MISSISSIPPI LEGISLATURE REGULAR SESSION 2024

By: Senator(s) Blackwell To: Medicaid

SENATE BILL NO. 2823

AN ACT TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972, TO MAKE CERTAIN TECHNICAL AMENDMENTS TO THE PROVISIONS THAT PROVIDE FOR MEDICAID ELIGIBILITY, TO CONFORM WITH FEDERAL LAW TO ALLOW CHILDREN IN FOSTER CARE TO BE ELIGIBLE UNTIL THEIR TWENTY SIXTH BIRTHDAY; TO AUTHORIZE THE DIVISION OF MEDICAID TO APPLY FOR A FEDERAL FAMILY PLANNING WAIVER OR TO AMEND ITS STATE PLAN FOR SUCH PURPOSE; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO MAKE CERTAIN TECHNICAL AMENDMENTS TO THE PROVISIONS THAT PROVIDE FOR MEDICAID SERVICES, TO COMPLY WITH FEDERAL LAW; TO PROVIDE THAT THE DIVISION OF MEDICAID SHALL UPDATE THE CASE MIX PAYMENT SYSTEM AND FAIR RENTAL REIMBURSEMENT SYSTEM AS NECESSARY TO MAINTAIN COMPLIANCE WITH FEDERAL LAW; TO REVISE CERTAIN PROVISIONS RELATED TO FAMILY PLANNING SERVICES, INCLUDING THAT CONTRACEPTIVES MAY BE PRESCRIBED AND DISPENSED IN TWELVE MONTH SUPPLY INCREMENTS; TO DELETE TECHNICAL PROVISIONS RELATED TO THE MISSISSIPPI HOSPITAL ACCESS PROGRAM (MHAP); TO PROVIDE THAT THE DIVISION SHALL CONTRACT WITH THE STATE DEPARTMENT OF HEALTH TO PROVIDE PERINATAL HIGH RISK MANAGEMENT/INFANT SERVICES SYSTEM FOR ANY ELIGIBLE BENEFICIARY THAT CANNOT RECEIVE SUCH SERVICES UNDER A DIFFERENT PROGRAM; TO AUTHORIZE THE DIVISION TO REIMBURSE FOR SERVICES AT CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTERS; TO EXTEND THE DATE OF REPEAL ON SUCH SECTION; TO REQUIRE THE DIVISION TO COVER A CONTINUING GLUCOSE MONITORING (CGM) SERVICE AS A PHARMACY BENEFIT WHEN CERTAIN CONDITIONS ARE MET; TO INCLUDE ADDITIONAL LICENSED PROVIDERS IN THE DIVISION'S UPPER PAYMENT LIMITS PROGRAM; TO REQUIRE THE DIVISION TO PROVIDE REIMBURSEMENT FOR BEHAVIORAL HEALTH ASSESSMENT AND INTERVENTION SERVICES, PROVIDED BY ANY QUALIFIED LICENSED BEHAVIORAL HEALTH PROVIDER APPROVED BY CMS, AS DETERMINED BY THE DIVISION; TO REQUIRE THE DIVISION TO REIMBURSE AMBULANCE TRANSPORTATION SERVICES PROVIDERS THAT PROVIDE AN ASSESSMENT, TRIAGE, TREAT OR TRANSPORT ELIGIBLE MEDICAID BENEFICIARIES TO AN ALTERNATIVE DESTINATION IN THIS STATE OR PROVIDE AN ASSESSMENT OR TREAT ELIGIBLE MEDICAID BENEFICIARIES IN PLACE; TO SET CERTAIN REIMBURSEMENT LEVELS FOR SUCH PROVIDERS;

TO AMEND SECTION 43-13-305, MISSISSIPPI CODE OF 1972, TO REVISE CERTAIN PROVISIONS RELATED TO MEDICAID AND THIRD PARTY BENEFITS TO COMPLY WITH FEDERAL LAW; TO AMEND SECTION 43-11-1, MISSISSIPPI CODE OF 1972, TO DEFINE ADULT DAY CARE FACILITY; TO AMEND SECTION 43-11-13, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT BEGINNING JULY 1, 2025, TO OPERATE AN ADULT DAY CARE CENTER IN MISSISSIPPI, A FACILITY PROVIDER SHALL BE LICENSED WITH THE LICENSING DIVISION OF THE STATE DEPARTMENT OF HEALTH; TO ESTABLISH THAT MISSISSIPPI MEDICAID WAIVER PROVIDERS ARE REQUIRED TO HAVE A STATE LICENSE AND HAVE A MEDICAID PROVIDER CONTRACT WITH THE DIVISION OF MEDICAID; AND FOR RELATED PURPOSES.

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

AND FOR RELATED PURPOSES.

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

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

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

(1) Those who are qualified for public assistance grants under provisions of Title IV-A and E of the federal Social Security Act, as amended, including those statutorily deemed to be IV-A and low income families and children under Section 1931 of the federal Social Security Act. For the purposes of this paragraph (1) and paragraphs (8), (17) and (18) of this section, any reference to Title IV-A or to Part A of Title IV of the federal Social Security Act, as amended, or the state plan under Title IV-A or Part A of Title IV, shall be considered as a reference to Title IV-A of the federal Social Security Act, as amended, and the state plan under Title IV-A, including the income and resource standards and methodologies under Title IV-A and the state plan, as they existed on July 16, 1996. The Department of

Human Services shall determine Medicaid eligibility for children receiving public assistance grants under Title IV-E. The division shall determine eligibility for low income families under Section 1931 of the federal Social Security Act and shall redetermine eligibility for those continuing under Title IV-A grants.

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

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

(4) [Deleted]

(5) A child born on or after October 1, 1984, to a woman eligible for and receiving Medicaid under the state plan on the date of the child's birth shall be deemed to have applied for Medicaid and to have been found eligible for Medicaid under the plan on the date of that birth, and will remain eligible for Medicaid for a period of one (1) year so long as the child is a member of the woman's household and the woman remains eligible for Medicaid or would be eligible for Medicaid if pregnant. The

eligibility of individuals covered in this paragraph shall be determined by the Division of Medicaid.

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

(7) Persons certified by the Division of Medicaid who are patients in a medical facility (nursing home, hospital, tuberculosis sanatorium or institution for treatment of mental diseases), and who, except for the fact that they are patients in that medical facility, would qualify for grants under Title IV, Supplementary Security Income (SSI) benefits under Title XVI or state supplements, and those aged, blind and disabled persons who would not be eligible for Supplemental Security Income (SSI) benefits under Title XVI or state supplements if they were not institutionalized in a medical facility but whose income is below the maximum standard set by the Division of Medicaid, which standard shall not exceed that prescribed by federal regulation.

(8) Children under eighteen (18) years of age and pregnant women (including those in intact families) who meet the

financial standards of the state plan approved under Title IV-A of the federal Social Security Act, as amended. The eligibility of children covered under this paragraph shall be determined by the Division of Medicaid.

(9) Individuals who are:

(a) Children born after September 30, 1983, who have not attained the age of nineteen (19), with family income that does not exceed one hundred percent (100%) of the nonfarm official poverty level;

(b) Pregnant women, infants and children who have not attained the age of six (6), with family income that does not exceed one hundred thirty-three percent (133%) of the federal poverty level; and

(c) Pregnant women and infants who have not attained the age of one (1), with family income that does not exceed one hundred eighty-five percent (185%) of the federal poverty level.

The eligibility of individuals covered in (a), (b) and (c) of this paragraph shall be determined by the division.

(10) Certain disabled children age eighteen (18) or under who are living at home, who would be eligible, if in a medical institution, for SSI or a state supplemental payment under Title XVI of the federal Social Security Act, as amended, and therefore for Medicaid under the plan, and for whom the state has made a determination as required under Section 1902(e)(3)(b) of

the federal Social Security Act, as amended. The eligibility of individuals under this paragraph shall be determined by the Division of Medicaid.

(11) Until the end of the day on December 31, 2005, individuals who are sixty-five (65) years of age or older or are disabled as determined under Section 1614(a)(3) of the federal Social Security Act, as amended, and whose income does not exceed one hundred thirty-five percent (135%) of the nonfarm official poverty level as defined by the Office of Management and Budget and revised annually, and whose resources do not exceed those established by the Division of Medicaid. The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid. After December 31, 2005, only those individuals covered under the 1115(c) Healthier Mississippi waiver will be covered under this category.

Any individual who applied for Medicaid during the period from July 1, 2004, through March 31, 2005, who otherwise would have been eligible for coverage under this paragraph (11) if it had been in effect at the time the individual submitted his or her application and is still eligible for coverage under this paragraph (11) on March 31, 2005, shall be eligible for Medicaid coverage under this paragraph (11) from March 31, 2005, through December 31, 2005. The division shall give priority in processing the applications for those individuals to determine their eligibility under this paragraph (11).

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

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

(13) (a) Individuals who are entitled to Medicare Part A as defined in Section 4501 of the Omnibus Budget Reconciliation Act of 1990, and whose income does not exceed one hundred twenty percent (120%) of the nonfarm official poverty level as defined by the Office of Management and Budget and revised annually. Eligibility for Medicaid benefits is limited to full payment of Medicare Part B premiums.

(b) Individuals entitled to Part A of Medicare, with income above one hundred twenty percent (120%), but less than one hundred thirty-five percent (135%) of the federal poverty level, and not otherwise eligible for Medicaid. Eligibility for Medicaid benefits is limited to full payment of Medicare Part B

premiums. The number of eligible individuals is limited by the availability of the federal capped allocation at one hundred percent (100%) of federal matching funds, as more fully defined in the Balanced Budget Act of 1997.

The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid.

(14) [Deleted]

(15) Disabled workers who are eligible to enroll in Part A Medicare as required by Public Law 101-239, known as the Omnibus Budget Reconciliation Act of 1989, and whose income does not exceed two hundred percent (200%) of the federal poverty level as determined in accordance with the Supplemental Security Income (SSI) program. The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid and those individuals shall be entitled to buy-in coverage of Medicare Part A premiums only under the provisions of this paragraph (15).

(16) In accordance with the terms and conditions of approved Title XIX waiver from the United States Department of Health and Human Services, persons provided home- and community-based services who are physically disabled and certified by the Division of Medicaid as eligible due to applying the income and deeming requirements as if they were institutionalized.

(17) In accordance with the terms of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193), persons who become ineligible for

assistance under Title IV-A of the federal Social Security Act, as amended, because of increased income from or hours of employment of the caretaker relative or because of the expiration of the applicable earned income disregards, who were eligible for Medicaid for at least three (3) of the six (6) months preceding the month in which the ineligibility begins, shall be eligible for Medicaid for up to twelve (12) months. The eligibility of the individuals covered under this paragraph shall be determined by the division.

(18) Persons who become ineligible for assistance under Title IV-A of the federal Social Security Act, as amended, as a result, in whole or in part, of the collection or increased collection of child or spousal support under Title IV-D of the federal Social Security Act, as amended, who were eligible for Medicaid for at least three (3) of the six (6) months immediately preceding the month in which the ineligibility begins, shall be eligible for Medicaid for an additional four (4) months beginning with the month in which the ineligibility begins. The eligibility of the individuals covered under this paragraph shall be determined by the division.

(19) Disabled workers, whose incomes are above the Medicaid eligibility limits, but below two hundred fifty percent (250%) of the federal poverty level, shall be allowed to purchase Medicaid coverage on a sliding fee scale developed by the Division of Medicaid.

(20) Medicaid eligible children under age eighteen (18) shall remain eligible for Medicaid benefits until the end of a period of twelve (12) months following an eligibility determination, or until such time that the individual exceeds age eighteen (18).

(21) Women and men of * * * reproductive age whose family income does not exceed one hundred eighty-five percent (185%) of the federal poverty level. The eligibility of individuals covered under this paragraph (21) shall be determined by the Division of Medicaid, and those individuals determined eligible shall only receive family planning services covered under Section 43-13-117(13) and not any other services covered under Medicaid. However, any individual eligible under this paragraph (21) who is also eligible under any other provision of this section shall receive the benefits to which he or she is entitled under that other provision, in addition to family planning services covered under Section 43-13-117(13).

The Division of Medicaid * * * may apply to the United States Secretary of Health and Human Services for a federal waiver of the applicable provisions of Title XIX of the federal Social Security Act, as amended, and any other applicable provisions of federal law as necessary to allow for the implementation of this paragraph (21). * * *

(22) Persons who are workers with a potentially severe disability, as determined by the division, shall be allowed to

purchase Medicaid coverage. The term "worker with a potentially severe disability" means a person who is at least sixteen (16) years of age but under sixty-five (65) years of age, who has a physical or mental impairment that is reasonably expected to cause the person to become blind or disabled as defined under Section 1614(a) of the federal Social Security Act, as amended, if the person does not receive items and services provided under Medicaid.

The eligibility of persons under this paragraph (22) shall be conducted as a demonstration project that is consistent with Section 204 of the Ticket to Work and Work Incentives Improvement Act of 1999, Public Law 106-170, for a certain number of persons as specified by the division. The eligibility of individuals covered under this paragraph (22) shall be determined by the Division of Medicaid.

(23) Children certified by the Mississippi Department of Human Services for whom the state and county departments of human services have custody and financial responsibility who are in foster care on their eighteenth birthday as reported by the Mississippi Department of Human Services shall be certified Medicaid eligible by the Division of Medicaid until their * * * twenty-sixth birthday. Children who have aged out of foster care while on Medicaid in other states shall qualify until their twenty-sixth birthday.

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

(25) The division shall apply to the Centers for Medicare and Medicaid Services (CMS) for any necessary waivers to provide services to individuals who are sixty-five (65) years of age or older or are disabled as determined under Section 1614(a)(3) of the federal Social Security Act, as amended, and whose income does not exceed one hundred thirty-five percent (135%) of the nonfarm official poverty level as defined by the Office of Management and Budget and revised annually, and whose resources do not exceed those established by the Division of Medicaid, and who are not otherwise covered by Medicare. Nothing contained in this paragraph (25) shall entitle an individual to benefits. The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid.

(26) The division shall apply to the Centers for Medicare and Medicaid Services (CMS) for any necessary waivers to

provide services to individuals who are sixty-five (65) years of age or older or are disabled as determined under Section 1614(a)(3) of the federal Social Security Act, as amended, who are end stage renal disease patients on dialysis, cancer patients on chemotherapy or organ transplant recipients on antirejection drugs, whose income does not exceed one hundred thirty-five percent (135%) of the nonfarm official poverty level as defined by the Office of Management and Budget and revised annually, and whose resources do not exceed those established by the division. Nothing contained in this paragraph (26) shall entitle an individual to benefits. The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid.

(27) Individuals who are entitled to Medicare Part D and whose income does not exceed one hundred fifty percent (150%) of the nonfarm official poverty level as defined by the Office of Management and Budget and revised annually. Eligibility for payment of the Medicare Part D subsidy under this paragraph shall be determined by the division.

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

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

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

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

(1) Inpatient hospital services.

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

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

(2) Outpatient hospital services.

(a) Emergency services.

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

(c) The division is authorized to implement an Ambulatory Payment Classification (APC) methodology for outpatient hospital services. The division shall give rural hospitals that have fifty (50) or fewer licensed beds the option to not be reimbursed for outpatient hospital services using the APC methodology, but reimbursement for outpatient hospital services provided by those hospitals shall be based on one hundred one percent (101%) of the rate established under Medicare for outpatient hospital services. Those hospitals choosing to not be

reimbursed under the APC methodology shall remain under cost-based reimbursement for a two-year period.

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

(3) Laboratory and x-ray services.

(4) Nursing facility services.

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

(b) From and after July 1, 1997, the division shall implement the integrated case-mix payment and quality monitoring system, which includes the fair rental system for property costs and in which recapture of depreciation is eliminated. The division may reduce the payment for hospital leave and therapeutic home leave days to the lower of the case-mix category as computed for the resident on leave using the assessment being utilized for payment at that point in time, or a case-mix score of 1.000 for nursing facilities, and shall compute

case-mix scores of residents so that only services provided at the nursing facility are considered in calculating a facility's per diem.

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

(d) * * * The division shall update the case-mix payment system * * * and fair rental reimbursement system as necessary to maintain compliance with federal law. The division shall develop and implement a payment add-on to reimburse nursing facilities for ventilator-dependent resident services.

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

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

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

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

matching funds through the division. The division, in obtaining medical and mental health assessments, treatment, care and services for children who are in, or at risk of being put in, the custody of the Mississippi Department of Human Services may enter into a cooperative agreement with the Mississippi Department of Human Services for the provision of those services using state funds that are provided from the appropriation to the Department of Human Services to obtain federal matching funds through the division.

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

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

(b) [Repealed]

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

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

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

The division may seek to establish relationships with other states in order to lower acquisition costs of prescription drugs to include single-source and innovator multiple-source drugs or generic drugs. In addition, if allowed by federal law or regulation, the division may seek to establish relationships with and negotiate with other countries to facilitate the acquisition

of prescription drugs to include single-source and innovator multiple-source drugs or generic drugs, if that will lower the acquisition costs of those prescription drugs.

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

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

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

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

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

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

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

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

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

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

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

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

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

The division shall cover a continuing glucose monitoring (CGM) service as a pharmacy benefit when medically necessary, prior authorized by the UM/QIO, Division of Medicaid or designee,

ordered by the physician who is actively managing the beneficiary's diabetes and the beneficiary has an established diagnosis of type I or type II diabetes mellitus with the use of insulin. The beneficiary must also be able, or have a caregiver who is able, to hear and view CGM alerts and respond appropriately; had an in-person visit with the ordering physician within six (6) months prior to ordering to evaluate their diabetes control and determined that criteria above are met; and has an in-person visit every six (6) months following the prescription of the CGM to assess adherence to the CGM regimen and diabetes treatment plan; or has an established diagnosis of gestational diabetes mellitus; or evidence of level 2 or level 3 hypoglycemia.

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

The division shall increase the amount of the reimbursement rate for diagnostic and preventative dental services for each of the fiscal years 2022, 2023 and 2024 by five percent (5%) above the amount of the reimbursement rate for the previous fiscal year. The division shall increase the amount of the reimbursement rate for restorative dental services for each of the fiscal years 2023, 2024 and 2025 by five percent (5%) above the amount of the reimbursement rate for the previous fiscal year. It is the intent of the Legislature that the reimbursement rate revision for

preventative dental services will be an incentive to increase the number of dentists who actively provide Medicaid services. This dental services reimbursement rate revision shall be known as the "James Russell Dumas Medicaid Dental Services Incentive Program."

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

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

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

(12) Intermediate care facility services.

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

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

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

(13) Family planning services, including drugs, supplies and devices, when those services are under the supervision of a physician or nurse practitioner. Contraceptives may be prescribed and dispensed in twelve-month supply increments.

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

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

(b) Dialysis center services.

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

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

facility described in subparagraph (b) must have the prior approval of the division to be reimbursable under this section.

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

(18) (a) Notwithstanding any other provision of this section to the contrary, as provided in the Medicaid state plan amendment or amendments as defined in Section 43-13-145(10), the division shall make additional reimbursement to hospitals that serve a disproportionate share of low-income patients and that

meet the federal requirements for those payments as provided in Section 1923 of the federal Social Security Act and any applicable regulations. It is the intent of the Legislature that the division shall draw down all available federal funds allotted to the state for disproportionate share hospitals. However, from and after January 1, 1999, public hospitals participating in the Medicaid disproportionate share program may be required to participate in an intergovernmental transfer program as provided in Section 1903 of the federal Social Security Act and any applicable regulations.

(b) (i) 1. The division may establish a Medicare Upper Payment Limits Program, as defined in Section 1902(a)(30) of the federal Social Security Act and any applicable federal regulations, or an allowable delivery system or provider payment initiative authorized under 42 CFR 438.6(c), for hospitals, nursing facilities * * *, physicians and other eligible licensed providers approved by the Centers for Medicare and Medicaid Services (CMS) who are employed or contracted by hospitals.

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

(ii) The division shall assess each hospital, nursing facility, and emergency ambulance transportation provider for the sole purpose of financing the state portion of the Medicare Upper Payment Limits Program or other program(s) authorized under this subsection (A)(18)(b). The hospital assessment shall be as provided in Section 43-13-145(4)(a), and the nursing facility and the emergency ambulance transportation assessments, if established, shall be based on Medicaid utilization or other appropriate method, as determined by the division, consistent with federal regulations. The assessments will remain in effect as long as the state participates in the Medicare Upper Payment Limits Program or other program(s) authorized under this subsection (A)(18)(b). In addition to the hospital assessment provided in Section 43-13-145(4)(a), hospitals with physicians and other eligible licensed providers approved by Centers for Medicare and Medicaid Services (CMS) participating in the Medicare Upper Payment Limits Program or other program(s) authorized under this subsection (A)(18)(b) shall be required to participate in an intergovernmental transfer or assessment, as determined by the division, for the purpose of financing the state portion of the physician UPL payments or other payment(s) authorized under this subsection (A)(18)(b).

(iii) Subject to approval by the Centers for Medicare and Medicaid Services (CMS) and the provisions of this subsection (A)(18)(b), the division shall make additional

reimbursement to hospitals, nursing facilities, and emergency ambulance transportation providers for the Medicare Upper Payment Limits Program or other program(s) authorized under this subsection (A)(18)(b), and, if the program is established for physicians and other eligible licensed providers approved by Centers for Medicare and Medicaid Services (CMS), shall make additional reimbursement for physicians and other eligible licensed providers approved by CMS, as defined in Section 1902(a)(30) of the federal Social Security Act and any applicable federal regulations, provided the assessment in this subsection (A)(18)(b) is in effect.

(iv) *** * *** The division is authorized to develop and implement an alternative fee-for-service Upper Payment Limits model in accordance with federal laws and regulations if necessary to preserve supplemental funding. *** * ***

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

2. The division shall calculate the ambulance service access payment amount as the balance of the portion of the Medical Care Fund related to ambulance

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

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

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

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

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

(c) (i) *** * *** The division shall, subject to approval by the Centers for Medicare and Medicaid Services (CMS), establish, implement and operate a Mississippi Hospital Access Program (MHAP) for the purpose of protecting patient access to hospital care through hospital inpatient reimbursement programs provided in this section designed to maintain total hospital reimbursement for inpatient services rendered by in-state hospitals and the out-of-state hospital that is authorized by federal law to submit intergovernmental transfers (IGTs) to the State of Mississippi and is classified as Level I trauma center located in a county contiguous to the state line at the maximum levels permissible under applicable federal statutes and regulations *** * ***.

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

(iii) *** * *** [Deleted]

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

(19) (a) Perinatal risk management services. The division shall promulgate regulations to be effective from and after October 1, 1988, to establish a comprehensive perinatal system for risk assessment of all pregnant and infant Medicaid recipients and for management, education and follow-up for those who are determined to be at risk. Services to be performed include case management, nutrition assessment/counseling, psychosocial assessment/counseling and health education. The division shall contract with the State Department of Health to provide services within this paragraph (Perinatal High Risk Management/Infant Services System (PHRM/ISS)) for any eligible beneficiary that cannot receive these services under a different program. The State Department of Health shall be reimbursed on a full reasonable cost basis for services provided under this subparagraph (a). Any program authorized under subsection H of this section shall develop a perinatal risk management services program in consultation with the division and the State Department of Health or shall contract with the State Department of Health

for these services, and the programs shall begin providing these services no later than January 1, 2025.

(b) Early intervention system services. The division shall cooperate with the State Department of Health, acting as lead agency, in the development and implementation of a statewide system of delivery of early intervention services, under Part C of the Individuals with Disabilities Education Act (IDEA). The State Department of Health shall certify annually in writing to the executive director of the division the dollar amount of state early intervention funds available that will be utilized as a certified match for Medicaid matching funds. Those funds then shall be used to provide expanded targeted case management services for Medicaid eligible children with special needs who are eligible for the state's early intervention system. Qualifications for persons providing service coordination shall be determined by the State Department of Health and the Division of Medicaid.

(20) Home- and community-based services for physically disabled approved services as allowed by a waiver from the United States Department of Health and Human Services for home- and community-based services for physically disabled people using state funds that are provided from the appropriation to the State Department of Rehabilitation Services and used to match federal funds under a cooperative agreement between the division and the department, provided that funds for these services are

specifically appropriated to the Department of Rehabilitation Services.

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

(22) Ambulatory services delivered in federally qualified health centers, rural health centers and clinics of the local health departments of the State Department of Health for individuals eligible for Medicaid under this article based on reasonable costs as determined by the division. Federally qualified health centers shall be reimbursed by the Medicaid prospective payment system as approved by the Centers for Medicare

and Medicaid Services. The division shall recognize federally qualified health centers (FQHCs), rural health clinics (RHCs) and community mental health centers (CMHCs) as both an originating and distant site provider for the purposes of telehealth reimbursement. The division is further authorized and directed to reimburse FQHCs, RHCs and CMHCs for both distant site and originating site services when such services are appropriately provided by the same organization.

(23) Inpatient psychiatric services.

(a) Inpatient psychiatric services to be determined by the division for recipients under age twenty-one (21) that are provided under the direction of a physician in an inpatient program in a licensed acute care psychiatric facility or in a licensed psychiatric residential treatment facility, before the recipient reaches age twenty-one (21) or, if the recipient was receiving the services immediately before he or she reached age twenty-one (21), before the earlier of the date he or she no longer requires the services or the date he or she reaches age twenty-two (22), as provided by federal regulations. From and after January 1, 2015, the division shall update the fair rental reimbursement system for psychiatric residential treatment facilities. Precertification of inpatient days and residential treatment days must be obtained as required by the division. From and after July 1, 2009, all state-owned and state-operated facilities that provide inpatient psychiatric services to persons

under age twenty-one (21) who are eligible for Medicaid reimbursement shall be reimbursed for those services on a full reasonable cost basis.

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

(24) * * * Certified Community Behavioral Health Centers (CCBHCs). The division may reimburse CCBHCs in accordance with the division's state plan.

(25) [Deleted]

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

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

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

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

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

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

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

(33) Podiatrist services.

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

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

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

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

(37) [Deleted]

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

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

(40) [Deleted]

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

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

(42) [Deleted]

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

(44) Nursing facility services for the severely disabled.

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

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

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

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

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

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

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

individual. An individual must affirmatively elect to participate in the disease management program in order to participate, and may elect to discontinue participation in the program at any time.

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

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

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

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

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

(51) Upon determination of Medicaid eligibility and in association with annual redetermination of Medicaid eligibility,

beneficiaries shall be encouraged to undertake a physical examination that will establish a base-line level of health and identification of a usual and customary source of care (a medical home) to aid utilization of disease management tools. This physical examination and utilization of these disease management tools shall be consistent with current United States Preventive Services Task Force or other recognized authority recommendations.

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

(52) Notwithstanding any provisions of this article, the division may pay enhanced reimbursement fees related to trauma care, as determined by the division in conjunction with the State Department of Health, using funds appropriated to the State Department of Health for trauma care and services and used to match federal funds under a cooperative agreement between the division and the State Department of Health. The division, in conjunction with the State Department of Health, may use grants, waivers, demonstrations, enhanced reimbursements, Upper Payment Limits Programs, supplemental payments, or other projects as necessary in the development and implementation of this reimbursement program.

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

(54) [Deleted]

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

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

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

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

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

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

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

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

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

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

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

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

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

(61) The division shall provide reimbursement for behavioral health assessment and intervention services, provided by any qualified licensed behavioral health provider approved by CMS, as determined by the Division.

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

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

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

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

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

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

(3) If the chairman of either committee or both chairmen jointly object to the proposed rate change or any part thereof, the chairman or chairmen shall notify the division and provide the reasons for their objection in writing not later than seven (7) calendar days after receipt of the notice from the division. The chairman or chairmen may make written

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

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

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

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

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

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

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

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

(E) Notwithstanding any provision of this article, no new groups or categories of recipients and new types of care and services may be added without enabling legislation from the Mississippi Legislature, except that the division may authorize

those changes without enabling legislation when the addition of recipients or services is ordered by a court of proper authority.

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

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

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

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

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

To the extent allowed under federal law, any reduction to services or reimbursement rates under this subsection (F) shall be accompanied by a reduction, to the fullest allowable amount, to the profit margin and administrative fee portions of capitated

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

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

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

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

health maintenance organization program, or provider-sponsored health plan may:

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

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

(c) Pay providers at a rate that is less than the normal Medicaid reimbursement rate. It is the intent of the Legislature that all managed care entities described in this subsection (H), in collaboration with the division, develop and implement innovative payment models that incentivize improvements in health care quality, outcomes, or value, as determined by the division. Participation in the provider network of any managed care, coordinated care, provider-sponsored health plan, or similar contractor shall not be conditioned on the provider's agreement to accept such alternative payment models;

(d) Implement a prior authorization and utilization review program for medical services, transportation

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

(e) [Deleted]

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

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

Each health maintenance organization, coordinated care organization, provider-sponsored health plan, or other organization paid for services on a capitated basis by the division under any managed care program or coordinated care program implemented by the division under this section shall use a clear set of level of care guidelines in the determination of medical necessity and in all utilization management practices,

including the prior authorization process, concurrent reviews, retrospective reviews and payments, that are consistent with widely accepted professional standards of care. Organizations participating in a managed care program or coordinated care program implemented by the division may not use any additional criteria that would result in denial of care that would be determined appropriate and, therefore, medically necessary under those levels of care guidelines.

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

(3) (a) Any contractors receiving capitated payments under a managed care delivery system established in this section shall provide to the Legislature and the division statistical data to be shared with provider groups in order to improve patient access, appropriate utilization, cost savings and health outcomes not later than October 1 of each year. Additionally, each contractor shall disclose to the Chairmen of the Senate and House

Medicaid Committees the administrative expenses costs for the prior calendar year, and the number of full-equivalent employees located in the State of Mississippi dedicated to the Medicaid and CHIP lines of business as of June 30 of the current year.

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

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

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

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

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

(iv) Administrative expense allocation methodologies,

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

(vi) Capitated arrangements with related party subcontractors,

(vii) Reasonableness of corporate allocations,

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

(ix) The effectiveness of subcontractor oversight, including subcontractor review,

(x) Whether health care outcomes have been improved, and

(xi) The most common claim denial codes to determine the reasons for the denials.

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

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

(5) No health maintenance organization, coordinated care organization, provider-sponsored health plan, or other organization paid for services on a capitated basis by the division under any managed care program or coordinated care program implemented by the division under this section shall

require its providers or beneficiaries to use any pharmacy that ships, mails or delivers prescription drugs or legend drugs or devices.

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

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

credentialing of the providers by the division's credentialing process.

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

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

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

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

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

the division. If a contractor does not issue a final ruling of denial within sixty (60) days as required by this subparagraph (b), the provider's claim shall be deemed to be automatically approved and the contractor shall pay the amount of the claim to the provider.

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

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

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

(10) It is the intent of the Legislature that any contractor receiving capitated payments under a managed care

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

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

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

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

(I) [Deleted]

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

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

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

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

(M) The Division of Medicaid shall reimburse ambulance transportation service providers that provide an assessment, triage, treatment or transportation for eligible Medicaid beneficiaries to an alternative destination in this state or provide an assessment or treat eligible Medicaid beneficiaries in place.

(1) As used in this section:

(a) "Alternative destination" means a lower-acuity facility that provides medical services, including without limitation:

(i) A federally qualified health center;

(ii) An urgent care center;

(iii) A physician office or medical clinic, as selected by the patient; and

(iv) A behavioral or mental healthcare facility including without limitation a crisis stabilization unit and a diversion center.

(b) "Alternative destination" does not include a:

(i) Critical access hospital;

(ii) Dialysis center;

(iii) Hospital;

(iv) Private residence; or

(v) Skilled nursing facility;

(c) "Ambulance service provider" as used in this section means a person or entity that provides ambulance transportation and emergency medical services to a patient for which a permit is required under Section 41-59-9;

(d) The reimbursement rate for an ambulance service provider whose operators provide an assessment, triage, treatment or transportation for an enrollee to an alternative destination shall be reimbursed at least at the advanced life support rate with mileage to scene in accordance with the Center for Medicaid Services (CMS) billing standards.

(N) This section shall stand repealed on July 1, * * * 2029.

SECTION 3. Section 43-13-305, Mississippi Code of 1972, is amended as follows:

43-13-305. (1) By accepting Medicaid from the Division of Medicaid in the Office of the Governor, the recipient shall, to the extent of the payment of medical expenses by the Division of Medicaid, be deemed to have made an assignment to the Division of Medicaid of any and all rights and interests in any third-party benefits, hospitalization or indemnity contract or any cause of action, past, present or future, against any person, firm or corporation for Medicaid benefits provided to the recipient by the Division of Medicaid for injuries, disease or sickness caused or

suffered under circumstances creating a cause of action in favor of the recipient against any such person, firm or corporation as set out in Section 43-13-125. The recipient shall be deemed, without the necessity of signing any document, to have appointed the Division of Medicaid as his or her true and lawful attorney-in-fact in his or her name, place and stead in collecting any and all amounts due and owing for medical expenses paid by the Division of Medicaid against such person, firm or corporation.

(2) Whenever a provider of medical services or the Division of Medicaid submits claims to an insurer on behalf of a Medicaid recipient for whom an assignment of rights has been received, or whose rights have been assigned by the operation of law, the insurer must respond within sixty (60) days of receipt of a claim by forwarding payment or issuing a notice of denial directly to the submitter of the claim. The failure of the insuring entity to comply with the provisions of this section shall subject the insuring entity to recourse by the Division of Medicaid in accordance with the provision of Section 43-13-315. In the case of a responsible insurer, other than the insurers exempted under federal law, that requires prior authorization for an item or service furnished to a recipient, the insurer shall accept authorization provided by the Division of Medicaid that the item or service is covered under the State plan (or waiver of such plan) for such recipient, as if such authorization were the prior authorization made by the third party for such item or service.

The Division of Medicaid shall be authorized to endorse any and all, including, but not limited to, multi-payee checks, drafts, money orders or other negotiable instruments representing Medicaid payment recoveries that are received by the Division of Medicaid.

(3) Court orders or agreements for medical support shall direct such payments to the Division of Medicaid, which shall be authorized to endorse any and all checks, drafts, money orders or other negotiable instruments representing medical support payments which are received. Any designated medical support funds received by the State Department of Human Services or through its local county departments shall be paid over to the Division of Medicaid. When medical support for a Medicaid recipient is available through an absent parent or custodial parent, the insuring entity shall direct the medical support payment(s) to the provider of medical services or to the Division of Medicaid.

SECTION 4. Section 43-11-1, Mississippi Code of 1972, is amended as follows:

43-11-1. When used in this chapter, the following words shall have the following meaning:

(a) "Institutions for the aged or infirm" means a place either governmental or private that provides group living arrangements for four (4) or more persons who are unrelated to the operator and who are being provided food, shelter and personal care, whether any such place is organized or operated for profit or not. The term "institution for the aged or infirm" includes

nursing homes, pediatric skilled nursing facilities, psychiatric residential treatment facilities, convalescent homes, homes for the aged, adult foster care facilities and special care facilities for paroled inmates, provided that these institutions fall within the scope of the definitions set forth above. The term "institution for the aged or infirm" does not include hospitals, clinics or mental institutions devoted primarily to providing medical service, and does not include any private residence in which the owner of the residence is providing personal care services to disabled or homeless veterans under an agreement with, and in compliance with the standards prescribed by, the United States Department of Veterans Affairs, if the owner of the residence also provided personal care services to disabled or homeless veterans at any time during calendar year 2008.

(b) "Person" means any individual, firm, partnership, corporation, company, association or joint-stock association, or any licensee herein or the legal successor thereof.

(c) "Personal care" means assistance rendered by personnel of the home to aged or infirm residents in performing one or more of the activities of daily living, which includes, but is not limited to, the bathing, walking, excretory functions, feeding, personal grooming and dressing of such residents.

(d) "Psychiatric residential treatment facility" means any nonhospital establishment with permanent facilities which provides a twenty-four-hour program of care by qualified

therapists, including, but not limited to, duly licensed mental health professionals, psychiatrists, psychologists, psychotherapists and licensed certified social workers, for emotionally disturbed children and adolescents referred to such facility by a court, local school district or by the Department of Human Services, who are not in an acute phase of illness requiring the services of a psychiatric hospital, and are in need of such restorative treatment services. For purposes of this paragraph, the term "emotionally disturbed" means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance:

1. An inability to learn which cannot be explained by intellectual, sensory or health factors;

2. An inability to build or maintain satisfactory relationships with peers and teachers;

3. Inappropriate types of behavior or feelings under normal circumstances;

4. A general pervasive mood of unhappiness or depression; or

5. A tendency to develop physical symptoms or fears associated with personal or school problems. An establishment furnishing primarily domiciliary care is not within this definition.

(e) "Pediatric skilled nursing facility" means an institution or a distinct part of an institution that is primarily engaged in providing to inpatients skilled nursing care and related services for persons under twenty-one (21) years of age who require medical or nursing care or rehabilitation services for the rehabilitation of injured, disabled or sick persons.

(f) "Licensing agency" means the State Department of Health.

(g) "Medical records" mean, without restriction, those medical histories, records, reports, summaries, diagnoses and prognoses, records of treatment and medication ordered and given, notes, entries, x-rays and other written or graphic data prepared, kept, made or maintained in institutions for the aged or infirm that pertain to residency in, or services rendered to residents of, an institution for the aged or infirm.

(h) "Adult foster care facility" means a home setting for vulnerable adults in the community who are unable to live independently due to physical, emotional, developmental or mental impairments, or in need of emergency and continuing protective social services for purposes of preventing further abuse or neglect and for safeguarding and enhancing the welfare of the abused or neglected vulnerable adult. Adult foster care programs shall be designed to meet the needs of vulnerable adults with impairments through individual plans of care, which provide a variety of health, social and related support services in a

protective setting, enabling participants to live in the community. Adult foster care programs may be (i) traditional, where the foster care provider lives in the residence and is the primary caregiver to clients in the home; (ii) corporate, where the foster care home is operated by a corporation with shift staff delivering services to clients; or (iii) shelter, where the foster care home accepts clients on an emergency short-term basis for up to thirty (30) days.

(i) "Special care facilities for paroled inmates" means long-term care and skilled nursing facilities licensed as special care facilities for medically frail paroled inmates, formed to ease the burden of prison overcrowding and provide compassionate release and medical parole initiatives while impacting economic outcomes for the Mississippi prison system. The facilities shall meet all Mississippi Department of Health and federal Center for Medicaid Services (CMS) requirements and shall be regulated by both agencies; provided, however, such regulations shall not be as restrictive as those required for personal care homes and other institutions devoted primarily to providing medical services. The facilities will offer physical, occupational and speech therapy, nursing services, wound care, a dedicated COVID services unit, individualized patient centered plans of care, social services, spiritual services, physical activities, transportation, medication, durable medical equipment, personalized meal plans by a licensed dietician and security services. There may be up to

three (3) facilities located in each Supreme Court district, to be designated by the Chairman of the State Parole Board or his designee.

(j) "Adult day care facility" means a public agency or private organization, or a subdivision of such an agency or organization, that:

(i) Provides the following items and services:

1. Nursing services;

2. Transportation of the individual to and from such adult day care facility in connection with any such item or service;

3. Meals;

4. A program of supervised activities that meets such criteria as the licensing agency determines appropriate designed to promote physical and mental health that are furnished to the individual by such a facility in a group setting for a period not greater than twelve (12) hours per day;

5. The administration of medication by a licensed nurse, and a medication management program to minimize unnecessary or inappropriate use of prescription drugs and adverse events due to unintended prescription drug-to-drug interactions; and

(ii) Meets such standards established by the licensing agency to assure quality of care and such other requirements as the licensing agency finds necessary in the

interest of the health and safety of individuals who are furnished services in the facility.

SECTION 5. Section 43-11-13, Mississippi Code of 1972, is amended as follows:

43-11-13. (1) The licensing agency shall adopt, amend, promulgate and enforce such rules, regulations and standards, including classifications, with respect to all institutions for the aged or infirm to be licensed under this chapter as may be designed to further the accomplishment of the purpose of this chapter in promoting adequate care of individuals in those institutions in the interest of public health, safety and welfare. Those rules, regulations and standards shall be adopted and promulgated by the licensing agency and shall be recorded and indexed in a book to be maintained by the licensing agency in its main office in the State of Mississippi, entitled "Rules, Regulations and Minimum Standards for Institutions for the Aged or Infirm" and the book shall be open and available to all institutions for the aged or infirm and the public generally at all reasonable times. Upon the adoption of those rules, regulations and standards, the licensing agency shall mail copies thereof to all those institutions in the state that have filed with the agency their names and addresses for this purpose, but the failure to mail the same or the failure of the institutions to receive the same shall in no way affect the validity thereof. The rules, regulations and standards may be amended by the licensing

agency, from time to time, as necessary to promote the health, safety and welfare of persons living in those institutions.

(2) The licensee shall keep posted in a conspicuous place on the licensed premises all current rules, regulations and minimum standards applicable to fire protection measures as adopted by the licensing agency. The licensee shall furnish to the licensing agency at least once each six (6) months a certificate of approval and inspection by state or local fire authorities. Failure to comply with state laws and/or municipal ordinances and current rules, regulations and minimum standards as adopted by the licensing agency, relative to fire prevention measures, shall be prima facie evidence for revocation of license.

(3) The State Board of Health shall promulgate rules and regulations restricting the storage, quantity and classes of drugs allowed in personal care homes and adult foster care facilities. Residents requiring administration of Schedule II Narcotics as defined in the Uniform Controlled Substances Law may be admitted to a personal care home. Schedule drugs may only be allowed in a personal care home if they are administered or stored utilizing proper procedures under the direct supervision of a licensed physician or nurse.

(4) (a) Notwithstanding any determination by the licensing agency that skilled nursing services would be appropriate for a resident of a personal care home, that resident, the resident's guardian or the legally recognized responsible party for the

resident may consent in writing for the resident to continue to reside in the personal care home, if approved in writing by a licensed physician. However, no personal care home shall allow more than two (2) residents, or ten percent (10%) of the total number of residents in the facility, whichever is greater, to remain in the personal care home under the provisions of this subsection (4). This consent shall be deemed to be appropriately informed consent as described in the regulations promulgated by the licensing agency. After that written consent has been obtained, the resident shall have the right to continue to reside in the personal care home for as long as the resident meets the other conditions for residing in the personal care home. A copy of the written consent and the physician's approval shall be forwarded by the personal care home to the licensing agency.

(b) The State Board of Health shall promulgate rules and regulations restricting the handling of a resident's personal deposits by the director of a personal care home. Any funds given or provided for the purpose of supplying extra comforts, conveniences or services to any resident in any personal care home, and any funds otherwise received and held from, for or on behalf of any such resident, shall be deposited by the director or other proper officer of the personal care home to the credit of that resident in an account that shall be known as the Resident's Personal Deposit Fund. No more than one (1) month's charge for the care, support, maintenance and medical attention of the

resident shall be applied from the account at any one time. After the death, discharge or transfer of any resident for whose benefit any such fund has been provided, any unexpended balance remaining in his personal deposit fund shall be applied for the payment of care, cost of support, maintenance and medical attention that is accrued. If any unexpended balance remains in that resident's personal deposit fund after complete reimbursement has been made for payment of care, support, maintenance and medical attention, and the director or other proper officer of the personal care home has been or shall be unable to locate the person or persons entitled to the unexpended balance, the director or other proper officer may, after the lapse of one (1) year from the date of that death, discharge or transfer, deposit the unexpended balance to the credit of the personal care home's operating fund.

(c) The State Board of Health shall promulgate rules and regulations requiring personal care homes to maintain records relating to health condition, medicine dispensed and administered, and any reaction to that medicine. The director of the personal care home shall be responsible for explaining the availability of those records to the family of the resident at any time upon reasonable request.

(5) The State Board of Health and the Mississippi Department of Corrections shall jointly issue rules and regulations for the operation of the special care facilities for paroled inmates.

(6) (a) For the purposes of this subsection (6):

(i) "Licensed entity" means a hospital, nursing home, personal care home, home health agency, hospice or adult foster care facility;

(ii) "Covered entity" means a licensed entity or a health care professional staffing agency;

(iii) "Employee" means any individual employed by a covered entity, and also includes any individual who by contract provides to the patients, residents or clients being served by the covered entity direct, hands-on, medical patient care in a patient's, resident's or client's room or in treatment or recovery rooms. The term "employee" does not include health care professional/vocational technical students performing clinical training in a licensed entity under contracts between their schools and the licensed entity, and does not include students at high schools located in Mississippi who observe the treatment and care of patients in a licensed entity as part of the requirements of an allied-health course taught in the high school, if:

1. The student is under the supervision of a licensed health care provider; and

2. The student has signed an affidavit that is on file at the student's school stating that he or she has not been convicted of or pleaded guilty or nolo contendere to a felony listed in paragraph (d) of this subsection (6), or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea. Before any student may sign such an

affidavit, the student's school shall provide information to the student explaining what a felony is and the nature of the felonies listed in paragraph (d) of this subsection (6).

However, the health care professional/vocational technical academic program in which the student is enrolled may require the student to obtain criminal history record checks. In such incidences, paragraph (a)(iii)1 and 2 of this subsection (6) does not preclude the licensing entity from processing submitted fingerprints of students from healthcare-related professional/vocational technical programs who, as part of their program of study, conduct observations and provide clinical care and services in a covered entity.

(b) Under regulations promulgated by the State Board of Health, the licensing agency shall require to be performed a criminal history record check on (i) every new employee of a covered entity who provides direct patient care or services and who is employed on or after July 1, 2003, and (ii) every employee of a covered entity employed before July 1, 2003, who has a documented disciplinary action by his or her present employer. In addition, the licensing agency shall require the covered entity to perform a disciplinary check with the professional licensing agency of each employee, if any, to determine if any disciplinary action has been taken against the employee by that agency.

Except as otherwise provided in paragraph (c) of this subsection (6), no such employee hired on or after July 1, 2003,

shall be permitted to provide direct patient care until the results of the criminal history record check have revealed no disqualifying record or the employee has been granted a waiver. In order to determine the employee applicant's suitability for employment, the applicant shall be fingerprinted. Fingerprints shall be submitted to the licensing agency from scanning, with the results processed through the Department of Public Safety's Criminal Information Center. The fingerprints shall then be forwarded by the Department of Public Safety to the Federal Bureau of Investigation for a national criminal history record check. The licensing agency shall notify the covered entity of the results of an employee applicant's criminal history record check. If the criminal history record check discloses a felony conviction, guilty plea or plea of nolo contendere to a felony of possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, sex offense listed in Section 45-33-23(h), child abuse, arson, grand larceny, burglary, gratification of lust or aggravated assault, or felonious abuse and/or battery of a vulnerable adult that has not been reversed on appeal or for which a pardon has not been granted, the employee applicant shall not be eligible to be employed by the covered entity.

(c) Any such new employee applicant may, however, be employed on a temporary basis pending the results of the criminal history record check, but any employment contract with the new employee shall be voidable if the new employee receives a

disqualifying criminal history record check and no waiver is granted as provided in this subsection (6).

(d) Under regulations promulgated by the State Board of Health, the licensing agency shall require every employee of a covered entity employed before July 1, 2003, to sign an affidavit stating that he or she has not been convicted of or pleaded guilty or nolo contendere to a felony of possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense listed in Section 45-33-23(h), child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea. No such employee of a covered entity hired before July 1, 2003, shall be permitted to provide direct patient care until the employee has signed the affidavit required by this paragraph (d). All such existing employees of covered entities must sign the affidavit required by this paragraph (d) within six (6) months of the final adoption of the regulations promulgated by the State Board of Health. If a person signs the affidavit required by this paragraph (d), and it is later determined that the person actually had been convicted of or pleaded guilty or nolo contendere to any of the offenses listed in this paragraph (d) and the conviction or plea has not been reversed on appeal or a pardon has not been granted for the conviction or plea, the person is guilty of perjury. If the

offense that the person was convicted of or pleaded guilty or nolo contendere to was a violent offense, the person, upon a conviction of perjury under this paragraph, shall be punished as provided in Section 97-9-61. If the offense that the person was convicted of or pleaded guilty or nolo contendere to was a nonviolent offense, the person, upon a conviction of perjury under this paragraph, shall be punished by a fine of not more than Five Hundred Dollars ($500.00), or by imprisonment in the county jail for not more than six (6) months, or by both such fine and imprisonment.

(e) The covered entity may, in its discretion, allow any employee who is unable to sign the affidavit required by paragraph (d) of this subsection (6) or any employee applicant aggrieved by an employment decision under this subsection (6) to appear before the covered entity's hiring officer, or his or her designee, to show mitigating circumstances that may exist and allow the employee or employee applicant to be employed by the covered entity. The covered entity, upon report and recommendation of the hiring officer, may grant waivers for those mitigating circumstances, which shall include, but not be limited to: (i) age at which the crime was committed; (ii) circumstances surrounding the crime; (iii) length of time since the conviction and criminal history since the conviction; (iv) work history; (v) current employment and character references; and (vi) other evidence demonstrating the ability of the individual to perform the employment responsibilities competently and that the

individual does not pose a threat to the health or safety of the patients of the covered entity.

(f) The licensing agency may charge the covered entity submitting the fingerprints a fee not to exceed Fifty Dollars ($50.00), which covered entity may, in its discretion, charge the same fee, or a portion thereof, to the employee applicant. Any increase in the fee charged by the licensing agency under this paragraph shall be in accordance with the provisions of Section 41-3-65. Any costs incurred by a covered entity implementing this subsection (6) shall be reimbursed as an allowable cost under Section 43-13-116.

(g) If the results of an employee applicant's criminal history record check reveals no disqualifying event, then the covered entity shall, within two (2) weeks of the notification of no disqualifying event, provide the employee applicant with a notarized letter signed by the chief executive officer of the covered entity, or his or her authorized designee, confirming the employee applicant's suitability for employment based on his or her criminal history record check. An employee applicant may use that letter for a period of two (2) years from the date of the letter to seek employment with any covered entity without the necessity of an additional criminal history record check. Any covered entity presented with the letter may rely on the letter with respect to an employee applicant's criminal background and is not required for a period of two (2) years from the date of the

letter to conduct or have conducted a criminal history record check as required in this subsection (6).

(h) The licensing agency, the covered entity, and their agents, officers, employees, attorneys and representatives, shall be presumed to be acting in good faith for any employment decision or action taken under this subsection (6). The presumption of good faith may be overcome by a preponderance of the evidence in any civil action. No licensing agency, covered entity, nor their agents, officers, employees, attorneys and representatives shall be held liable in any employment decision or action based in whole or in part on compliance with or attempts to comply with the requirements of this subsection (6).

(i) The licensing agency shall promulgate regulations to implement this subsection (6).

(j) The provisions of this subsection (6) shall not apply to:

(i) Applicants and employees of the University of Mississippi Medical Center for whom criminal history record checks and fingerprinting are obtained in accordance with Section 37-115-41; or

(ii) Health care professional/vocational technical students for whom criminal history record checks and fingerprinting are obtained in accordance with Section 37-29-232.

(7) The State Board of Health shall promulgate rules, regulations and standards regarding the operation of adult foster care facilities and adult day care facilities.

(8) Beginning July 1, 2025, to operate an adult day care center in Mississippi, the facility provider shall be licensed with the licensing division of the State Department of Health.

Mississippi Medicaid waiver providers are required to have a state license and have a Medicaid provider contract with the Division of Medicaid. The licensure shall consist of one of the following two (2) levels of service:

(a) Basic level-Level I. Facilities shall be licensed to serve clients based on the size and capacity of the facility. The facilities shall be required to provide nursing services, nutritional services, socialization and therapeutic activities. Level I Facilities shall maintain, at a minimum, a staff to client ratio in accordance with the State Department of Health's standards. Standards governing the qualify of care and services rendered shall be developed with input from all stakeholders, including the Division of Medicaid. In addition to providing adult day care services, the licensed provider is required to offer transportation services consistent with State Department of Health regulations.

(b) Enhanced Level-Level II. Enhanced level facilities shall be licensed to serve clients based on the size and capacity of the facility. This type of facility may serve clients with

significant impairments and medical needs as determined by the State Department of Health. The facility will be required to provide skilled nursing services in addition to nutritional services, socialization and therapeutic activities. Standards governing the quality of care and services rendered shall be developed with input from all stakeholders, including the Division of Medicaid. Enhanced level facilities shall maintain a staff-to-client ratio in accordance with the State Department of Health's standards. In addition to providing adult day care services, the license provider is required to offer transportation services consistent with State Department of Health regulations.

SECTION 6. This act shall take effect and be in force from and after July 1, 2024.