

Medicaid Advisory Committee
July 10, 2026 - 2:00 PM
Sillers Building – Cobb Conference Center
550 High Street, Jackson, MS 39201

Meeting Agenda

1. Call to Order and Disclosure of Conflicts of Interest
2. Approval of Meeting Minutes for April 17, 2026
3. Approval of Annual Report
4. Financial Update
5. Agency Updates
 - a. House Bill 565 aka Jill's Law
 - b. Hospital Returns Policy
 - c. SPA/AC Overview
 - d. Presumptive Eligibility for Pregnant Women
6. Old Business
 - a. None
7. New Business
8. Adjournment

Next Meeting: October 16, 2026



Medicaid Advisory Committee Annual Report SFY2026

Introduction

The Mississippi Medicaid Advisory Committee's (MAC) efforts have focused on program oversight, policy guidance, community engagement, and addressing fiscal challenges to ensure access to quality healthcare for Mississippians.

Key Discussions and Activities

- **Program Updates and Oversight:** The MAC reviewed ongoing Medicaid initiatives, including eligibility requirements, benefits, waiver programs, and recent operational improvements such as application processing enhancements and the presumption of eligibility for pregnant women.
- **Financial Planning:** The committee discussed the fiscal state of the Mississippi Division of Medicaid, emphasizing the need for a budget increase for FY2026 to support expanding demand and program needs.
- **Community Engagement:** Members explored innovative community health strategies, including the pilot Community Health Worker (CHW) program overseen by the Department of Health, aimed at improving health outcomes through community-based services.
- **Operational Improvements:** Updates on the application process, including reductions in processing times and program expansions, were shared to highlight more efficient access for beneficiaries.
- **Partnerships and Outreach:** The committee reviewed collaborative efforts supporting maternal and child health programs, emphasizing the importance of outreach and community support.

Accomplishments

- **Enhanced Program Efficiency:** The MAC supported initiatives that improved application processing and eligibility determinations, reducing delays and increasing access.
- **Strategic Planning:** The committee contributed to discussions on future budget needs and program sustainability.
- **Stakeholder Engagement:** The MAC maintained open lines of communication with Medicaid beneficiaries, providers, and community organizations, fostering a collaborative environment.

Looking Forward

- Addressing Funding Challenges: The MAC will continue to focus on strategies to manage projected funding gaps for SFY2027.
- Expanding Community Programs: Building on the CHW pilot, the committee aims to promote broader community health initiatives to improve health outcomes.
- Streamlining Access: Further efforts will be directed towards simplifying eligibility and application processes to enhance beneficiary access and reduce administrative burdens for both members and providers.
- Strengthening Partnerships: The MAC plans to enhance collaborations with community organizations and health providers to support vulnerable populations.

Conclusion

In SFY2026, the MAC demonstrated strong interest in Mississippi's Medicaid program, supporting operational improvements, and fostering innovative community health strategies. The committee remains committed to ensuring the program's sustainability, access, and responsiveness to the needs of Mississippians.

By: Representatives Creekmore IV, Bell
(65th), Felsher, Owen, Eure, McKnight,
Currie, Scott

To: Public Health and Human
Services; Insurance

HOUSE BILL NO. 565
(As Passed the House)

1 AN ACT TO BE KNOWN AS THE "JILL GARY EURE ACT" OR "JILL'S
2 LAW"; TO REQUIRE EACH HEALTH BENEFIT PLAN, CONTRACT OR AGREEMENT
3 THAT IS ENTERED INTO OR RENEWED ON OR AFTER JULY 1, 2026,
4 INCLUDING THE MEDICAID PROGRAM AND THE STATE AND SCHOOL EMPLOYEES
5 HEALTH INSURANCE PLAN, TO OFFER COVERAGE FOR BIOMARKER TESTING FOR
6 THE PURPOSES OF DIAGNOSIS, TREATMENT, APPROPRIATE MANAGEMENT, OR
7 ONGOING MONITORING OF AN ENROLLEE'S DISEASE OR CONDITION WHEN USE
8 OF THE TEST IS SUPPORTED BY MEDICAL AND SCIENTIFIC EVIDENCE; TO
9 AMEND SECTIONS 43-13-117 AND 83-5-907, MISSISSIPPI CODE OF 1972,
10 TO CONFORM TO THE PROVISIONS OF THIS ACT; AND FOR RELATED
11 PURPOSES.

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

13 **SECTION 1.** This act shall be known and may be cited as the
14 "Jill Gary Eure Act" or "Jill's Law".

15 **SECTION 2.** As used in Sections 2 and 3 of this act, the
16 following terms shall be defined as provided in this section:

17 (a) "Biomarker" means a characteristic that is
18 objectively measured and evaluated as an indicator of normal
19 biological processes, pathogenic processes or pharmacologic
20 responses to a specific therapeutic intervention, including known
21 gene-drug interactions for medications being considered for use or
22 already being administered. Biomarkers include, but are not



23 limited to, gene mutations, characteristics of genes, or protein
24 expression.

25 (b) "Biomarker testing" means the analysis of a
26 patient's tissue, blood or other biospecimen for the presence of a
27 biomarker. Biomarker testing includes, but is not limited to,
28 single-analyte tests, multi-plex panel tests, protein expression,
29 whole exome, whole genome, and whole transcriptome sequencing and
30 other genomic or molecular sequencing.

31 (c) "Consensus statement" means a statement developed
32 by an independent, multidisciplinary panel of experts using a
33 transparent methodology and reporting structure and with a
34 conflict of interest policy. A consensus statement is aimed at
35 specific clinical circumstances and the statement is based on the
36 best available evidence for the purpose of optimizing the outcomes
37 of clinical care.

38 (d) "Health benefit plan" has the meaning given to that
39 term in Section 83-9-6.3, and also includes nonprofit health
40 service plans and the State and School Employees Health Insurance
41 Plan.

42 (e) "Health insurance issuer" has the meaning given to
43 that term in Section 83-9-6.3.

44 (f) "Nationally recognized clinical practice
45 guidelines" means evidence-based clinical practice guidelines
46 developed by independent organizations or medical professional
47 societies using a transparent methodology and reporting structure



and with a conflict of interest policy. Clinical practice guidelines establish standards of care informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options and include recommendations intended to optimize patient care.

SECTION 3. (1) All health benefit plans and any third-party contractor or agent of such entities shall provide coverage for biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's disease or condition when use of the test is supported by medical and scientific evidence, including, but not limited to, any one of the following:

(a) Labeled indications for an FDA-approved or -cleared test;

(b) Indicated tests for an FDA-approved drug;

(c) Warnings and precautions on FDA-approved drug labels;

(d) Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations or any Medicare Administrative Contractor (MAC) Local Coverage Determinations and associated Local Coverage Articles, regardless of jurisdiction; or

(e) Testing recommendations or considerations from a:

(i) Nationally recognized clinical practice guideline; or

(ii) Consensus statement.



73 (2) All health benefit plans shall ensure that coverage as
74 required in subsection (1) of this section is provided in a manner
75 that limits disruptions in care including the need for multiple
76 biopsies or biospecimen samples.

77 (3) Health benefit plans and health insurance issuers
78 subject to this section shall update and make publicly available
79 medical policies and coverage guidelines within sixty (60) days
80 after enactment. Any updates or changes to medical policies
81 impacting coverage of biomarker testing must be made publicly
82 available thirty (30) days in advance of the effective date of the
83 updated policy.

84 (4) If a health benefit plan or health insurance issuer
85 denies a claim for coverage of testing that is supported by any
86 evidence in subsection (1) of this section, the health benefit
87 plan or health insurance issuer shall provide to the requesting
88 entity, whether it is the provider, individual or laboratory,
89 specific written justification explaining in detail why the claim
90 for coverage was denied as it pertains to the individual for whom
91 the test was ordered.

92 (5) If utilization review, including, but not limited to,
93 prior authorization, is required, the health benefit plan,
94 utilization review entity or any third party acting on behalf of
95 an organization or entity subject to Sections 2 and 3 of this act
96 shall approve or deny a prior authorization request and notify the
97 enrollee, the enrollee's health care provider, and any entity



requesting authorization of the service within the timeframe established in Section 83-5-913 for nonurgent requests and Section 83-5-915 for urgent requests.

(6) If prior authorization is required, requests for biomarker tests may be submitted by:

(a) The ordering or treating provider;

(b) The rendering laboratory provider; or

(c) The enrollee or enrollee's representative.

(7) In addition to the provisions of Section 83-5-901 et seq., a patient and prescribing practitioner shall have access to a clear, readily accessible, and convenient process to request an exception to a coverage policy or an adverse utilization review determination of a health benefit plan or health insurance issuer. The process shall be made readily accessible on the health benefit plan's or health insurance issuer's website.

(8) The Department of Insurance may conduct periodic audits and reviews to ensure entity compliance with Sections 2 and 3 of this act.

(9) Sections 2 and 3 of this act shall apply to all health benefit plans, contracts or agreements that are entered into or renewed on or after July 1, 2026.

SECTION 4. Section 43-13-117, Mississippi Code of 1972, is amended as follows:

43-13-117. (A) Medicaid as authorized by this article shall include payment of part or all of the costs, at the discretion of



the division, with approval of the Governor and the Centers for Medicare and Medicaid Services, of the following types of care and services rendered to eligible applicants who have been determined to be eligible for that care and services, within the limits of state appropriations and federal matching funds:

(1) Inpatient hospital services.

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

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

(2) Outpatient hospital services.

(a) Emergency services.

(b) Other outpatient hospital services. The division shall allow benefits for other medically necessary outpatient hospital services (such as chemotherapy, radiation, surgery and therapy), including outpatient services in a clinic or other facility that is not located inside the hospital, but that has been designated as an outpatient facility by the hospital, and that was in operation or under construction on July 1, 2009, provided that the costs and charges associated with the operation



of the hospital clinic are included in the hospital's cost report. In addition, the Medicare thirty-five-mile rule will apply to those hospital clinics not located inside the hospital that are constructed after July 1, 2009. Where the same services are reimbursed as clinic services, the division may revise the rate or methodology of outpatient reimbursement to maintain consistency, efficiency, economy and quality of care.

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

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

(3) Laboratory and x-ray services.

(4) Nursing facility services.



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

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

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

(d) On or after January 1, 2015, the division shall update the case-mix payment system resource utilization grouper and classifications and fair rental reimbursement system.



The division shall develop and implement a payment add-on to reimburse nursing facilities for ventilator-dependent resident services.

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

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

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



222 (5) Periodic screening and diagnostic services for
223 individuals under age twenty-one (21) years as are needed to
224 identify physical and mental defects and to provide health care
225 treatment and other measures designed to correct or ameliorate
226 defects and physical and mental illness and conditions discovered
227 by the screening services, regardless of whether these services
228 are included in the state plan. The division may include in its
229 periodic screening and diagnostic program those discretionary
230 services authorized under the federal regulations adopted to
231 implement Title XIX of the federal Social Security Act, as
232 amended. The division, in obtaining physical therapy services,
233 occupational therapy services, and services for individuals with
234 speech, hearing and language disorders, may enter into a
235 cooperative agreement with the State Department of Education for
236 the provision of those services to handicapped students by public
237 school districts using state funds that are provided from the
238 appropriation to the Department of Education to obtain federal
239 matching funds through the division. The division, in obtaining
240 medical and mental health assessments, treatment, care and
241 services for children who are in, or at risk of being put in, the
242 custody of the Mississippi Department of Human Services may enter
243 into a cooperative agreement with the Mississippi Department of
244 Human Services for the provision of those services using state
245 funds that are provided from the appropriation to the Department



of Human Services to obtain federal matching funds through the division.

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

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



conduct the required initial face-to-face visit with the recipient of the services.

(b) [Repealed]

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

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

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

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

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



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

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

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

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



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

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

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

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

341 The dispensing fee for each new or refill prescription,
342 including nonlegend or over-the-counter drugs covered by the



division, shall be not less than Three Dollars and Ninety-one Cents (\$3.91), as determined by the division.

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

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

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

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

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

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



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

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

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

(11) Eyeglasses for all Medicaid beneficiaries who have (a) had surgery on the eyeball or ocular muscle that results in a vision change for which eyeglasses or a change in eyeglasses is medically indicated within six (6) months of the surgery and is in



393 accordance with policies established by the division, or (b) one
394 (1) pair every five (5) years and in accordance with policies
395 established by the division. In either instance, the eyeglasses
396 must be prescribed by a physician skilled in diseases of the eye
397 or an optometrist, whichever the beneficiary may select.

398 (12) Intermediate care facility services.

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

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

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

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

416 (14) Clinic services. Preventive, diagnostic,
417 therapeutic, rehabilitative or palliative services that are



furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Clinic services include, but are not limited to:

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

(b) Dialysis center services.

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

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



provided in the community by a facility or program operated by the Department of Mental Health. Any such services provided by a facility described in subparagraph (b) must have the prior approval of the division to be reimbursable under this section.

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

(18) (a) Notwithstanding any other provision of this section to the contrary, as provided in the Medicaid state plan amendment or amendments as defined in Section 43-13-145(10), the



468 division shall make additional reimbursement to hospitals that
469 serve a disproportionate share of low-income patients and that
470 meet the federal requirements for those payments as provided in
471 Section 1923 of the federal Social Security Act and any applicable
472 regulations. It is the intent of the Legislature that the
473 division shall draw down all available federal funds allotted to
474 the state for disproportionate share hospitals. However, from and
475 after January 1, 1999, public hospitals participating in the
476 Medicaid disproportionate share program may be required to
477 participate in an intergovernmental transfer program as provided
478 in Section 1903 of the federal Social Security Act and any
479 applicable regulations.

480 (b) (i) 1. The division may establish a Medicare
481 Upper Payment Limits Program, as defined in Section 1902(a)(30) of
482 the federal Social Security Act and any applicable federal
483 regulations, or an allowable delivery system or provider payment
484 initiative authorized under 42 CFR 438.6(c), for hospitals,
485 nursing facilities and physicians employed or contracted by
486 hospitals.

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



493 (ii) The division shall assess each hospital,
494 nursing facility, and emergency ambulance transportation provider
495 for the sole purpose of financing the state portion of the
496 Medicare Upper Payment Limits Program or other program(s)
497 authorized under this subsection (A)(18)(b). The hospital
498 assessment shall be as provided in Section 43-13-145(4)(a), and
499 the nursing facility and the emergency ambulance transportation
500 assessments, if established, shall be based on Medicaid
501 utilization or other appropriate method, as determined by the
502 division, consistent with federal regulations. The assessments
503 will remain in effect as long as the state participates in the
504 Medicare Upper Payment Limits Program or other program(s)
505 authorized under this subsection (A)(18)(b). In addition to the
506 hospital assessment provided in Section 43-13-145(4)(a), hospitals
507 with physicians participating in the Medicare Upper Payment Limits
508 Program or other program(s) authorized under this subsection
509 (A)(18)(b) shall be required to participate in an
510 intergovernmental transfer or assessment, as determined by the
511 division, for the purpose of financing the state portion of the
512 physician UPL payments or other payment(s) authorized under this
513 subsection (A)(18)(b).

514 (iii) Subject to approval by the Centers for
515 Medicare and Medicaid Services (CMS) and the provisions of this
516 subsection (A)(18)(b), the division shall make additional
517 reimbursement to hospitals, nursing facilities, and emergency



518 ambulance transportation providers for the Medicare Upper Payment
519 Limits Program or other program(s) authorized under this
520 subsection (A)(18)(b), and, if the program is established for
521 physicians, shall make additional reimbursement for physicians, as
522 defined in Section 1902(a)(30) of the federal Social Security Act
523 and any applicable federal regulations, provided the assessment in
524 this subsection (A)(18)(b) is in effect.

525 (iv) Notwithstanding any other provision of
526 this article to the contrary, effective upon implementation of the
527 Mississippi Hospital Access Program (MHAP) provided in
528 subparagraph (c)(i) below, the hospital portion of the inpatient
529 Upper Payment Limits Program shall transition into and be replaced
530 by the MHAP program. However, the division is authorized to
531 develop and implement an alternative fee-for-service Upper Payment
532 Limits model in accordance with federal laws and regulations if
533 necessary to preserve supplemental funding. Further, the
534 division, in consultation with the hospital industry shall develop
535 alternative models for distribution of medical claims and
536 supplemental payments for inpatient and outpatient hospital
537 services, and such models may include, but shall not be limited to
538 the following: increasing rates for inpatient and outpatient
539 services; creating a low-income utilization pool of funds to
540 reimburse hospitals for the costs of uncompensated care, charity
541 care and bad debts as permitted and approved pursuant to federal
542 regulations and the Centers for Medicare and Medicaid Services;



543 supplemental payments based upon Medicaid utilization, quality,
544 service lines and/or costs of providing such services to Medicaid
545 beneficiaries and to uninsured patients. The goals of such
546 payment models shall be to ensure access to inpatient and
547 outpatient care and to maximize any federal funds that are
548 available to reimburse hospitals for services provided. Any such
549 documents required to achieve the goals described in this
550 paragraph shall be submitted to the Centers for Medicare and
551 Medicaid Services, with a proposed effective date of July 1, 2019,
552 to the extent possible, but in no event shall the effective date
553 of such payment models be later than July 1, 2020. The Chairmen
554 of the Senate and House Medicaid Committees shall be provided a
555 copy of the proposed payment model(s) prior to submission.
556 Effective July 1, 2018, and until such time as any payment
557 model(s) as described above become effective, the division, in
558 consultation with the hospital industry, is authorized to
559 implement a transitional program for inpatient and outpatient
560 payments and/or supplemental payments (including, but not limited
561 to, MHAP and directed payments), to redistribute available
562 supplemental funds among hospital providers, provided that when
563 compared to a hospital's prior year supplemental payments,
564 supplemental payments made pursuant to any such transitional
565 program shall not result in a decrease of more than five percent
566 (5%) and shall not increase by more than the amount needed to
567 maximize the distribution of the available funds.



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

575 2. The division shall calculate the
576 ambulance service access payment amount as the balance of the
577 portion of the Medical Care Fund related to ambulance
578 transportation service provider assessments plus any federal
579 matching funds earned on the balance, up to, but not to exceed,
580 the upper payment limit gap for all emergency ambulance service
581 providers.

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

587 b. In addition to any other funds
588 paid to ambulance transportation service providers for emergency
589 medical services provided to Medicaid beneficiaries, each eligible
590 ambulance transportation service provider shall receive ambulance
591 service access payments each state fiscal year equal to the
592 ambulance transportation service provider's upper payment limit



gap. Subject to approval by the Centers for Medicare and Medicaid Services, ambulance service access payments shall be made no less than on a quarterly basis.

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

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

(c) (i) Not later than December 1, 2015, the division shall, subject to approval by the Centers for Medicare and Medicaid Services (CMS), establish, implement and operate a Mississippi Hospital Access Program (MHAP) for the purpose of protecting patient access to hospital care through hospital inpatient reimbursement programs provided in this section designed to maintain total hospital reimbursement for inpatient services rendered by in-state hospitals and the out-of-state hospital that is authorized by federal law to submit intergovernmental transfers (IGTs) to the State of Mississippi and is classified as Level I trauma center located in a county contiguous to the state line at the maximum levels permissible under applicable federal statutes



618 and regulations, at which time the current inpatient Medicare
619 Upper Payment Limits (UPL) Program for hospital inpatient services
620 shall transition to the MHAP.

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

628 (iii) The intent of this subparagraph (c) is
629 that effective for all inpatient hospital Medicaid services during
630 state fiscal year 2016, and so long as this provision shall remain
631 in effect hereafter, the division shall to the fullest extent
632 feasible replace the additional reimbursement for hospital
633 inpatient services under the inpatient Medicare Upper Payment
634 Limits (UPL) Program with additional reimbursement under the MHAP
635 and other payment programs for inpatient and/or outpatient
636 payments which may be developed under the authority of this
637 paragraph.

638 (iv) The division shall assess each hospital
639 as provided in Section 43-13-145(4) (a) for the purpose of
640 financing the state portion of the MHAP, supplemental payments and
641 such other purposes as specified in Section 43-13-145. The



642 assessment will remain in effect as long as the MHAP and
643 supplemental payments are in effect.

644 (19) (a) Perinatal risk management services. The
645 division shall promulgate regulations to be effective from and
646 after October 1, 1988, to establish a comprehensive perinatal
647 system for risk assessment of all pregnant and infant Medicaid
648 recipients and for management, education and follow-up for those
649 who are determined to be at risk. Services to be performed
650 include case management, nutrition assessment/counseling,
651 psychosocial assessment/counseling and health education. The
652 division shall contract with the State Department of Health to
653 provide services within this paragraph (Perinatal High Risk
654 Management/Infant Services System (PHRM/ISS)). The State
655 Department of Health shall be reimbursed on a full reasonable cost
656 basis for services provided under this subparagraph (a).

657 (b) Early intervention system services. The
658 division shall cooperate with the State Department of Health,
659 acting as lead agency, in the development and implementation of a
660 statewide system of delivery of early intervention services, under
661 Part C of the Individuals with Disabilities Education Act (IDEA).
662 The State Department of Health shall certify annually in writing
663 to the executive director of the division the dollar amount of
664 state early intervention funds available that will be utilized as
665 a certified match for Medicaid matching funds. Those funds then
666 shall be used to provide expanded targeted case management



667 services for Medicaid eligible children with special needs who are
668 eligible for the state's early intervention system.

669 Qualifications for persons providing service coordination shall be
670 determined by the State Department of Health and the Division of
671 Medicaid.

672 (20) Home- and community-based services for physically
673 disabled approved services as allowed by a waiver from the United
674 States Department of Health and Human Services for home- and
675 community-based services for physically disabled people using
676 state funds that are provided from the appropriation to the State
677 Department of Rehabilitation Services and used to match federal
678 funds under a cooperative agreement between the division and the
679 department, provided that funds for these services are
680 specifically appropriated to the Department of Rehabilitation
681 Services.

682 (21) Nurse practitioner services. Services furnished
683 by a registered nurse who is licensed and certified by the
684 Mississippi Board of Nursing as a nurse practitioner, including,
685 but not limited to, nurse anesthetists, nurse midwives, family
686 nurse practitioners, family planning nurse practitioners,
687 pediatric nurse practitioners, obstetrics-gynecology nurse
688 practitioners and neonatal nurse practitioners, under regulations
689 adopted by the division. Reimbursement for those services shall
690 not exceed ninety percent (90%) of the reimbursement rate for
691 comparable services rendered by a physician. The division may



692 provide for a reimbursement rate for nurse practitioner services
693 of up to one hundred percent (100%) of the reimbursement rate for
694 comparable services rendered by a physician for nurse practitioner
695 services that are provided after the normal working hours of the
696 nurse practitioner, as determined in accordance with regulations
697 of the division.

698 (22) Ambulatory services delivered in federally
699 qualified health centers, rural health centers and clinics of the
700 local health departments of the State Department of Health for
701 individuals eligible for Medicaid under this article based on
702 reasonable costs as determined by the division. Federally
703 qualified health centers shall be reimbursed by the Medicaid
704 prospective payment system as approved by the Centers for Medicare
705 and Medicaid Services. The division shall recognize federally
706 qualified health centers (FQHCs), rural health clinics (RHCs) and
707 community mental health centers (CMHCs) as both an originating and
708 distant site provider for the purposes of telehealth
709 reimbursement. The division is further authorized and directed to
710 reimburse FQHCs, RHCs and CMHCs for both distant site and
711 originating site services when such services are appropriately
712 provided by the same organization.

713 (23) Inpatient psychiatric services.

714 (a) Inpatient psychiatric services to be
715 determined by the division for recipients under age twenty-one
716 (21) that are provided under the direction of a physician in an



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

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

(24) [Deleted]

(25) [Deleted]

(26) Hospice care. As used in this paragraph, the term "hospice care" means a coordinated program of active professional medical attention within the home and outpatient and inpatient



742 care that treats the terminally ill patient and family as a unit,
743 employing a medically directed interdisciplinary team. The
744 program provides relief of severe pain or other physical symptoms
745 and supportive care to meet the special needs arising out of
746 physical, psychological, spiritual, social and economic stresses
747 that are experienced during the final stages of illness and during
748 dying and bereavement and meets the Medicare requirements for
749 participation as a hospice as provided in federal regulations.

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

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

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



Department of Mental Health and/or transferred to the department
by a political subdivision or instrumentality of the state.

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

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

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

(33) Podiatrist services.

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

(35) Services and activities authorized in Sections
43-27-101 and 43-27-103, using state funds that are provided from



791 the appropriation to the Mississippi Department of Human Services
792 and used to match federal funds under a cooperative agreement
793 between the division and the department.

794 (36) Nonemergency transportation services for
795 Medicaid-eligible persons as determined by the division. The PEER
796 Committee shall conduct a performance evaluation of the
797 nonemergency transportation program to evaluate the administration
798 of the program and the providers of transportation services to
799 determine the most cost-effective ways of providing nonemergency
800 transportation services to the patients served under the program.
801 The performance evaluation shall be completed and provided to the
802 members of the Senate Medicaid Committee and the House Medicaid
803 Committee not later than January 1, 2019, and every two (2) years
804 thereafter.

805 (37) [Deleted]

806 (38) Chiropractic services. A chiropractor's manual
807 manipulation of the spine to correct a subluxation, if x-ray
808 demonstrates that a subluxation exists and if the subluxation has
809 resulted in a neuromusculoskeletal condition for which
810 manipulation is appropriate treatment, and related spinal x-rays
811 performed to document these conditions. Reimbursement for
812 chiropractic services shall not exceed Seven Hundred Dollars
813 (\$700.00) per year per beneficiary.

814 (39) Dually eligible Medicare/Medicaid beneficiaries.
815 The division shall pay the Medicare deductible and coinsurance



816 amounts for services available under Medicare, as determined by
817 the division. From and after July 1, 2009, the division shall
818 reimburse crossover claims for inpatient hospital services and
819 crossover claims covered under Medicare Part B in the same manner
820 that was in effect on January 1, 2008, unless specifically
821 authorized by the Legislature to change this method.

822 (40) [Deleted]

823 (41) Services provided by the State Department of
824 Rehabilitation Services for the care and rehabilitation of persons
825 with spinal cord injuries or traumatic brain injuries, as allowed
826 under waivers from the United States Department of Health and
827 Human Services, using up to seventy-five percent (75%) of the
828 funds that are appropriated to the Department of Rehabilitation
829 Services from the Spinal Cord and Head Injury Trust Fund
830 established under Section 37-33-261 and used to match federal
831 funds under a cooperative agreement between the division and the
832 department.

833 (42) [Deleted]

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

839 (44) Nursing facility services for the severely
840 disabled.



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

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

847 (45) Physician assistant services. Services furnished
848 by a physician assistant who is licensed by the State Board of
849 Medical Licensure and is practicing with physician supervision
850 under regulations adopted by the board, under regulations adopted
851 by the division. Reimbursement for those services shall not
852 exceed ninety percent (90%) of the reimbursement rate for
853 comparable services rendered by a physician. The division may
854 provide for a reimbursement rate for physician assistant services
855 of up to one hundred percent (100%) or the reimbursement rate for
856 comparable services rendered by a physician for physician
857 assistant services that are provided after the normal working
858 hours of the physician assistant, as determined in accordance with
859 regulations of the division.

860 (46) The division shall make application to the federal
861 Centers for Medicare and Medicaid Services (CMS) for a waiver to
862 develop and provide services for children with serious emotional
863 disturbances as defined in Section 43-14-1(1), which may include
864 home- and community-based services, case management services or
865 managed care services through mental health providers certified by



866 the Department of Mental Health. The division may implement and
867 provide services under this waived program only if funds for
868 these services are specifically appropriated for this purpose by
869 the Legislature, or if funds are voluntarily provided by affected
870 agencies.

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

875 (b) Participation in any disease management
876 program implemented under this paragraph (47) is optional with the
877 individual. An individual must affirmatively elect to participate
878 in the disease management program in order to participate, and may
879 elect to discontinue participation in the program at any time.

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

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

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



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

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

900 (51) Upon determination of Medicaid eligibility and in
901 association with annual redetermination of Medicaid eligibility,
902 beneficiaries shall be encouraged to undertake a physical
903 examination that will establish a base-line level of health and
904 identification of a usual and customary source of care (a medical
905 home) to aid utilization of disease management tools. This
906 physical examination and utilization of these disease management
907 tools shall be consistent with current United States Preventive
908 Services Task Force or other recognized authority recommendations.

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

912 (52) Notwithstanding any provisions of this article,
913 the division may pay enhanced reimbursement fees related to trauma
914 care, as determined by the division in conjunction with the State



915 Department of Health, using funds appropriated to the State
916 Department of Health for trauma care and services and used to
917 match federal funds under a cooperative agreement between the
918 division and the State Department of Health. The division, in
919 conjunction with the State Department of Health, may use grants,
920 waivers, demonstrations, enhanced reimbursements, Upper Payment
921 Limits Programs, supplemental payments, or other projects as
922 necessary in the development and implementation of this
923 reimbursement program.

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

927 (54) [Deleted]

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



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

945 (57) No Medicaid benefit shall restrict coverage for
946 medically appropriate treatment prescribed by a physician and
947 agreed to by a fully informed individual, or if the individual
948 lacks legal capacity to consent by a person who has legal
949 authority to consent on his or her behalf, based on an
950 individual's diagnosis with a terminal condition. As used in this
951 paragraph (57), "terminal condition" means any aggressive
952 malignancy, chronic end-stage cardiovascular or cerebral vascular
953 disease, or any other disease, illness or condition which a
954 physician diagnoses as terminal.

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

962 (59) The division shall allow beneficiaries between the
963 ages of ten (10) and eighteen (18) years to receive vaccines
964 through a pharmacy venue. The division and the State Department



965 of Health shall coordinate and notify OB-GYN providers that the
966 Vaccines for Children program is available to providers free of
967 charge.

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

970 (a) Payments may only be made to a border city
971 university-affiliated pediatric teaching hospital if the Centers
972 for Medicare and Medicaid Services (CMS) approve an increase in
973 the annual request for the provider payment initiative authorized
974 under 42 CFR Section 438.6(c) in an amount equal to or greater
975 than the estimated annual payment to be made to the border city
976 university-affiliated pediatric teaching hospital. The estimate
977 shall be based on the hospital's prior year Mississippi managed
978 care utilization.

979 (b) As used in this paragraph (60), the term
980 "border city university-affiliated pediatric teaching hospital"
981 means an out-of-state hospital located within a city bordering the
982 eastern bank of the Mississippi River and the State of Mississippi
983 that submits to the division a copy of a current and effective
984 affiliation agreement with an accredited university and other
985 documentation establishing that the hospital is
986 university-affiliated, is licensed and designated as a pediatric
987 hospital or pediatric primary hospital within its home state,
988 maintains at least five (5) different pediatric specialty training
989 programs, and maintains at least one hundred (100) operated beds



dedicated exclusively for the treatment of patients under the age of twenty-one (21) years.

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

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

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

(61) Services described in Section 41-140-3 that are provided by certified community health workers employed and supervised by a Medicaid provider. Reimbursement for these services shall be provided only if the division has received approval from the Centers for Medicare and Medicaid Services for a state plan amendment, waiver or alternative payment model for services delivered by certified community health workers.

(62) Biomarker testing in accordance with the provisions of Sections 2 and 3 of this act. With respect to biomarker testing, the division shall, within sixty (60) days after the effective date of this act, update the fee schedule for



1015 Medicaid services to include the appropriate current procedural
1016 terminology (CPT) and proprietary laboratory analysis (PLA) codes
1017 for all biomarker tests coverage that is mandated under Sections 2
1018 and 3 of this act.

1019 (B) Planning and development districts participating in the
1020 home- and community-based services program for the elderly and
1021 disabled as case management providers shall be reimbursed for case
1022 management services at the maximum rate approved by the Centers
1023 for Medicare and Medicaid Services (CMS).

1024 (C) The division may pay to those providers who participate
1025 in and accept patient referrals from the division's emergency room
1026 redirection program a percentage, as determined by the division,
1027 of savings achieved according to the performance measures and
1028 reduction of costs required of that program. Federally qualified
1029 health centers may participate in the emergency room redirection
1030 program, and the division may pay those centers a percentage of
1031 any savings to the Medicaid program achieved by the centers'
1032 accepting patient referrals through the program, as provided in
1033 this subsection (C).

1034 (D) (1) As used in this subsection (D), the following terms
1035 shall be defined as provided in this paragraph, except as
1036 otherwise provided in this subsection:

1037 (a) "Committees" means the Medicaid Committees of
1038 the House of Representatives and the Senate, and "committee" means
1039 either one of those committees.



1040 (b) "Rate change" means an increase, decrease or
1041 other change in the payments or rates of reimbursement, or a
1042 change in any payment methodology that results in an increase,
1043 decrease or other change in the payments or rates of
1044 reimbursement, to any Medicaid provider that renders any services
1045 authorized to be provided to Medicaid recipients under this
1046 article.

1047 (2) Whenever the Division of Medicaid proposes a rate
1048 change, the division shall give notice to the chairmen of the
1049 committees at least thirty (30) calendar days before the proposed
1050 rate change is scheduled to take effect. The division shall
1051 furnish the chairmen with a concise summary of each proposed rate
1052 change along with the notice, and shall furnish the chairmen with
1053 a copy of any proposed rate change upon request. The division
1054 also shall provide a summary and copy of any proposed rate change
1055 to any other member of the Legislature upon request.

1056 (3) If the chairman of either committee or both
1057 chairmen jointly object to the proposed rate change or any part
1058 thereof, the chairman or chairmen shall notify the division and
1059 provide the reasons for their objection in writing not later than
1060 seven (7) calendar days after receipt of the notice from the
1061 division. The chairman or chairmen may make written
1062 recommendations to the division for changes to be made to a
1063 proposed rate change.



1064 (4) (a) The chairman of either committee or both
1065 chairmen jointly may hold a committee meeting to review a proposed
1066 rate change. If either chairman or both chairmen decide to hold a
1067 meeting, they shall notify the division of their intention in
1068 writing within seven (7) calendar days after receipt of the notice
1069 from the division, and shall set the date and time for the meeting
1070 in their notice to the division, which shall not be later than
1071 fourteen (14) calendar days after receipt of the notice from the
1072 division.

1073 (b) After the committee meeting, the committee or
1074 committees may object to the proposed rate change or any part
1075 thereof. The committee or committees shall notify the division
1076 and the reasons for their objection in writing not later than
1077 seven (7) calendar days after the meeting. The committee or
1078 committees may make written recommendations to the division for
1079 changes to be made to a proposed rate change.

1080 (5) If both chairmen notify the division in writing
1081 within seven (7) calendar days after receipt of the notice from
1082 the division that they do not object to the proposed rate change
1083 and will not be holding a meeting to review the proposed rate
1084 change, the proposed rate change will take effect on the original
1085 date as scheduled by the division or on such other date as
1086 specified by the division.

1087 (6) (a) If there are any objections to a proposed rate
1088 change or any part thereof from either or both of the chairmen or



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

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

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

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

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



1114 (F) The executive director shall keep the Governor advised
1115 on a timely basis of the funds available for expenditure and the
1116 projected expenditures. Notwithstanding any other provisions of
1117 this article, if current or projected expenditures of the division
1118 are reasonably anticipated to exceed the amount of funds
1119 appropriated to the division for any fiscal year, the Governor,
1120 after consultation with the executive director, shall take all
1121 appropriate measures to reduce costs, which may include, but are
1122 not limited to:

1123 (1) Reducing or discontinuing any or all services that
1124 are deemed to be optional under Title XIX of the Social Security
1125 Act;

1126 (2) Reducing reimbursement rates for any or all service
1127 types;

1128 (3) Imposing additional assessments on health care
1129 providers; or

1130 (4) Any additional cost-containment measures deemed
1131 appropriate by the Governor.

1132 To the extent allowed under federal law, any reduction to
1133 services or reimbursement rates under this subsection (F) shall be
1134 accompanied by a reduction, to the fullest allowable amount, to
1135 the profit margin and administrative fee portions of capitated
1136 payments to organizations described in paragraph (1) of subsection
1137 (H).



1138 Beginning in fiscal year 2010 and in fiscal years thereafter,
1139 when Medicaid expenditures are projected to exceed funds available
1140 for the fiscal year, the division shall submit the expected
1141 shortfall information to the PEER Committee not later than
1142 December 1 of the year in which the shortfall is projected to
1143 occur. PEER shall review the computations of the division and
1144 report its findings to the Legislative Budget Office not later
1145 than January 7 in any year.

1146 (G) Notwithstanding any other provision of this article, it
1147 shall be the duty of each provider participating in the Medicaid
1148 program to keep and maintain books, documents and other records as
1149 prescribed by the Division of Medicaid in accordance with federal
1150 laws and regulations.

1151 (H) (1) Notwithstanding any other provision of this
1152 article, the division is authorized to implement (a) a managed
1153 care program, (b) a coordinated care program, (c) a coordinated
1154 care organization program, (d) a health maintenance organization
1155 program, (e) a patient-centered medical home program, (f) an
1156 accountable care organization program, (g) provider-sponsored
1157 health plan, or (h) any combination of the above programs. As a
1158 condition for the approval of any program under this subsection
1159 (H)(1), the division shall require that no managed care program,
1160 coordinated care program, coordinated care organization program,
1161 health maintenance organization program, or provider-sponsored
1162 health plan may:



1163 (a) Pay providers at a rate that is less than the
1164 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
1165 reimbursement rate;

1166 (b) Override the medical decisions of hospital
1167 physicians or staff regarding patients admitted to a hospital for
1168 an emergency medical condition as defined by 42 US Code Section
1169 1395dd. This restriction (b) does not prohibit the retrospective
1170 review of the appropriateness of the determination that an
1171 emergency medical condition exists by chart review or coding
1172 algorithm, nor does it prohibit prior authorization for
1173 nonemergency hospital admissions;

1174 (c) Pay providers at a rate that is less than the
1175 normal Medicaid reimbursement rate. It is the intent of the
1176 Legislature that all managed care entities described in this
1177 subsection (H), in collaboration with the division, develop and
1178 implement innovative payment models that incentivize improvements
1179 in health care quality, outcomes, or value, as determined by the
1180 division. Participation in the provider network of any managed
1181 care, coordinated care, provider-sponsored health plan, or similar
1182 contractor shall not be conditioned on the provider's agreement to
1183 accept such alternative payment models;

1184 (d) Implement a prior authorization and
1185 utilization review program for medical services, transportation
1186 services and prescription drugs that is more stringent than the
1187 prior authorization processes used by the division in its



1188 administration of the Medicaid program. Not later than December
1189 2, 2021, the contractors that are receiving capitated payments
1190 under a managed care delivery system established under this
1191 subsection (H) shall submit a report to the Chairmen of the House
1192 and Senate Medicaid Committees on the status of the prior
1193 authorization and utilization review program for medical services,
1194 transportation services and prescription drugs that is required to
1195 be implemented under this subparagraph (d);

1196 (e) [Deleted]

1197 (f) Implement a preferred drug list that is more
1198 stringent than the mandatory preferred drug list established by
1199 the division under subsection (A)(9) of this section;

1200 (g) Implement a policy which denies beneficiaries
1201 with hemophilia access to the federally funded hemophilia
1202 treatment centers as part of the Medicaid Managed Care network of
1203 providers.

1204 Each health maintenance organization, coordinated care
1205 organization, provider-sponsored health plan, or other
1206 organization paid for services on a capitated basis by the
1207 division under any managed care program or coordinated care
1208 program implemented by the division under this section shall use a
1209 clear set of level of care guidelines in the determination of
1210 medical necessity and in all utilization management practices,
1211 including the prior authorization process, concurrent reviews,
1212 retrospective reviews and payments, that are consistent with



1213 widely accepted professional standards of care. Organizations
1214 participating in a managed care program or coordinated care
1215 program implemented by the division may not use any additional
1216 criteria that would result in denial of care that would be
1217 determined appropriate and, therefore, medically necessary under
1218 those levels of care guidelines.

1219 (2) Notwithstanding any provision of this section, the
1220 recipients eligible for enrollment into a Medicaid Managed Care
1221 Program authorized under this subsection (H) may include only
1222 those categories of recipients eligible for participation in the
1223 Medicaid Managed Care Program as of January 1, 2021, the
1224 Children's Health Insurance Program (CHIP), and the CMS-approved
1225 Section 1115 demonstration waivers in operation as of January 1,
1226 2021. No expansion of Medicaid Managed Care Program contracts may
1227 be implemented by the division without enabling legislation from
1228 the Mississippi Legislature.

1229 (3) (a) Any contractors receiving capitated payments
1230 under a managed care delivery system established in this section
1231 shall provide to the Legislature and the division statistical data
1232 to be shared with provider groups in order to improve patient
1233 access, appropriate utilization, cost savings and health outcomes
1234 not later than October 1 of each year. Additionally, each
1235 contractor shall disclose to the Chairmen of the Senate and House
1236 Medicaid Committees the administrative expenses costs for the
1237 prior calendar year, and the number of full-equivalent employees



1238 located in the State of Mississippi dedicated to the Medicaid and
1239 CHIP lines of business as of June 30 of the current year.

1240 (b) The division and the contractors participating
1241 in the managed care program, a coordinated care program or a
1242 provider-sponsored health plan shall be subject to annual program
1243 reviews or audits performed by the Office of the State Auditor,
1244 the PEER Committee, the Department of Insurance and/or independent
1245 third parties.

1246 (c) Those reviews shall include, but not be
1247 limited to, at least two (2) of the following items:

1248 (i) The financial benefit to the State of
1249 Mississippi of the managed care program,

1250 (ii) The difference between the premiums paid
1251 to the managed care contractors and the payments made by those
1252 contractors to health care providers,

1253 (iii) Compliance with performance measures
1254 required under the contracts,

1255 (iv) Administrative expense allocation
1256 methodologies,

1257 (v) Whether nonprovider payments assigned as
1258 medical expenses are appropriate,

1259 (vi) Capitated arrangements with related
1260 party subcontractors,

1261 (vii) Reasonableness of corporate
1262 allocations,



1263 (viii) Value-added benefits and the extent to
1264 which they are used,
1265 (ix) The effectiveness of subcontractor
1266 oversight, including subcontractor review,
1267 (x) Whether health care outcomes have been
1268 improved, and
1269 (xi) The most common claim denial codes to
1270 determine the reasons for the denials.

1271 The audit reports shall be considered public documents and
1272 shall be posted in their entirety on the division's website.

1273 (4) All health maintenance organizations, coordinated
1274 care organizations, provider-sponsored health plans, or other
1275 organizations paid for services on a capitated basis by the
1276 division under any managed care program or coordinated care
1277 program implemented by the division under this section shall
1278 reimburse all providers in those organizations at rates no lower
1279 than those provided under this section for beneficiaries who are
1280 not participating in those programs.

1281 (5) No health maintenance organization, coordinated
1282 care organization, provider-sponsored health plan, or other
1283 organization paid for services on a capitated basis by the
1284 division under any managed care program or coordinated care
1285 program implemented by the division under this section shall
1286 require its providers or beneficiaries to use any pharmacy that



1287 ships, mails or delivers prescription drugs or legend drugs or
1288 devices.

1289 (6) (a) Not later than December 1, 2021, the
1290 contractors who are receiving capitated payments under a managed
1291 care delivery system established under this subsection (H) shall
1292 develop and implement a uniform credentialing process for
1293 providers. Under that uniform credentialing process, a provider
1294 who meets the criteria for credentialing will be credentialed with
1295 all of those contractors and no such provider will have to be
1296 separately credentialed by any individual contractor in order to
1297 receive reimbursement from the contractor. Not later than
1298 December 2, 2021, those contractors shall submit a report to the
1299 Chairmen of the House and Senate Medicaid Committees on the status
1300 of the uniform credentialing process for providers that is
1301 required under this subparagraph (a).

1302 (b) If those contractors have not implemented a
1303 uniform credentialing process as described in subparagraph (a) by
1304 December 1, 2021, the division shall develop and implement, not
1305 later than July 1, 2022, a single, consolidated credentialing
1306 process by which all providers will be credentialed. Under the
1307 division's single, consolidated credentialing process, no such
1308 contractor shall require its providers to be separately
1309 credentialed by the contractor in order to receive reimbursement
1310 from the contractor, but those contractors shall recognize the



1311 credentialing of the providers by the division's credentialing
1312 process.

1313 (c) The division shall require a uniform provider
1314 credentialing application that shall be used in the credentialing
1315 process that is established under subparagraph (a) or (b). If the
1316 contractor or division, as applicable, has not approved or denied
1317 the provider credentialing application within sixty (60) days of
1318 receipt of the completed application that includes all required
1319 information necessary for credentialing, then the contractor or
1320 division, upon receipt of a written request from the applicant and
1321 within five (5) business days of its receipt, shall issue a
1322 temporary provider credential/enrollment to the applicant if the
1323 applicant has a valid Mississippi professional or occupational
1324 license to provide the health care services to which the
1325 credential/enrollment would apply. The contractor or the division
1326 shall not issue a temporary credential/enrollment if the applicant
1327 has reported on the application a history of medical or other
1328 professional or occupational malpractice claims, a history of
1329 substance abuse or mental health issues, a criminal record, or a
1330 history of medical or other licensing board, state or federal
1331 disciplinary action, including any suspension from participation
1332 in a federal or state program. The temporary
1333 credential/enrollment shall be effective upon issuance and shall
1334 remain in effect until the provider's credentialing/enrollment
1335 application is approved or denied by the contractor or division.



1336 The contractor or division shall render a final decision regarding
1337 credentialing/enrollment of the provider within sixty (60) days
1338 from the date that the temporary provider credential/enrollment is
1339 issued to the applicant.

1340 (d) If the contractor or division does not render
1341 a final decision regarding credentialing/enrollment of the
1342 provider within the time required in subparagraph (c), the
1343 provider shall be deemed to be credentialed by and enrolled with
1344 all of the contractors and eligible to receive reimbursement from
1345 the contractors.

1346 (7) (a) Each contractor that is receiving capitated
1347 payments under a managed care delivery system established under
1348 this subsection (H) shall provide to each provider for whom the
1349 contractor has denied the coverage of a procedure that was ordered
1350 or requested by the provider for or on behalf of a patient, a
1351 letter that provides a detailed explanation of the reasons for the
1352 denial of coverage of the procedure and the name and the
1353 credentials of the person who denied the coverage. The letter
1354 shall be sent to the provider in electronic format.

1355 (b) After a contractor that is receiving capitated
1356 payments under a managed care delivery system established under
1357 this subsection (H) has denied coverage for a claim submitted by a
1358 provider, the contractor shall issue to the provider within sixty
1359 (60) days a final ruling of denial of the claim that allows the
1360 provider to have a state fair hearing and/or agency appeal with



1361 the division. If a contractor does not issue a final ruling of
1362 denial within sixty (60) days as required by this subparagraph
1363 (b), the provider's claim shall be deemed to be automatically
1364 approved and the contractor shall pay the amount of the claim to
1365 the provider.

1366 (c) After a contractor has issued a final ruling
1367 of denial of a claim submitted by a provider, the division shall
1368 conduct a state fair hearing and/or agency appeal on the matter of
1369 the disputed claim between the contractor and the provider within
1370 sixty (60) days, and shall render a decision on the matter within
1371 thirty (30) days after the date of the hearing and/or appeal.

1372 (8) It is the intention of the Legislature that the
1373 division evaluate the feasibility of using a single vendor to
1374 administer pharmacy benefits provided under a managed care
1375 delivery system established under this subsection (H). Providers
1376 of pharmacy benefits shall cooperate with the division in any
1377 transition to a carve-out of pharmacy benefits under managed care.

1378 (9) The division shall evaluate the feasibility of
1379 using a single vendor to administer dental benefits provided under
1380 a managed care delivery system established in this subsection (H).
1381 Providers of dental benefits shall cooperate with the division in
1382 any transition to a carve-out of dental benefits under managed
1383 care.

1384 (10) It is the intent of the Legislature that any
1385 contractor receiving capitated payments under a managed care



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

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

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



1411 shall be revised to incorporate any provisions of this subsection
1412 (H) .

1413 (I) [Deleted]

1414 (J) There shall be no cuts in inpatient and outpatient
1415 hospital payments, or allowable days or volumes, as long as the
1416 hospital assessment provided in Section 43-13-145 is in effect.
1417 This subsection (J) shall not apply to decreases in payments that
1418 are a result of: reduced hospital admissions, audits or payments
1419 under the APR-DRG or APC models, or a managed care program or
1420 similar model described in subsection (H) of this section.

1421 (K) In the negotiation and execution of such contracts
1422 involving services performed by actuarial firms, the Executive
1423 Director of the Division of Medicaid may negotiate a limitation on
1424 liability to the state of prospective contractors.

1425 (L) The Division of Medicaid shall reimburse for services
1426 provided to eligible Medicaid beneficiaries by a licensed birthing
1427 center in a method and manner to be determined by the division in
1428 accordance with federal laws and federal regulations. The
1429 division shall seek any necessary waivers, make any required
1430 amendments to its State Plan or revise any contracts authorized
1431 under subsection (H) of this section as necessary to provide the
1432 services authorized under this subsection. As used in this
1433 subsection, the term "birthing centers" shall have the meaning as
1434 defined in Section 41-77-1(a), which is a publicly or privately
1435 owned facility, place or institution constructed, renovated,



1436 leased or otherwise established where nonemergency births are
1437 planned to occur away from the mother's usual residence following
1438 a documented period of prenatal care for a normal uncomplicated
1439 pregnancy which has been determined to be low risk through a
1440 formal risk-scoring examination.

1441 (M) This section shall stand repealed on July 1, 2028.

1442 **SECTION 5.** Section 83-5-907, Mississippi Code of 1972, is
1443 amended as follows:

1444 83-5-907. **Definitions.** For purposes of this article, unless
1445 the context requires otherwise, the following terms shall have the
1446 meanings as defined in this section:

1447 (a) "Adverse determination" means a determination by a
1448 health insurance issuer that, based on the information provided, a
1449 request for a benefit under the health insurance issuer's health
1450 benefit plan upon application of any utilization review technique
1451 does not meet the health insurance issuer's requirements for
1452 medical necessity, appropriateness, health care setting, level of
1453 care, or effectiveness or is determined to be experimental or
1454 investigational and the requested benefit is therefore denied,
1455 reduced, or terminated or payment is not provided or made, in
1456 whole or in part, for the benefit; the denial, reduction, or
1457 termination of or failure to provide or make payment, in whole or
1458 in part, for a benefit based on a determination by a health
1459 insurance issuer that a preexisting condition was present before
1460 the effective date of coverage; or a rescission of coverage



1461 determination, which does not include a cancellation or
1462 discontinuance of coverage that is attributable to a failure to
1463 timely pay required premiums or contributions toward the cost of
1464 coverage.

1465 (b) "Appeal" means a formal request, either orally or
1466 in writing, to reconsider an adverse determination.

1467 (c) "Approval" means a determination by a health
1468 insurance issuer that a health care service has been reviewed and,
1469 based on the information provided, satisfies the health insurance
1470 issuer's requirements for medical necessity and appropriateness.

1471 (d) "Clinical review criteria" means the written
1472 screening procedures, decision abstracts, clinical protocols and
1473 practice guidelines used by a health insurance issuer to determine
1474 the necessity and appropriateness of health care services.

1475 (e) "Department" means the Mississippi State Department
1476 of Insurance.

1477 (f) "Emergency medical condition" means a medical
1478 condition manifesting itself by acute symptoms of sufficient
1479 severity, including, but not limited to, severe pain, such that a
1480 prudent layperson who possesses an average knowledge of health and
1481 medicine could reasonably expect the absence of immediate medical
1482 attention to result in:

1483 (i) Placing the health of the individual or, with
1484 respect to a pregnant woman, the health of the woman or her unborn
1485 child, in serious jeopardy;



1486 (ii) Serious impairment to bodily functions; or
1487 (iii) Serious dysfunction of any bodily organ or
1488 part.

1489 (g) "Emergency services" means health care items and
1490 services furnished or required to evaluate and treat an emergency
1491 medical condition.

1492 (h) "Enrollee" means any person and his or her
1493 dependents enrolled in or covered by a health care plan.

1494 (i) "Health care professional" means a physician, a
1495 registered professional nurse or other individual appropriately
1496 licensed or registered to provide health care services.

1497 (j) "Health care provider" means any physician,
1498 hospital, ambulatory surgery center, or other person or facility
1499 that is licensed or otherwise authorized to deliver health care
1500 services.

1501 (k) "Health care service" means any services or level
1502 of services included in the furnishing to an individual of medical
1503 care or the hospitalization incident to the furnishing of such
1504 care, as well as the furnishing to any person of any other
1505 services for the purpose of preventing, alleviating, curing,
1506 diagnosing, screening for, or healing human illness or injury,
1507 including behavioral health, mental health, home health and
1508 pharmaceutical services and products.

1509 (l) "Health insurance issuer" has the meaning given to
1510 that term in Section 83-9-6.3. Any provision of this article that



1511 applies to a "health insurance issuer" also applies to any person
1512 or entity covered under the scope of this article in Section
1513 83-5-905.

1514 (m) "Medically necessary" means a health care
1515 professional exercising prudent clinical judgment would provide
1516 care to a patient for the purpose of preventing, diagnosing, or
1517 treating an illness, injury, disease or its symptoms and that are:

1518 (i) In accordance with generally accepted
1519 standards of medical practice; and

1520 (ii) Clinically appropriate in terms of type,
1521 frequency, extent, site and duration and are considered effective
1522 for the patient's illness, injury or disease; and not primarily
1523 for the convenience of the patient, treating physician, other
1524 health care professional, caregiver, family member or other
1525 interested party, but focused on what is best for the patient's
1526 health outcome.

1527 (n) "Physician" means any person with a valid doctor of
1528 medicine, doctor of osteopathy or doctor of podiatry degree.

1529 (o) "Prior authorization" means the process by which a
1530 health insurance issuer determines the medical necessity and
1531 medical appropriateness of an otherwise covered health care
1532 service before the rendering of such health care service. "Prior
1533 authorization" includes any health insurance issuer's requirement
1534 that an enrollee, health care professional or health care provider



1535 notify the health insurance issuer before, at the time of, or
1536 concurrent to providing a health care service.

1537 (p) "Urgent health care service" means a health care
1538 service with respect to which the application of the time periods
1539 for making a nonexpedited prior authorization that in the opinion
1540 of a treating health care professional or health care provider
1541 with knowledge of the enrollee's medical condition:

1542 (i) Could seriously jeopardize the life or health
1543 of the enrollee or the ability of the enrollee to regain maximum
1544 function;

1545 (ii) Could subject the enrollee to severe pain
1546 that cannot be adequately managed without the care or treatment
1547 that is the subject of the utilization review; or

1548 (iii) Could lead to likely onset of an emergency
1549 medical condition if the service is not rendered during the time
1550 period to render a prior authorization determination for an urgent
1551 medical service.

1552 (q) "Urgent health care service" does not include
1553 emergency services.

1554 (r) "Private review agent" has the meaning given to
1555 that term in Section 41-83-1.

1556 **SECTION 6.** This act shall take effect and be in force from
1557 and after July 1, 2026.



Presumptive Eligibility for Pregnant Women

Background:

House Bill 539, approved by the Mississippi Legislature during the 2024 regular session, authorized the Division of Medicaid to offer presumptive eligible for pregnant women (PEPW) to provide coverage for ambulatory prenatal care effective July 1, 2024.

Overview:

PEPW permits qualified providers to deem qualifying pregnant women temporarily eligible with limited Medicaid benefits.

- PEPW aims to improve individuals' access to Medicaid and covered services by providing another channel to apply for coverage.
- It ensures the qualified provider will be reimbursed for ambulatory prenatal services provided, just as if the individual was enrolled in standard Medicaid.
- PEPW is not about short-term coverage; it provides pregnant women an opportunity to get connected to longer-term coverage options by submitting a full Medicaid application.

Eligible Populations via PEPW Determinations:

- Pregnant child up to the age of 19
- Pregnant women 19 or older who meet the income limits

Covered Services Under PEPW:

Benefits are limited to ambulatory prenatal care rendered by a Mississippi Medicaid provider such as:

- Medically necessary pregnancy-related services rendered in a clinic or outpatient setting
- Outpatient lab services
- Outpatient radiologic exams
- Pregnancy related prescription drugs when ordered and prescribed by a licensed and enrolled Medicaid provider
- Current State Plan service limits apply to all PEPW services

*Birthing expenses and hospital services are not covered unless approved for full Medicaid

Update:

Training began in August of 2025. There are now 178 providers certified to submit PEPW applications. Of the 178 providers, 84 are located within the Health Departments throughout the state.

The following is a list of facilities that have been certified for PEPW:

Facility Name	Total Certified
Action Potential (Gautier)	1
Action Potential (Hattiesburg)	1
Alexander Vincent & Alexandria	1
Central MS Health Services (Jackson)	1
Delta Health Center (Mound Bayou)	5
Delta Health System (Greenville)	3
Delta Medical Group (Greenville)	1
Delta Medical Group (Arcola)	3
Family Health Center (Laurel)	3
GA Carmichael	29
Health Depts	84
Jackson Hinds	29
NW MS Regional Medical Center	5
Physicians & Surgeons Clinic	5
SE MS Rural Health Initiative	3
UMMC	4
TOTAL	178

Since January of 2026, we have enrolled 276 applicants. Below is a breakdown of the enrollments by county.

County	Enrolled 1/1/26 – 5/31/26	County	Enrolled 1/1/26 – 5/31/26	County	Enrolled 1/1/26 – 5/31/26
Adams	2	Holmes	2	Neshoba	7
Amite	1	Jackson	24	Newton	3
Bolivar	4	Jefferson	2	Oktibbeha	1
Calhoun	0	Jones	45	Panola	4
Chickasaw	0	Kemper	1	Pike	1
Clarke	1	Lamar	4	Pontotoc	1
Clay	1	Lauderdale	3	Scott	4
Coahoma	35	Lawrence	4	Tippah	4
Copiah	2	Leake	7	Union	16
Covington	4	Lee	3	Warren	4
Forrest	19	Leflore	1	Wayne	2
Franklin	7	Madison	4	Wilkinson	3
Grenada	9	Marion	2	Winston	3
Hinds	22	Monroe	7	Yazoo	7
TOTAL					276