Line Summary of Senate Bill 2799

Lines 94-112	Removes cost-based reimbursement language and $10k for baclofen pump that is added to old hospital per diem payments
Line 141	Requires Medicaid to allow small rural hospitals with 50 beds or less to choose to be reimbursed for outpatient services at 101% of cost
Lines 232-238	Removes different reimbursement model for physician services provided at an academic health center and by physicians at a rural health center associated with an academic health center
Lines 240	Sets physician reimbursement at 90% of Medicare
Lines 258-264	APRNs, Physician assistants and clinical nurse specialists are authorized to prescribe or order home health services and plans of care and certify/recertify eligibility for home health services and conduct the required face to face visit
Lines 344-345	Requires that Medicaid allow physician administered drugs to be reimbursed as either a pharmacy claim or medical claim
Lines 360-369	Increases dental rates for each of SFY 2022-2024 by 5% each year
Lines 409-438	Cleans up clinic services payment methodologies to conform with federal regs
Lines 444-448	Deletes requirement that DOM seek a waiver to reimburse Adult Day Care Services up $75 per hour
Lines 473-626	Adds ambulance services to supplemental payments, authorizes expansion of physician supplemental payment program to physicians contracted or employed by any hospital and provides for sate share for such supplemental payment programs to be assessed to providers. Requires Medicaid to consult with the hospital industry on supplemental payment models for hospitals
Lines 638-640	Allows for MSDH to be reimbursed at full reasonable cost for perinatal risk management services
Lines 689-696	FQHCs, RHCs and CMHCs shall be recognized as both originating and distant site providers for telehealth reimbursement and shall be reimbursed as both distant and originating site providers when the services are appropriately provided by the same organization
Lines 717-720	Authorizes Medicaid to reimburse for services provided by freestanding psych hospitals to recipients over the age of 21
Lines 752-755	Medicaid determines pediatric skilled nursing services consistent with MSDH regulations
Lines 780-791	Removes some statutory requirements for non-emergency transportation providers such as valid driver's license, tags, and insurance and allows the Division to set the requirements.
Lines 885-886	Allows DOM discretion regarding copays
Lines 916-917	Allows the Division to enhance reimbursement for trauma services by also using UPL or supplemental payments

Lines 960-963	Requires DOM and MSDH to notify OBGYNs Vaccines for Children is available free of charge
Lines 964-1005	Deletes 5% withhold and requirement for the medical care advisory committee to study reimbursement rates
Line 1016-1032	Prohibits Medicaid from increasing or decreasing reimbursement rates or limitations on services from the levels in effect on July 1, 2021 unless authorized by the Legislature.
Lines 1057-1062	If Medicaid reduces rates to providers because projected expenditures exceed appropriation, then Medicaid must accompany any reimbursement reductions with reductions in the MCO profit and administrative fees to the fullest extent allowable
Lines 1074-1079	Deletes the 3-year record retention for cost reports and defaults to federal laws or regs
Lines 1086-1100	Removes the specific percentage limitation on managed care enrollment
Lines 1127-1137	Prohibits MCOs from implementing more stringent requirement than Medicaid for prior authorization, utilization review, medical services, transportation services and prescription drugs. Also requires the MCOs to submit a report to the Medicaid Chairmen by December 2, 2021 on the status of the processes for these services. Intention is to have alignment and standardization for these processes.
Lines 1145-1147	Deletes requirement that MCOs provided unrestricted access to hemophilia factor
Lines 1148-1162	Requires all MCOs or similar programs to adopt level of care guidelines in determining medical necessity in all utilization management practices including PA, concurrent reviews, retro reviews and payments.
Lines 1163-1243	Authorizes MCO categories of eligibility to only include categories eligible for participation in Medicaid managed care as of 1/1/21 and CHIP waiver in operation as of 1/1/21 and removes the Commission on Expanding Managed Care.
Lines 1244-1255	MCOs required to annually share administrative cost data and number of Mississippi FTEs dedicated to the Mississippi contracts for Medicaid and CHIP with the Medicaid Chairmen
Lines 1256-1292	More stringent reporting/review/audit requirements on MCOs performed by PEER, State Auditor, Mississippi Insurance Department or an independent third party and publish the results in their entirety on the Division's website
Lines 1313-1371	By 12/1/21 MCOs must adopt a standardized and expedited credentialing process; if not, then DOM must do it by July 1, 2022. Provisions for temporary credentialing are provided.
Lines 1372-1397	MCOs must give detailed explanation of reasons for a denial of a procedure that was ordered or requested by a provider as well as provide the name and credentials of the person who denied the coverage. MCOs and Medicaid must also expedite the review and appeals process.
Lines 1398-1403	Legislative intent for DOM to study feasibility of using one vendor for pharmacy benefits
Lines 1404-1409	Legislative intent for DOM to study feasibility of using one vendor for dental benefits
Lines 1410-1414	Legislative intent for MCOs to implement innovative programs to improve the health for members with diabetes and prediabetes
Lines 1415-1428	Legislative intent for MCOs to work with providers to improve the utilization of long-acting reversible contraceptives and submit a report to the Medicaid Chairmen by 12/1/21.
Lines 1429-1438	DOM is authorized to extend the MCO contracts for up to one year with the full requirements of the technical bill in place

Lines 1447-1450	DOM may negotiate a limitation of liability for services performed by actuarial firms.
Line 1452	Extends the repeal date for 43-13-117 to 7/1/24
Lines 1766-1797	Changes the timing of the hospital tax
Line 1811	Repeals the assessment provisions effective 7/1/24
Lines 1820-1841	Removes the Medicaid moratorium on post-acute residential brain injury facilities