MISSISSIPPI LEGISLATURE REGULAR SESSION 2024

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

SENATE BILL NO. 2751

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE THAT THE DIVISION OF MEDICAID SHALL ENSURE THAT NO
3 NON-OPIOID DRUG APPROVED BY THE UNITED STATES FOOD AND DRUG
4 ADMINISTRATION FOR THE TREATMENT OR MANAGEMENT OF PAIN SHALL BE
5 DISADVANTAGED OR DISCOURAGED WITH RESPECT TO COVERAGE RELATIVE TO
6 ANY OPIOID OR NARCOTIC DRUG FOR THE TREATMENT OR MANAGEMENT OF
7 PAIN ON THE DIVISION'S MANDATORY PREFERRED DRUG LIST; TO PROVIDE
8 CERTAIN PROVISIONS RELATED TO SUCH NONOPIOID DRUGS; TO EXTEND THE
9 DATE OF REPEAL THEREON; AND FOR RELATED PURPOSES.

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

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

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

20 (1) Inpatient hospital services.

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

45 methodology of outpatient reimbursement to maintain consistency,
46 efficiency, economy and quality of care.

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

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

63 (3) Laboratory and x-ray services.

64 (4) Nursing facility services.

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

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

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

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

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

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

165 (b) [Repealed]

166 (8) Emergency medical transportation services as
167 determined by the division.

168 (9) Prescription drugs and other covered drugs and
169 services as determined by the division.

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

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

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

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

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

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

220 The division shall develop and implement a method or methods
221 by which the division will provide on a regular basis to Medicaid
222 providers who are authorized to prescribe drugs, information about
223 the costs to the Medicaid program of single-source drugs and
224 innovator multiple-source drugs, and information about other drugs
225 that may be prescribed as alternatives to those single-source
226 drugs and innovator multiple-source drugs and the costs to the
227 Medicaid program of those alternative drugs.
228 Notwithstanding any law or regulation, information obtained
229 or maintained by the division regarding the prescription drug
230 program, including trade secrets and manufacturer or labeler
231 pricing, is confidential and not subject to disclosure except to
232 other state agencies.
233 The dispensing fee for each new or refill prescription,
234 including nonlegend or over-the-counter drugs covered by the
235 division, shall be not less than Three Dollars and Ninety-one
236 Cents ($3.91), as determined by the division.
237 The division shall not reimburse for single-source or
238 innovator multiple-source drugs if there are equally effective
239 generic equivalents available and if the generic equivalents are
240 the least expensive.
241 It is the intent of the Legislature that the pharmacists
242 providers be reimbursed for the reasonable costs of filling and
243 dispensing prescriptions for Medicaid beneficiaries.

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

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

254 In establishing and maintaining the mandatory preferred drug
255 list, the division shall ensure that no nonopioid drug approved by
256 the United States Food and Drug Administration for the treatment
257 or management of pain shall be disadvantaged or discouraged with
258 respect to coverage relative to any opioid or narcotic drug for
259 the treatment or management of pain on such mandatory preferred
260 drug list, where impermissible disadvantaging or discouragement
261 includes, without limitation: designating any such nonopioid drug
262 as a nonpreferred drug if any opioid or narcotic drug is
263 designated as a preferred drug; or establishing more restrictive
264 or more extensive utilization controls, including, but not limited
265 to, more restrictive or more extensive prior authorization or step
266 therapy requirements, for such nonopioid drug than the least
267 restrictive or extensive utilization controls applicable to any
268 such opioid or narcotic drug.

269 <u>This section shall apply to a nonopioid drug immediately upon</u>
270 <u>its approval by the United States Food and Drug Administration for</u>
271 <u>the treatment or management of pain, regardless of whether such</u>
272 <u>drug has been reviewed by the Division of Medicaid for inclusion</u>
273 <u>mandatory preferred drug list. This section shall apply to drugs</u>
274 <u>being provided under a contract between the division and any</u>
275 <u>managed care entity.</u>
276 (10) Dental and orthodontic services to be determined
277 by the division.
278 The division shall increase the amount of the reimbursement
279 rate for diagnostic and preventative dental services for each of
280 the fiscal years 2022, 2023 and 2024 by five percent (5%) above
281 the amount of the reimbursement rate for the previous fiscal year.
282 The division shall increase the amount of the reimbursement rate
283 for restorative dental services for each of the fiscal years 2023,
284 2024 and 2025 by five percent (5%) above the amount of the
285 reimbursement rate for the previous fiscal year. It is the intent
286 of the Legislature that the reimbursement rate revision for
287 preventative dental services will be an incentive to increase the
288 number of dentists who actively provide Medicaid services. This
289 dental services reimbursement rate revision shall be known as the
290 "James Russell Dumas Medicaid Dental Services Incentive Program."
291 The Medical Care Advisory Committee, assisted by the Division
292 of Medicaid, shall annually determine the effect of this incentive
293 by evaluating the number of dentists who are Medicaid providers,

294 the number who and the degree to which they are actively billing
295 Medicaid, the geographic trends of where dentists are offering
296 what types of Medicaid services and other statistics pertinent to
297 the goals of this legislative intent. This data shall annually be
298 presented to the Chair of the Senate Medicaid Committee and the
299 Chair of the House Medicaid Committee.

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

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

312 (12) Intermediate care facility services.

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

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

343 (16) Mental health services. Certain services provided
344 by a psychiatrist shall be reimbursed at up to one hundred percent
345 (100%) of the Medicare rate. Approved therapeutic and case
346 management services (a) provided by an approved regional mental
347 health/intellectual disability center established under Sections
348 41-19-31 through 41-19-39, or by another community mental health
349 service provider meeting the requirements of the Department of
350 Mental Health to be an approved mental health/intellectual
351 disability center if determined necessary by the Department of
352 Mental Health, using state funds that are provided in the
353 appropriation to the division to match federal funds, or (b)
354 provided by a facility that is certified by the State Department
355 of Mental Health to provide therapeutic and case management
356 services, to be reimbursed on a fee for service basis, or (c)
357 provided in the community by a facility or program operated by the
358 Department of Mental Health. Any such services provided by a
359 facility described in subparagraph (b) must have the prior
360 approval of the division to be reimbursable under this section.
361 (17) Durable medical equipment services and medical
362 supplies. Precertification of durable medical equipment and
363 medical supplies must be obtained as required by the division.
364 The Division of Medicaid may require durable medical equipment
365 providers to obtain a surety bond in the amount and to the
366 specifications as established by the Balanced Budget Act of 1997.
367 A maximum dollar amount of reimbursement for noninvasive

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

392 in Section 1903 of the federal Social Security Act and any
393 applicable regulations.
394 (b) (i) 1. The division may establish a Medicare
395 Upper Payment Limits Program, as defined in Section 1902(a)(30) of
396 the federal Social Security Act and any applicable federal
397 regulations, or an allowable delivery system or provider payment
398 initiative authorized under 42 CFR 438.6(c), for hospitals,
399 nursing facilities and physicians employed or contracted by
400 hospitals.
401 2. The division shall establish a
402 Medicaid Supplemental Payment Program, as permitted by the federal
403 Social Security Act and a comparable allowable delivery system or
404 provider payment initiative authorized under 42 CFR 438.6(c), for
405 emergency ambulance transportation providers in accordance with
406 this subsection (A)(18)(b).
407 (ii) The division shall assess each hospital,
408 nursing facility, and emergency ambulance transportation provider
409 for the sole purpose of financing the state portion of the
410 Medicare Upper Payment Limits Program or other program(s)
411 authorized under this subsection (A)(18)(b). The hospital
412 assessment shall be as provided in Section 43-13-145(4)(a), and
413 the nursing facility and the emergency ambulance transportation
414 assessments, if established, shall be based on Medicaid
415 utilization or other appropriate method, as determined by the
416 division, consistent with federal regulations. The assessments

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

442 subparagraph (c)(i) below, the hospital portion of the inpatient
443 Upper Payment Limits Program shall transition into and be replaced
444 by the MHAP program. However, the division is authorized to
445 develop and implement an alternative fee-for-service Upper Payment
446 Limits model in accordance with federal laws and regulations if
447 necessary to preserve supplemental funding. Further, the
448 division, in consultation with the hospital industry shall develop
449 alternative models for distribution of medical claims and
450 supplemental payments for inpatient and outpatient hospital
451 services, and such models may include, but shall not be limited to
452 the following: increasing rates for inpatient and outpatient
453 services; creating a low-income utilization pool of funds to
454 reimburse hospitals for the costs of uncompensated care, charity
455 care and bad debts as permitted and approved pursuant to federal
456 regulations and the Centers for Medicare and Medicaid Services;
457 supplemental payments based upon Medicaid utilization, quality,
458 service lines and/or costs of providing such services to Medicaid
459 beneficiaries and to uninsured patients. The goals of such
460 payment models shall be to ensure access to inpatient and
461 outpatient care and to maximize any federal funds that are
462 available to reimburse hospitals for services provided. Any such
463 documents required to achieve the goals described in this
464 paragraph shall be submitted to the Centers for Medicare and
465 Medicaid Services, with a proposed effective date of July 1, 2019,
466 to the extent possible, but in no event shall the effective date

467 of such payment models be later than July 1, 2020. The Chairmen
468 of the Senate and House Medicaid Committees shall be provided a
469 copy of the proposed payment model(s) prior to submission.
470 Effective July 1, 2018, and until such time as any payment
471 model(s) as described above become effective, the division, in
472 consultation with the hospital industry, is authorized to
473 implement a transitional program for inpatient and outpatient
474 payments and/or supplemental payments (including, but not limited
475 to, MHAP and directed payments), to redistribute available
476 supplemental funds among hospital providers, provided that when
477 compared to a hospital's prior year supplemental payments,
478 supplemental payments made pursuant to any such transitional
479 program shall not result in a decrease of more than five percent
480 (5%) and shall not increase by more than the amount needed to
481 maximize the distribution of the available funds.
482 (v) 1. To preserve and improve access to
483 ambulance transportation provider services, the division shall
484 seek CMS approval to make ambulance service access payments as set
485 forth in this subsection (A)(18)(b) for all covered emergency
486 ambulance services rendered on or after July 1, 2022, and shall
487 make such ambulance service access payments for all covered
488 services rendered on or after the effective date of CMS approval.
489 2. The division shall calculate the
490 ambulance service access payment amount as the balance of the
491 portion of the Medical Care Fund related to ambulance

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

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

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

510 c. As used in this paragraph
511 (18)(b)(v), the term "upper payment limit gap" means the
512 difference between the total amount that the ambulance
513 transportation service provider received from Medicaid and the
514 average amount that the ambulance transportation service provider
515 would have received from commercial insurers for those services
516 reimbursed by Medicaid.

517 4. An ambulance service access payment
518 shall not be used to offset any other payment by the division for
519 emergency or nonemergency services to Medicaid beneficiaries.
520 (c) (i) Not later than December 1, 2015, the
521 division shall, subject to approval by the Centers for Medicare
522 and Medicaid Services (CMS), establish, implement and operate a
523 Mississippi Hospital Access Program (MHAP) for the purpose of
524 protecting patient access to hospital care through hospital
525 inpatient reimbursement programs provided in this section designed
526 to maintain total hospital reimbursement for inpatient services
527 rendered by in-state hospitals and the out-of-state hospital that
528 is authorized by federal law to submit intergovernmental transfers
529 (IGTs) to the State of Mississippi and is classified as Level I
530 trauma center located in a county contiguous to the state line at
531 the maximum levels permissible under applicable federal statutes
532 and regulations, at which time the current inpatient Medicare
533 Upper Payment Limits (UPL) Program for hospital inpatient services
534 shall transition to the MHAP.
535 (ii) Subject to approval by the Centers for
536 Medicare and Medicaid Services (CMS), the MHAP shall provide
537 increased inpatient capitation (PMPM) payments to managed care
538 entities contracting with the division pursuant to subsection (H)
539 of this section to support availability of hospital services or
540 such other payments permissible under federal law necessary to
541 accomplish the intent of this subsection.

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

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

592 funds under a cooperative agreement between the division and the
593 department, provided that funds for these services are
594 specifically appropriated to the Department of Rehabilitation
595 Services.

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

612 (22) Ambulatory services delivered in federally
613 qualified health centers, rural health centers and clinics of the
614 local health departments of the State Department of Health for
615 individuals eligible for Medicaid under this article based on
616 reasonable costs as determined by the division. Federally

617 qualified health centers shall be reimbursed by the Medicaid
618 prospective payment system as approved by the Centers for Medicare
619 and Medicaid Services. The division shall recognize federally
620 qualified health centers (FQHCs), rural health clinics (RHCs) and
621 community mental health centers (CMHCs) as both an originating and
622 distant site provider for the purposes of telehealth
623 reimbursement. The division is further authorized and directed to
624 reimburse FQHCs, RHCs and CMHCs for both distant site and
625 originating site services when such services are appropriately
626 provided by the same organization.
627 (23) Inpatient psychiatric services.
628 (a) Inpatient psychiatric services to be
629 determined by the division for recipients under age twenty-one
630 (21) that are provided under the direction of a physician in an
631 inpatient program in a licensed acute care psychiatric facility or
632 in a licensed psychiatric residential treatment facility, before
633 the recipient reaches age twenty-one (21) or, if the recipient was
634 receiving the services immediately before he or she reached age
635 twenty-one (21), before the earlier of the date he or she no
636 longer requires the services or the date he or she reaches age
637 twenty-two (22), as provided by federal regulations. From and
638 after January 1, 2015, the division shall update the fair rental
639 reimbursement system for psychiatric residential treatment
640 facilities. Precertification of inpatient days and residential
641 treatment days must be obtained as required by the division. From

642 and after July 1, 2009, all state-owned and state-operated
643 facilities that provide inpatient psychiatric services to persons
644 under age twenty-one (21) who are eligible for Medicaid
645 reimbursement shall be reimbursed for those services on a full
646 reasonable cost basis.
647 (b) The division may reimburse for services
648 provided by a licensed freestanding psychiatric hospital to
649 Medicaid recipients over the age of twenty-one (21) in a method
650 and manner consistent with the provisions of Section 43-13-117.5.
651 (24) [Deleted]
652 (25) [Deleted]
653 (26) Hospice care. As used in this paragraph, the term
654 "hospice care" means a coordinated program of active professional
655 medical attention within the home and outpatient and inpatient
656 care that treats the terminally ill patient and family as a unit,
657 employing a medically directed interdisciplinary team. The
658 program provides relief of severe pain or other physical symptoms
659 and supportive care to meet the special needs arising out of
660 physical, psychological, spiritual, social and economic stresses
661 that are experienced during the final stages of illness and during
662 dying and bereavement and meets the Medicare requirements for
663 participation as a hospice as provided in federal regulations.
664 (27) Group health plan premiums and cost-sharing if it
665 is cost-effective as defined by the United States Secretary of
666 Health and Human Services.

667 (28) Other health insurance premiums that are
668 cost-effective as defined by the United States Secretary of Health
669 and Human Services. Medicare eligible must have Medicare Part B
670 before other insurance premiums can be paid.
671 (29) The Division of Medicaid may apply for a waiver
672 from the United States Department of Health and Human Services for
673 home- and community-based services for developmentally disabled
674 people using state funds that are provided from the appropriation
675 to the State Department of Mental Health and/or funds transferred
676 to the department by a political subdivision or instrumentality of
677 the state and used to match federal funds under a cooperative
678 agreement between the division and the department, provided that
679 funds for these services are specifically appropriated to the
680 Department of Mental Health and/or transferred to the department
681 by a political subdivision or instrumentality of the state.
682 (30) Pediatric skilled nursing services as determined
683 by the division and in a manner consistent with regulations
684 promulgated by the Mississippi State Department of Health.
685 (31) Targeted case management services for children
686 with special needs, under waivers from the United States
687 Department of Health and Human Services, using state funds that
688 are provided from the appropriation to the Mississippi Department
689 of Human Services and used to match federal funds under a
690 cooperative agreement between the division and the department.

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

697 (33) Podiatrist services.

698 (34) Assisted living services as provided through
699 home- and community-based services under Title XIX of the federal
700 Social Security Act, as amended, subject to the availability of
701 funds specifically appropriated for that purpose by the
702 Legislature.

703 (35) Services and activities authorized in Sections
704 43-27-101 and 43-27-103, using state funds that are provided from
705 the appropriation to the Mississippi Department of Human Services
706 and used to match federal funds under a cooperative agreement
707 between the division and the department.

708 (36) Nonemergency transportation services for
709 Medicaid-eligible persons as determined by the division. The PEER
710 Committee shall conduct a performance evaluation of the
711 nonemergency transportation program to evaluate the administration
712 of the program and the providers of transportation services to
713 determine the most cost-effective ways of providing nonemergency
714 transportation services to the patients served under the program.
715 The performance evaluation shall be completed and provided to the

716 members of the Senate Medicaid Committee and the House Medicaid
717 Committee not later than January 1, 2019, and every two (2) years
718 thereafter.

719 (37) [Deleted]

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

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

736 (40) [Deleted]

737 (41) Services provided by the State Department of
738 Rehabilitation Services for the care and rehabilitation of persons
739 with spinal cord injuries or traumatic brain injuries, as allowed
740 under waivers from the United States Department of Health and

741 Human Services, using up to seventy-five percent (75%) of the
742 funds that are appropriated to the Department of Rehabilitation
743 Services from the Spinal Cord and Head Injury Trust Fund
744 established under Section 37-33-261 and used to match federal
745 funds under a cooperative agreement between the division and the
746 department.

747 (42) [Deleted]

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

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

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

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

761 (45) Physician assistant services. Services furnished
762 by a physician assistant who is licensed by the State Board of
763 Medical Licensure and is practicing with physician supervision
764 under regulations adopted by the board, under regulations adopted
765 by the division. Reimbursement for those services shall not

766 exceed ninety percent (90%) of the reimbursement rate for
767 comparable services rendered by a physician. The division may
768 provide for a reimbursement rate for physician assistant services
769 of up to one hundred percent (100%) or the reimbursement rate for
770 comparable services rendered by a physician for physician
771 assistant services that are provided after the normal working
772 hours of the physician assistant, as determined in accordance with
773 regulations of the division.

774 (46) The division shall make application to the federal
775 Centers for Medicare and Medicaid Services (CMS) for a waiver to
776 develop and provide services for children with serious emotional
777 disturbances as defined in Section 43-14-1(1), which may include
778 home- and community-based services, case management services or
779 managed care services through mental health providers certified by
780 the Department of Mental Health. The division may implement and
781 provide services under this waivered program only if funds for
782 these services are specifically appropriated for this purpose by
783 the Legislature, or if funds are voluntarily provided by affected
784 agencies.

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

789 (b) Participation in any disease management
790 program implemented under this paragraph (47) is optional with the

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

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

841 (54) [Deleted]

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

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

859 (57) No Medicaid benefit shall restrict coverage for
860 medically appropriate treatment prescribed by a physician and
861 agreed to by a fully informed individual, or if the individual
862 lacks legal capacity to consent by a person who has legal
863 authority to consent on his or her behalf, based on an
864 individual's diagnosis with a terminal condition. As used in this
865 paragraph (57), "terminal condition" means any aggressive

866 malignancy, chronic end-stage cardiovascular or cerebral vascular
867 disease, or any other disease, illness or condition which a
868 physician diagnoses as terminal.

869 (58) Treatment services for persons with opioid
870 dependency or other highly addictive substance use disorders. The
871 division is authorized to reimburse eligible providers for
872 treatment of opioid dependency and other highly addictive
873 substance use disorders, as determined by the division. Treatment
874 related to these conditions shall not count against any physician
875 visit limit imposed under this section.

876 (59) The division shall allow beneficiaries between the
877 ages of ten (10) and eighteen (18) years to receive vaccines
878 through a pharmacy venue. The division and the State Department
879 of Health shall coordinate and notify OB-GYN providers that the
880 Vaccines for Children program is available to providers free of
881 charge.

882 (60) Border city university-affiliated pediatric
883 teaching hospital.

884 (a) Payments may only be made to a border city
885 university-affiliated pediatric teaching hospital if the Centers
886 for Medicare and Medicaid Services (CMS) approve an increase in
887 the annual request for the provider payment initiative authorized
888 under 42 CFR Section 438.6(c) in an amount equal to or greater
889 than the estimated annual payment to be made to the border city
890 university-affiliated pediatric teaching hospital. The estimate

891 shall be based on the hospital's prior year Mississippi managed
892 care utilization.

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

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

911 (d) It is the intent of the Legislature that
912 payments shall not result in any in-state hospital receiving
913 payments lower than they would otherwise receive if not for the
914 payments made to any border city university-affiliated pediatric
915 teaching hospital.

916 (e) This paragraph (60) shall stand repealed on
917 July 1, 2024.
918 (B) Planning and development districts participating in the
919 home- and community-based services program for the elderly and
920 disabled as case management providers shall be reimbursed for case
921 management services at the maximum rate approved by the Centers
922 for Medicare and Medicaid Services (CMS).
923 (C) The division may pay to those providers who participate
924 in and accept patient referrals from the division's emergency room
925 redirection program a percentage, as determined by the division,
926 of savings achieved according to the performance measures and
927 reduction of costs required of that program. Federally qualified
928 health centers may participate in the emergency room redirection
929 program, and the division may pay those centers a percentage of
930 any savings to the Medicaid program achieved by the centers'
931 accepting patient referrals through the program, as provided in
932 this subsection (C).
933 (D) (1) As used in this subsection (D), the following terms
934 shall be defined as provided in this paragraph, except as
935 otherwise provided in this subsection:
936 (a) "Committees" means the Medicaid Committees of
937 the House of Representatives and the Senate, and "committee" means
938 either one of those committees.
939 (b) "Rate change" means an increase, decrease or
940 other change in the payments or rates of reimbursement, or a

941 change in any payment methodology that results in an increase,
942 decrease or other change in the payments or rates of
943 reimbursement, to any Medicaid provider that renders any services
944 authorized to be provided to Medicaid recipients under this
945 article.

946 (2) Whenever the Division of Medicaid proposes a rate
947 change, the division shall give notice to the chairmen of the
948 committees at least thirty (30) calendar days before the proposed
949 rate change is scheduled to take effect. The division shall
950 furnish the chairmen with a concise summary of each proposed rate
951 change along with the notice, and shall furnish the chairmen with
952 a copy of any proposed rate change upon request. The division
953 also shall provide a summary and copy of any proposed rate change
954 to any other member of the Legislature upon request.

955 (3) If the chairman of either committee or both
956 chairmen jointly object to the proposed rate change or any part
957 thereof, the chairman or chairmen shall notify the division and
958 provide the reasons for their objection in writing not later than
959 seven (7) calendar days after receipt of the notice from the
960 division. The chairman or chairmen may make written
961 recommendations to the division for changes to be made to a
962 proposed rate change.

963 (4) (a) The chairman of either committee or both
964 chairmen jointly may hold a committee meeting to review a proposed
965 rate change. If either chairman or both chairmen decide to hold a

966 meeting, they shall notify the division of their intention in
967 writing within seven (7) calendar days after receipt of the notice
968 from the division, and shall set the date and time for the meeting
969 in their notice to the division, which shall not be later than
970 fourteen (14) calendar days after receipt of the notice from the
971 division.

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

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

986 (6) (a) If there are any objections to a proposed rate
987 change or any part thereof from either or both of the chairmen or
988 the committees, the division may withdraw the proposed rate
989 change, make any of the recommended changes to the proposed rate
990 change, or not make any changes to the proposed rate change.

991 (b) If the division does not make any changes to
992 the proposed rate change, it shall notify the chairmen of that
993 fact in writing, and the proposed rate change shall take effect on
994 the original date as scheduled by the division or on such other
995 date as specified by the division.
996 (c) If the division makes any changes to the
997 proposed rate change, the division shall notify the chairmen of
998 its actions in writing, and the revised proposed rate change shall
999 take effect on the date as specified by the division.
1000 (7) Nothing in this subsection (D) shall be construed
1001 as giving the chairmen or the committees any authority to veto,
1002 nullify or revise any rate change proposed by the division. The
1003 authority of the chairmen or the committees under this subsection
1004 shall be limited to reviewing, making objections to and making
1005 recommendations for changes to rate changes proposed by the
1006 division.
1007 (E) Notwithstanding any provision of this article, no new
1008 groups or categories of recipients and new types of care and
1009 services may be added without enabling legislation from the
1010 Mississippi Legislature, except that the division may authorize
1011 those changes without enabling legislation when the addition of
1012 recipients or services is ordered by a court of proper authority.
1013 (F) The executive director shall keep the Governor advised
1014 on a timely basis of the funds available for expenditure and the
1015 projected expenditures. Notwithstanding any other provisions of

1016 this article, if current or projected expenditures of the division
1017 are reasonably anticipated to exceed the amount of funds
1018 appropriated to the division for any fiscal year, the Governor,
1019 after consultation with the executive director, shall take all
1020 appropriate measures to reduce costs, which may include, but are
1021 not limited to:

1022 (1) Reducing or discontinuing any or all services that
1023 are deemed to be optional under Title XIX of the Social Security
1024 Act;

1025 (2) Reducing reimbursement rates for any or all service
1026 types;

1027 (3) Imposing additional assessments on health care
1028 providers; or

1029 (4) Any additional cost-containment measures deemed
1030 appropriate by the Governor.

1031 To the extent allowed under federal law, any reduction to
1032 services or reimbursement rates under this subsection (F) shall be
1033 accompanied by a reduction, to the fullest allowable amount, to
1034 the profit margin and administrative fee portions of capitated
1035 payments to organizations described in paragraph (1) of subsection
1036 (H).

1037 Beginning in fiscal year 2010 and in fiscal years thereafter,
1038 when Medicaid expenditures are projected to exceed funds available
1039 for the fiscal year, the division shall submit the expected
1040 shortfall information to the PEER Committee not later than

1041 December 1 of the year in which the shortfall is projected to
1042 occur. PEER shall review the computations of the division and
1043 report its findings to the Legislative Budget Office not later
1044 than January 7 in any year.

1045 (G) Notwithstanding any other provision of this article, it
1046 shall be the duty of each provider participating in the Medicaid
1047 program to keep and maintain books, documents and other records as
1048 prescribed by the Division of Medicaid in accordance with federal
1049 laws and regulations.

1050 (H) (1) Notwithstanding any other provision of this
1051 article, the division is authorized to implement (a) a managed
1052 care program, (b) a coordinated care program, (c) a coordinated
1053 care organization program, (d) a health maintenance organization
1054 program, (e) a patient-centered medical home program, (f) an
1055 accountable care organization program, (g) provider-sponsored
1056 health plan, or (h) any combination of the above programs. As a
1057 condition for the approval of any program under this subsection
1058 (H)(1), the division shall require that no managed care program,
1059 coordinated care program, coordinated care organization program,
1060 health maintenance organization program, or provider-sponsored
1061 health plan may:

1062 (a) Pay providers at a rate that is less than the
1063 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
1064 reimbursement rate;

1065 (b) Override the medical decisions of hospital
1066 physicians or staff regarding patients admitted to a hospital for
1067 an emergency medical condition as defined by 42 US Code Section
1068 1395dd. This restriction (b) does not prohibit the retrospective
1069 review of the appropriateness of the determination that an
1070 emergency medical condition exists by chart review or coding
1071 algorithm, nor does it prohibit prior authorization for
1072 nonemergency hospital admissions;
1073 (c) Pay providers at a rate that is less than the
1074 normal Medicaid reimbursement rate. It is the intent of the
1075 Legislature that all managed care entities described in this
1076 subsection (H), in collaboration with the division, develop and
1077 implement innovative payment models that incentivize improvements
1078 in health care quality, outcomes, or value, as determined by the
1079 division. Participation in the provider network of any managed
1080 care, coordinated care, provider-sponsored health plan, or similar
1081 contractor shall not be conditioned on the provider's agreement to
1082 accept such alternative payment models;
1083 (d) Implement a prior authorization and
1084 utilization review program for medical services, transportation
1085 services and prescription drugs that is more stringent than the
1086 prior authorization processes used by the division in its
1087 administration of the Medicaid program. Not later than December
1088 2, 2021, the contractors that are receiving capitated payments
1089 under a managed care delivery system established under this

1090 subsection (H) shall submit a report to the Chairmen of the House
1091 and Senate Medicaid Committees on the status of the prior
1092 authorization and utilization review program for medical services,
1093 transportation services and prescription drugs that is required to
1094 be implemented under this subparagraph (d);
1095 (e) [Deleted]
1096 (f) Implement a preferred drug list that is more
1097 stringent than the mandatory preferred drug list established by
1098 the division under subsection (A)(9) of this section;
1099 (g) Implement a policy which denies beneficiaries
1100 with hemophilia access to the federally funded hemophilia
1101 treatment centers as part of the Medicaid Managed Care network of
1102 providers.
1103 Each health maintenance organization, coordinated care
1104 organization, provider-sponsored health plan, or other
1105 organization paid for services on a capitated basis by the
1106 division under any managed care program or coordinated care
1107 program implemented by the division under this section shall use a
1108 clear set of level of care guidelines in the determination of
1109 medical necessity and in all utilization management practices,
1110 including the prior authorization process, concurrent reviews,
1111 retrospective reviews and payments, that are consistent with
1112 widely accepted professional standards of care. Organizations
1113 participating in a managed care program or coordinated care
1114 program implemented by the division may not use any additional

1115 criteria that would result in denial of care that would be
1116 determined appropriate and, therefore, medically necessary under
1117 those levels of care guidelines.

1118 (2) Notwithstanding any provision of this section, the
1119 recipients eligible for enrollment into a Medicaid Managed Care
1120 Program authorized under this subsection (H) may include only
1121 those categories of recipients eligible for participation in the
1122 Medicaid Managed Care Program as of January 1, 2021, the
1123 Children's Health Insurance Program (CHIP), and the CMS-approved
1124 Section 1115 demonstration waivers in operation as of January 1,
1125 2021. No expansion of Medicaid Managed Care Program contracts may
1126 be implemented by the division without enabling legislation from
1127 the Mississippi Legislature.

1128 (3) (a) Any contractors receiving capitated payments
1129 under a managed care delivery system established in this section
1130 shall provide to the Legislature and the division statistical data
1131 to be shared with provider groups in order to improve patient
1132 access, appropriate utilization, cost savings and health outcomes
1133 not later than October 1 of each year. Additionally, each
1134 contractor shall disclose to the Chairmen of the Senate and House
1135 Medicaid Committees the administrative expenses costs for the
1136 prior calendar year, and the number of full-equivalent employees
1137 located in the State of Mississippi dedicated to the Medicaid and
1138 CHIP lines of business as of June 30 of the current year.

1139 (b) The division and the contractors participating
1140 in the managed care program, a coordinated care program or a
1141 provider-sponsored health plan shall be subject to annual program
1142 reviews or audits performed by the Office of the State Auditor,
1143 the PEER Committee, the Department of Insurance and/or independent
1144 third parties.

1145 (c) Those reviews shall include, but not be
1146 limited to, at least two (2) of the following items:

1147 (i) The financial benefit to the State of
1148 Mississippi of the managed care program,

1149 (ii) The difference between the premiums paid
1150 to the managed care contractors and the payments made by those
1151 contractors to health care providers,

1152 (iii) Compliance with performance measures
1153 required under the contracts,

1154 (iv) Administrative expense allocation
1155 methodologies,

1156 (v) Whether nonprovider payments assigned as
1157 medical expenses are appropriate,

1158 (vi) Capitated arrangements with related
1159 party subcontractors,

1160 (vii) Reasonableness of corporate
1161 allocations,

1162 (viii) Value-added benefits and the extent to
1163 which they are used,

1164 (ix) The effectiveness of subcontractor
1165 oversight, including subcontractor review,
1166 (x) Whether health care outcomes have been
1167 improved, and
1168 (xi) The most common claim denial codes to
1169 determine the reasons for the denials.
1170 The audit reports shall be considered public documents and
1171 shall be posted in their entirety on the division's website.
1172 (4) All health maintenance organizations, coordinated
1173 care organizations, provider-sponsored health plans, or other
1174 organizations paid for services on a capitated basis by the
1175 division under any managed care program or coordinated care
1176 program implemented by the division under this section shall
1177 reimburse all providers in those organizations at rates no lower
1178 than those provided under this section for beneficiaries who are
1179 not participating in those programs.
1180 (5) No health maintenance organization, coordinated
1181 care organization, provider-sponsored health plan, or other
1182 organization paid for services on a capitated basis by the
1183 division under any managed care program or coordinated care
1184 program implemented by the division under this section shall
1185 require its providers or beneficiaries to use any pharmacy that
1186 ships, mails or delivers prescription drugs or legend drugs or
1187 devices.

1188 (6) (a) Not later than December 1, 2021, the
1189 contractors who are receiving capitated payments under a managed
1190 care delivery system established under this subsection (H) shall
1191 develop and implement a uniform credentialing process for
1192 providers. Under that uniform credentialing process, a provider
1193 who meets the criteria for credentialing will be credentialed with
1194 all of those contractors and no such provider will have to be
1195 separately credentialed by any individual contractor in order to
1196 receive reimbursement from the contractor. Not later than
1197 December 2, 2021, those contractors shall submit a report to the
1198 Chairmen of the House and Senate Medicaid Committees on the status
1199 of the uniform credentialing process for providers that is
1200 required under this subparagraph (a).
1201 (b) If those contractors have not implemented a
1202 uniform credentialing process as described in subparagraph (a) by
1203 December 1, 2021, the division shall develop and implement, not
1204 later than July 1, 2022, a single, consolidated credentialing
1205 process by which all providers will be credentialed. Under the
1206 division's single, consolidated credentialing process, no such
1207 contractor shall require its providers to be separately
1208 credentialed by the contractor in order to receive reimbursement
1209 from the contractor, but those contractors shall recognize the
1210 credentialing of the providers by the division's credentialing
1211 process.

1212 (c) The division shall require a uniform provider
1213 credentialing application that shall be used in the credentialing
1214 process that is established under subparagraph (a) or (b). If the
1215 contractor or division, as applicable, has not approved or denied
1216 the provider credentialing application within sixty (60) days of
1217 receipt of the completed application that includes all required
1218 information necessary for credentialing, then the contractor or
1219 division, upon receipt of a written request from the applicant and
1220 within five (5) business days of its receipt, shall issue a
1221 temporary provider credential/enrollment to the applicant if the
1222 applicant has a valid Mississippi professional or occupational
1223 license to provide the health care services to which the
1224 credential/enrollment would apply. The contractor or the division
1225 shall not issue a temporary credential/enrollment if the applicant
1226 has reported on the application a history of medical or other
1227 professional or occupational malpractice claims, a history of
1228 substance abuse or mental health issues, a criminal record, or a
1229 history of medical or other licensing board, state or federal
1230 disciplinary action, including any suspension from participation
1231 in a federal or state program. The temporary
1232 credential/enrollment shall be effective upon issuance and shall
1233 remain in effect until the provider's credentialing/enrollment
1234 application is approved or denied by the contractor or division.
1235 The contractor or division shall render a final decision regarding
1236 credentialing/enrollment of the provider within sixty (60) days

1237 from the date that the temporary provider credential/enrollment is
1238 issued to the applicant.

1239 (d) If the contractor or division does not render
1240 a final decision regarding credentialing/enrollment of the
1241 provider within the time required in subparagraph (c), the
1242 provider shall be deemed to be credentialed by and enrolled with
1243 all of the contractors and eligible to receive reimbursement from
1244 the contractors.

1245 (7) (a) Each contractor that is receiving capitated
1246 payments under a managed care delivery system established under
1247 this subsection (H) shall provide to each provider for whom the
1248 contractor has denied the coverage of a procedure that was ordered
1249 or requested by the provider for or on behalf of a patient, a
1250 letter that provides a detailed explanation of the reasons for the
1251 denial of coverage of the procedure and the name and the
1252 credentials of the person who denied the coverage. The letter
1253 shall be sent to the provider in electronic format.

1254 (b) After a contractor that is receiving capitated
1255 payments under a managed care delivery system established under
1256 this subsection (H) has denied coverage for a claim submitted by a
1257 provider, the contractor shall issue to the provider within sixty
1258 (60) days a final ruling of denial of the claim that allows the
1259 provider to have a state fair hearing and/or agency appeal with
1260 the division. If a contractor does not issue a final ruling of
1261 denial within sixty (60) days as required by this subparagraph

1262 (b), the provider's claim shall be deemed to be automatically
1263 approved and the contractor shall pay the amount of the claim to
1264 the provider.

1265 (c) After a contractor has issued a final ruling
1266 of denial of a claim submitted by a provider, the division shall
1267 conduct a state fair hearing and/or agency appeal on the matter of
1268 the disputed claim between the contractor and the provider within
1269 sixty (60) days, and shall render a decision on the matter within
1270 thirty (30) days after the date of the hearing and/or appeal.

1271 (8) It is the intention of the Legislature that the
1272 division evaluate the feasibility of using a single vendor to
1273 administer pharmacy benefits provided under a managed care
1274 delivery system established under this subsection (H). Providers
1275 of pharmacy benefits shall cooperate with the division in any
1276 transition to a carve-out of pharmacy benefits under managed care.

1277 (9) The division shall evaluate the feasibility of
1278 using a single vendor to administer dental benefits provided under
1279 a managed care delivery system established in this subsection (H).
1280 Providers of dental benefits shall cooperate with the division in
1281 any transition to a carve-out of dental benefits under managed
1282 care.

1283 (10) It is the intent of the Legislature that any
1284 contractor receiving capitated payments under a managed care
1285 delivery system established in this section shall implement

1286 innovative programs to improve the health and well-being of
1287 members diagnosed with prediabetes and diabetes.
1288 (11) It is the intent of the Legislature that any
1289 contractors receiving capitated payments under a managed care
1290 delivery system established under this subsection (H) shall work
1291 with providers of Medicaid services to improve the utilization of
1292 long-acting reversible contraceptives (LARCs). Not later than
1293 December 1, 2021, any contractors receiving capitated payments
1294 under a managed care delivery system established under this
1295 subsection (H) shall provide to the Chairmen of the House and
1296 Senate Medicaid Committees and House and Senate Public Health
1297 Committees a report of LARC utilization for State Fiscal Years
1298 2018 through 2020 as well as any programs, initiatives, or efforts
1299 made by the contractors and providers to increase LARC
1300 utilization. This report shall be updated annually to include
1301 information for subsequent state fiscal years.
1302 (12) The division is authorized to make not more than
1303 one (1) emergency extension of the contracts that are in effect on
1304 July 1, 2021, with contractors who are receiving capitated
1305 payments under a managed care delivery system established under
1306 this subsection (H), as provided in this paragraph (12). The
1307 maximum period of any such extension shall be one (1) year, and
1308 under any such extensions, the contractors shall be subject to all
1309 of the provisions of this subsection (H). The extended contracts

1310 shall be revised to incorporate any provisions of this subsection
1311 (H).

1312 (I) [Deleted]

1313 (J) There shall be no cuts in inpatient and outpatient
1314 hospital payments, or allowable days or volumes, as long as the
1315 hospital assessment provided in Section 43-13-145 is in effect.
1316 This subsection (J) shall not apply to decreases in payments that
1317 are a result of: reduced hospital admissions, audits or payments
1318 under the APR-DRG or APC models, or a managed care program or
1319 similar model described in subsection (H) of this section.

1320 (K) In the negotiation and execution of such contracts
1321 involving services performed by actuarial firms, the Executive
1322 Director of the Division of Medicaid may negotiate a limitation on
1323 liability to the state of prospective contractors.

1324 (L) The Division of Medicaid shall reimburse for services
1325 provided to eligible Medicaid beneficiaries by a licensed birthing
1326 center in a method and manner to be determined by the division in
1327 accordance with federal laws and federal regulations. The
1328 division shall seek any necessary waivers, make any required
1329 amendments to its State Plan or revise any contracts authorized
1330 under subsection (H) of this section as necessary to provide the
1331 services authorized under this subsection. As used in this
1332 subsection, the term "birthing centers" shall have the meaning as
1333 defined in Section 41-77-1(a), which is a publicly or privately
1334 owned facility, place or institution constructed, renovated,

1335 leased or otherwise established where nonemergency births are
1336 planned to occur away from the mother's usual residence following
1337 a documented period of prenatal care for a normal uncomplicated
1338 pregnancy which has been determined to be low risk through a
1339 formal risk-scoring examination.

1340 (M) This section shall stand repealed on July 1, *** * *** 2027.

1341 **SECTION 2.** This act shall take effect and be in force from
1342 and after July 1, 2024.

ST: Medicaid services; require division to ensure nonopioid drug is disadvantaged relative to an opioid or narcotic.