By: Senator(s) Blackwell To: Medicaid

SENATE BILL NO. 2823
(As Passed the Senate)

1 AN ACT TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972,
2 TO MAKE CERTAIN TECHNICAL AMENDMENTS TO THE PROVISIONS THAT
3 PROVIDE FOR MEDICAID ELIGIBILITY, TO CONFORM WITH FEDERAL LAW TO
4 ALLOW CHILDREN IN FOSTER CARE TO BE ELIGIBLE UNTIL THEIR 26TH
5 BIRTHDAY; TO AUTHORIZE THE DIVISION OF MEDICAID TO APPLY FOR A
6 FEDERAL FAMILY PLANNING WAIVER OR TO AMEND ITS STATE PLAN FOR SUCH
7 PURPOSE; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, AS
8 AMENDED BY HOUSE BILL NO 970, 2024 REGULAR SESSION, TO MAKE
9 CERTAIN TECHNICAL AMENDMENTS TO THE PROVISIONS THAT PROVIDE FOR
10 MEDICAID SERVICES, TO COMPLY WITH FEDERAL LAW; TO PROVIDE THAT THE
11 DIVISION OF MEDICAID SHALL UPDATE THE CASE-MIX PAYMENT SYSTEM AND
12 FAIR RENTAL REIMBURSEMENT SYSTEM AS NECESSARY TO MAINTAIN
13 COMPLIANCE WITH FEDERAL LAW; TO REVISE CERTAIN PROVISIONS RELATED
14 TO FAMILY PLANNING SERVICES, INCLUDING THAT CONTRACEPTIVES MAY BE
15 PRESCRIBED AND DISPENSED IN 12-MONTH SUPPLY INCREMENTS; TO REQUIRE
16 THE DIVISION TO SUBMIT A WAIVER BY JULY 1, 2024, TO CMS TO
17 AUTHORIZE THE DIVISION TO CONDUCT LESS FREQUENT MEDICAL
18 REDETERMINATIONS FOR ELIGIBLE CHILDREN WHO HAVE CERTAIN LONG-TERM
19 OR CHRONIC CONDITIONS THAT DO NOT NEED TO BE REIDENTIFIED EVERY
20 YEAR; TO DELETE TECHNICAL PROVISIONS RELATED TO THE MISSISSIPPI
21 HOSPITAL ACCESS PROGRAM (MHAP); TO REQUIRE THE DIVISION TO
22 REIMBURSE PEDIATRICIANS FOR CERTAIN PRIMARY CARE SERVICES AS
23 DEFINED BY THE DIVISION AT 100% OF THE RATE ESTABLISHED UNDER
24 MEDICARE; TO REQUIRE THE DIVISION, IN CONSULTATION WITH THE
25 MISSISSIPPI HOSPITAL ASSOCIATION, TO DEVELOP ALTERNATIVE MODELS
26 FOR DISTRIBUTION OF MEDICAL CLAIMS AND SUPPLEMENTAL PAYMENTS FOR
27 INPATIENT AND OUTPATIENT HOSPITAL SERVICES; TO PROVIDE THAT
28 SUPPLEMENTAL PAYMENTS TO A HOSPITAL SHALL NOT DECREASE BY MORE
29 THAN 5% WHEN COMPARED TO A HOSPITAL'S PRIOR YEAR PAYMENT UNLESS
30 THAT HOSPITAL HAS CLOSED, OR CHANGED SERVICES OR PATIENT VOLUME
31 WHICH IMPACT THAT HOSPITAL'S PAYMENT, AND THE DIVISION SHALL NOT
32 SUBSTANTIALLY CHANGE THE METHODOLOGIES USED TO CALCULATE A
33 HOSPITAL'S SUPPLEMENTAL PAYMENT; TO EXTEND THE DATE OF REPEAL ON
34 THE PROVISIONS THAT PROVIDE FOR CERTAIN REIMBURSEMENTS TO ANY

35 BORDER CITY UNIVERSITY-AFFILIATED PEDIATRIC TEACHING HOSPITAL; TO
36 PROVIDE THAT THE DIVISION SHALL CONTRACT WITH THE STATE DEPARTMENT
37 OF HEALTH TO PROVIDE PERINATAL HIGH-RISK MANAGEMENT/INFANT
38 SERVICES SYSTEM FOR ANY ELIGIBLE BENEFICIARY THAT CANNOT RECEIVE
39 SUCH SERVICES UNDER A DIFFERENT PROGRAM; TO AUTHORIZE THE DIVISION
40 TO REIMBURSE FOR SERVICES AT CERTIFIED COMMUNITY BEHAVIORAL HEALTH
41 CENTERS; TO EXTEND THE DATE OF REPEAL ON SUCH SECTION; TO REQUIRE
42 THE DIVISION TO COVER A CONTINUING GLUCOSE MONITORING (CGM)
43 SERVICE AS A PHARMACY BENEFIT WHEN CERTAIN CONDITIONS ARE MET; TO
44 INCLUDE ADDITIONAL LICENSED PROVIDERS IN THE DIVISION'S UPPER
45 PAYMENT LIMITS PROGRAM; TO AUTHORIZE THE DIVISION TO PROVIDE
46 REIMBURSEMENT FOR NEUROMUSCULAR TONGUE MUSCLE STIMULATOR FOR THE
47 REDUCTION OF SNORING AND OBSTRUCTIVE SLEEP APNEA; TO REQUIRE THE
48 DIVISION TO DEVELOP AND IMPLEMENT A METHOD FOR REIMBURSEMENT OF
49 AUTISM SPECTRUM DISORDER SERVICES BASED ON A CONTINUUM OF CARE FOR
50 BEST PRACTICES IN MEDICALLY NECESSARY EARLY INTERVENTION
51 TREATMENT; TO PROVIDE THAT THE DIVISION MAY REIMBURSE AMBULATORY
52 SURGICAL CARE (ASC) BASED ON 100% OF THE MEDICARE ASC PAYMENT
53 SYSTEM RATE IN EFFECT JULY 1 OF EACH YEAR AS SET BY THE CENTER FOR
54 MEDICARE AND MEDICAID SERVICES; TO REQUIRE THE DIVISION TO
55 REIMBURSE AMBULANCE TRANSPORTATION SERVICE PROVIDERS THAT PROVIDE
56 AN ASSESSMENT, TRIAGE, TREAT OR TRANSPORT ELIGIBLE MEDICAID
57 BENEFICIARIES TO AN ALTERNATIVE DESTINATION IN THIS STATE OR
58 PROVIDE AN ASSESSMENT OR TREAT ELIGIBLE MEDICAID BENEFICIARIES IN
59 PLACE; TO SET CERTAIN REIMBURSEMENT LEVELS FOR SUCH PROVIDERS; TO
60 AMEND SECTION 43-13-305, MISSISSIPPI CODE OF 1972, TO REVISE
61 CERTAIN PROVISIONS RELATED TO MEDICAID AND THIRD-PARTY BENEFITS TO
62 COMPLY WITH FEDERAL LAW; TO AMEND SECTION 43-11-1, MISSISSIPPI
63 CODE OF 1972, TO DEFINE ADULT DAY CARE FACILITY; TO AMEND SECTION
64 43-11-13, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT BEGINNING JULY
65 1, 2025, TO OPERATE AN ADULT DAY CARE CENTER IN MISSISSIPPI, A
66 FACILITY PROVIDER SHALL BE LICENSED WITH THE LICENSING DIVISION OF
67 THE STATE DEPARTMENT OF HEALTH; TO ESTABLISH THAT MISSISSIPPI
68 MEDICAID WAIVER PROVIDERS ARE REQUIRED TO HAVE A STATE LICENSE AND
69 HAVE A MEDICAID PROVIDER CONTRACT WITH THE DIVISION OF MEDICAID;
70 TO AMEND SECTION 43-13-117.1, MISSISSIPPI CODE OF 1972, TO REQUIRE
71 THE DIVISION TO REIMBURSE ADULT DAY CARE CENTERS; AND FOR RELATED
72 PURPOSES.

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

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

76 43-13-115. Recipients of Medicaid shall be the following
77 persons only:

78 (1) Those who are qualified for public assistance
79 grants under provisions of Title IV-A and E of the federal Social
80 Security Act, as amended, including those statutorily deemed to be
81 IV-A and low income families and children under Section 1931 of
82 the federal Social Security Act. For the purposes of this
83 paragraph (1) and paragraphs (8), (17) and (18) of this section,
84 any reference to Title IV-A or to Part A of Title IV of the
85 federal Social Security Act, as amended, or the state plan under
86 Title IV-A or Part A of Title IV, shall be considered as a
87 reference to Title IV-A of the federal Social Security Act, as
88 amended, and the state plan under Title IV-A, including the income
89 and resource standards and methodologies under Title IV-A and the
90 state plan, as they existed on July 16, 1996. The Department of
91 Human Services shall determine Medicaid eligibility for children
92 receiving public assistance grants under Title IV-E. The division
93 shall determine eligibility for low income families under Section
94 1931 of the federal Social Security Act and shall redetermine
95 eligibility for those continuing under Title IV-A grants.
96 (2) Those qualified for Supplemental Security Income
97 (SSI) benefits under Title XVI of the federal Social Security Act,
98 as amended, and those who are deemed SSI eligible as contained in
99 federal statute. The eligibility of individuals covered in this
100 paragraph shall be determined by the Social Security
101 Administration and certified to the Division of Medicaid.

102 (3) Qualified pregnant women who would be eligible for
103 Medicaid as a low income family member under Section 1931 of the
104 federal Social Security Act if her child were born. The
105 eligibility of the individuals covered under this paragraph shall
106 be determined by the division.
107 (4) [Deleted]
108 (5) A child born on or after October 1, 1984, to a
109 woman eligible for and receiving Medicaid under the state plan on
110 the date of the child's birth shall be deemed to have applied for
111 Medicaid and to have been found eligible for Medicaid under the
112 plan on the date of that birth, and will remain eligible for
113 Medicaid for a period of one (1) year so long as the child is a
114 member of the woman's household and the woman remains eligible for
115 Medicaid or would be eligible for Medicaid if pregnant. The
116 eligibility of individuals covered in this paragraph shall be
117 determined by the Division of Medicaid.
118 (6) Children certified by the State Department of Human
119 Services to the Division of Medicaid of whom the state and county
120 departments of human services have custody and financial
121 responsibility, and children who are in adoptions subsidized in
122 full or part by the Department of Human Services, including
123 special needs children in non-Title IV-E adoption assistance, who
124 are approvable under Title XIX of the Medicaid program. The
125 eligibility of the children covered under this paragraph shall be
126 determined by the State Department of Human Services.

127 (7) Persons certified by the Division of Medicaid who
128 are patients in a medical facility (nursing home, hospital,
129 tuberculosis sanatorium or institution for treatment of mental
130 diseases), and who, except for the fact that they are patients in
131 that medical facility, would qualify for grants under Title IV,
132 Supplementary Security Income (SSI) benefits under Title XVI or
133 state supplements, and those aged, blind and disabled persons who
134 would not be eligible for Supplemental Security Income (SSI)
135 benefits under Title XVI or state supplements if they were not
136 institutionalized in a medical facility but whose income is below
137 the maximum standard set by the Division of Medicaid, which
138 standard shall not exceed that prescribed by federal regulation.
139 (8) Children under eighteen (18) years of age and
140 pregnant women (including those in intact families) who meet the
141 financial standards of the state plan approved under Title IV-A of
142 the federal Social Security Act, as amended. The eligibility of
143 children covered under this paragraph shall be determined by the
144 Division of Medicaid.
145 (9) Individuals who are:
146 (a) Children born after September 30, 1983, who
147 have not attained the age of nineteen (19), with family income
148 that does not exceed one hundred percent (100%) of the nonfarm
149 official poverty level;
150 (b) Pregnant women, infants and children who have
151 not attained the age of six (6), with family income that does not

152 exceed one hundred thirty-three percent (133%) of the federal
153 poverty level; and
154 (c) Pregnant women and infants who have not
155 attained the age of one (1), with family income that does not
156 exceed one hundred eighty-five percent (185%) of the federal
157 poverty level.
158 The eligibility of individuals covered in (a), (b) and (c) of
159 this paragraph shall be determined by the division.
160 (10) Certain disabled children age eighteen (18) or
161 under who are living at home, who would be eligible, if in a
162 medical institution, for SSI or a state supplemental payment under
163 Title XVI of the federal Social Security Act, as amended, and
164 therefore for Medicaid under the plan, and for whom the state has
165 made a determination as required under Section 1902(e)(3)(b) of
166 the federal Social Security Act, as amended. The eligibility of
167 individuals under this paragraph shall be determined by the
168 Division of Medicaid. The division shall submit a waiver by July
169 1, 2024, to the Centers for Medicare and Medicaid Services to
170 authorize the division to conduct less frequent medical
171 redeterminations for children eligible under this subsection who
172 have certain long-term or chronic conditions that do not need to
173 be reidentified every year.
174 (11) Until the end of the day on December 31, 2005,
175 individuals who are sixty-five (65) years of age or older or are
176 disabled as determined under Section 1614(a)(3) of the federal

177 Social Security Act, as amended, and whose income does not exceed
178 one hundred thirty-five percent (135%) of the nonfarm official
179 poverty level as defined by the Office of Management and Budget
180 and revised annually, and whose resources do not exceed those
181 established by the Division of Medicaid. The eligibility of
182 individuals covered under this paragraph shall be determined by
183 the Division of Medicaid. After December 31, 2005, only those
184 individuals covered under the 1115(c) Healthier Mississippi waiver
185 will be covered under this category.

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

196 (12) Individuals who are qualified Medicare
197 beneficiaries (QMB) entitled to Part A Medicare as defined under
198 Section 301, Public Law 100-360, known as the Medicare
199 Catastrophic Coverage Act of 1988, and whose income does not
200 exceed one hundred percent (100%) of the nonfarm official poverty

201 level as defined by the Office of Management and Budget and
202 revised annually.

203 The eligibility of individuals covered under this paragraph
204 shall be determined by the Division of Medicaid, and those
205 individuals determined eligible shall receive Medicare
206 cost-sharing expenses only as more fully defined by the Medicare
207 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
208 1997.

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

216 (b) Individuals entitled to Part A of Medicare,
217 with income above one hundred twenty percent (120%), but less than
218 one hundred thirty-five percent (135%) of the federal poverty
219 level, and not otherwise eligible for Medicaid. Eligibility for
220 Medicaid benefits is limited to full payment of Medicare Part B
221 premiums. The number of eligible individuals is limited by the
222 availability of the federal capped allocation at one hundred
223 percent (100%) of federal matching funds, as more fully defined in
224 the Balanced Budget Act of 1997.

225 The eligibility of individuals covered under this paragraph
226 shall be determined by the Division of Medicaid.
227 (14) [Deleted]
228 (15) Disabled workers who are eligible to enroll in
229 Part A Medicare as required by Public Law 101-239, known as the
230 Omnibus Budget Reconciliation Act of 1989, and whose income does
231 not exceed two hundred percent (200%) of the federal poverty level
232 as determined in accordance with the Supplemental Security Income
233 (SSI) program. The eligibility of individuals covered under this
234 paragraph shall be determined by the Division of Medicaid and
235 those individuals shall be entitled to buy-in coverage of Medicare
236 Part A premiums only under the provisions of this paragraph (15).
237 (16) In accordance with the terms and conditions of
238 approved Title XIX waiver from the United States Department of
239 Health and Human Services, persons provided home- and
240 community-based services who are physically disabled and certified
241 by the Division of Medicaid as eligible due to applying the income
242 and deeming requirements as if they were institutionalized.
243 (17) In accordance with the terms of the federal
244 Personal Responsibility and Work Opportunity Reconciliation Act of
245 1996 (Public Law 104-193), persons who become ineligible for
246 assistance under Title IV-A of the federal Social Security Act, as
247 amended, because of increased income from or hours of employment
248 of the caretaker relative or because of the expiration of the
249 applicable earned income disregards, who were eligible for

250 Medicaid for at least three (3) of the six (6) months preceding
251 the month in which the ineligibility begins, shall be eligible for
252 Medicaid for up to twelve (12) months. The eligibility of the
253 individuals covered under this paragraph shall be determined by
254 the division.

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

266 (19) Disabled workers, whose incomes are above the
267 Medicaid eligibility limits, but below two hundred fifty percent
268 (250%) of the federal poverty level, shall be allowed to purchase
269 Medicaid coverage on a sliding fee scale developed by the Division
270 of Medicaid.

271 (20) Medicaid eligible children under age eighteen (18)
272 shall remain eligible for Medicaid benefits until the end of a
273 period of twelve (12) months following an eligibility

274 determination, or until such time that the individual exceeds age
275 eighteen (18).
276 (21) Women <u>and men</u> of *** * *** <u>reproductive</u> age whose
277 family income does not exceed one hundred eighty-five percent
278 (185%) of the federal poverty level. The eligibility of
279 individuals covered under this paragraph (21) shall be determined
280 by the Division of Medicaid, and those individuals determined
281 eligible shall only receive family planning services covered under
282 Section 43-13-117(13) and not any other services covered under
283 Medicaid. However, any individual eligible under this paragraph
284 (21) who is also eligible under any other provision of this
285 section shall receive the benefits to which he or she is entitled
286 under that other provision, in addition to family planning
287 services covered under Section 43-13-117(13).
288 The Division of Medicaid *** * *** <u>may</u> apply to the United States
289 Secretary of Health and Human Services for a federal waiver of the
290 applicable provisions of Title XIX of the federal Social Security
291 Act, as amended, and any other applicable provisions of federal
292 law as necessary to allow for the implementation of this paragraph
293 (21). *** * ***
294 (22) Persons who are workers with a potentially severe
295 disability, as determined by the division, shall be allowed to
296 purchase Medicaid coverage. The term "worker with a potentially
297 severe disability" means a person who is at least sixteen (16)
298 years of age but under sixty-five (65) years of age, who has a

299 physical or mental impairment that is reasonably expected to cause
300 the person to become blind or disabled as defined under Section
301 1614(a) of the federal Social Security Act, as amended, if the
302 person does not receive items and services provided under
303 Medicaid.

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

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

320 (24) Individuals who have not attained age sixty-five
321 (65), are not otherwise covered by creditable coverage as defined
322 in the Public Health Services Act, and have been screened for
323 breast and cervical cancer under the Centers for Disease Control

324 and Prevention Breast and Cervical Cancer Early Detection Program
325 established under Title XV of the Public Health Service Act in
326 accordance with the requirements of that act and who need
327 treatment for breast or cervical cancer. Eligibility of
328 individuals under this paragraph (24) shall be determined by the
329 Division of Medicaid.

330 (25) The division shall apply to the Centers for
331 Medicare and Medicaid Services (CMS) for any necessary waivers to
332 provide services to individuals who are sixty-five (65) years of
333 age or older or are disabled as determined under Section
334 1614(a)(3) of the federal Social Security Act, as amended, and
335 whose income does not exceed one hundred thirty-five percent
336 (135%) of the nonfarm official poverty level as defined by the
337 Office of Management and Budget and revised annually, and whose
338 resources do not exceed those established by the Division of
339 Medicaid, and who are not otherwise covered by Medicare. Nothing
340 contained in this paragraph (25) shall entitle an individual to
341 benefits. The eligibility of individuals covered under this
342 paragraph shall be determined by the Division of Medicaid.

343 (26) The division shall apply to the Centers for
344 Medicare and Medicaid Services (CMS) for any necessary waivers to
345 provide services to individuals who are sixty-five (65) years of
346 age or older or are disabled as determined under Section
347 1614(a)(3) of the federal Social Security Act, as amended, who are
348 end stage renal disease patients on dialysis, cancer patients on

349 chemotherapy or organ transplant recipients on antirejection
350 drugs, whose income does not exceed one hundred thirty-five
351 percent (135%) of the nonfarm official poverty level as defined by
352 the Office of Management and Budget and revised annually, and
353 whose resources do not exceed those established by the division.
354 Nothing contained in this paragraph (26) shall entitle an
355 individual to benefits. The eligibility of individuals covered
356 under this paragraph shall be determined by the Division of
357 Medicaid.
358 (27) Individuals who are entitled to Medicare Part D
359 and whose income does not exceed one hundred fifty percent (150%)
360 of the nonfarm official poverty level as defined by the Office of
361 Management and Budget and revised annually. Eligibility for
362 payment of the Medicare Part D subsidy under this paragraph shall
363 be determined by the division.
364 (28) The division is authorized and directed to provide
365 up to twelve (12) months of continuous coverage postpartum for any
366 individual who qualifies for Medicaid coverage under this section
367 as a pregnant woman, to the extent allowable under federal law and
368 as determined by the division.
369 The division shall redetermine eligibility for all categories
370 of recipients described in each paragraph of this section not less
371 frequently than required by federal law.

372 **SECTION 2.** Section 43-13-117, Mississippi Code of 1972, as
373 amended by House Bill 970, 2024 Regular Session, is amended as
374 follows:

375 43-13-117. (A) Medicaid as authorized by this article shall
376 include payment of part or all of the costs, at the discretion of
377 the division, with approval of the Governor and the Centers for
378 Medicare and Medicaid Services, of the following types of care and
379 services rendered to eligible applicants who have been determined
380 to be eligible for that care and services, within the limits of
381 state appropriations and federal matching funds:

382 (1) Inpatient hospital services.

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

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

392 (2) Outpatient hospital services.

393 (a) Emergency services.

394 (b) Other outpatient hospital services. The
395 division shall allow benefits for other medically necessary
396 outpatient hospital services (such as chemotherapy, radiation,

397 surgery and therapy), including outpatient services in a clinic or
398 other facility that is not located inside the hospital, but that
399 has been designated as an outpatient facility by the hospital, and
400 that was in operation or under construction on July 1, 2009,
401 provided that the costs and charges associated with the operation
402 of the hospital clinic are included in the hospital's cost report.
403 In addition, the Medicare thirty-five-mile rule will apply to
404 those hospital clinics not located inside the hospital that are
405 constructed after July 1, 2009. Where the same services are
406 reimbursed as clinic services, the division may revise the rate or
407 methodology of outpatient reimbursement to maintain consistency,
408 efficiency, economy and quality of care.
409 (c) The division is authorized to implement an
410 Ambulatory Payment Classification (APC) methodology for outpatient
411 hospital services. The division shall give rural hospitals that
412 have fifty (50) or fewer licensed beds the option to not be
413 reimbursed for outpatient hospital services using the APC
414 methodology, but reimbursement for outpatient hospital services
415 provided by those hospitals shall be based on one hundred one
416 percent (101%) of the rate established under Medicare for
417 outpatient hospital services. Those hospitals choosing to not be
418 reimbursed under the APC methodology shall remain under cost-based
419 reimbursement for a two-year period.
420 (d) No service benefits or reimbursement
421 limitations in this subsection (A)(2) shall apply to payments

422 under an APR-DRG or APC model or a managed care program or similar
423 model described in subsection (H) of this section unless
424 specifically authorized by the division.

425 (3) Laboratory and x-ray services.

426 (4) Nursing facility services.

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

434 (b) From and after July 1, 1997, the division
435 shall implement the integrated case-mix payment and quality
436 monitoring system, which includes the fair rental system for
437 property costs and in which recapture of depreciation is
438 eliminated. The division may reduce the payment for hospital
439 leave and therapeutic home leave days to the lower of the case-mix
440 category as computed for the resident on leave using the
441 assessment being utilized for payment at that point in time, or a
442 case-mix score of 1.000 for nursing facilities, and shall compute
443 case-mix scores of residents so that only services provided at the
444 nursing facility are considered in calculating a facility's per
445 diem.

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

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

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

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

471 The division shall apply for necessary federal waivers to
472 assure that additional services providing alternatives to nursing
473 facility care are made available to applicants for nursing
474 facility care.
475 (5) Periodic screening and diagnostic services for
476 individuals under age twenty-one (21) years as are needed to
477 identify physical and mental defects and to provide health care
478 treatment and other measures designed to correct or ameliorate
479 defects and physical and mental illness and conditions discovered
480 by the screening services, regardless of whether these services
481 are included in the state plan. The division may include in its
482 periodic screening and diagnostic program those discretionary
483 services authorized under the federal regulations adopted to
484 implement Title XIX of the federal Social Security Act, as
485 amended. The division, in obtaining physical therapy services,
486 occupational therapy services, and services for individuals with
487 speech, hearing and language disorders, may enter into a
488 cooperative agreement with the State Department of Education for
489 the provision of those services to handicapped students by public
490 school districts using state funds that are provided from the
491 appropriation to the Department of Education to obtain federal
492 matching funds through the division. The division, in obtaining
493 medical and mental health assessments, treatment, care and
494 services for children who are in, or at risk of being put in, the
495 custody of the Mississippi Department of Human Services may enter

496 into a cooperative agreement with the Mississippi Department of
497 Human Services for the provision of those services using state
498 funds that are provided from the appropriation to the Department
499 of Human Services to obtain federal matching funds through the
500 division.

501 (6) Physician services. Fees for physician's services
502 that are covered only by Medicaid shall be reimbursed at ninety
503 percent (90%) of the rate established on January 1, 2018, and as
504 may be adjusted each July thereafter, under Medicare. The
505 division may provide for a reimbursement rate for physician's
506 services of up to one hundred percent (100%) of the rate
507 established under Medicare for physician's services that are
508 provided after the normal working hours of the physician, as
509 determined in accordance with regulations of the division. The
510 division may reimburse eligible providers, as determined by the
511 division, for certain primary care services at one hundred percent
512 (100%) of the rate established under Medicare. The division shall
513 reimburse obstetricians *** * *,** gynecologists and pediatricians for
514 certain primary care services as defined by the division at one
515 hundred percent (100%) of the rate established under Medicare.

516 (7) (a) Home health services for eligible persons, not
517 to exceed in cost the prevailing cost of nursing facility
518 services. All home health visits must be precertified as required
519 by the division. In addition to physicians, certified registered
520 nurse practitioners, physician assistants and clinical nurse

521 specialists are authorized to prescribe or order home health
522 services and plans of care, sign home health plans of care,
523 certify and recertify eligibility for home health services and
524 conduct the required initial face-to-face visit with the recipient
525 of the services.

526 (b) [Repealed]

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

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

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

535 The division may seek to establish relationships with other
536 states in order to lower acquisition costs of prescription drugs
537 to include single-source and innovator multiple-source drugs or
538 generic drugs. In addition, if allowed by federal law or
539 regulation, the division may seek to establish relationships with
540 and negotiate with other countries to facilitate the acquisition
541 of prescription drugs to include single-source and innovator
542 multiple-source drugs or generic drugs, if that will lower the
543 acquisition costs of those prescription drugs.

544 The division may allow for a combination of prescriptions for
545 single-source and innovator multiple-source drugs and generic
546 drugs to meet the needs of the beneficiaries.
547 The executive director may approve specific maintenance drugs
548 for beneficiaries with certain medical conditions, which may be
549 prescribed and dispensed in three-month supply increments.
550 Drugs prescribed for a resident of a psychiatric residential
551 treatment facility must be provided in true unit doses when
552 available. The division may require that drugs not covered by
553 Medicare Part D for a resident of a long-term care facility be
554 provided in true unit doses when available. Those drugs that were
555 originally billed to the division but are not used by a resident
556 in any of those facilities shall be returned to the billing
557 pharmacy for credit to the division, in accordance with the
558 guidelines of the State Board of Pharmacy and any requirements of
559 federal law and regulation. Drugs shall be dispensed to a
560 recipient and only one (1) dispensing fee per month may be
561 charged. The division shall develop a methodology for reimbursing
562 for restocked drugs, which shall include a restock fee as
563 determined by the division not exceeding Seven Dollars and
564 Eighty-two Cents ($7.82).
565 Except for those specific maintenance drugs approved by the
566 executive director, the division shall not reimburse for any
567 portion of a prescription that exceeds a thirty-one-day supply of
568 the drug based on the daily dosage.

569 The division is authorized to develop and implement a program
570 of payment for additional pharmacist services as determined by the
571 division.
572 All claims for drugs for dually eligible Medicare/Medicaid
573 beneficiaries that are paid for by Medicare must be submitted to
574 Medicare for payment before they may be processed by the
575 division's online payment system.
576 The division shall develop a pharmacy policy in which drugs
577 in tamper-resistant packaging that are prescribed for a resident
578 of a nursing facility but are not dispensed to the resident shall
579 be returned to the pharmacy and not billed to Medicaid, in
580 accordance with guidelines of the State Board of Pharmacy.
581 The division shall develop and implement a method or methods
582 by which the division will provide on a regular basis to Medicaid
583 providers who are authorized to prescribe drugs, information about
584 the costs to the Medicaid program of single-source drugs and
585 innovator multiple-source drugs, and information about other drugs
586 that may be prescribed as alternatives to those single-source
587 drugs and innovator multiple-source drugs and the costs to the
588 Medicaid program of those alternative drugs.
589 Notwithstanding any law or regulation, information obtained
590 or maintained by the division regarding the prescription drug
591 program, including trade secrets and manufacturer or labeler
592 pricing, is confidential and not subject to disclosure except to
593 other state agencies.

594 The dispensing fee for each new or refill prescription,
595 including nonlegend or over-the-counter drugs covered by the
596 division, shall be not less than Three Dollars and Ninety-one
597 Cents ($3.91), as determined by the division.
598 The division shall not reimburse for single-source or
599 innovator multiple-source drugs if there are equally effective
600 generic equivalents available and if the generic equivalents are
601 the least expensive.
602 It is the intent of the Legislature that the pharmacists
603 providers be reimbursed for the reasonable costs of filling and
604 dispensing prescriptions for Medicaid beneficiaries.
605 The division shall allow certain drugs, including
606 physician-administered drugs, and implantable drug system devices,
607 and medical supplies, with limited distribution or limited access
608 for beneficiaries and administered in an appropriate clinical
609 setting, to be reimbursed as either a medical claim or pharmacy
610 claim, as determined by the division.
611 The division shall cover a continuing glucose monitoring
612 (CGM) service as a pharmacy benefit when medically necessary,
613 prior authorized by the UM/QIO, Division of Medicaid or designee,
614 ordered by the physician who is actively managing the
615 beneficiary's diabetes and the beneficiary has an established
616 diagnosis of type I or type II diabetes mellitus with the use of
617 insulin. The beneficiary must also be able, or have a caregiver
618 who is able, to hear and view CGM alerts and respond

619 appropriately; had an in-person visit with the ordering physician
620 within six (6) months prior to ordering to evaluate their diabetes
621 control and determined that criteria above are met; and has an
622 in-person visit every six (6) months following the prescription of
623 the CGM to assess adherence to the CGM regimen and diabetes
624 treatment plan; or has an established diagnosis of gestational
625 diabetes mellitus; or evidence of level 2 or level 3 hypoglycemia.
626 * * *
627 (10) Dental and orthodontic services to be determined
628 by the division.
629 The division shall increase the amount of the reimbursement
630 rate for diagnostic and preventative dental services for each of
631 the fiscal years 2022, 2023 and 2024 by five percent (5%) above
632 the amount of the reimbursement rate for the previous fiscal year.
633 The division shall increase the amount of the reimbursement rate
634 for restorative dental services for each of the fiscal years 2023,
635 2024 and 2025 by five percent (5%) above the amount of the
636 reimbursement rate for the previous fiscal year. It is the intent
637 of the Legislature that the reimbursement rate revision for
638 preventative dental services will be an incentive to increase the
639 number of dentists who actively provide Medicaid services. This
640 dental services reimbursement rate revision shall be known as the
641 "James Russell Dumas Medicaid Dental Services Incentive Program."
642 The Medical Care Advisory Committee, assisted by the Division
643 of Medicaid, shall annually determine the effect of this incentive

644 by evaluating the number of dentists who are Medicaid providers,
645 the number who and the degree to which they are actively billing
646 Medicaid, the geographic trends of where dentists are offering
647 what types of Medicaid services and other statistics pertinent to
648 the goals of this legislative intent. This data shall annually be
649 presented to the Chair of the Senate Medicaid Committee and the
650 Chair of the House Medicaid Committee.

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

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

663 (12) Intermediate care facility services.

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

669 to the sixty-three-day limitation: Christmas, the day before
670 Christmas, the day after Christmas, Thanksgiving, the day before
671 Thanksgiving and the day after Thanksgiving.
672 (b) All state-owned intermediate care facilities
673 for individuals with intellectual disabilities shall be reimbursed
674 on a full reasonable cost basis.
675 (c) Effective January 1, 2015, the division shall
676 update the fair rental reimbursement system for intermediate care
677 facilities for individuals with intellectual disabilities.
678 (13) Family planning services, including drugs,
679 supplies and devices, when those services are under the
680 supervision of a physician or nurse practitioner. Contraceptives
681 may be prescribed and dispensed in twelve-month supply increments.
682 (14) Clinic services. Preventive, diagnostic,
683 therapeutic, rehabilitative or palliative services that are
684 furnished by a facility that is not part of a hospital but is
685 organized and operated to provide medical care to outpatients.
686 Clinic services include, but are not limited to:
687 (a) Services provided by ambulatory surgical
688 centers (ACSs) as defined in Section 41-75-1(a); and
689 (b) Dialysis center services.
690 Ambulatory Surgical Care (ASCs) may be reimbursed by the
691 division based on one hundred percent (100%) of the Medicare ASC
692 Payment System rate in effect July 1 of each year as set by the
693 Center for Medicare and Medicaid Services.

694 (15) Home- and community-based services for the elderly
695 and disabled, as provided under Title XIX of the federal Social
696 Security Act, as amended, under waivers, subject to the
697 availability of funds specifically appropriated for that purpose
698 by the Legislature.
699 (16) Mental health services. Certain services provided
700 by a psychiatrist shall be reimbursed at up to one hundred percent
701 (100%) of the Medicare rate. Approved therapeutic and case
702 management services (a) provided by an approved regional mental
703 health/intellectual disability center established under Sections
704 41-19-31 through 41-19-39, or by another community mental health
705 service provider meeting the requirements of the Department of
706 Mental Health to be an approved mental health/intellectual
707 disability center if determined necessary by the Department of
708 Mental Health, using state funds that are provided in the
709 appropriation to the division to match federal funds, or (b)
710 provided by a facility that is certified by the State Department
711 of Mental Health to provide therapeutic and case management
712 services, to be reimbursed on a fee for service basis, or (c)
713 provided in the community by a facility or program operated by the
714 Department of Mental Health. Any such services provided by a
715 facility described in subparagraph (b) must have the prior
716 approval of the division to be reimbursable under this section.
717 (17) Durable medical equipment services and medical
718 supplies. Precertification of durable medical equipment and

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

735 The division may provide reimbursement for neuromuscular
736 tongue muscle stimulator for the reduction of snoring and
737 obstructive sleep apnea.

738 (18) (a) Notwithstanding any other provision of this
739 section to the contrary, as provided in the Medicaid state plan
740 amendment or amendments as defined in Section 43-13-145(10), the
741 division shall make additional reimbursement to hospitals that
742 serve a disproportionate share of low-income patients and that
743 meet the federal requirements for those payments as provided in

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

753 (b) (i) 1. The division may establish a Medicare
754 Upper Payment Limits Program, as defined in Section 1902(a)(30) of
755 the federal Social Security Act and any applicable federal
756 regulations, or an allowable delivery system or provider payment
757 initiative authorized under 42 CFR 438.6(c), for hospitals,
758 nursing facilities *** * ***, physicians <u>and other eligible licensed</u>
759 <u>providers as determined by the division</u> employed or contracted by
760 hospitals.

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

767 (ii) The division shall assess each hospital,
768 nursing facility, and emergency ambulance transportation provider


ST: Medicaid; revise various technical provisions related thereto, including reimbursement levels and facility eligibility.

769 for the sole purpose of financing the state portion of the
770 Medicare Upper Payment Limits Program or other program(s)
771 authorized under this subsection (A)(18)(b). The hospital
772 assessment shall be as provided in Section 43-13-145(4)(a), and
773 the nursing facility and the emergency ambulance transportation
774 assessments, if established, shall be based on Medicaid
775 utilization or other appropriate method, as determined by the
776 division, consistent with federal regulations. The assessments
777 will remain in effect as long as the state participates in the
778 Medicare Upper Payment Limits Program or other program(s)
779 authorized under this subsection (A)(18)(b). In addition to the
780 hospital assessment provided in Section 43-13-145(4)(a), hospitals
781 with physicians <u>and other eligible licensed providers as</u>
782 <u>determined by the division</u> participating in the Medicare Upper
783 Payment Limits Program or other program(s) authorized under this
784 subsection (A)(18)(b) shall be required to participate in an
785 intergovernmental transfer or assessment, as determined by the
786 division, for the purpose of financing the state portion of the
787 physician UPL payments or other payment(s) authorized under this
788 subsection (A)(18)(b).
789 (iii) Subject to approval by the Centers for
790 Medicare and Medicaid Services (CMS) and the provisions of this
791 subsection (A)(18)(b), the division shall make additional
792 reimbursement to hospitals, nursing facilities, and emergency
793 ambulance transportation providers for the Medicare Upper Payment


ST: Medicaid; revise various technical provisions related thereto, including reimbursement levels and facility eligibility.

794 Limits Program or other program(s) authorized under this
795 subsection (A)(18)(b), and, if the program is established for
796 physicians and other eligible licensed providers as determined by
797 the division, shall make additional reimbursement for physicians
798 and other eligible licensed providers as determined by the
799 division, as defined in Section 1902(a)(30) of the federal Social
800 Security Act and any applicable federal regulations, provided the
801 assessment in this subsection (A)(18)(b) is in effect.
802 (iv) *** The division is authorized to
803 develop and implement an alternative fee-for-service Upper Payment
804 Limits model in accordance with federal laws and regulations if
805 necessary to preserve supplemental funding. *** The division,
806 in consultation with the Mississippi Hospital Association, shall
807 develop alternative models for distribution of medical claims and
808 supplemental payments for inpatient and outpatient hospital
809 services, and such models may include, but shall not be limited to
810 the following: increasing rates for inpatient and outpatient
811 services; creating a low-income utilization pool of funds to
812 reimburse hospitals for the costs of uncompensated care, charity
813 care and bad debts as permitted and approved pursuant to federal
814 regulations and the Centers for Medicare and Medicaid Services;
815 supplemental payments based upon Medicaid utilization, quality,
816 service lines and/or costs of providing such services to Medicaid
817 beneficiaries and to uninsured patients. The goals of such
818 payment models shall be to ensure access to inpatient and

819 outpatient care and to maximize any federal funds that are
820 available to reimburse hospitals for services provided. The
821 Chairmen of the Senate and House Medicaid Committees shall be
822 provided a copy of the proposed payment model(s) prior to
823 submission.

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

831 2. The division shall calculate the
832 ambulance service access payment amount as the balance of the
833 portion of the Medical Care Fund related to ambulance
834 transportation service provider assessments plus any federal
835 matching funds earned on the balance, up to, but not to exceed,
836 the upper payment limit gap for all emergency ambulance service
837 providers.

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

843 b. In addition to any other funds
844 paid to ambulance transportation service providers for emergency
845 medical services provided to Medicaid beneficiaries, each eligible
846 ambulance transportation service provider shall receive ambulance
847 service access payments each state fiscal year equal to the
848 ambulance transportation service provider's upper payment limit
849 gap. Subject to approval by the Centers for Medicare and Medicaid
850 Services, ambulance service access payments shall be made no less
851 than on a quarterly basis.
852 c. As used in this paragraph
853 (18)(b)(v), the term "upper payment limit gap" means the
854 difference between the total amount that the ambulance
855 transportation service provider received from Medicaid and the
856 average amount that the ambulance transportation service provider
857 would have received from commercial insurers for those services
858 reimbursed by Medicaid.
859 4. An ambulance service access payment
860 shall not be used to offset any other payment by the division for
861 emergency or nonemergency services to Medicaid beneficiaries.
862 (c) (i) *** The division shall, subject to
863 approval by the Centers for Medicare and Medicaid Services (CMS),
864 establish, implement and operate a Mississippi Hospital Access
865 Program (MHAP) for the purpose of protecting patient access to
866 hospital care through hospital inpatient reimbursement programs
867 provided in this section designed to maintain total hospital

868 reimbursement for inpatient services rendered by in-state
869 hospitals and the out-of-state hospital that is authorized by
870 federal law to submit intergovernmental transfers (IGTs) to the
871 State of Mississippi and is classified as Level I trauma center
872 located in a county contiguous to the state line at the maximum
873 levels permissible under applicable federal statutes and
874 regulations *** * * ***.
875 (ii) Subject to approval by the Centers for
876 Medicare and Medicaid Services (CMS), the MHAP shall provide
877 increased inpatient capitation (PMPM) payments to managed care
878 entities contracting with the division pursuant to subsection (H)
879 of this section to support availability of hospital services or
880 such other payments permissible under federal law necessary to
881 accomplish the intent of this subsection.
882 (iii) *** * * *** [Deleted]
883 (iv) The division shall assess each hospital
884 as provided in Section 43-13-145(4)(a) for the purpose of
885 financing the state portion of the MHAP, supplemental payments and
886 such other purposes as specified in Section 43-13-145. The
887 assessment will remain in effect as long as the MHAP and
888 supplemental payments are in effect.
889 (d) Supplemental payments to a hospital shall not
890 decrease by more than five percent (5%) when compared to a
891 hospital's prior year payment unless that hospital has closed, or
892 changed services or patient volume which impact that hospital's

893 payment, and the division shall not substantially change the
894 methodologies used to calculate a hospital's supplemental payment.
895 Nothing in this paragraph shall be construed to prohibit an
896 increase in total funding available for hospital supplemental
897 payment programs. For Mississippi providers described under this
898 section, the division shall, subject to approval by the Centers
899 for Medicare and Medicaid Services (CMS), implement and operate
900 supplemental payment programs at the maximum levels permissible
901 under applicable federal statutes and regulations.
902 (19) (a) Perinatal risk-management services. The
903 division shall promulgate regulations to be effective from and
904 after October 1, 1988, to establish a comprehensive perinatal
905 system for risk assessment of all pregnant and infant Medicaid
906 recipients and for management, education and follow-up for those
907 who are determined to be at risk. Services to be performed
908 include case management, nutrition assessment/counseling,
909 psychosocial assessment/counseling and health education. The
910 division shall contract with the State Department of Health to
911 provide services within this paragraph (Perinatal High Risk
912 Management/Infant Services System (PHRM/ISS)) for any eligible
913 beneficiary who cannot receive these services under a different
914 program. The State Department of Health shall be reimbursed on a
915 full reasonable cost basis for services provided under this
916 subparagraph (a). Any program authorized under subsection H of
917 this section shall develop a perinatal risk-management services

918 program in consultation with the division and the State Department
919 of Health or shall contract with the State Department of Health
920 for these services, and the programs shall begin providing these
921 services no later than January 1, 2025.
922 (b) Early intervention system services. The
923 division shall cooperate with the State Department of Health,
924 acting as lead agency, in the development and implementation of a
925 statewide system of delivery of early intervention services, under
926 Part C of the Individuals with Disabilities Education Act (IDEA).
927 The State Department of Health shall certify annually in writing
928 to the executive director of the division the dollar amount of
929 state early intervention funds available that will be utilized as
930 a certified match for Medicaid matching funds. Those funds then
931 shall be used to provide expanded targeted case management
932 services for Medicaid eligible children with special needs who are
933 eligible for the state's early intervention system.
934 Qualifications for persons providing service coordination shall be
935 determined by the State Department of Health and the Division of
936 Medicaid.
937 (20) Home- and community-based services for physically
938 disabled approved services as allowed by a waiver from the United
939 States Department of Health and Human Services for home- and
940 community-based services for physically disabled people using
941 state funds that are provided from the appropriation to the State
942 Department of Rehabilitation Services and used to match federal

943 funds under a cooperative agreement between the division and the
944 department, provided that funds for these services are
945 specifically appropriated to the Department of Rehabilitation
946 Services.

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

963 (22) Ambulatory services delivered in federally
964 qualified health centers, rural health centers and clinics of the
965 local health departments of the State Department of Health for
966 individuals eligible for Medicaid under this article based on
967 reasonable costs as determined by the division. Federally

968 qualified health centers shall be reimbursed by the Medicaid
969 prospective payment system as approved by the Centers for Medicare
970 and Medicaid Services. The division shall recognize federally
971 qualified health centers (FQHCs), rural health clinics (RHCs) and
972 community mental health centers (CMHCs) as both an originating and
973 distant site provider for the purposes of telehealth
974 reimbursement. The division is further authorized and directed to
975 reimburse FQHCs, RHCs and CMHCs for both distant site and
976 originating site services when such services are appropriately
977 provided by the same organization.
978 (23) Inpatient psychiatric services.
979 (a) Inpatient psychiatric services to be
980 determined by the division for recipients under age twenty-one
981 (21) that are provided under the direction of a physician in an
982 inpatient program in a licensed acute care psychiatric facility or
983 in a licensed psychiatric residential treatment facility, before
984 the recipient reaches age twenty-one (21) or, if the recipient was
985 receiving the services immediately before he or she reached age
986 twenty-one (21), before the earlier of the date he or she no
987 longer requires the services or the date he or she reaches age
988 twenty-two (22), as provided by federal regulations. From and
989 after January 1, 2015, the division shall update the fair rental
990 reimbursement system for psychiatric residential treatment
991 facilities. Precertification of inpatient days and residential
992 treatment days must be obtained as required by the division. From


ST: Medicaid; revise various technical provisions related thereto, including reimbursement levels and facility eligibility.

993 and after July 1, 2009, all state-owned and state-operated
994 facilities that provide inpatient psychiatric services to persons
995 under age twenty-one (21) who are eligible for Medicaid
996 reimbursement shall be reimbursed for those services on a full
997 reasonable cost basis.

998 (b) The division may reimburse for services
999 provided by a licensed freestanding psychiatric hospital to
1000 Medicaid recipients over the age of twenty-one (21) in a method
1001 and manner consistent with the provisions of Section 43-13-117.5.

1002 (24) *** * *** Certified Community Behavioral Health
1003 Centers (CCBHCs). The division may reimburse CCBHCs in a manner
1004 as determined by the division.

1005 (25) [Deleted]

1006 (26) Hospice care. As used in this paragraph, the term
1007 "hospice care" means a coordinated program of active professional
1008 medical attention within the home and outpatient and inpatient
1009 care that treats the terminally ill patient and family as a unit,
1010 employing a medically directed interdisciplinary team. The
1011 program provides relief of severe pain or other physical symptoms
1012 and supportive care to meet the special needs arising out of
1013 physical, psychological, spiritual, social and economic stresses
1014 that are experienced during the final stages of illness and during
1015 dying and bereavement and meets the Medicare requirements for
1016 participation as a hospice as provided in federal regulations.

1017 (27) Group health plan premiums and cost-sharing if it
1018 is cost-effective as defined by the United States Secretary of
1019 Health and Human Services.

1020 (28) Other health insurance premiums that are
1021 cost-effective as defined by the United States Secretary of Health
1022 and Human Services. Medicare eligible must have Medicare Part B
1023 before other insurance premiums can be paid.

1024 (29) The Division of Medicaid may apply for a waiver
1025 from the United States Department of Health and Human Services for
1026 home- and community-based services for developmentally disabled
1027 people using state funds that are provided from the appropriation
1028 to the State Department of Mental Health and/or funds transferred
1029 to the department by a political subdivision or instrumentality of
1030 the state and used to match federal funds under a cooperative
1031 agreement between the division and the department, provided that
1032 funds for these services are specifically appropriated to the
1033 Department of Mental Health and/or transferred to the department
1034 by a political subdivision or instrumentality of the state.

1035 (30) Pediatric skilled nursing services as determined
1036 by the division and in a manner consistent with regulations
1037 promulgated by the Mississippi State Department of Health.

1038 (31) Targeted case management services for children
1039 with special needs, under waivers from the United States
1040 Department of Health and Human Services, using state funds that
1041 are provided from the appropriation to the Mississippi Department

1042 of Human Services and used to match federal funds under a
1043 cooperative agreement between the division and the department.
1044 (32) Care and services provided in Christian Science
1045 Sanatoria listed and certified by the Commission for Accreditation
1046 of Christian Science Nursing Organizations/Facilities, Inc.,
1047 rendered in connection with treatment by prayer or spiritual means
1048 to the extent that those services are subject to reimbursement
1049 under Section 1903 of the federal Social Security Act.
1050 (33) Podiatrist services.
1051 (34) Assisted living services as provided through
1052 home- and community-based services under Title XIX of the federal
1053 Social Security Act, as amended, subject to the availability of
1054 funds specifically appropriated for that purpose by the
1055 Legislature.
1056 (35) Services and activities authorized in Sections
1057 43-27-101 and 43-27-103, using state funds that are provided from
1058 the appropriation to the Mississippi Department of Human Services
1059 and used to match federal funds under a cooperative agreement
1060 between the division and the department.
1061 (36) Nonemergency transportation services for
1062 Medicaid-eligible persons as determined by the division. The PEER
1063 Committee shall conduct a performance evaluation of the
1064 nonemergency transportation program to evaluate the administration
1065 of the program and the providers of transportation services to
1066 determine the most cost-effective ways of providing nonemergency

1067 transportation services to the patients served under the program.
1068 The performance evaluation shall be completed and provided to the
1069 members of the Senate Medicaid Committee and the House Medicaid
1070 Committee not later than January 1, 2019, and every two (2) years
1071 thereafter.

1072 (37) [Deleted]

1073 (38) Chiropractic services. A chiropractor's manual
1074 manipulation of the spine to correct a subluxation, if x-ray
1075 demonstrates that a subluxation exists and if the subluxation has
1076 resulted in a neuromusculoskeletal condition for which
1077 manipulation is appropriate treatment, and related spinal x-rays
1078 performed to document these conditions. Reimbursement for
1079 chiropractic services shall not exceed Seven Hundred Dollars
1080 ($700.00) per year per beneficiary.

1081 (39) Dually eligible Medicare/Medicaid beneficiaries.
1082 The division shall pay the Medicare deductible and coinsurance
1083 amounts for services available under Medicare, as determined by
1084 the division. From and after July 1, 2009, the division shall
1085 reimburse crossover claims for inpatient hospital services and
1086 crossover claims covered under Medicare Part B in the same manner
1087 that was in effect on January 1, 2008, unless specifically
1088 authorized by the Legislature to change this method.

1089 (40) [Deleted]

1090 (41) Services provided by the State Department of
1091 Rehabilitation Services for the care and rehabilitation of persons

1092 with spinal cord injuries or traumatic brain injuries, as allowed
1093 under waivers from the United States Department of Health and
1094 Human Services, using up to seventy-five percent (75%) of the
1095 funds that are appropriated to the Department of Rehabilitation
1096 Services from the Spinal Cord and Head Injury Trust Fund
1097 established under Section 37-33-261 and used to match federal
1098 funds under a cooperative agreement between the division and the
1099 department.

1100 (42) [Deleted]

1101 (43) The division shall provide reimbursement,
1102 according to a payment schedule developed by the division, for
1103 smoking cessation medications for pregnant women during their
1104 pregnancy and other Medicaid-eligible women who are of
1105 child-bearing age.

1106 (44) Nursing facility services for the severely
1107 disabled.

1108 (a) Severe disabilities include, but are not
1109 limited to, spinal cord injuries, closed-head injuries and
1110 ventilator-dependent patients.

1111 (b) Those services must be provided in a long-term
1112 care nursing facility dedicated to the care and treatment of
1113 persons with severe disabilities.

1114 (45) Physician assistant services. Services furnished
1115 by a physician assistant who is licensed by the State Board of
1116 Medical Licensure and is practicing with physician supervision

1117 under regulations adopted by the board, under regulations adopted
1118 by the division. Reimbursement for those services shall not
1119 exceed ninety percent (90%) of the reimbursement rate for
1120 comparable services rendered by a physician. The division may
1121 provide for a reimbursement rate for physician assistant services
1122 of up to one hundred percent (100%) or the reimbursement rate for
1123 comparable services rendered by a physician for physician
1124 assistant services that are provided after the normal working
1125 hours of the physician assistant, as determined in accordance with
1126 regulations of the division.

1127 (46) The division shall make application to the federal
1128 Centers for Medicare and Medicaid Services (CMS) for a waiver to
1129 develop and provide services for children with serious emotional
1130 disturbances as defined in Section 43-14-1(1), which may include
1131 home- and community-based services, case management services or
1132 managed care services through mental health providers certified by
1133 the Department of Mental Health. The division may implement and
1134 provide services under this waivered program only if funds for
1135 these services are specifically appropriated for this purpose by
1136 the Legislature, or if funds are voluntarily provided by affected
1137 agencies.

1138 (47) (a) The division may develop and implement
1139 disease management programs for individuals with high-cost chronic
1140 diseases and conditions, including the use of grants, waivers,
1141 demonstrations or other projects as necessary.

1142 (b) Participation in any disease management
1143 program implemented under this paragraph (47) is optional with the
1144 individual. An individual must affirmatively elect to participate
1145 in the disease management program in order to participate, and may
1146 elect to discontinue participation in the program at any time.
1147 (48) Pediatric long-term acute care hospital services.
1148 (a) Pediatric long-term acute care hospital
1149 services means services provided to eligible persons under
1150 twenty-one (21) years of age by a freestanding Medicare-certified
1151 hospital that has an average length of inpatient stay greater than
1152 twenty-five (25) days and that is primarily engaged in providing
1153 chronic or long-term medical care to persons under twenty-one (21)
1154 years of age.
1155 (b) The services under this paragraph (48) shall
1156 be reimbursed as a separate category of hospital services.
1157 (49) The division may establish copayments and/or
1158 coinsurance for any Medicaid services for which copayments and/or
1159 coinsurance are allowable under federal law or regulation.
1160 (50) Services provided by the State Department of
1161 Rehabilitation Services for the care and rehabilitation of persons
1162 who are deaf and blind, as allowed under waivers from the United
1163 States Department of Health and Human Services to provide home-
1164 and community-based services using state funds that are provided
1165 from the appropriation to the State Department of Rehabilitation
1166 Services or if funds are voluntarily provided by another agency.

1167 (51) Upon determination of Medicaid eligibility and in
1168 association with annual redetermination of Medicaid eligibility,
1169 beneficiaries shall be encouraged to undertake a physical
1170 examination that will establish a base-line level of health and
1171 identification of a usual and customary source of care (a medical
1172 home) to aid utilization of disease management tools. This
1173 physical examination and utilization of these disease management
1174 tools shall be consistent with current United States Preventive
1175 Services Task Force or other recognized authority recommendations.
1176 For persons who are determined ineligible for Medicaid, the
1177 division will provide information and direction for accessing
1178 medical care and services in the area of their residence.
1179 (52) Notwithstanding any provisions of this article,
1180 the division may pay enhanced reimbursement fees related to trauma
1181 care, as determined by the division in conjunction with the State
1182 Department of Health, using funds appropriated to the State
1183 Department of Health for trauma care and services and used to
1184 match federal funds under a cooperative agreement between the
1185 division and the State Department of Health. The division, in
1186 conjunction with the State Department of Health, may use grants,
1187 waivers, demonstrations, enhanced reimbursements, Upper Payment
1188 Limits Programs, supplemental payments, or other projects as
1189 necessary in the development and implementation of this
1190 reimbursement program.

1191 (53) Targeted case management services for high-cost
1192 beneficiaries may be developed by the division for all services
1193 under this section.

1194 (54) [Deleted]

1195 (55) Therapy services. The plan of care for therapy
1196 services may be developed to cover a period of treatment for up to
1197 six (6) months, but in no event shall the plan of care exceed a
1198 six-month period of treatment. The projected period of treatment
1199 must be indicated on the initial plan of care and must be updated
1200 with each subsequent revised plan of care. Based on medical
1201 necessity, the division shall approve certification periods for
1202 less than or up to six (6) months, but in no event shall the
1203 certification period exceed the period of treatment indicated on
1204 the plan of care. The appeal process for any reduction in therapy
1205 services shall be consistent with the appeal process in federal
1206 regulations.

1207 (56) Prescribed pediatric extended care centers
1208 services for medically dependent or technologically dependent
1209 children with complex medical conditions that require continual
1210 care as prescribed by the child's attending physician, as
1211 determined by the division.

1212 (57) No Medicaid benefit shall restrict coverage for
1213 medically appropriate treatment prescribed by a physician and
1214 agreed to by a fully informed individual, or if the individual
1215 lacks legal capacity to consent by a person who has legal

1216 authority to consent on his or her behalf, based on an
1217 individual's diagnosis with a terminal condition. As used in this
1218 paragraph (57), "terminal condition" means any aggressive
1219 malignancy, chronic end-stage cardiovascular or cerebral vascular
1220 disease, or any other disease, illness or condition which a
1221 physician diagnoses as terminal.

1222 (58) Treatment services for persons with opioid
1223 dependency or other highly addictive substance use disorders. The
1224 division is authorized to reimburse eligible providers for
1225 treatment of opioid dependency and other highly addictive
1226 substance use disorders, as determined by the division. Treatment
1227 related to these conditions shall not count against any physician
1228 visit limit imposed under this section.

1229 (59) The division shall allow beneficiaries between the
1230 ages of ten (10) and eighteen (18) years to receive vaccines
1231 through a pharmacy venue. The division and the State Department
1232 of Health shall coordinate and notify OB-GYN providers that the
1233 Vaccines for Children program is available to providers free of
1234 charge.

1235 (60) Border city university-affiliated pediatric
1236 teaching hospital.

1237 (a) Payments may only be made to a border city
1238 university-affiliated pediatric teaching hospital if the Centers
1239 for Medicare and Medicaid Services (CMS) approve an increase in
1240 the annual request for the provider payment initiative authorized

1241 under 42 CFR Section 438.6(c) in an amount equal to or greater
1242 than the estimated annual payment to be made to the border city
1243 university-affiliated pediatric teaching hospital. The estimate
1244 shall be based on the hospital's prior year Mississippi managed
1245 care utilization.

1246 (b) As used in this paragraph (60), the term
1247 "border city university-affiliated pediatric teaching hospital"
1248 means an out-of-state hospital located within a city bordering the
1249 eastern bank of the Mississippi River and the State of Mississippi
1250 that submits to the division a copy of a current and effective
1251 affiliation agreement with an accredited university and other
1252 documentation establishing that the hospital is
1253 university-affiliated, is licensed and designated as a pediatric
1254 hospital or pediatric primary hospital within its home state,
1255 maintains at least five (5) different pediatric specialty training
1256 programs, and maintains at least one hundred (100) operated beds
1257 dedicated exclusively for the treatment of patients under the age
1258 of twenty-one (21) years.

1259 (c) The cost of providing services to Mississippi
1260 Medicaid beneficiaries under the age of twenty-one (21) years who
1261 are treated by a border city university-affiliated pediatric
1262 teaching hospital shall not exceed the cost of providing the same
1263 services to individuals in hospitals in the state.

1264 (d) It is the intent of the Legislature that
1265 payments shall not result in any in-state hospital receiving

1266 payments lower than they would otherwise receive if not for the
1267 payments made to any border city university-affiliated pediatric
1268 teaching hospital.

1269 (e) This paragraph (60) shall stand repealed on
1270 July 1, *** 2028.

1271 (61) Autism Spectrum Disorder Services. The division
1272 shall develop and implement a method for reimbursement of autism
1273 spectrum disorder services based on a continuum of care for best
1274 practices in medically necessary early intervention treatment.
1275 The division shall work in consultation with the Department of
1276 Mental Health, healthcare providers, the Autism Advisory
1277 Committee, and other stakeholders relevant to the autism industry
1278 to develop these reimbursement rates. The requirements of this
1279 subsection shall apply to any autism spectrum disorder services
1280 rendered under the authority of the Medicaid State Plan and any
1281 Home and Community Based Services Waiver authorized under this
1282 section through which autism spectrum disorder services are
1283 provided.

1284 (B) Planning and development districts participating in the
1285 home- and community-based services program for the elderly and
1286 disabled as case management providers shall be reimbursed for case
1287 management services at the maximum rate approved by the Centers
1288 for Medicare and Medicaid Services (CMS).

1289 (C) The division may pay to those providers who participate
1290 in and accept patient referrals from the division's emergency room

1291 redirection program a percentage, as determined by the division,
1292 of savings achieved according to the performance measures and
1293 reduction of costs required of that program. Federally qualified
1294 health centers may participate in the emergency room redirection
1295 program, and the division may pay those centers a percentage of
1296 any savings to the Medicaid program achieved by the centers'
1297 accepting patient referrals through the program, as provided in
1298 this subsection (C).

1299 (D) (1) As used in this subsection (D), the following terms
1300 shall be defined as provided in this paragraph, except as
1301 otherwise provided in this subsection:

1302 (a) "Committees" means the Medicaid Committees of
1303 the House of Representatives and the Senate, and "committee" means
1304 either one of those committees.

1305 (b) "Rate change" means an increase, decrease or
1306 other change in the payments or rates of reimbursement, or a
1307 change in any payment methodology that results in an increase,
1308 decrease or other change in the payments or rates of
1309 reimbursement, to any Medicaid provider that renders any services
1310 authorized to be provided to Medicaid recipients under this
1311 article.

1312 (2) Whenever the Division of Medicaid proposes a rate
1313 change, the division shall give notice to the chairmen of the
1314 committees at least thirty (30) calendar days before the proposed
1315 rate change is scheduled to take effect. The division shall

1316 furnish the chairmen with a concise summary of each proposed rate
1317 change along with the notice, and shall furnish the chairmen with
1318 a copy of any proposed rate change upon request. The division
1319 also shall provide a summary and copy of any proposed rate change
1320 to any other member of the Legislature upon request.

1321 (3) If the chairman of either committee or both
1322 chairmen jointly object to the proposed rate change or any part
1323 thereof, the chairman or chairmen shall notify the division and
1324 provide the reasons for their objection in writing not later than
1325 seven (7) calendar days after receipt of the notice from the
1326 division. The chairman or chairmen may make written
1327 recommendations to the division for changes to be made to a
1328 proposed rate change.

1329 (4) (a) The chairman of either committee or both
1330 chairmen jointly may hold a committee meeting to review a proposed
1331 rate change. If either chairman or both chairmen decide to hold a
1332 meeting, they shall notify the division of their intention in
1333 writing within seven (7) calendar days after receipt of the notice
1334 from the division, and shall set the date and time for the meeting
1335 in their notice to the division, which shall not be later than
1336 fourteen (14) calendar days after receipt of the notice from the
1337 division.

1338 (b) After the committee meeting, the committee or
1339 committees may object to the proposed rate change or any part
1340 thereof. The committee or committees shall notify the division

1341 and the reasons for their objection in writing not later than
1342 seven (7) calendar days after the meeting. The committee or
1343 committees may make written recommendations to the division for
1344 changes to be made to a proposed rate change.
1345 (5) If both chairmen notify the division in writing
1346 within seven (7) calendar days after receipt of the notice from
1347 the division that they do not object to the proposed rate change
1348 and will not be holding a meeting to review the proposed rate
1349 change, the proposed rate change will take effect on the original
1350 date as scheduled by the division or on such other date as
1351 specified by the division.
1352 (6) (a) If there are any objections to a proposed rate
1353 change or any part thereof from either or both of the chairmen or
1354 the committees, the division may withdraw the proposed rate
1355 change, make any of the recommended changes to the proposed rate
1356 change, or not make any changes to the proposed rate change.
1357 (b) If the division does not make any changes to
1358 the proposed rate change, it shall notify the chairmen of that
1359 fact in writing, and the proposed rate change shall take effect on
1360 the original date as scheduled by the division or on such other
1361 date as specified by the division.
1362 (c) If the division makes any changes to the
1363 proposed rate change, the division shall notify the chairmen of
1364 its actions in writing, and the revised proposed rate change shall
1365 take effect on the date as specified by the division.


ST: Medicaid; revise various technical provisions related thereto, including reimbursement levels and facility eligibility.

1366 (7) Nothing in this subsection (D) shall be construed
1367 as giving the chairmen or the committees any authority to veto,
1368 nullify or revise any rate change proposed by the division. The
1369 authority of the chairmen or the committees under this subsection
1370 shall be limited to reviewing, making objections to and making
1371 recommendations for changes to rate changes proposed by the
1372 division.

1373 (E) Notwithstanding any provision of this article, no new
1374 groups or categories of recipients and new types of care and
1375 services may be added without enabling legislation from the
1376 Mississippi Legislature, except that the division may authorize
1377 those changes without enabling legislation when the addition of
1378 recipients or services is ordered by a court of proper authority.

1379 (F) The executive director shall keep the Governor advised
1380 on a timely basis of the funds available for expenditure and the
1381 projected expenditures. Notwithstanding any other provisions of
1382 this article, if current or projected expenditures of the division
1383 are reasonably anticipated to exceed the amount of funds
1384 appropriated to the division for any fiscal year, the Governor,
1385 after consultation with the executive director, shall take all
1386 appropriate measures to reduce costs, which may include, but are
1387 not limited to:

1388 (1) Reducing or discontinuing any or all services that
1389 are deemed to be optional under Title XIX of the Social Security
1390 Act;

1391 (2) Reducing reimbursement rates for any or all service
1392 types;
1393 (3) Imposing additional assessments on health care
1394 providers; or
1395 (4) Any additional cost-containment measures deemed
1396 appropriate by the Governor.
1397 To the extent allowed under federal law, any reduction to
1398 services or reimbursement rates under this subsection (F) shall be
1399 accompanied by a reduction, to the fullest allowable amount, to
1400 the profit margin and administrative fee portions of capitated
1401 payments to organizations described in paragraph (1) of subsection
1402 (H).
1403 Beginning in fiscal year 2010 and in fiscal years thereafter,
1404 when Medicaid expenditures are projected to exceed funds available
1405 for the fiscal year, the division shall submit the expected
1406 shortfall information to the PEER Committee not later than
1407 December 1 of the year in which the shortfall is projected to
1408 occur. PEER shall review the computations of the division and
1409 report its findings to the Legislative Budget Office not later
1410 than January 7 in any year.
1411 (G) Notwithstanding any other provision of this article, it
1412 shall be the duty of each provider participating in the Medicaid
1413 program to keep and maintain books, documents and other records as
1414 prescribed by the Division of Medicaid in accordance with federal
1415 laws and regulations.

1416 (H) (1) Notwithstanding any other provision of this
1417 article, the division is authorized to implement (a) a managed
1418 care program, (b) a coordinated care program, (c) a coordinated
1419 care organization program, (d) a health maintenance organization
1420 program, (e) a patient-centered medical home program, (f) an
1421 accountable care organization program, (g) provider-sponsored
1422 health plan, or (h) any combination of the above programs. As a
1423 condition for the approval of any program under this subsection
1424 (H)(1), the division shall require that no managed care program,
1425 coordinated care program, coordinated care organization program,
1426 health maintenance organization program, or provider-sponsored
1427 health plan may:

1428 (a) Pay providers at a rate that is less than the
1429 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
1430 reimbursement rate;

1431 (b) Override the medical decisions of hospital
1432 physicians or staff regarding patients admitted to a hospital for
1433 an emergency medical condition as defined by 42 US Code Section
1434 1395dd. This restriction (b) does not prohibit the retrospective
1435 review of the appropriateness of the determination that an
1436 emergency medical condition exists by chart review or coding
1437 algorithm, nor does it prohibit prior authorization for
1438 nonemergency hospital admissions;

1439 (c) Pay providers at a rate that is less than the
1440 normal Medicaid reimbursement rate. It is the intent of the

1441 Legislature that all managed care entities described in this
1442 subsection (H), in collaboration with the division, develop and
1443 implement innovative payment models that incentivize improvements
1444 in health care quality, outcomes, or value, as determined by the
1445 division. Participation in the provider network of any managed
1446 care, coordinated care, provider-sponsored health plan, or similar
1447 contractor shall not be conditioned on the provider's agreement to
1448 accept such alternative payment models;
1449 (d) Implement a prior authorization and
1450 utilization review program for medical services, transportation
1451 services and prescription drugs that is more stringent than the
1452 prior authorization processes used by the division in its
1453 administration of the Medicaid program. Not later than December
1454 2, 2021, the contractors that are receiving capitated payments
1455 under a managed care delivery system established under this
1456 subsection (H) shall submit a report to the Chairmen of the House
1457 and Senate Medicaid Committees on the status of the prior
1458 authorization and utilization review program for medical services,
1459 transportation services and prescription drugs that is required to
1460 be implemented under this subparagraph (d);
1461 (e) [Deleted]
1462 (f) Implement a preferred drug list that is more
1463 stringent than the mandatory preferred drug list established by
1464 the division under subsection (A)(9) of this section;

1465 (g) Implement a policy which denies beneficiaries
1466 with hemophilia access to the federally funded hemophilia
1467 treatment centers as part of the Medicaid Managed Care network of
1468 providers.
1469 Each health maintenance organization, coordinated care
1470 organization, provider-sponsored health plan, or other
1471 organization paid for services on a capitated basis by the
1472 division under any managed care program or coordinated care
1473 program implemented by the division under this section shall use a
1474 clear set of level of care guidelines in the determination of
1475 medical necessity and in all utilization management practices,
1476 including the prior authorization process, concurrent reviews,
1477 retrospective reviews and payments, that are consistent with
1478 widely accepted professional standards of care. Organizations
1479 participating in a managed care program or coordinated care
1480 program implemented by the division may not use any additional
1481 criteria that would result in denial of care that would be
1482 determined appropriate and, therefore, medically necessary under
1483 those levels of care guidelines.
1484 (2) Notwithstanding any provision of this section, the
1485 recipients eligible for enrollment into a Medicaid Managed Care
1486 Program authorized under this subsection (H) may include only
1487 those categories of recipients eligible for participation in the
1488 Medicaid Managed Care Program as of January 1, 2021, the
1489 Children's Health Insurance Program (CHIP), and the CMS-approved

1490 Section 1115 demonstration waivers in operation as of January 1,
1491 2021. No expansion of Medicaid Managed Care Program contracts may
1492 be implemented by the division without enabling legislation from
1493 the Mississippi Legislature.

1494 (3) (a) Any contractors receiving capitated payments
1495 under a managed care delivery system established in this section
1496 shall provide to the Legislature and the division statistical data
1497 to be shared with provider groups in order to improve patient
1498 access, appropriate utilization, cost savings and health outcomes
1499 not later than October 1 of each year. Additionally, each
1500 contractor shall disclose to the Chairmen of the Senate and House
1501 Medicaid Committees the administrative expenses costs for the
1502 prior calendar year, and the number of full-equivalent employees
1503 located in the State of Mississippi dedicated to the Medicaid and
1504 CHIP lines of business as of June 30 of the current year.

1505 (b) The division and the contractors participating
1506 in the managed care program, a coordinated care program or a
1507 provider-sponsored health plan shall be subject to annual program
1508 reviews or audits performed by the Office of the State Auditor,
1509 the PEER Committee, the Department of Insurance and/or independent
1510 third parties.

1511 (c) Those reviews shall include, but not be
1512 limited to, at least two (2) of the following items:

1513 (i) The financial benefit to the State of
1514 Mississippi of the managed care program,

1515 (ii) The difference between the premiums paid
1516 to the managed care contractors and the payments made by those
1517 contractors to health care providers,
1518 (iii) Compliance with performance measures
1519 required under the contracts,
1520 (iv) Administrative expense allocation
1521 methodologies,
1522 (v) Whether nonprovider payments assigned as
1523 medical expenses are appropriate,
1524 (vi) Capitated arrangements with related
1525 party subcontractors,
1526 (vii) Reasonableness of corporate
1527 allocations,
1528 (viii) Value-added benefits and the extent to
1529 which they are used,
1530 (ix) The effectiveness of subcontractor
1531 oversight, including subcontractor review,
1532 (x) Whether health care outcomes have been
1533 improved, and
1534 (xi) The most common claim denial codes to
1535 determine the reasons for the denials.
1536 The audit reports shall be considered public documents and
1537 shall be posted in their entirety on the division's website.
1538 (4) All health maintenance organizations, coordinated
1539 care organizations, provider-sponsored health plans, or other

1540 organizations paid for services on a capitated basis by the
1541 division under any managed care program or coordinated care
1542 program implemented by the division under this section shall
1543 reimburse all providers in those organizations at rates no lower
1544 than those provided under this section for beneficiaries who are
1545 not participating in those programs.

1546 (5) No health maintenance organization, coordinated
1547 care organization, provider-sponsored health plan, or other
1548 organization paid for services on a capitated basis by the
1549 division under any managed care program or coordinated care
1550 program implemented by the division under this section shall
1551 require its providers or beneficiaries to use any pharmacy that
1552 ships, mails or delivers prescription drugs or legend drugs or
1553 devices.

1554 (6) (a) Not later than December 1, 2021, the
1555 contractors who are receiving capitated payments under a managed
1556 care delivery system established under this subsection (H) shall
1557 develop and implement a uniform credentialing process for
1558 providers. Under that uniform credentialing process, a provider
1559 who meets the criteria for credentialing will be credentialed with
1560 all of those contractors and no such provider will have to be
1561 separately credentialed by any individual contractor in order to
1562 receive reimbursement from the contractor. Not later than
1563 December 2, 2021, those contractors shall submit a report to the
1564 Chairmen of the House and Senate Medicaid Committees on the status

1565 of the uniform credentialing process for providers that is
1566 required under this subparagraph (a).
1567 (b) If those contractors have not implemented a
1568 uniform credentialing process as described in subparagraph (a) by
1569 December 1, 2021, the division shall develop and implement, not
1570 later than July 1, 2022, a single, consolidated credentialing
1571 process by which all providers will be credentialed. Under the
1572 division's single, consolidated credentialing process, no such
1573 contractor shall require its providers to be separately
1574 credentialed by the contractor in order to receive reimbursement
1575 from the contractor, but those contractors shall recognize the
1576 credentialing of the providers by the division's credentialing
1577 process.
1578 (c) The division shall require a uniform provider
1579 credentialing application that shall be used in the credentialing
1580 process that is established under subparagraph (a) or (b). If the
1581 contractor or division, as applicable, has not approved or denied
1582 the provider credentialing application within sixty (60) days of
1583 receipt of the completed application that includes all required
1584 information necessary for credentialing, then the contractor or
1585 division, upon receipt of a written request from the applicant and
1586 within five (5) business days of its receipt, shall issue a
1587 temporary provider credential/enrollment to the applicant if the
1588 applicant has a valid Mississippi professional or occupational
1589 license to provide the health care services to which the

1590 credential/enrollment would apply. The contractor or the division
1591 shall not issue a temporary credential/enrollment if the applicant
1592 has reported on the application a history of medical or other
1593 professional or occupational malpractice claims, a history of
1594 substance abuse or mental health issues, a criminal record, or a
1595 history of medical or other licensing board, state or federal
1596 disciplinary action, including any suspension from participation
1597 in a federal or state program. The temporary
1598 credential/enrollment shall be effective upon issuance and shall
1599 remain in effect until the provider's credentialing/enrollment
1600 application is approved or denied by the contractor or division.
1601 The contractor or division shall render a final decision regarding
1602 credentialing/enrollment of the provider within sixty (60) days
1603 from the date that the temporary provider credential/enrollment is
1604 issued to the applicant.

1605 (d) If the contractor or division does not render
1606 a final decision regarding credentialing/enrollment of the
1607 provider within the time required in subparagraph (c), the
1608 provider shall be deemed to be credentialed by and enrolled with
1609 all of the contractors and eligible to receive reimbursement from
1610 the contractors.

1611 (7) (a) Each contractor that is receiving capitated
1612 payments under a managed care delivery system established under
1613 this subsection (H) shall provide to each provider for whom the
1614 contractor has denied the coverage of a procedure that was ordered


ST: Medicaid; revise various technical provisions related thereto, including reimbursement levels and facility eligibility.

1615 or requested by the provider for or on behalf of a patient, a
1616 letter that provides a detailed explanation of the reasons for the
1617 denial of coverage of the procedure and the name and the
1618 credentials of the person who denied the coverage. The letter
1619 shall be sent to the provider in electronic format.

1620 (b) After a contractor that is receiving capitated
1621 payments under a managed care delivery system established under
1622 this subsection (H) has denied coverage for a claim submitted by a
1623 provider, the contractor shall issue to the provider within sixty
1624 (60) days a final ruling of denial of the claim that allows the
1625 provider to have a state fair hearing and/or agency appeal with
1626 the division. If a contractor does not issue a final ruling of
1627 denial within sixty (60) days as required by this subparagraph
1628 (b), the provider's claim shall be deemed to be automatically
1629 approved and the contractor shall pay the amount of the claim to
1630 the provider.

1631 (c) After a contractor has issued a final ruling
1632 of denial of a claim submitted by a provider, the division shall
1633 conduct a state fair hearing and/or agency appeal on the matter of
1634 the disputed claim between the contractor and the provider within
1635 sixty (60) days, and shall render a decision on the matter within
1636 thirty (30) days after the date of the hearing and/or appeal.

1637 (8) It is the intention of the Legislature that the
1638 division evaluate the feasibility of using a single vendor to
1639 administer pharmacy benefits provided under a managed care

1640 delivery system established under this subsection (H). Providers
1641 of pharmacy benefits shall cooperate with the division in any
1642 transition to a carve-out of pharmacy benefits under managed care.
1643 (9) The division shall evaluate the feasibility of
1644 using a single vendor to administer dental benefits provided under
1645 a managed care delivery system established in this subsection (H).
1646 Providers of dental benefits shall cooperate with the division in
1647 any transition to a carve-out of dental benefits under managed
1648 care.
1649 (10) It is the intent of the Legislature that any
1650 contractor receiving capitated payments under a managed care
1651 delivery system established in this section shall implement
1652 innovative programs to improve the health and well-being of
1653 members diagnosed with prediabetes and diabetes.
1654 (11) It is the intent of the Legislature that any
1655 contractors receiving capitated payments under a managed care
1656 delivery system established under this subsection (H) shall work
1657 with providers of Medicaid services to improve the utilization of
1658 long-acting reversible contraceptives (LARCs). Not later than
1659 December 1, 2021, any contractors receiving capitated payments
1660 under a managed care delivery system established under this
1661 subsection (H) shall provide to the Chairmen of the House and
1662 Senate Medicaid Committees and House and Senate Public Health
1663 Committees a report of LARC utilization for State Fiscal Years
1664 2018 through 2020 as well as any programs, initiatives, or efforts

1665 made by the contractors and providers to increase LARC
1666 utilization. This report shall be updated annually to include
1667 information for subsequent state fiscal years.
1668 (12) The division is authorized to make not more than
1669 one (1) emergency extension of the contracts that are in effect on
1670 July 1, 2021, with contractors who are receiving capitated
1671 payments under a managed care delivery system established under
1672 this subsection (H), as provided in this paragraph (12). The
1673 maximum period of any such extension shall be one (1) year, and
1674 under any such extensions, the contractors shall be subject to all
1675 of the provisions of this subsection (H). The extended contracts
1676 shall be revised to incorporate any provisions of this subsection
1677 (H).
1678 (I) [Deleted]
1679 (J) There shall be no cuts in inpatient and outpatient
1680 hospital payments, or allowable days or volumes, as long as the
1681 hospital assessment provided in Section 43-13-145 is in effect.
1682 This subsection (J) shall not apply to decreases in payments that
1683 are a result of: reduced hospital admissions, audits or payments
1684 under the APR-DRG or APC models, or a managed care program or
1685 similar model described in subsection (H) of this section.
1686 (K) In the negotiation and execution of such contracts
1687 involving services performed by actuarial firms, the Executive
1688 Director of the Division of Medicaid may negotiate a limitation on
1689 liability to the state of prospective contractors.

1690 (L) The Division of Medicaid shall reimburse for services
1691 provided to eligible Medicaid beneficiaries by a licensed birthing
1692 center in a method and manner to be determined by the division in
1693 accordance with federal laws and federal regulations. The
1694 division shall seek any necessary waivers, make any required
1695 amendments to its State Plan or revise any contracts authorized
1696 under subsection (H) of this section as necessary to provide the
1697 services authorized under this subsection. As used in this
1698 subsection, the term "birthing centers" shall have the meaning as
1699 defined in Section 41-77-1(a), which is a publicly or privately
1700 owned facility, place or institution constructed, renovated,
1701 leased or otherwise established where nonemergency births are
1702 planned to occur away from the mother's usual residence following
1703 a documented period of prenatal care for a normal uncomplicated
1704 pregnancy which has been determined to be low risk through a
1705 formal risk-scoring examination.
1706 (M) The Division of Medicaid shall reimburse ambulance
1707 service providers that provide an assessment, triage, treatment or
1708 transportation for eligible Medicaid beneficiaries to an
1709 alternative destination in this state or provide an assessment or
1710 treat eligible Medicaid beneficiaries in place.
1711 (1) As used in this section:
1712 (a) "Alternative destination" means a lower-acuity
1713 facility that provides medical services, including:
1714 (i) An urgent care center;

1715 (ii) Federal Qualified Community Health
1716 Clinic;
1717 (iii) A behavioral or mental healthcare
1718 facility including a crisis stabilization unit and a diversion
1719 center; and
1720 (iv) Any other facilities as determined by
1721 the division with due consideration of the CMS Emergency Triage,
1722 Treat, and Transport (ET3) Model.
1723 (b) "Alternative destination" does not include a:
1724 (i) Critical access hospital;
1725 (ii) Dialysis center;
1726 (iii) Hospital;
1727 (iv) Private residence; or
1728 (v) Skilled nursing facility.
1729 (c) "Ambulance service provider" as used in this
1730 section means a person or entity that provides ambulance
1731 transportation and emergency medical services to a patient for
1732 which a permit is required under Section 41-59-9.
1733 (d) The reimbursement rate for an ambulance
1734 service provider whose operators provide an assessment, triage,
1735 treatment or transportation for an enrollee to an alternative
1736 destination shall be reimbursed at a rate or methodology as
1737 determined by the division. The division shall consult with the
1738 Mississippi Ambulance Alliance in determining the initial rate or
1739 methodology, and the division shall give due consideration to the

1740 CMS ET3 Model and shall give due consideration of the inclusion in
1741 the Transforming Reimbursement for Emergency Ambulance
1742 Transportation program.
1743 ( * * *N) This section shall stand repealed on July 1, * * *
1744 2028.
1745 **SECTION 3.** Section 43-13-305, Mississippi Code of 1972, is
1746 amended as follows:
1747 43-13-305. (1) By accepting Medicaid from the Division of
1748 Medicaid in the Office of the Governor, the recipient shall, to
1749 the extent of the payment of medical expenses by the Division of
1750 Medicaid, be deemed to have made an assignment to the Division of
1751 Medicaid of any and all rights and interests in any third-party
1752 benefits, hospitalization or indemnity contract or any cause of
1753 action, past, present or future, against any person, firm or
1754 corporation for Medicaid benefits provided to the recipient by the
1755 Division of Medicaid for injuries, disease or sickness caused or
1756 suffered under circumstances creating a cause of action in favor
1757 of the recipient against any such person, firm or corporation as
1758 set out in Section 43-13-125. The recipient shall be deemed,
1759 without the necessity of signing any document, to have appointed
1760 the Division of Medicaid as his or her true and lawful
1761 attorney-in-fact in his or her name, place and stead in collecting
1762 any and all amounts due and owing for medical expenses paid by the
1763 Division of Medicaid against such person, firm or corporation.

1764 (2) Whenever a provider of medical services or the Division
1765 of Medicaid submits claims to an insurer on behalf of a Medicaid
1766 recipient for whom an assignment of rights has been received, or
1767 whose rights have been assigned by the operation of law, the
1768 insurer must respond within sixty (60) days of receipt of a claim
1769 by forwarding payment or issuing a notice of denial directly to
1770 the submitter of the claim. The failure of the insuring entity to
1771 comply with the provisions of this section shall subject the
1772 insuring entity to recourse by the Division of Medicaid in
1773 accordance with the provision of Section 43-13-315. In the case
1774 of a responsible insurer, other than the insurers exempted under
1775 federal law, that requires prior authorization for an item or
1776 service furnished to a recipient, the insurer shall accept
1777 authorization provided by the Division of Medicaid that the item
1778 or service is covered under the state plan (or waiver of such
1779 plan) for such recipient, as if such authorization were the prior
1780 authorization made by the third party for such item or service.
1781 The Division of Medicaid shall be authorized to endorse any and
1782 all, including, but not limited to, multi-payee checks, drafts,
1783 money orders or other negotiable instruments representing Medicaid
1784 payment recoveries that are received by the Division of Medicaid.
1785 (3) Court orders or agreements for medical support shall
1786 direct such payments to the Division of Medicaid, which shall be
1787 authorized to endorse any and all checks, drafts, money orders or
1788 other negotiable instruments representing medical support payments


ST: Medicaid; revise various technical provisions related thereto, including reimbursement levels and facility eligibility.

1789 which are received. Any designated medical support funds received
1790 by the State Department of Human Services or through its local
1791 county departments shall be paid over to the Division of Medicaid.
1792 When medical support for a Medicaid recipient is available through
1793 an absent parent or custodial parent, the insuring entity shall
1794 direct the medical support payment(s) to the provider of medical
1795 services or to the Division of Medicaid.

1796 **SECTION 4.** Section 43-11-1, Mississippi Code of 1972, is
1797 amended as follows:

1798 43-11-1. When used in this chapter, the following words
1799 shall have the following meaning:

1800 (a) "Institutions for the aged or infirm" means a place
1801 either governmental or private that provides group living
1802 arrangements for four (4) or more persons who are unrelated to the
1803 operator and who are being provided food, shelter and personal
1804 care, whether any such place is organized or operated for profit
1805 or not. The term "institution for the aged or infirm" includes
1806 nursing homes, pediatric skilled nursing facilities, psychiatric
1807 residential treatment facilities, convalescent homes, homes for
1808 the aged, adult foster care facilities and special care facilities
1809 for paroled inmates, provided that these institutions fall within
1810 the scope of the definitions set forth above. The term
1811 "institution for the aged or infirm" does not include hospitals,
1812 clinics or mental institutions devoted primarily to providing
1813 medical service, and does not include any private residence in

1814 which the owner of the residence is providing personal care
1815 services to disabled or homeless veterans under an agreement with,
1816 and in compliance with the standards prescribed by, the United
1817 States Department of Veterans Affairs, if the owner of the
1818 residence also provided personal care services to disabled or
1819 homeless veterans at any time during calendar year 2008.
1820 (b) "Person" means any individual, firm, partnership,
1821 corporation, company, association or joint-stock association, or
1822 any licensee herein or the legal successor thereof.
1823 (c) "Personal care" means assistance rendered by
1824 personnel of the home to aged or infirm residents in performing
1825 one or more of the activities of daily living, which includes, but
1826 is not limited to, the bathing, walking, excretory functions,
1827 feeding, personal grooming and dressing of such residents.
1828 (d) "Psychiatric residential treatment facility" means
1829 any nonhospital establishment with permanent facilities which
1830 provides a twenty-four-hour program of care by qualified
1831 therapists, including, but not limited to, duly licensed mental
1832 health professionals, psychiatrists, psychologists,
1833 psychotherapists and licensed certified social workers, for
1834 emotionally disturbed children and adolescents referred to such
1835 facility by a court, local school district or by the Department of
1836 Human Services, who are not in an acute phase of illness requiring
1837 the services of a psychiatric hospital, and are in need of such
1838 restorative treatment services. For purposes of this paragraph,

1839 the term "emotionally disturbed" means a condition exhibiting one
1840 or more of the following characteristics over a long period of
1841 time and to a marked degree, which adversely affects educational
1842 performance:

1843 1. An inability to learn which cannot be explained
1844 by intellectual, sensory or health factors;

1845 2. An inability to build or maintain satisfactory
1846 relationships with peers and teachers;

1847 3. Inappropriate types of behavior or feelings
1848 under normal circumstances;

1849 4. A general pervasive mood of unhappiness or
1850 depression; or

1851 5. A tendency to develop physical symptoms or
1852 fears associated with personal or school problems. An
1853 establishment furnishing primarily domiciliary care is not within
1854 this definition.

1855 (e) "Pediatric skilled nursing facility" means an
1856 institution or a distinct part of an institution that is primarily
1857 engaged in providing to inpatients skilled nursing care and
1858 related services for persons under twenty-one (21) years of age
1859 who require medical or nursing care or rehabilitation services for
1860 the rehabilitation of injured, disabled or sick persons.

1861 (f) "Licensing agency" means the State Department of
1862 Health.

1863 (g) "Medical records" mean, without restriction, those
1864 medical histories, records, reports, summaries, diagnoses and
1865 prognoses, records of treatment and medication ordered and given,
1866 notes, entries, x-rays and other written or graphic data prepared,
1867 kept, made or maintained in institutions for the aged or infirm
1868 that pertain to residency in, or services rendered to residents
1869 of, an institution for the aged or infirm.

1870 (h) "Adult foster care facility" means a home setting
1871 for vulnerable adults in the community who are unable to live
1872 independently due to physical, emotional, developmental or mental
1873 impairments, or in need of emergency and continuing protective
1874 social services for purposes of preventing further abuse or
1875 neglect and for safeguarding and enhancing the welfare of the
1876 abused or neglected vulnerable adult. Adult foster care programs
1877 shall be designed to meet the needs of vulnerable adults with
1878 impairments through individual plans of care, which provide a
1879 variety of health, social and related support services in a
1880 protective setting, enabling participants to live in the
1881 community. Adult foster care programs may be (i) traditional,
1882 where the foster care provider lives in the residence and is the
1883 primary caregiver to clients in the home; (ii) corporate, where
1884 the foster care home is operated by a corporation with shift staff
1885 delivering services to clients; or (iii) shelter, where the foster
1886 care home accepts clients on an emergency short-term basis for up
1887 to thirty (30) days.

1888 (i) "Special care facilities for paroled inmates" means
1889 long-term care and skilled nursing facilities licensed as special
1890 care facilities for medically frail paroled inmates, formed to
1891 ease the burden of prison overcrowding and provide compassionate
1892 release and medical parole initiatives while impacting economic
1893 outcomes for the Mississippi prison system. The facilities shall
1894 meet all Mississippi Department of Health and federal Center for
1895 Medicaid Services (CMS) requirements and shall be regulated by
1896 both agencies; provided, however, such regulations shall not be as
1897 restrictive as those required for personal care homes and other
1898 institutions devoted primarily to providing medical services. The
1899 facilities will offer physical, occupational and speech therapy,
1900 nursing services, wound care, a dedicated COVID services unit,
1901 individualized patient centered plans of care, social services,
1902 spiritual services, physical activities, transportation,
1903 medication, durable medical equipment, personalized meal plans by
1904 a licensed dietician and security services. There may be up to
1905 three (3) facilities located in each Supreme Court district, to be
1906 designated by the Chairman of the State Parole Board or his
1907 designee.

1908 <u>(j) "Adult day care facility" means a public agency or</u>
1909 <u>private organization, or a subdivision of such an agency or</u>
1910 <u>organization, that:</u>

1911 <u>(i) Provides the following items and services:</u>

1912 <u>1. Nursing services;</u>

1913 2. Transportation of the individual to and
1914 from such adult day care facility in connection with any such item
1915 or service;
1916 3. Meals;
1917 4. A program of supervised activities that
1918 meets such criteria as the licensing agency determines appropriate
1919 designed to promote physical and mental health that are furnished
1920 to the individual by such a facility in a group setting for a
1921 period not greater than twelve (12) hours per day;
1922 5. The administration of medication by a
1923 licensed nurse, and a medication management program to minimize
1924 unnecessary or inappropriate use of prescription drugs and adverse
1925 events due to unintended prescription drug-to-drug interactions;
1926 and
1927 (ii) Meets such standards established by the
1928 licensing agency to assure quality of care and such other
1929 requirements as the licensing agency finds necessary in the
1930 interest of the health and safety of individuals who are furnished
1931 services in the facility.
1932 **SECTION 5.** Section 43-11-13, Mississippi Code of 1972, is
1933 amended as follows:
1934 43-11-13. (1) The licensing agency shall adopt, amend,
1935 promulgate and enforce such rules, regulations and standards,
1936 including classifications, with respect to all institutions for
1937 the aged or infirm to be licensed under this chapter as may be

1938 designed to further the accomplishment of the purpose of this
1939 chapter in promoting adequate care of individuals in those
1940 institutions in the interest of public health, safety and welfare.
1941 Those rules, regulations and standards shall be adopted and
1942 promulgated by the licensing agency and shall be recorded and
1943 indexed in a book to be maintained by the licensing agency in its
1944 main office in the State of Mississippi, entitled "Rules,
1945 Regulations and Minimum Standards for Institutions for the Aged or
1946 Infirm" and the book shall be open and available to all
1947 institutions for the aged or infirm and the public generally at
1948 all reasonable times. Upon the adoption of those rules,
1949 regulations and standards, the licensing agency shall mail copies
1950 thereof to all those institutions in the state that have filed
1951 with the agency their names and addresses for this purpose, but
1952 the failure to mail the same or the failure of the institutions to
1953 receive the same shall in no way affect the validity thereof. The
1954 rules, regulations and standards may be amended by the licensing
1955 agency, from time to time, as necessary to promote the health,
1956 safety and welfare of persons living in those institutions.
1957 (2) The licensee shall keep posted in a conspicuous place on
1958 the licensed premises all current rules, regulations and minimum
1959 standards applicable to fire protection measures as adopted by the
1960 licensing agency. The licensee shall furnish to the licensing
1961 agency at least once each six (6) months a certificate of approval
1962 and inspection by state or local fire authorities. Failure to

1963 comply with state laws and/or municipal ordinances and current
1964 rules, regulations and minimum standards as adopted by the
1965 licensing agency, relative to fire prevention measures, shall be
1966 prima facie evidence for revocation of license.

1967 (3) The State Board of Health shall promulgate rules and
1968 regulations restricting the storage, quantity and classes of drugs
1969 allowed in personal care homes and adult foster care facilities.
1970 Residents requiring administration of Schedule II Narcotics as
1971 defined in the Uniform Controlled Substances Law may be admitted
1972 to a personal care home. Schedule drugs may only be allowed in a
1973 personal care home if they are administered or stored utilizing
1974 proper procedures under the direct supervision of a licensed
1975 physician or nurse.

1976 (4) (a) Notwithstanding any determination by the licensing
1977 agency that skilled nursing services would be appropriate for a
1978 resident of a personal care home, that resident, the resident's
1979 guardian or the legally recognized responsible party for the
1980 resident may consent in writing for the resident to continue to
1981 reside in the personal care home, if approved in writing by a
1982 licensed physician. However, no personal care home shall allow
1983 more than two (2) residents, or ten percent (10%) of the total
1984 number of residents in the facility, whichever is greater, to
1985 remain in the personal care home under the provisions of this
1986 subsection (4). This consent shall be deemed to be appropriately
1987 informed consent as described in the regulations promulgated by

1988 the licensing agency. After that written consent has been
1989 obtained, the resident shall have the right to continue to reside
1990 in the personal care home for as long as the resident meets the
1991 other conditions for residing in the personal care home. A copy
1992 of the written consent and the physician's approval shall be
1993 forwarded by the personal care home to the licensing agency.
1994 (b) The State Board of Health shall promulgate rules
1995 and regulations restricting the handling of a resident's personal
1996 deposits by the director of a personal care home. Any funds given
1997 or provided for the purpose of supplying extra comforts,
1998 conveniences or services to any resident in any personal care
1999 home, and any funds otherwise received and held from, for or on
2000 behalf of any such resident, shall be deposited by the director or
2001 other proper officer of the personal care home to the credit of
2002 that resident in an account that shall be known as the Resident's
2003 Personal Deposit Fund. No more than one (1) month's charge for
2004 the care, support, maintenance and medical attention of the
2005 resident shall be applied from the account at any one time. After
2006 the death, discharge or transfer of any resident for whose benefit
2007 any such fund has been provided, any unexpended balance remaining
2008 in his personal deposit fund shall be applied for the payment of
2009 care, cost of support, maintenance and medical attention that is
2010 accrued. If any unexpended balance remains in that resident's
2011 personal deposit fund after complete reimbursement has been made
2012 for payment of care, support, maintenance and medical attention,

2013 and the director or other proper officer of the personal care home
2014 has been or shall be unable to locate the person or persons
2015 entitled to the unexpended balance, the director or other proper
2016 officer may, after the lapse of one (1) year from the date of that
2017 death, discharge or transfer, deposit the unexpended balance to
2018 the credit of the personal care home's operating fund.

2019 (c) The State Board of Health shall promulgate rules
2020 and regulations requiring personal care homes to maintain records
2021 relating to health condition, medicine dispensed and administered,
2022 and any reaction to that medicine. The director of the personal
2023 care home shall be responsible for explaining the availability of
2024 those records to the family of the resident at any time upon
2025 reasonable request.

2026 (5) The State Board of Health and the Mississippi Department
2027 of Corrections shall jointly issue rules and regulations for the
2028 operation of the special care facilities for paroled inmates.

2029 (6) (a) For the purposes of this subsection (6):

2030 (i) "Licensed entity" means a hospital, nursing
2031 home, personal care home, home health agency, hospice or adult
2032 foster care facility;

2033 (ii) "Covered entity" means a licensed entity or a
2034 health care professional staffing agency;

2035 (iii) "Employee" means any individual employed by
2036 a covered entity, and also includes any individual who by contract
2037 provides to the patients, residents or clients being served by the

2038 covered entity direct, hands-on, medical patient care in a
2039 patient's, resident's or client's room or in treatment or recovery
2040 rooms. The term "employee" does not include health care
2041 professional/vocational technical students performing clinical
2042 training in a licensed entity under contracts between their
2043 schools and the licensed entity, and does not include students at
2044 high schools located in Mississippi who observe the treatment and
2045 care of patients in a licensed entity as part of the requirements
2046 of an allied-health course taught in the high school, if:
2047 1. The student is under the supervision of a
2048 licensed health care provider; and
2049 2. The student has signed an affidavit that
2050 is on file at the student's school stating that he or she has not
2051 been convicted of or pleaded guilty or nolo contendere to a felony
2052 listed in paragraph (d) of this subsection (6), or that any such
2053 conviction or plea was reversed on appeal or a pardon was granted
2054 for the conviction or plea. Before any student may sign such an
2055 affidavit, the student's school shall provide information to the
2056 student explaining what a felony is and the nature of the felonies
2057 listed in paragraph (d) of this subsection (6).
2058 However, the health care professional/vocational technical
2059 academic program in which the student is enrolled may require the
2060 student to obtain criminal history record checks. In such
2061 incidences, paragraph (a)(iii)1 and 2 of this subsection (6) does
2062 not preclude the licensing entity from processing submitted

2063 fingerprints of students from healthcare-related
2064 professional/vocational technical programs who, as part of their
2065 program of study, conduct observations and provide clinical care
2066 and services in a covered entity.
2067 (b) Under regulations promulgated by the State Board of
2068 Health, the licensing agency shall require to be performed a
2069 criminal history record check on (i) every new employee of a
2070 covered entity who provides direct patient care or services and
2071 who is employed on or after July 1, 2003, and (ii) every employee
2072 of a covered entity employed before July 1, 2003, who has a
2073 documented disciplinary action by his or her present employer. In
2074 addition, the licensing agency shall require the covered entity to
2075 perform a disciplinary check with the professional licensing
2076 agency of each employee, if any, to determine if any disciplinary
2077 action has been taken against the employee by that agency.
2078 Except as otherwise provided in paragraph (c) of this
2079 subsection (6), no such employee hired on or after July 1, 2003,
2080 shall be permitted to provide direct patient care until the
2081 results of the criminal history record check have revealed no
2082 disqualifying record or the employee has been granted a waiver.
2083 In order to determine the employee applicant's suitability for
2084 employment, the applicant shall be fingerprinted. Fingerprints
2085 shall be submitted to the licensing agency from scanning, with the
2086 results processed through the Department of Public Safety's
2087 Criminal Information Center. The fingerprints shall then be

2088 forwarded by the Department of Public Safety to the Federal Bureau
2089 of Investigation for a national criminal history record check.
2090 The licensing agency shall notify the covered entity of the
2091 results of an employee applicant's criminal history record check.
2092 If the criminal history record check discloses a felony
2093 conviction, guilty plea or plea of nolo contendere to a felony of
2094 possession or sale of drugs, murder, manslaughter, armed robbery,
2095 rape, sexual battery, sex offense listed in Section 45-33-23(h),
2096 child abuse, arson, grand larceny, burglary, gratification of lust
2097 or aggravated assault, or felonious abuse and/or battery of a
2098 vulnerable adult that has not been reversed on appeal or for which
2099 a pardon has not been granted, the employee applicant shall not be
2100 eligible to be employed by the covered entity.
2101 (c) Any such new employee applicant may, however, be
2102 employed on a temporary basis pending the results of the criminal
2103 history record check, but any employment contract with the new
2104 employee shall be voidable if the new employee receives a
2105 disqualifying criminal history record check and no waiver is
2106 granted as provided in this subsection (6).
2107 (d) Under regulations promulgated by the State Board of
2108 Health, the licensing agency shall require every employee of a
2109 covered entity employed before July 1, 2003, to sign an affidavit
2110 stating that he or she has not been convicted of or pleaded guilty
2111 or nolo contendere to a felony of possession or sale of drugs,
2112 murder, manslaughter, armed robbery, rape, sexual battery, any sex

2113 offense listed in Section 45-33-23(h), child abuse, arson, grand
2114 larceny, burglary, gratification of lust, aggravated assault, or
2115 felonious abuse and/or battery of a vulnerable adult, or that any
2116 such conviction or plea was reversed on appeal or a pardon was
2117 granted for the conviction or plea. No such employee of a covered
2118 entity hired before July 1, 2003, shall be permitted to provide
2119 direct patient care until the employee has signed the affidavit
2120 required by this paragraph (d). All such existing employees of
2121 covered entities must sign the affidavit required by this
2122 paragraph (d) within six (6) months of the final adoption of the
2123 regulations promulgated by the State Board of Health. If a person
2124 signs the affidavit required by this paragraph (d), and it is
2125 later determined that the person actually had been convicted of or
2126 pleaded guilty or nolo contendere to any of the offenses listed in
2127 this paragraph (d) and the conviction or plea has not been
2128 reversed on appeal or a pardon has not been granted for the
2129 conviction or plea, the person is guilty of perjury. If the
2130 offense that the person was convicted of or pleaded guilty or nolo
2131 contendere to was a violent offense, the person, upon a conviction
2132 of perjury under this paragraph, shall be punished as provided in
2133 Section 97-9-61. If the offense that the person was convicted of
2134 or pleaded guilty or nolo contendere to was a nonviolent offense,
2135 the person, upon a conviction of perjury under this paragraph,
2136 shall be punished by a fine of not more than Five Hundred Dollars

2137 ($500.00), or by imprisonment in the county jail for not more than
2138 six (6) months, or by both such fine and imprisonment.

2139 (e) The covered entity may, in its discretion, allow
2140 any employee who is unable to sign the affidavit required by
2141 paragraph (d) of this subsection (6) or any employee applicant
2142 aggrieved by an employment decision under this subsection (6) to
2143 appear before the covered entity's hiring officer, or his or her
2144 designee, to show mitigating circumstances that may exist and
2145 allow the employee or employee applicant to be employed by the
2146 covered entity. The covered entity, upon report and
2147 recommendation of the hiring officer, may grant waivers for those
2148 mitigating circumstances, which shall include, but not be limited
2149 to: (i) age at which the crime was committed; (ii) circumstances
2150 surrounding the crime; (iii) length of time since the conviction
2151 and criminal history since the conviction; (iv) work history; (v)
2152 current employment and character references; and (vi) other
2153 evidence demonstrating the ability of the individual to perform
2154 the employment responsibilities competently and that the
2155 individual does not pose a threat to the health or safety of the
2156 patients of the covered entity.

2157 (f) The licensing agency may charge the covered entity
2158 submitting the fingerprints a fee not to exceed Fifty Dollars
2159 ($50.00), which covered entity may, in its discretion, charge the
2160 same fee, or a portion thereof, to the employee applicant. Any
2161 increase in the fee charged by the licensing agency under this

2162 paragraph shall be in accordance with the provisions of Section
2163 41-3-65. Any costs incurred by a covered entity implementing this
2164 subsection (6) shall be reimbursed as an allowable cost under
2165 Section 43-13-116.

2166 (g) If the results of an employee applicant's criminal
2167 history record check reveals no disqualifying event, then the
2168 covered entity shall, within two (2) weeks of the notification of
2169 no disqualifying event, provide the employee applicant with a
2170 notarized letter signed by the chief executive officer of the
2171 covered entity, or his or her authorized designee, confirming the
2172 employee applicant's suitability for employment based on his or
2173 her criminal history record check. An employee applicant may use
2174 that letter for a period of two (2) years from the date of the
2175 letter to seek employment with any covered entity without the
2176 necessity of an additional criminal history record check. Any
2177 covered entity presented with the letter may rely on the letter
2178 with respect to an employee applicant's criminal background and is
2179 not required for a period of two (2) years from the date of the
2180 letter to conduct or have conducted a criminal history record
2181 check as required in this subsection (6).

2182 (h) The licensing agency, the covered entity, and their
2183 agents, officers, employees, attorneys and representatives, shall
2184 be presumed to be acting in good faith for any employment decision
2185 or action taken under this subsection (6). The presumption of
2186 good faith may be overcome by a preponderance of the evidence in

2187 any civil action. No licensing agency, covered entity, nor their
2188 agents, officers, employees, attorneys and representatives shall
2189 be held liable in any employment decision or action based in whole
2190 or in part on compliance with or attempts to comply with the
2191 requirements of this subsection (6).
2192 (i) The licensing agency shall promulgate regulations
2193 to implement this subsection (6).
2194 (j) The provisions of this subsection (6) shall not
2195 apply to:
2196 (i) Applicants and employees of the University of
2197 Mississippi Medical Center for whom criminal history record checks
2198 and fingerprinting are obtained in accordance with Section
2199 37-115-41; or
2200 (ii) Health care professional/vocational technical
2201 students for whom criminal history record checks and
2202 fingerprinting are obtained in accordance with Section 37-29-232.
2203 (7) The State Board of Health shall promulgate rules,
2204 regulations and standards regarding the operation of adult foster
2205 care facilities and adult day care facilities.
2206 (8) Beginning July 1, 2025, to operate an adult day care
2207 center in Mississippi, the facility provider shall be licensed
2208 with the licensing division of the State Department of Health.
2209 Mississippi Medicaid waiver providers are required to have a
2210 state license and have a Medicaid provider contract with the

2211 Division of Medicaid. The licensure shall consist of one (1) of
2212 the following two (2) levels of service:
2213 (a) Basic level-Level I. Facilities shall be licensed
2214 to serve clients based on the size and capacity of the facility.
2215 The facilities shall be required to provide nursing services,
2216 nutritional services, socialization and therapeutic activities.
2217 Level I facilities shall maintain, at a minimum, a staff-to-client
2218 ratio in accordance with the State Department of Health's
2219 standards. Standards governing the qualify of care and services
2220 rendered shall be developed with input from all stakeholders,
2221 including the Division of Medicaid. In addition to providing
2222 adult day care services, the licensed provider is required to
2223 offer transportation services consistent with State Department of
2224 Health regulations.
2225 (b) Enhanced Level-Level II. Enhanced level facilities
2226 shall be licensed to serve clients based on the size and capacity
2227 of the facility. This type of facility may serve clients with
2228 significant impairments and medical needs as determined by the
2229 State Department of Health. The facility will be required to
2230 provide skilled nursing services in addition to nutritional
2231 services, socialization and therapeutic activities. Standards
2232 governing the quality of care and services rendered shall be
2233 developed with input from all stakeholders, including the Division
2234 of Medicaid. Enhanced level facilities shall maintain a
2235 staff-to-client ratio in accordance with the State Department of

2236 Health's standards. In addition to providing adult day care
2237 services, the license provider is required to offer transportation
2238 services consistent with State Department of Health regulations.

2239 **SECTION 6.** Section 43-13-117.1, Mississippi Code of 1972, is
2240 amended as follows:

2241 43-13-117.1. (1) It is the intent of the Legislature to
2242 expand access to Medicaid-funded home- and community-based
2243 services for eligible nursing facility residents who choose those
2244 services. The Executive Director of the Division of Medicaid is
2245 authorized to transfer funds allocated for nursing facility
2246 services for eligible residents to cover the cost of services
2247 available through the Independent Living Waiver, the Traumatic
2248 Brain Injury/Spinal Cord Injury Waiver, the Elderly and Disabled
2249 Waiver, and the Assisted Living Waiver programs when eligible
2250 residents choose those community services. The amount of funding
2251 transferred by the division shall be sufficient to cover the cost
2252 of home- and community-based waiver services for each eligible
2253 nursing facility *** * *** resident who *** * *** chooses those services.
2254 The number of nursing facility residents who return to the
2255 community and home- and community-based waiver services shall not
2256 count against the total number of waiver slots for which the
2257 Legislature appropriates funding each year. Any funds remaining
2258 in the program when a former nursing facility resident ceases to
2259 participate in a home- and community-based waiver program under
2260 this provision shall be returned to nursing facility funding.

2261 (2) Beginning July 1, 2025, the Division of Medicaid shall
2262 reimburse adult day care centers based on the level of services
2263 provided by the adult day care centers, as described in section
2264 43-11-13.
2265 **SECTION 7.** This act shall take effect and be in force from
2266 and after July 1, 2024.