of
169 approved Title XIX waiver from the United States Department of

170 Health and Human Services, persons provided home- and
171 community-based services who are physically disabled and certified
172 by the Division of Medicaid as eligible due to applying the income
173 and deeming requirements as if they were institutionalized.
174 (17) In accordance with the terms of the federal
175 Personal Responsibility and Work Opportunity Reconciliation Act of
176 1996 (Public Law 104-193), persons who become ineligible for
177 assistance under Title IV-A of the federal Social Security Act, as
178 amended, because of increased income from or hours of employment
179 of the caretaker relative or because of the expiration of the
180 applicable earned income disregards, who were eligible for
181 Medicaid for at least three (3) of the six (6) months preceding
182 the month in which the ineligibility begins, shall be eligible for
183 Medicaid for up to twelve (12) months. The eligibility of the
184 individuals covered under this paragraph shall be determined by
185 the division.
186 (18) Persons who become ineligible for assistance under
187 Title IV-A of the federal Social Security Act, as amended, as a
188 result, in whole or in part, of the collection or increased
189 collection of child or spousal support under Title IV-D of the
190 federal Social Security Act, as amended, who were eligible for
191 Medicaid for at least three (3) of the six (6) months immediately
192 preceding the month in which the ineligibility begins, shall be
193 eligible for Medicaid for an additional four (4) months beginning
194 with the month in which the ineligibility begins. The eligibility

195 of the individuals covered under this paragraph shall be
196 determined by the division.
197 (19) Disabled workers, whose incomes are above the
198 Medicaid eligibility limits, but below two hundred fifty percent
199 (250%) of the federal poverty level, shall be allowed to purchase
200 Medicaid coverage on a sliding fee scale developed by the Division
201 of Medicaid.
202 (20) Medicaid eligible children under age eighteen (18)
203 shall remain eligible for Medicaid benefits until the end of a
204 period of twelve (12) months following an eligibility
205 determination, or until such time that the individual exceeds age
206 eighteen (18).
207 (21) Women of childbearing age whose family income does
208 not exceed one hundred eighty-five percent (185%) of the federal
209 poverty level. The eligibility of individuals covered under this
210 paragraph (21) shall be determined by the Division of Medicaid,
211 and those individuals determined eligible shall only receive
212 family planning services covered under Section 43-13-117(13) and
213 not any other services covered under Medicaid. However, any
214 individual eligible under this paragraph (21) who is also eligible
215 under any other provision of this section shall receive the
216 benefits to which he or she is entitled under that other
217 provision, in addition to family planning services covered under
218 Section 43-13-117(13).

219 The Division of Medicaid shall apply to the United States
220 Secretary of Health and Human Services for a federal waiver of the
221 applicable provisions of Title XIX of the federal Social Security
222 Act, as amended, and any other applicable provisions of federal
223 law as necessary to allow for the implementation of this paragraph
224 (21). The provisions of this paragraph (21) shall be implemented
225 from and after the date that the Division of Medicaid receives the
226 federal waiver.
227 (22) Persons who are workers with a potentially severe
228 disability, as determined by the division, shall be allowed to
229 purchase Medicaid coverage. The term "worker with a potentially
230 severe disability" means a person who is at least sixteen (16)
231 years of age but under sixty-five (65) years of age, who has a
232 physical or mental impairment that is reasonably expected to cause
233 the person to become blind or disabled as defined under Section
234 1614(a) of the federal Social Security Act, as amended, if the
235 person does not receive items and services provided under
236 Medicaid.
237 The eligibility of persons under this paragraph (22) shall be
238 conducted as a demonstration project that is consistent with
239 Section 204 of the Ticket to Work and Work Incentives Improvement
240 Act of 1999, Public Law 106-170, for a certain number of persons
241 as specified by the division. The eligibility of individuals
242 covered under this paragraph (22) shall be determined by the
243 Division of Medicaid.

244 (23) Children certified by the Mississippi Department
245 of Human Services for whom the state and county departments of
246 human services have custody and financial responsibility who are
247 in foster care on their eighteenth birthday as reported by the
248 Mississippi Department of Human Services shall be certified
249 Medicaid eligible by the Division of Medicaid until their
250 twenty-first birthday.

251 (24) Individuals who have not attained age sixty-five
252 (65), are not otherwise covered by creditable coverage as defined
253 in the Public Health Services Act, and have been screened for
254 breast and cervical cancer under the Centers for Disease Control
255 and Prevention Breast and Cervical Cancer Early Detection Program
256 established under Title XV of the Public Health Service Act in
257 accordance with the requirements of that act and who need
258 treatment for breast or cervical cancer. Eligibility of
259 individuals under this paragraph (24) shall be determined by the
260 Division of Medicaid.

261 (25) The division shall apply to the Centers for
262 Medicare and Medicaid Services (CMS) for any necessary waivers to
263 provide services to individuals who are sixty-five (65) years of
264 age or older or are disabled as determined under Section
265 1614(a)(3) of the federal Social Security Act, as amended, and
266 whose income does not exceed one hundred thirty-five percent
267 (135%) of the nonfarm official poverty level as defined by the
268 Office of Management and Budget and revised annually, and whose

269 resources do not exceed those established by the Division of
270 Medicaid, and who are not otherwise covered by Medicare. Nothing
271 contained in this paragraph (25) shall entitle an individual to
272 benefits. The eligibility of individuals covered under this
273 paragraph shall be determined by the Division of Medicaid.

274 (26) The division shall apply to the Centers for
275 Medicare and Medicaid Services (CMS) for any necessary waivers to
276 provide services to individuals who are sixty-five (65) years of
277 age or older or are disabled as determined under Section
278 1614(a)(3) of the federal Social Security Act, as amended, who are
279 end stage renal disease patients on dialysis, cancer patients on
280 chemotherapy or organ transplant recipients on antirejection
281 drugs, whose income does not exceed one hundred thirty-five
282 percent (135%) of the nonfarm official poverty level as defined by
283 the Office of Management and Budget and revised annually, and
284 whose resources do not exceed those established by the division.
285 Nothing contained in this paragraph (26) shall entitle an
286 individual to benefits. The eligibility of individuals covered
287 under this paragraph shall be determined by the Division of
288 Medicaid.

289 (27) Individuals who are entitled to Medicare Part D
290 and whose income does not exceed one hundred fifty percent (150%)
291 of the nonfarm official poverty level as defined by the Office of
292 Management and Budget and revised annually. Eligibility for

293 payment of the Medicare Part D subsidy under this paragraph shall
294 be determined by the division.

295 (28) The division is authorized and directed to provide
296 up to twelve (12) months of continuous coverage postpartum for any
297 individual who qualifies for Medicaid coverage under this section
298 as a pregnant woman, to the extent allowable under federal law and
299 as determined by the division.

300 <u>(29) Under the federal Patient Protection and</u>
301 <u>Affordable Care Act of 2010 and as amended, beginning July 1,</u>
302 <u>2024, individuals who are under sixty five (65) years of age, not</u>
303 <u>pregnant, not entitled to nor enrolled for benefits in Part A of</u>
304 <u>Title XVIII of the federal Social Security Act or enrolled for</u>
305 <u>benefits in Part B of Title XVIII of the federal Social Security</u>
306 <u>Act, are not described in any other part of this section, and</u>
307 <u>whose income does not exceed one hundred thirty three percent</u>
308 <u>(133%) of the Federal Poverty Level applicable to a family of the</u>
309 <u>size involved. The eligibility of individuals covered under this</u>
310 <u>paragraph (28) shall be determined by the Division of Medicaid,</u>
311 <u>and those individuals determined eligible shall only receive</u>
312 <u>essential health benefits as described in the federal Patient</u>
313 <u>Protection and Affordable Care Act of 2010 as amended. This</u>
314 <u>paragraph (28) shall stand repealed on December 31, 2026.</u>

315 The division shall redetermine eligibility for all categories
316 of recipients described in each paragraph of this section not less
317 frequently than required by federal law.

318 **SECTION 2.** Section 43-13-117, Mississippi Code of 1972, is
319 amended as follows:
320 43-13-117. (A) Medicaid as authorized by this article shall
321 include payment of part or all of the costs, at the discretion of
322 the division, with approval of the Governor and the Centers for
323 Medicare and Medicaid Services, of the following types of care and
324 services rendered to eligible applicants who have been determined
325 to be eligible for that care and services, within the limits of
326 state appropriations and federal matching funds:
327 (1) Inpatient hospital services.
328 (a) The division is authorized to implement an All
329 Patient Refined Diagnosis Related Groups (APR-DRG) reimbursement
330 methodology for inpatient hospital services.
331 (b) No service benefits or reimbursement
332 limitations in this subsection (A)(1) shall apply to payments
333 under an APR-DRG or Ambulatory Payment Classification (APC) model
334 or a managed care program or similar model described in subsection
335 (H) of this section unless specifically authorized by the
336 division.
337 (2) Outpatient hospital services.
338 (a) Emergency services.
339 (b) Other outpatient hospital services. The
340 division shall allow benefits for other medically necessary
341 outpatient hospital services (such as chemotherapy, radiation,
342 surgery and therapy), including outpatient services in a clinic or

343 other facility that is not located inside the hospital, but that
344 has been designated as an outpatient facility by the hospital, and
345 that was in operation or under construction on July 1, 2009,
346 provided that the costs and charges associated with the operation
347 of the hospital clinic are included in the hospital's cost report.
348 In addition, the Medicare thirty-five-mile rule will apply to
349 those hospital clinics not located inside the hospital that are
350 constructed after July 1, 2009. Where the same services are
351 reimbursed as clinic services, the division may revise the rate or
352 methodology of outpatient reimbursement to maintain consistency,
353 efficiency, economy and quality of care.
354 (c) The division is authorized to implement an
355 Ambulatory Payment Classification (APC) methodology for outpatient
356 hospital services. The division shall give rural hospitals that
357 have fifty (50) or fewer licensed beds the option to not be
358 reimbursed for outpatient hospital services using the APC
359 methodology, but reimbursement for outpatient hospital services
360 provided by those hospitals shall be based on one hundred one
361 percent (101%) of the rate established under Medicare for
362 outpatient hospital services. Those hospitals choosing to not be
363 reimbursed under the APC methodology shall remain under cost-based
364 reimbursement for a two-year period.
365 (d) No service benefits or reimbursement
366 limitations in this subsection (A)(2) shall apply to payments
367 under an APR-DRG or APC model or a managed care program or similar

368 model described in subsection (H) of this section unless
369 specifically authorized by the division.
370 (3) Laboratory and x-ray services.
371 (4) Nursing facility services.
372 (a) The division shall make full payment to
373 nursing facilities for each day, not exceeding forty-two (42) days
374 per year, that a patient is absent from the facility on home
375 leave. Payment may be made for the following home leave days in
376 addition to the forty-two-day limitation: Christmas, the day
377 before Christmas, the day after Christmas, Thanksgiving, the day
378 before Thanksgiving and the day after Thanksgiving.
379 (b) From and after July 1, 1997, the division
380 shall implement the integrated case-mix payment and quality
381 monitoring system, which includes the fair rental system for
382 property costs and in which recapture of depreciation is
383 eliminated. The division may reduce the payment for hospital
384 leave and therapeutic home leave days to the lower of the case-mix
385 category as computed for the resident on leave using the
386 assessment being utilized for payment at that point in time, or a
387 case-mix score of 1.000 for nursing facilities, and shall compute
388 case-mix scores of residents so that only services provided at the
389 nursing facility are considered in calculating a facility's per
390 diem.

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

394 (d) On or after January 1, 2015, the division
395 shall update the case-mix payment system resource utilization
396 grouper and classifications and fair rental reimbursement system.
397 The division shall develop and implement a payment add-on to
398 reimburse nursing facilities for ventilator-dependent resident
399 services.

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

413 (f) The division shall develop and implement an
414 assessment process for long-term care services. The division may

415 provide the assessment and related functions directly or through
416 contract with the area agencies on aging.

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

421 (5) Periodic screening and diagnostic services for
422 individuals under age twenty-one (21) years as are needed to
423 identify physical and mental defects and to provide health care
424 treatment and other measures designed to correct or ameliorate
425 defects and physical and mental illness and conditions discovered
426 by the screening services, regardless of whether these services
427 are included in the state plan. The division may include in its
428 periodic screening and diagnostic program those discretionary
429 services authorized under the federal regulations adopted to
430 implement Title XIX of the federal Social Security Act, as
431 amended. The division, in obtaining physical therapy services,
432 occupational therapy services, and services for individuals with
433 speech, hearing and language disorders, may enter into a
434 cooperative agreement with the State Department of Education for
435 the provision of those services to handicapped students by public
436 school districts using state funds that are provided from the
437 appropriation to the Department of Education to obtain federal
438 matching funds through the division. The division, in obtaining
439 medical and mental health assessments, treatment, care and

440 services for children who are in, or at risk of being put in, the
441 custody of the Mississippi Department of Human Services may enter
442 into a cooperative agreement with the Mississippi Department of
443 Human Services for the provision of those services using state
444 funds that are provided from the appropriation to the Department
445 of Human Services to obtain federal matching funds through the
446 division.

447 (6) Physician services. Fees for physician's services
448 that are covered only by Medicaid shall be reimbursed at ninety
449 percent (90%) of the rate established on January 1, 2018, and as
450 may be adjusted each July thereafter, under Medicare. The
451 division may provide for a reimbursement rate for physician's
452 services of up to one hundred percent (100%) of the rate
453 established under Medicare for physician's services that are
454 provided after the normal working hours of the physician, as
455 determined in accordance with regulations of the division. The
456 division may reimburse eligible providers, as determined by the
457 division, for certain primary care services at one hundred percent
458 (100%) of the rate established under Medicare. The division shall
459 reimburse obstetricians and gynecologists for certain primary care
460 services as defined by the division at one hundred percent (100%)
461 of the rate established under Medicare.

462 (7) (a) Home health services for eligible persons, not
463 to exceed in cost the prevailing cost of nursing facility
464 services. All home health visits must be precertified as required

465 by the division. In addition to physicians, certified registered
466 nurse practitioners, physician assistants and clinical nurse
467 specialists are authorized to prescribe or order home health
468 services and plans of care, sign home health plans of care,
469 certify and recertify eligibility for home health services and
470 conduct the required initial face-to-face visit with the recipient
471 of the services.

472 (b) [Repealed]

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

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

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

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

490 The division may allow for a combination of prescriptions for
491 single-source and innovator multiple-source drugs and generic
492 drugs to meet the needs of the beneficiaries.
493 The executive director may approve specific maintenance drugs
494 for beneficiaries with certain medical conditions, which may be
495 prescribed and dispensed in three-month supply increments.
496 Drugs prescribed for a resident of a psychiatric residential
497 treatment facility must be provided in true unit doses when
498 available. The division may require that drugs not covered by
499 Medicare Part D for a resident of a long-term care facility be
500 provided in true unit doses when available. Those drugs that were
501 originally billed to the division but are not used by a resident
502 in any of those facilities shall be returned to the billing
503 pharmacy for credit to the division, in accordance with the
504 guidelines of the State Board of Pharmacy and any requirements of
505 federal law and regulation. Drugs shall be dispensed to a
506 recipient and only one (1) dispensing fee per month may be
507 charged. The division shall develop a methodology for reimbursing
508 for restocked drugs, which shall include a restock fee as
509 determined by the division not exceeding Seven Dollars and
510 Eighty-two Cents ($7.82).
511 Except for those specific maintenance drugs approved by the
512 executive director, the division shall not reimburse for any
513 portion of a prescription that exceeds a thirty-one-day supply of
514 the drug based on the daily dosage.

515 The division is authorized to develop and implement a program
516 of payment for additional pharmacist services as determined by the
517 division.
518 All claims for drugs for dually eligible Medicare/Medicaid
519 beneficiaries that are paid for by Medicare must be submitted to
520 Medicare for payment before they may be processed by the
521 division's online payment system.
522 The division shall develop a pharmacy policy in which drugs
523 in tamper-resistant packaging that are prescribed for a resident
524 of a nursing facility but are not dispensed to the resident shall
525 be returned to the pharmacy and not billed to Medicaid, in
526 accordance with guidelines of the State Board of Pharmacy.
527 The division shall develop and implement a method or methods
528 by which the division will provide on a regular basis to Medicaid
529 providers who are authorized to prescribe drugs, information about
530 the costs to the Medicaid program of single-source drugs and
531 innovator multiple-source drugs, and information about other drugs
532 that may be prescribed as alternatives to those single-source
533 drugs and innovator multiple-source drugs and the costs to the
534 Medicaid program of those alternative drugs.
535 Notwithstanding any law or regulation, information obtained
536 or maintained by the division regarding the prescription drug
537 program, including trade secrets and manufacturer or labeler
538 pricing, is confidential and not subject to disclosure except to
539 other state agencies.

540 The dispensing fee for each new or refill prescription,
541 including nonlegend or over-the-counter drugs covered by the
542 division, shall be not less than Three Dollars and Ninety-one
543 Cents ($3.91), as determined by the division.
544 The division shall not reimburse for single-source or
545 innovator multiple-source drugs if there are equally effective
546 generic equivalents available and if the generic equivalents are
547 the least expensive.
548 It is the intent of the Legislature that the pharmacists
549 providers be reimbursed for the reasonable costs of filling and
550 dispensing prescriptions for Medicaid beneficiaries.
551 The division shall allow certain drugs, including
552 physician-administered drugs, and implantable drug system devices,
553 and medical supplies, with limited distribution or limited access
554 for beneficiaries and administered in an appropriate clinical
555 setting, to be reimbursed as either a medical claim or pharmacy
556 claim, as determined by the division.
557 It is the intent of the Legislature that the division and any
558 managed care entity described in subsection (H) of this section
559 encourage the use of Alpha-Hydroxyprogesterone Caproate (17P) to
560 prevent recurrent preterm birth.
561 (10) Dental and orthodontic services to be determined
562 by the division.
563 The division shall increase the amount of the reimbursement
564 rate for diagnostic and preventative dental services for each of

565 the fiscal years 2022, 2023 and 2024 by five percent (5%) above
566 the amount of the reimbursement rate for the previous fiscal year.
567 The division shall increase the amount of the reimbursement rate
568 for restorative dental services for each of the fiscal years 2023,
569 2024 and 2025 by five percent (5%) above the amount of the
570 reimbursement rate for the previous fiscal year. It is the intent
571 of the Legislature that the reimbursement rate revision for
572 preventative dental services will be an incentive to increase the
573 number of dentists who actively provide Medicaid services. This
574 dental services reimbursement rate revision shall be known as the
575 "James Russell Dumas Medicaid Dental Services Incentive Program."
576 The Medical Care Advisory Committee, assisted by the Division
577 of Medicaid, shall annually determine the effect of this incentive
578 by evaluating the number of dentists who are Medicaid providers,
579 the number who and the degree to which they are actively billing
580 Medicaid, the geographic trends of where dentists are offering
581 what types of Medicaid services and other statistics pertinent to
582 the goals of this legislative intent. This data shall annually be
583 presented to the Chair of the Senate Medicaid Committee and the
584 Chair of the House Medicaid Committee.
585 The division shall include dental services as a necessary
586 component of overall health services provided to children who are
587 eligible for services.
588 (11) Eyeglasses for all Medicaid beneficiaries who have
589 (a) had surgery on the eyeball or ocular muscle that results in a

590 vision change for which eyeglasses or a change in eyeglasses is
591 medically indicated within six (6) months of the surgery and is in
592 accordance with policies established by the division, or (b) one
593 (1) pair every five (5) years and in accordance with policies
594 established by the division. In either instance, the eyeglasses
595 must be prescribed by a physician skilled in diseases of the eye
596 or an optometrist, whichever the beneficiary may select.

597 (12) Intermediate care facility services.

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

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

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

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

615 (14) Clinic services. Preventive, diagnostic,
616 therapeutic, rehabilitative or palliative services that are
617 furnished by a facility that is not part of a hospital but is
618 organized and operated to provide medical care to outpatients.
619 Clinic services include, but are not limited to:
620 (a) Services provided by ambulatory surgical
621 centers (ACSs) as defined in Section 41-75-1(a); and
622 (b) Dialysis center services.
623 (15) Home- and community-based services for the elderly
624 and disabled, as provided under Title XIX of the federal Social
625 Security Act, as amended, under waivers, subject to the
626 availability of funds specifically appropriated for that purpose
627 by the Legislature.
628 (16) Mental health services. Certain services provided
629 by a psychiatrist shall be reimbursed at up to one hundred percent
630 (100%) of the Medicare rate. Approved therapeutic and case
631 management services (a) provided by an approved regional mental
632 health/intellectual disability center established under Sections
633 41-19-31 through 41-19-39, or by another community mental health
634 service provider meeting the requirements of the Department of
635 Mental Health to be an approved mental health/intellectual
636 disability center if determined necessary by the Department of
637 Mental Health, using state funds that are provided in the
638 appropriation to the division to match federal funds, or (b)
639 provided by a facility that is certified by the State Department

640 of Mental Health to provide therapeutic and case management
641 services, to be reimbursed on a fee for service basis, or (c)
642 provided in the community by a facility or program operated by the
643 Department of Mental Health. Any such services provided by a
644 facility described in subparagraph (b) must have the prior
645 approval of the division to be reimbursable under this section.
646 (17) Durable medical equipment services and medical
647 supplies. Precertification of durable medical equipment and
648 medical supplies must be obtained as required by the division.
649 The Division of Medicaid may require durable medical equipment
650 providers to obtain a surety bond in the amount and to the
651 specifications as established by the Balanced Budget Act of 1997.
652 A maximum dollar amount of reimbursement for noninvasive
653 ventilators or ventilation treatments properly ordered and being
654 used in an appropriate care setting shall not be set by any health
655 maintenance organization, coordinated care organization,
656 provider-sponsored health plan, or other organization paid for
657 services on a capitated basis by the division under any managed
658 care program or coordinated care program implemented by the
659 division under this section. Reimbursement by these organizations
660 to durable medical equipment suppliers for home use of noninvasive
661 and invasive ventilators shall be on a continuous monthly payment
662 basis for the duration of medical need throughout a patient's
663 valid prescription period.

664 (18) (a) Notwithstanding any other provision of this
665 section to the contrary, as provided in the Medicaid state plan
666 amendment or amendments as defined in Section 43-13-145(10), the
667 division shall make additional reimbursement to hospitals that
668 serve a disproportionate share of low-income patients and that
669 meet the federal requirements for those payments as provided in
670 Section 1923 of the federal Social Security Act and any applicable
671 regulations. It is the intent of the Legislature that the
672 division shall draw down all available federal funds allotted to
673 the state for disproportionate share hospitals. However, from and
674 after January 1, 1999, public hospitals participating in the
675 Medicaid disproportionate share program may be required to
676 participate in an intergovernmental transfer program as provided
677 in Section 1903 of the federal Social Security Act and any
678 applicable regulations.
679 (b) (i) 1. The division may establish a Medicare
680 Upper Payment Limits Program, as defined in Section 1902(a)(30) of
681 the federal Social Security Act and any applicable federal
682 regulations, or an allowable delivery system or provider payment
683 initiative authorized under 42 CFR 438.6(c), for hospitals,
684 nursing facilities and physicians employed or contracted by
685 hospitals.
686 2. The division shall establish a
687 Medicaid Supplemental Payment Program, as permitted by the federal
688 Social Security Act and a comparable allowable delivery system or

689 provider payment initiative authorized under 42 CFR 438.6(c), for
690 emergency ambulance transportation providers in accordance with
691 this subsection (A)(18)(b).

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

713 (iii) Subject to approval by the Centers for
714 Medicare and Medicaid Services (CMS) and the provisions of this
715 subsection (A)(18)(b), the division shall make additional
716 reimbursement to hospitals, nursing facilities, and emergency
717 ambulance transportation providers for the Medicare Upper Payment
718 Limits Program or other program(s) authorized under this
719 subsection (A)(18)(b), and, if the program is established for
720 physicians, shall make additional reimbursement for physicians, as
721 defined in Section 1902(a)(30) of the federal Social Security Act
722 and any applicable federal regulations, provided the assessment in
723 this subsection (A)(18)(b) is in effect.
724 (iv) Notwithstanding any other provision of
725 this article to the contrary, effective upon implementation of the
726 Mississippi Hospital Access Program (MHAP) provided in
727 subparagraph (c)(i) below, the hospital portion of the inpatient
728 Upper Payment Limits Program shall transition into and be replaced
729 by the MHAP program. However, the division is authorized to
730 develop and implement an alternative fee-for-service Upper Payment
731 Limits model in accordance with federal laws and regulations if
732 necessary to preserve supplemental funding. Further, the
733 division, in consultation with the hospital industry shall develop
734 alternative models for distribution of medical claims and
735 supplemental payments for inpatient and outpatient hospital
736 services, and such models may include, but shall not be limited to
737 the following: increasing rates for inpatient and outpatient

738 services; creating a low-income utilization pool of funds to
739 reimburse hospitals for the costs of uncompensated care, charity
740 care and bad debts as permitted and approved pursuant to federal
741 regulations and the Centers for Medicare and Medicaid Services;
742 supplemental payments based upon Medicaid utilization, quality,
743 service lines and/or costs of providing such services to Medicaid
744 beneficiaries and to uninsured patients. The goals of such
745 payment models shall be to ensure access to inpatient and
746 outpatient care and to maximize any federal funds that are
747 available to reimburse hospitals for services provided. Any such
748 documents required to achieve the goals described in this
749 paragraph shall be submitted to the Centers for Medicare and
750 Medicaid Services, with a proposed effective date of July 1, 2019,
751 to the extent possible, but in no event shall the effective date
752 of such payment models be later than July 1, 2020. The Chairmen
753 of the Senate and House Medicaid Committees shall be provided a
754 copy of the proposed payment model(s) prior to submission.
755 Effective July 1, 2018, and until such time as any payment
756 model(s) as described above become effective, the division, in
757 consultation with the hospital industry, is authorized to
758 implement a transitional program for inpatient and outpatient
759 payments and/or supplemental payments (including, but not limited
760 to, MHAP and directed payments), to redistribute available
761 supplemental funds among hospital providers, provided that when
762 compared to a hospital's prior year supplemental payments,

763 supplemental payments made pursuant to any such transitional
764 program shall not result in a decrease of more than five percent
765 (5%) and shall not increase by more than the amount needed to
766 maximize the distribution of the available funds.

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

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

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

786 b. In addition to any other funds
787 paid to ambulance transportation service providers for emergency

788 medical services provided to Medicaid beneficiaries, each eligible
789 ambulance transportation service provider shall receive ambulance
790 service access payments each state fiscal year equal to the
791 ambulance transportation service provider's upper payment limit
792 gap. Subject to approval by the Centers for Medicare and Medicaid
793 Services, ambulance service access payments shall be made no less
794 than on a quarterly basis.

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

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

805 (c) (i) Not later than December 1, 2015, the
806 division shall, subject to approval by the Centers for Medicare
807 and Medicaid Services (CMS), establish, implement and operate a
808 Mississippi Hospital Access Program (MHAP) for the purpose of
809 protecting patient access to hospital care through hospital
810 inpatient reimbursement programs provided in this section designed
811 to maintain total hospital reimbursement for inpatient services
812 rendered by in-state hospitals and the out-of-state hospital that

813 is authorized by federal law to submit intergovernmental transfers
814 (IGTs) to the State of Mississippi and is classified as Level I
815 trauma center located in a county contiguous to the state line at
816 the maximum levels permissible under applicable federal statutes
817 and regulations, at which time the current inpatient Medicare
818 Upper Payment Limits (UPL) Program for hospital inpatient services
819 shall transition to the MHAP.

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

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

837 (iv) The division shall assess each hospital
838 as provided in Section 43-13-145(4)(a) for the purpose of
839 financing the state portion of the MHAP, supplemental payments and
840 such other purposes as specified in Section 43-13-145. The
841 assessment will remain in effect as long as the MHAP and
842 supplemental payments are in effect.
843 (19) (a) Perinatal risk management services. The
844 division shall promulgate regulations to be effective from and
845 after October 1, 1988, to establish a comprehensive perinatal
846 system for risk assessment of all pregnant and infant Medicaid
847 recipients and for management, education and follow-up for those
848 who are determined to be at risk. Services to be performed
849 include case management, nutrition assessment/counseling,
850 psychosocial assessment/counseling and health education. The
851 division shall contract with the State Department of Health to
852 provide services within this paragraph (Perinatal High Risk
853 Management/Infant Services System (PHRM/ISS)). The State
854 Department of Health shall be reimbursed on a full reasonable cost
855 basis for services provided under this subparagraph (a).
856 (b) Early intervention system services. The
857 division shall cooperate with the State Department of Health,
858 acting as lead agency, in the development and implementation of a
859 statewide system of delivery of early intervention services, under
860 Part C of the Individuals with Disabilities Education Act (IDEA).
861 The State Department of Health shall certify annually in writing

862 to the executive director of the division the dollar amount of
863 state early intervention funds available that will be utilized as
864 a certified match for Medicaid matching funds. Those funds then
865 shall be used to provide expanded targeted case management
866 services for Medicaid eligible children with special needs who are
867 eligible for the state's early intervention system.
868 Qualifications for persons providing service coordination shall be
869 determined by the State Department of Health and the Division of
870 Medicaid.

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

881 (21) Nurse practitioner services. Services furnished
882 by a registered nurse who is licensed and certified by the
883 Mississippi Board of Nursing as a nurse practitioner, including,
884 but not limited to, nurse anesthetists, nurse midwives, family
885 nurse practitioners, family planning nurse practitioners,
886 pediatric nurse practitioners, obstetrics-gynecology nurse

887 practitioners and neonatal nurse practitioners, under regulations
888 adopted by the division. Reimbursement for those services shall
889 not exceed ninety percent (90%) of the reimbursement rate for
890 comparable services rendered by a physician. The division may
891 provide for a reimbursement rate for nurse practitioner services
892 of up to one hundred percent (100%) of the reimbursement rate for
893 comparable services rendered by a physician for nurse practitioner
894 services that are provided after the normal working hours of the
895 nurse practitioner, as determined in accordance with regulations
896 of the division.

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

912 (23) Inpatient psychiatric services.

913 (a) Inpatient psychiatric services to be
914 determined by the division for recipients under age twenty-one
915 (21) that are provided under the direction of a physician in an
916 inpatient program in a licensed acute care psychiatric facility or
917 in a licensed psychiatric residential treatment facility, before
918 the recipient reaches age twenty-one (21) or, if the recipient was
919 receiving the services immediately before he or she reached age
920 twenty-one (21), before the earlier of the date he or she no
921 longer requires the services or the date he or she reaches age
922 twenty-two (22), as provided by federal regulations. From and
923 after January 1, 2015, the division shall update the fair rental
924 reimbursement system for psychiatric residential treatment
925 facilities. Precertification of inpatient days and residential
926 treatment days must be obtained as required by the division. From
927 and after July 1, 2009, all state-owned and state-operated
928 facilities that provide inpatient psychiatric services to persons
929 under age twenty-one (21) who are eligible for Medicaid
930 reimbursement shall be reimbursed for those services on a full
931 reasonable cost basis.

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

936 (24) [Deleted]

937 (25) [Deleted]
938 (26) Hospice care. As used in this paragraph, the term
939 "hospice care" means a coordinated program of active professional
940 medical attention within the home and outpatient and inpatient
941 care that treats the terminally ill patient and family as a unit,
942 employing a medically directed interdisciplinary team. The
943 program provides relief of severe pain or other physical symptoms
944 and supportive care to meet the special needs arising out of
945 physical, psychological, spiritual, social and economic stresses
946 that are experienced during the final stages of illness and during
947 dying and bereavement and meets the Medicare requirements for
948 participation as a hospice as provided in federal regulations.
949 (27) Group health plan premiums and cost-sharing if it
950 is cost-effective as defined by the United States Secretary of
951 Health and Human Services.
952 (28) Other health insurance premiums that are
953 cost-effective as defined by the United States Secretary of Health
954 and Human Services. Medicare eligible must have Medicare Part B
955 before other insurance premiums can be paid.
956 (29) The Division of Medicaid may apply for a waiver
957 from the United States Department of Health and Human Services for
958 home- and community-based services for developmentally disabled
959 people using state funds that are provided from the appropriation
960 to the State Department of Mental Health and/or funds transferred
961 to the department by a political subdivision or instrumentality of

962 the state and used to match federal funds under a cooperative
963 agreement between the division and the department, provided that
964 funds for these services are specifically appropriated to the
965 Department of Mental Health and/or transferred to the department
966 by a political subdivision or instrumentality of the state.
967 (30) Pediatric skilled nursing services as determined
968 by the division and in a manner consistent with regulations
969 promulgated by the Mississippi State Department of Health.
970 (31) Targeted case management services for children
971 with special needs, under waivers from the United States
972 Department of Health and Human Services, using state funds that
973 are provided from the appropriation to the Mississippi Department
974 of Human Services and used to match federal funds under a
975 cooperative agreement between the division and the department.
976 (32) Care and services provided in Christian Science
977 Sanatoria listed and certified by the Commission for Accreditation
978 of Christian Science Nursing Organizations/Facilities, Inc.,
979 rendered in connection with treatment by prayer or spiritual means
980 to the extent that those services are subject to reimbursement
981 under Section 1903 of the federal Social Security Act.
982 (33) Podiatrist services.
983 (34) Assisted living services as provided through
984 home- and community-based services under Title XIX of the federal
985 Social Security Act, as amended, subject to the availability of

986 funds specifically appropriated for that purpose by the
987 Legislature.
988 (35) Services and activities authorized in Sections
989 43-27-101 and 43-27-103, using state funds that are provided from
990 the appropriation to the Mississippi Department of Human Services
991 and used to match federal funds under a cooperative agreement
992 between the division and the department.
993 (36) Nonemergency transportation services for
994 Medicaid-eligible persons as determined by the division. The PEER
995 Committee shall conduct a performance evaluation of the
996 nonemergency transportation program to evaluate the administration
997 of the program and the providers of transportation services to
998 determine the most cost-effective ways of providing nonemergency
999 transportation services to the patients served under the program.
1000 The performance evaluation shall be completed and provided to the
1001 members of the Senate Medicaid Committee and the House Medicaid
1002 Committee not later than January 1, 2019, and every two (2) years
1003 thereafter.
1004 (37) [Deleted]
1005 (38) Chiropractic services. A chiropractor's manual
1006 manipulation of the spine to correct a subluxation, if x-ray
1007 demonstrates that a subluxation exists and if the subluxation has
1008 resulted in a neuromusculoskeletal condition for which
1009 manipulation is appropriate treatment, and related spinal x-rays
1010 performed to document these conditions. Reimbursement for

1011 chiropractic services shall not exceed Seven Hundred Dollars
1012 ($700.00) per year per beneficiary.
1013 (39) Dually eligible Medicare/Medicaid beneficiaries.
1014 The division shall pay the Medicare deductible and coinsurance
1015 amounts for services available under Medicare, as determined by
1016 the division. From and after July 1, 2009, the division shall
1017 reimburse crossover claims for inpatient hospital services and
1018 crossover claims covered under Medicare Part B in the same manner
1019 that was in effect on January 1, 2008, unless specifically
1020 authorized by the Legislature to change this method.
1021 (40) [Deleted]
1022 (41) Services provided by the State Department of
1023 Rehabilitation Services for the care and rehabilitation of persons
1024 with spinal cord injuries or traumatic brain injuries, as allowed
1025 under waivers from the United States Department of Health and
1026 Human Services, using up to seventy-five percent (75%) of the
1027 funds that are appropriated to the Department of Rehabilitation
1028 Services from the Spinal Cord and Head Injury Trust Fund
1029 established under Section 37-33-261 and used to match federal
1030 funds under a cooperative agreement between the division and the
1031 department.
1032 (42) [Deleted]
1033 (43) The division shall provide reimbursement,
1034 according to a payment schedule developed by the division, for
1035 smoking cessation medications for pregnant women during their

1036 pregnancy and other Medicaid-eligible women who are of
1037 child-bearing age.
1038 (44) Nursing facility services for the severely
1039 disabled.
1040 (a) Severe disabilities include, but are not
1041 limited to, spinal cord injuries, closed-head injuries and
1042 ventilator-dependent patients.
1043 (b) Those services must be provided in a long-term
1044 care nursing facility dedicated to the care and treatment of
1045 persons with severe disabilities.
1046 (45) Physician assistant services. Services furnished
1047 by a physician assistant who is licensed by the State Board of
1048 Medical Licensure and is practicing with physician supervision
1049 under regulations adopted by the board, under regulations adopted
1050 by the division. Reimbursement for those services shall not
1051 exceed ninety percent (90%) of the reimbursement rate for
1052 comparable services rendered by a physician. The division may
1053 provide for a reimbursement rate for physician assistant services
1054 of up to one hundred percent (100%) or the reimbursement rate for
1055 comparable services rendered by a physician for physician
1056 assistant services that are provided after the normal working
1057 hours of the physician assistant, as determined in accordance with
1058 regulations of the division.
1059 (46) The division shall make application to the federal
1060 Centers for Medicare and Medicaid Services (CMS) for a waiver to

1061 develop and provide services for children with serious emotional
1062 disturbances as defined in Section 43-14-1(1), which may include
1063 home- and community-based services, case management services or
1064 managed care services through mental health providers certified by
1065 the Department of Mental Health. The division may implement and
1066 provide services under this waivered program only if funds for
1067 these services are specifically appropriated for this purpose by
1068 the Legislature, or if funds are voluntarily provided by affected
1069 agencies.
1070 (47) (a) The division may develop and implement
1071 disease management programs for individuals with high-cost chronic
1072 diseases and conditions, including the use of grants, waivers,
1073 demonstrations or other projects as necessary.
1074 (b) Participation in any disease management
1075 program implemented under this paragraph (47) is optional with the
1076 individual. An individual must affirmatively elect to participate
1077 in the disease management program in order to participate, and may
1078 elect to discontinue participation in the program at any time.
1079 (48) Pediatric long-term acute care hospital services.
1080 (a) Pediatric long-term acute care hospital
1081 services means services provided to eligible persons under
1082 twenty-one (21) years of age by a freestanding Medicare-certified
1083 hospital that has an average length of inpatient stay greater than
1084 twenty-five (25) days and that is primarily engaged in providing

1085 chronic or long-term medical care to persons under twenty-one (21)
1086 years of age.

1087 (b) The services under this paragraph (48) shall
1088 be reimbursed as a separate category of hospital services.

1089 (49) The division may establish copayments and/or
1090 coinsurance for any Medicaid services for which copayments and/or
1091 coinsurance are allowable under federal law or regulation.

1092 (50) Services provided by the State Department of
1093 Rehabilitation Services for the care and rehabilitation of persons
1094 who are deaf and blind, as allowed under waivers from the United
1095 States Department of Health and Human Services to provide home-
1096 and community-based services using state funds that are provided
1097 from the appropriation to the State Department of Rehabilitation
1098 Services or if funds are voluntarily provided by another agency.

1099 (51) Upon determination of Medicaid eligibility and in
1100 association with annual redetermination of Medicaid eligibility,
1101 beneficiaries shall be encouraged to undertake a physical
1102 examination that will establish a base-line level of health and
1103 identification of a usual and customary source of care (a medical
1104 home) to aid utilization of disease management tools. This
1105 physical examination and utilization of these disease management
1106 tools shall be consistent with current United States Preventive
1107 Services Task Force or other recognized authority recommendations.

1108 For persons who are determined ineligible for Medicaid, the
1109 division will provide information and direction for accessing
1110 medical care and services in the area of their residence.
1111 (52) Notwithstanding any provisions of this article,
1112 the division may pay enhanced reimbursement fees related to trauma
1113 care, as determined by the division in conjunction with the State
1114 Department of Health, using funds appropriated to the State
1115 Department of Health for trauma care and services and used to
1116 match federal funds under a cooperative agreement between the
1117 division and the State Department of Health. The division, in
1118 conjunction with the State Department of Health, may use grants,
1119 waivers, demonstrations, enhanced reimbursements, Upper Payment
1120 Limits Programs, supplemental payments, or other projects as
1121 necessary in the development and implementation of this
1122 reimbursement program.
1123 (53) Targeted case management services for high-cost
1124 beneficiaries may be developed by the division for all services
1125 under this section.
1126 (54) [Deleted]
1127 (55) Therapy services. The plan of care for therapy
1128 services may be developed to cover a period of treatment for up to
1129 six (6) months, but in no event shall the plan of care exceed a
1130 six-month period of treatment. The projected period of treatment
1131 must be indicated on the initial plan of care and must be updated
1132 with each subsequent revised plan of care. Based on medical

1133 necessity, the division shall approve certification periods for
1134 less than or up to six (6) months, but in no event shall the
1135 certification period exceed the period of treatment indicated on
1136 the plan of care. The appeal process for any reduction in therapy
1137 services shall be consistent with the appeal process in federal
1138 regulations.

1139 (56) Prescribed pediatric extended care centers
1140 services for medically dependent or technologically dependent
1141 children with complex medical conditions that require continual
1142 care as prescribed by the child's attending physician, as
1143 determined by the division.

1144 (57) No Medicaid benefit shall restrict coverage for
1145 medically appropriate treatment prescribed by a physician and
1146 agreed to by a fully informed individual, or if the individual
1147 lacks legal capacity to consent by a person who has legal
1148 authority to consent on his or her behalf, based on an
1149 individual's diagnosis with a terminal condition. As used in this
1150 paragraph (57), "terminal condition" means any aggressive
1151 malignancy, chronic end-stage cardiovascular or cerebral vascular
1152 disease, or any other disease, illness or condition which a
1153 physician diagnoses as terminal.

1154 (58) Treatment services for persons with opioid
1155 dependency or other highly addictive substance use disorders. The
1156 division is authorized to reimburse eligible providers for
1157 treatment of opioid dependency and other highly addictive

1158 substance use disorders, as determined by the division. Treatment
1159 related to these conditions shall not count against any physician
1160 visit limit imposed under this section.

1161 (59) The division shall allow beneficiaries between the
1162 ages of ten (10) and eighteen (18) years to receive vaccines
1163 through a pharmacy venue. The division and the State Department
1164 of Health shall coordinate and notify OB-GYN providers that the
1165 Vaccines for Children program is available to providers free of
1166 charge.

1167 (60) Border city university-affiliated pediatric
1168 teaching hospital.

1169 (a) Payments may only be made to a border city
1170 university-affiliated pediatric teaching hospital if the Centers
1171 for Medicare and Medicaid Services (CMS) approve an increase in
1172 the annual request for the provider payment initiative authorized
1173 under 42 CFR Section 438.6(c) in an amount equal to or greater
1174 than the estimated annual payment to be made to the border city
1175 university-affiliated pediatric teaching hospital. The estimate
1176 shall be based on the hospital's prior year Mississippi managed
1177 care utilization.

1178 b) As used in this paragraph (60), the term
1179 "border city university-affiliated pediatric teaching hospital"
1180 means an out-of-state hospital located within a city bordering the
1181 eastern bank of the Mississippi River and the State of Mississippi
1182 that submits to the division a copy of a current and effective

1183 affiliation agreement with an accredited university and other
1184 documentation establishing that the hospital is
1185 university-affiliated, is licensed and designated as a pediatric
1186 hospital or pediatric primary hospital within its home state,
1187 maintains at least five (5) different pediatric specialty training
1188 programs, and maintains at least one hundred (100) operated beds
1189 dedicated exclusively for the treatment of patients under the age
1190 of twenty-one (21) years.

1191 (c) The cost of providing services to Mississippi
1192 Medicaid beneficiaries under the age of twenty-one (21) years who
1193 are treated by a border city university-affiliated pediatric
1194 teaching hospital shall not exceed the cost of providing the same
1195 services to individuals in hospitals in the state.

1196 (d) It is the intent of the Legislature that
1197 payments shall not result in any in-state hospital receiving
1198 payments lower than they would otherwise receive if not for the
1199 payments made to any border city university-affiliated pediatric
1200 teaching hospital.

1201 (e) This paragraph (60) shall stand repealed on
1202 July 1, 2024.

1203 (61) Beginning July 1, 2024, essential health benefits as
1204 described in the federal Patient Protection and Affordable Care
1205 Act of 2010 and as amended, for individuals eligible for Medicaid
1206 under the federal Patient Protection and Affordable Care Act of
1207 2010 as amended, as described in Section 43-13-115(28) of this

1208 article. These services shall be provided only so long as the
1209 Medicaid federal matching percentage is not less than ninety
1210 percent (90%) for Medicaid services to this population. This
1211 paragraph (61) shall stand repealed on December 31, 2026.

1212 (B) Planning and development districts participating in the
1213 home- and community-based services program for the elderly and
1214 disabled as case management providers shall be reimbursed for case
1215 management services at the maximum rate approved by the Centers
1216 for Medicare and Medicaid Services (CMS).

1217 (C) The division may pay to those providers who participate
1218 in and accept patient referrals from the division's emergency room
1219 redirection program a percentage, as determined by the division,
1220 of savings achieved according to the performance measures and
1221 reduction of costs required of that program. Federally qualified
1222 health centers may participate in the emergency room redirection
1223 program, and the division may pay those centers a percentage of
1224 any savings to the Medicaid program achieved by the centers'
1225 accepting patient referrals through the program, as provided in
1226 this subsection (C).

1227 (D) (1) As used in this subsection (D), the following terms
1228 shall be defined as provided in this paragraph, except as
1229 otherwise provided in this subsection:

1230 (a) "Committees" means the Medicaid Committees of
1231 the House of Representatives and the Senate, and "committee" means
1232 either one of those committees.

1233 (b) "Rate change" means an increase, decrease or
1234 other change in the payments or rates of reimbursement, or a
1235 change in any payment methodology that results in an increase,
1236 decrease or other change in the payments or rates of
1237 reimbursement, to any Medicaid provider that renders any services
1238 authorized to be provided to Medicaid recipients under this
1239 article.

1240 (2) Whenever the Division of Medicaid proposes a rate
1241 change, the division shall give notice to the chairmen of the
1242 committees at least thirty (30) calendar days before the proposed
1243 rate change is scheduled to take effect. The division shall
1244 furnish the chairmen with a concise summary of each proposed rate
1245 change along with the notice, and shall furnish the chairmen with
1246 a copy of any proposed rate change upon request. The division
1247 also shall provide a summary and copy of any proposed rate change
1248 to any other member of the Legislature upon request.

1249 (3) If the chairman of either committee or both
1250 chairmen jointly object to the proposed rate change or any part
1251 thereof, the chairman or chairmen shall notify the division and
1252 provide the reasons for their objection in writing not later than
1253 seven (7) calendar days after receipt of the notice from the
1254 division. The chairman or chairmen may make written
1255 recommendations to the division for changes to be made to a
1256 proposed rate change.

1257 (4) (a) The chairman of either committee or both
1258 chairmen jointly may hold a committee meeting to review a proposed
1259 rate change. If either chairman or both chairmen decide to hold a
1260 meeting, they shall notify the division of their intention in
1261 writing within seven (7) calendar days after receipt of the notice
1262 from the division, and shall set the date and time for the meeting
1263 in their notice to the division, which shall not be later than
1264 fourteen (14) calendar days after receipt of the notice from the
1265 division.

1266 (b) After the committee meeting, the committee or
1267 committees may object to the proposed rate change or any part
1268 thereof. The committee or committees shall notify the division
1269 and the reasons for their objection in writing not later than
1270 seven (7) calendar days after the meeting. The committee or
1271 committees may make written recommendations to the division for
1272 changes to be made to a proposed rate change.

1273 (5) If both chairmen notify the division in writing
1274 within seven (7) calendar days after receipt of the notice from
1275 the division that they do not object to the proposed rate change
1276 and will not be holding a meeting to review the proposed rate
1277 change, the proposed rate change will take effect on the original
1278 date as scheduled by the division or on such other date as
1279 specified by the division.

1280 (6) (a) If there are any objections to a proposed rate
1281 change or any part thereof from either or both of the chairmen or

1282 the committees, the division may withdraw the proposed rate
1283 change, make any of the recommended changes to the proposed rate
1284 change, or not make any changes to the proposed rate change.

1285 (b) If the division does not make any changes to
1286 the proposed rate change, it shall notify the chairmen of that
1287 fact in writing, and the proposed rate change shall take effect on
1288 the original date as scheduled by the division or on such other
1289 date as specified by the division.

1290 (c) If the division makes any changes to the
1291 proposed rate change, the division shall notify the chairmen of
1292 its actions in writing, and the revised proposed rate change shall
1293 take effect on the date as specified by the division.

1294 (7) Nothing in this subsection (D) shall be construed
1295 as giving the chairmen or the committees any authority to veto,
1296 nullify or revise any rate change proposed by the division. The
1297 authority of the chairmen or the committees under this subsection
1298 shall be limited to reviewing, making objections to and making
1299 recommendations for changes to rate changes proposed by the
1300 division.

1301 (E) Notwithstanding any provision of this article, no new
1302 groups or categories of recipients and new types of care and
1303 services may be added without enabling legislation from the
1304 Mississippi Legislature, except that the division may authorize
1305 those changes without enabling legislation when the addition of
1306 recipients or services is ordered by a court of proper authority.

1307 (F) The executive director shall keep the Governor advised
1308 on a timely basis of the funds available for expenditure and the
1309 projected expenditures. Notwithstanding any other provisions of
1310 this article, if current or projected expenditures of the division
1311 are reasonably anticipated to exceed the amount of funds
1312 appropriated to the division for any fiscal year, the Governor,
1313 after consultation with the executive director, shall take all
1314 appropriate measures to reduce costs, which may include, but are
1315 not limited to:

1316 (1) Reducing or discontinuing any or all services that
1317 are deemed to be optional under Title XIX of the Social Security
1318 Act;

1319 (2) Reducing reimbursement rates for any or all service
1320 types;

1321 (3) Imposing additional assessments on health care
1322 providers; or

1323 (4) Any additional cost-containment measures deemed
1324 appropriate by the Governor.

1325 To the extent allowed under federal law, any reduction to
1326 services or reimbursement rates under this subsection (F) shall be
1327 accompanied by a reduction, to the fullest allowable amount, to
1328 the profit margin and administrative fee portions of capitated
1329 payments to organizations described in paragraph (1) of subsection
1330 (H).

1331 Beginning in fiscal year 2010 and in fiscal years thereafter,
1332 when Medicaid expenditures are projected to exceed funds available
1333 for the fiscal year, the division shall submit the expected
1334 shortfall information to the PEER Committee not later than
1335 December 1 of the year in which the shortfall is projected to
1336 occur. PEER shall review the computations of the division and
1337 report its findings to the Legislative Budget Office not later
1338 than January 7 in any year.

1339 (G) Notwithstanding any other provision of this article, it
1340 shall be the duty of each provider participating in the Medicaid
1341 program to keep and maintain books, documents and other records as
1342 prescribed by the Division of Medicaid in accordance with federal
1343 laws and regulations.

1344 (H) (1) Notwithstanding any other provision of this
1345 article, the division is authorized to implement (a) a managed
1346 care program, (b) a coordinated care program, (c) a coordinated
1347 care organization program, (d) a health maintenance organization
1348 program, (e) a patient-centered medical home program, (f) an
1349 accountable care organization program, (g) provider-sponsored
1350 health plan, or (h) any combination of the above programs. As a
1351 condition for the approval of any program under this subsection
1352 (H)(1), the division shall require that no managed care program,
1353 coordinated care program, coordinated care organization program,
1354 health maintenance organization program, or provider-sponsored
1355 health plan may:

1356 (a) Pay providers at a rate that is less than the
1357 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
1358 reimbursement rate;
1359 (b) Override the medical decisions of hospital
1360 physicians or staff regarding patients admitted to a hospital for
1361 an emergency medical condition as defined by 42 US Code Section
1362 1395dd. This restriction (b) does not prohibit the retrospective
1363 review of the appropriateness of the determination that an
1364 emergency medical condition exists by chart review or coding
1365 algorithm, nor does it prohibit prior authorization for
1366 nonemergency hospital admissions;
1367 (c) Pay providers at a rate that is less than the
1368 normal Medicaid reimbursement rate. It is the intent of the
1369 Legislature that all managed care entities described in this
1370 subsection (H), in collaboration with the division, develop and
1371 implement innovative payment models that incentivize improvements
1372 in health care quality, outcomes, or value, as determined by the
1373 division. Participation in the provider network of any managed
1374 care, coordinated care, provider-sponsored health plan, or similar
1375 contractor shall not be conditioned on the provider's agreement to
1376 accept such alternative payment models;
1377 (d) Implement a prior authorization and
1378 utilization review program for medical services, transportation
1379 services and prescription drugs that is more stringent than the
1380 prior authorization processes used by the division in its

1381 administration of the Medicaid program. Not later than December
1382 2, 2021, the contractors that are receiving capitated payments
1383 under a managed care delivery system established under this
1384 subsection (H) shall submit a report to the Chairmen of the House
1385 and Senate Medicaid Committees on the status of the prior
1386 authorization and utilization review program for medical services,
1387 transportation services and prescription drugs that is required to
1388 be implemented under this subparagraph (d);

1389 (e) [Deleted]

1390 (f) Implement a preferred drug list that is more
1391 stringent than the mandatory preferred drug list established by
1392 the division under subsection (A)(9) of this section;

1393 (g) Implement a policy which denies beneficiaries
1394 with hemophilia access to the federally funded hemophilia
1395 treatment centers as part of the Medicaid Managed Care network of
1396 providers.

1397 Each health maintenance organization, coordinated care
1398 organization, provider-sponsored health plan, or other
1399 organization paid for services on a capitated basis by the
1400 division under any managed care program or coordinated care
1401 program implemented by the division under this section shall use a
1402 clear set of level of care guidelines in the determination of
1403 medical necessity and in all utilization management practices,
1404 including the prior authorization process, concurrent reviews,
1405 retrospective reviews and payments, that are consistent with

1406 widely accepted professional standards of care. Organizations
1407 participating in a managed care program or coordinated care
1408 program implemented by the division may not use any additional
1409 criteria that would result in denial of care that would be
1410 determined appropriate and, therefore, medically necessary under
1411 those levels of care guidelines.

1412 (2) Notwithstanding any provision of this section, the
1413 recipients eligible for enrollment into a Medicaid Managed Care
1414 Program authorized under this subsection (H) may include only
1415 those categories of recipients eligible for participation in the
1416 Medicaid Managed Care Program as of January 1, 2021, the
1417 Children's Health Insurance Program (CHIP), and the CMS-approved
1418 Section 1115 demonstration waivers in operation as of January 1,
1419 2021. No expansion of Medicaid Managed Care Program contracts may
1420 be implemented by the division without enabling legislation from
1421 the Mississippi Legislature.

1422 (3) (a) Any contractors receiving capitated payments
1423 under a managed care delivery system established in this section
1424 shall provide to the Legislature and the division statistical data
1425 to be shared with provider groups in order to improve patient
1426 access, appropriate utilization, cost savings and health outcomes
1427 not later than October 1 of each year. Additionally, each
1428 contractor shall disclose to the Chairmen of the Senate and House
1429 Medicaid Committees the administrative expenses costs for the
1430 prior calendar year, and the number of full-equivalent employees

1431 located in the State of Mississippi dedicated to the Medicaid and
1432 CHIP lines of business as of June 30 of the current year.
1433 (b) The division and the contractors participating
1434 in the managed care program, a coordinated care program or a
1435 provider-sponsored health plan shall be subject to annual program
1436 reviews or audits performed by the Office of the State Auditor,
1437 the PEER Committee, the Department of Insurance and/or independent
1438 third parties.
1439 (c) Those reviews shall include, but not be
1440 limited to, at least two (2) of the following items:
1441 (i) The financial benefit to the State of
1442 Mississippi of the managed care program,
1443 (ii) The difference between the premiums paid
1444 to the managed care contractors and the payments made by those
1445 contractors to health care providers,
1446 (iii) Compliance with performance measures
1447 required under the contracts,
1448 (iv) Administrative expense allocation
1449 methodologies,
1450 (v) Whether nonprovider payments assigned as
1451 medical expenses are appropriate,
1452 (vi) Capitated arrangements with related
1453 party subcontractors,
1454 (vii) Reasonableness of corporate
1455 allocations,

1456 (viii) Value-added benefits and the extent to
1457 which they are used,
1458 (ix) The effectiveness of subcontractor
1459 oversight, including subcontractor review,
1460 (x) Whether health care outcomes have been
1461 improved, and
1462 (xi) The most common claim denial codes to
1463 determine the reasons for the denials.
1464 The audit reports shall be considered public documents and
1465 shall be posted in their entirety on the division's website.
1466 (4) All health maintenance organizations, coordinated
1467 care organizations, provider-sponsored health plans, or other
1468 organizations paid for services on a capitated basis by the
1469 division under any managed care program or coordinated care
1470 program implemented by the division under this section shall
1471 reimburse all providers in those organizations at rates no lower
1472 than those provided under this section for beneficiaries who are
1473 not participating in those programs.
1474 (5) No health maintenance organization, coordinated
1475 care organization, provider-sponsored health plan, or other
1476 organization paid for services on a capitated basis by the
1477 division under any managed care program or coordinated care
1478 program implemented by the division under this section shall
1479 require its providers or beneficiaries to use any pharmacy that

1480 ships, mails or delivers prescription drugs or legend drugs or
1481 devices.

1482 (6) (a) Not later than December 1, 2021, the
1483 contractors who are receiving capitated payments under a managed
1484 care delivery system established under this subsection (H) shall
1485 develop and implement a uniform credentialing process for
1486 providers. Under that uniform credentialing process, a provider
1487 who meets the criteria for credentialing will be credentialed with
1488 all of those contractors and no such provider will have to be
1489 separately credentialed by any individual contractor in order to
1490 receive reimbursement from the contractor. Not later than
1491 December 2, 2021, those contractors shall submit a report to the
1492 Chairmen of the House and Senate Medicaid Committees on the status
1493 of the uniform credentialing process for providers that is
1494 required under this subparagraph (a).

1495 (b) If those contractors have not implemented a
1496 uniform credentialing process as described in subparagraph (a) by
1497 December 1, 2021, the division shall develop and implement, not
1498 later than July 1, 2022, a single, consolidated credentialing
1499 process by which all providers will be credentialed. Under the
1500 division's single, consolidated credentialing process, no such
1501 contractor shall require its providers to be separately
1502 credentialed by the contractor in order to receive reimbursement
1503 from the contractor, but those contractors shall recognize the

1504 credentialing of the providers by the division's credentialing
1505 process.
1506 (c) The division shall require a uniform provider
1507 credentialing application that shall be used in the credentialing
1508 process that is established under subparagraph (a) or (b). If the
1509 contractor or division, as applicable, has not approved or denied
1510 the provider credentialing application within sixty (60) days of
1511 receipt of the completed application that includes all required
1512 information necessary for credentialing, then the contractor or
1513 division, upon receipt of a written request from the applicant and
1514 within five (5) business days of its receipt, shall issue a
1515 temporary provider credential/enrollment to the applicant if the
1516 applicant has a valid Mississippi professional or occupational
1517 license to provide the health care services to which the
1518 credential/enrollment would apply. The contractor or the division
1519 shall not issue a temporary credential/enrollment if the applicant
1520 has reported on the application a history of medical or other
1521 professional or occupational malpractice claims, a history of
1522 substance abuse or mental health issues, a criminal record, or a
1523 history of medical or other licensing board, state or federal
1524 disciplinary action, including any suspension from participation
1525 in a federal or state program. The temporary
1526 credential/enrollment shall be effective upon issuance and shall
1527 remain in effect until the provider's credentialing/enrollment
1528 application is approved or denied by the contractor or division.

1529 The contractor or division shall render a final decision regarding
1530 credentialing/enrollment of the provider within sixty (60) days
1531 from the date that the temporary provider credential/enrollment is
1532 issued to the applicant.

1533 (d) If the contractor or division does not render
1534 a final decision regarding credentialing/enrollment of the
1535 provider within the time required in subparagraph (c), the
1536 provider shall be deemed to be credentialed by and enrolled with
1537 all of the contractors and eligible to receive reimbursement from
1538 the contractors.

1539 (7) (a) Each contractor that is receiving capitated
1540 payments under a managed care delivery system established under
1541 this subsection (H) shall provide to each provider for whom the
1542 contractor has denied the coverage of a procedure that was ordered
1543 or requested by the provider for or on behalf of a patient, a
1544 letter that provides a detailed explanation of the reasons for the
1545 denial of coverage of the procedure and the name and the
1546 credentials of the person who denied the coverage. The letter
1547 shall be sent to the provider in electronic format.

1548 (b) After a contractor that is receiving capitated
1549 payments under a managed care delivery system established under
1550 this subsection (H) has denied coverage for a claim submitted by a
1551 provider, the contractor shall issue to the provider within sixty
1552 (60) days a final ruling of denial of the claim that allows the
1553 provider to have a state fair hearing and/or agency appeal with

1554 the division. If a contractor does not issue a final ruling of
1555 denial within sixty (60) days as required by this subparagraph
1556 (b), the provider's claim shall be deemed to be automatically
1557 approved and the contractor shall pay the amount of the claim to
1558 the provider.
1559 (c) After a contractor has issued a final ruling
1560 of denial of a claim submitted by a provider, the division shall
1561 conduct a state fair hearing and/or agency appeal on the matter of
1562 the disputed claim between the contractor and the provider within
1563 sixty (60) days, and shall render a decision on the matter within
1564 thirty (30) days after the date of the hearing and/or appeal.
1565 (8) It is the intention of the Legislature that the
1566 division evaluate the feasibility of using a single vendor to
1567 administer pharmacy benefits provided under a managed care
1568 delivery system established under this subsection (H). Providers
1569 of pharmacy benefits shall cooperate with the division in any
1570 transition to a carve-out of pharmacy benefits under managed care.
1571 (9) The division shall evaluate the feasibility of
1572 using a single vendor to administer dental benefits provided under
1573 a managed care delivery system established in this subsection (H).
1574 Providers of dental benefits shall cooperate with the division in
1575 any transition to a carve-out of dental benefits under managed
1576 care.
1577 (10) It is the intent of the Legislature that any
1578 contractor receiving capitated payments under a managed care

1579 delivery system established in this section shall implement
1580 innovative programs to improve the health and well-being of
1581 members diagnosed with prediabetes and diabetes.

1582 (11) It is the intent of the Legislature that any
1583 contractors receiving capitated payments under a managed care
1584 delivery system established under this subsection (H) shall work
1585 with providers of Medicaid services to improve the utilization of
1586 long-acting reversible contraceptives (LARCs). Not later than
1587 December 1, 2021, any contractors receiving capitated payments
1588 under a managed care delivery system established under this
1589 subsection (H) shall provide to the Chairmen of the House and
1590 Senate Medicaid Committees and House and Senate Public Health
1591 Committees a report of LARC utilization for State Fiscal Years
1592 2018 through 2020 as well as any programs, initiatives, or efforts
1593 made by the contractors and providers to increase LARC
1594 utilization. This report shall be updated annually to include
1595 information for subsequent state fiscal years.

1596 (12) The division is authorized to make not more than
1597 one (1) emergency extension of the contracts that are in effect on
1598 July 1, 2021, with contractors who are receiving capitated
1599 payments under a managed care delivery system established under
1600 this subsection (H), as provided in this paragraph (12). The
1601 maximum period of any such extension shall be one (1) year, and
1602 under any such extensions, the contractors shall be subject to all
1603 of the provisions of this subsection (H). The extended contracts

1604 shall be revised to incorporate any provisions of this subsection
1605 (H).

1606 (I) [Deleted]

1607 (J) There shall be no cuts in inpatient and outpatient
1608 hospital payments, or allowable days or volumes, as long as the
1609 hospital assessment provided in Section 43-13-145 is in effect.
1610 This subsection (J) shall not apply to decreases in payments that
1611 are a result of: reduced hospital admissions, audits or payments
1612 under the APR-DRG or APC models, or a managed care program or
1613 similar model described in subsection (H) of this section.

1614 (K) In the negotiation and execution of such contracts
1615 involving services performed by actuarial firms, the Executive
1616 Director of the Division of Medicaid may negotiate a limitation on
1617 liability to the state of prospective contractors.

1618 (L) The Division of Medicaid shall reimburse for services
1619 provided to eligible Medicaid beneficiaries by a licensed birthing
1620 center in a method and manner to be determined by the division in
1621 accordance with federal laws and federal regulations. The
1622 division shall seek any necessary waivers, make any required
1623 amendments to its State Plan or revise any contracts authorized
1624 under subsection (H) of this section as necessary to provide the
1625 services authorized under this subsection. As used in this
1626 subsection, the term "birthing centers" shall have the meaning as
1627 defined in Section 41-77-1(a), which is a publicly or privately
1628 owned facility, place or institution constructed, renovated,

1629 leased or otherwise established where nonemergency births are
1630 planned to occur away from the mother's usual residence following
1631 a documented period of prenatal care for a normal uncomplicated
1632 pregnancy which has been determined to be low risk through a
1633 formal risk-scoring examination.

1634 (M) This section shall stand repealed on July 1, *** 2028.

1635 **SECTION 3.** This act shall take effect and be in force from
1636 and after July 1, 2024.

ST: Medicaid; expand eligibility to include individuals entitled to benefits under federal Patient Protection and Affordable Care Act.