MISSISSIPPI LEGISLATURE REGULAR SESSION 2002

By: Representatives Moody, Holland

To: Public Health and Welfare; Appropriations

COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 1200

AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO REDUCE THE MONTHLY NUMBER OF PRESCRIPTIONS FOR ALL MEDICAID RECIPIENTS AND REQUIRE PRIOR APPROVAL FOR PRESCRIPTIONS ABOVE A CERTAIN NUMBER; TO PROVIDE THAT THE DIVISION OF MEDICAID WILL NOT REIMBURSE FOR ANY PORTION OF A PRESCRIPTION THAT EXCEEDS A THIRTY-FOUR DAY SUPPLY OF THE DRUG; TO REDUCE THE PHARMACY DISPENSING FEE FOR PRESCRIPTIONS; TO PROVIDE THAT IF A GENERIC DRUG IS AVAILABLE FOR A PRESCRIPTION, THE DIVISION WILL REIMBURSE THE PROVIDER AS IF THE PRESCRIPTION HAD BEEN FILLED WITH THE GENERIC DRUG, REGARDLESS OF WHETHER THE PRESCRIPTION WAS WRITTEN FOR OR FILLED WITH THAT GENERIC DRUG OR A PATENTED OR TRADEMARKED DRUG; TO PROVIDE THAT CLAIMS FOR DRUGS FOR DUALLY ELIGIBLE MEDICARE/MEDICAID BENEFICIARIES THAT ARE PAID FOR BY MEDICARE MUST BE SUBMITTED TO MEDICARE FOR PAYMENT BEFORE THEY MAY BE PROCESSED BY MEDICAID'S ON-LINE PAYMENT SYSTEM; TO PROVIDE THAT CERTAIN DRUGS PRESCRIBED FOR RESIDENTS OF NURSING FACILITIES THAT WERE ORIGINALLY BILLED TO MEDICAID BUT ARE NOT USED BY THE RESIDENTS SHALL BE RETURNED TO THE BILLING PHARMACY FOR CREDIT TO MEDICAID; TO PROVIDE THAT THE ESTIMATED ACQUISITION COST OF A DRUG THAT IS USED FOR REIMBURSEMENT PURPOSES SHALL BE THIRTEEN AND ONE-HALF PERCENT LESS THAN THE AVERAGE WHOLESALE PRICE FOR THE DRUG; TO ALLOW MEDICAID RECIPIENTS ONE PAIR OF EYEGLASSES EVERY FIVE YEARS INSTEAD OF EVERY THREE YEARS; TO DELETE THE AUTHORITY FOR THE DIVISION TO PROVIDE MANAGED CARE SERVICES; TO DIRECT THE DIVISION TO DEVELOP AND IMPLEMENT DISEASE MANAGEMENT PROGRAMS STATEWIDE FOR INDIVIDUALS WITH ASTHMA, DIABETES OR HYPERTENSION; TO DIRECT THE DIVISION TO ESTABLISH COPAYMENTS FOR ALL MEDICAID SERVICES FOR WHICH COPAYMENTS ARE ALLOWABLE UNDER FEDERAL LAW OR REGULATION, AND TO SET THE AMOUNT OF THE COPAYMENT FOR EACH OF THOSE SERVICES AT THE MAXIMUM AMOUNT ALLOWABLE UNDER FEDERAL LAW OR REGULATION; TO DIRECT THE DIVISION TO REDUCE THE RATE OF REIMBURSEMENT TO PROVIDERS FOR MEDICAID SERVICES BY FIVE PERCENT OF THE REIMBURSEMENT RATE ON JANUARY 1, 2002; TO AMEND SECTION 43-13-407, MISSISSIPPI CODE OF 1972, TO DIRECT THE STATE TREASURER TO TRANSFER $87,000,000.00 FROM THE HEALTH CARE TRUST FUND INTO THE HEALTH CARE EXPENDABLE FUND; TO DIRECT THE TREASURER TO DEPOSIT THE FULL AMOUNT OF THE 2002 TOBACCO SETTLEMENT INSTALLMENT PAYMENT RECEIVED BY THE STATE INTO THE HEALTH CARE EXPENDABLE FUND; TO PROVIDE THAT IF DURING ANY FISCAL YEAR AFTER THE EFFECTIVE DATE OF THIS ACT, THE GENERAL FUND REVENUES RECEIVED BY THE STATE EXCEED THE GENERAL FUND REVENUES RECEIVED DURING THE PREVIOUS FISCAL YEAR BY FIVE PERCENT OR MORE, THE LEGISLATURE SHALL REPAY TO THE HEALTH CARE TRUST FUND ONE-THIRD OF THE AMOUNT OF THE GENERAL FUND REVENUES THAT EXCEED THE FIVE PERCENT GROWTH; TO AMEND SECTION 43-13-405, MISSISSIPPI CODE OF 1972, TO CONFORM TO THE PRECEDING PROVISION; TO BRING FORWARD FOR THE PURPOSE OF AMENDMENT SECTIONS 43-13-105, 43-13-107, 43-13-115, 43-13-115.1, 43-13-121 AND 43-13-125, MISSISSIPPI CODE OF 1972, WHICH RELATE TO THE MEDICAID PROGRAM, AND SECTION 41-86-15, MISSISSIPPI CODE OF 1972, WHICH RELATES TO THE CHILDREN'S HEALTH INSURANCE PROGRAM; AND FOR RELATED PURPOSES.

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

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

43-13-117. Medicaid as authorized by this article shall include payment of part or all of the costs, at the discretion of the division or its successor, with approval of the Governor, 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 shall allow thirty (30) days of inpatient hospital care annually for all Medicaid recipients. Precertification of inpatient days must be obtained as required by the division. The division may allow unlimited days in disproportionate hospitals as defined by the division for eligible infants under the age of six (6) years.

(b) From and after July 1, 1994, the Executive Director of the Division of Medicaid shall amend the Mississippi Title XIX Inpatient Hospital Reimbursement Plan to remove the occupancy rate penalty from the calculation of the Medicaid Capital Cost Component utilized to determine total hospital costs allocated to the Medicaid program.

(c) Hospitals will receive an additional payment for the implantable programmable baclofen drug pump used to treat spasticity which is implanted on an inpatient basis. The payment pursuant to written invoice will be in addition to the facility's per diem reimbursement and will represent a reduction of costs on the facility's annual cost report, and shall not exceed Ten Thousand Dollars ($10,000.00) per year per recipient. This paragraph (c) shall stand repealed on July 1, 2005.

(2) Outpatient hospital services. *** * *** 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. * * *

(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 fifty-two (52) 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 fifty-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) When a facility of a category that does not require a certificate of need for construction and that could not be eligible for Medicaid reimbursement is constructed to nursing facility specifications for licensure and certification, and the facility is subsequently converted to a nursing facility under a certificate of need that authorizes conversion only and the

applicant for the certificate of need was assessed an application review fee based on capital expenditures incurred in constructing the facility, the division shall allow reimbursement for capital expenditures necessary for construction of the facility that were incurred within the twenty-four (24) consecutive calendar months immediately preceding the date that the certificate of need authorizing the conversion was issued, to the same extent that reimbursement would be allowed for construction of a new nursing facility under a certificate of need that authorizes that construction. The reimbursement authorized in this subparagraph (d) may be made only to facilities the construction of which was completed after June 30, 1989. Before the division shall be authorized to make the reimbursement authorized in this subparagraph (d), the division first must have received approval from the Health Care Financing Administration of the United States Department of Health and Human Services of the change in the state Medicaid plan providing for the reimbursement.

(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 of Medicaid shall develop and implement a referral process for long-term care alternatives for Medicaid beneficiaries and applicants. No Medicaid beneficiary

shall be admitted to a Medicaid-certified nursing facility unless a licensed physician certifies that nursing facility care is appropriate for that person on a standardized form to be prepared and provided to nursing facilities by the Division of Medicaid. The physician shall forward a copy of that certification to the Division of Medicaid within twenty-four (24) hours after it is signed by the physician. Any physician who fails to forward the certification to the Division of Medicaid within the time period specified in this paragraph shall be ineligible for Medicaid reimbursement for any physician's services performed for the applicant. The Division of Medicaid shall determine, through an assessment of the applicant conducted within two (2) business days after receipt of the physician's certification, whether the applicant also could live appropriately and cost-effectively at home or in some other community-based setting if home- or community-based services were available to the applicant. The time limitation prescribed in this paragraph shall be waived in cases of emergency. If the Division of Medicaid determines that a home- or other community-based setting is appropriate and cost-effective, the division shall:

(i) Advise the applicant or the applicant's legal representative that a home- or other community-based setting is appropriate;

(ii) Provide a proposed care plan and inform the applicant or the applicant's legal representative regarding the degree to which the services in the care plan are available in a home- or in other community-based setting rather than nursing facility care; and

(iii) Explain that the plan and services are available only if the applicant or the applicant's legal representative chooses a home- or community-based alternative to nursing facility care, and that the applicant is free to choose nursing facility care.

The Division of Medicaid may provide the services described in this paragraph (f) directly or through contract with case managers from the local Area Agencies on Aging, and shall coordinate long-term care alternatives to avoid duplication with hospital discharge planning procedures.

Placement in a nursing facility may not be denied by the division if home- or community-based services that would be more appropriate than nursing facility care are not actually available, or if the applicant chooses not to receive the appropriate home- or community-based services.

The division shall provide an opportunity for a fair hearing under federal regulations to any applicant who is not given the choice of home- or community-based services as an alternative to institutional care.

The division shall make full payment for long-term care alternative services.

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

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

cooperative agreement with the State Department of Education for the provision of those services to handicapped students by public school districts using state funds that are provided from the appropriation to the Department of Education to obtain federal matching funds through the division. The division, in obtaining medical and psychological evaluations for children in the custody of the State Department of Human Services may enter into a cooperative agreement with the State Department of Human Services for the provision of those services using state funds that are provided from the appropriation to the Department of Human Services to obtain federal matching funds through the division.

On July 1, 1993, all fees for periodic screening and diagnostic services under this paragraph (5) shall be increased by twenty-five percent (25%) of the reimbursement rate in effect on June 30, 1993.

(6) Physician's services. The division shall allow twelve (12) physician visits annually. All fees for physicians' services that are covered only by Medicaid shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act, as amended), and which shall in no event be less than seventy percent (70%) of the rate established on January 1, 1994. All fees for physicians' services that are covered by both Medicare and Medicaid shall be reimbursed at ten percent (10%) of the adjusted Medicare payment established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act, as amended), and which shall in no event be less than seventy percent (70%) of the adjusted Medicare payment established on January 1, 1994.

(7) (a) Home health services for eligible persons, not to exceed in cost the prevailing cost of nursing facility services, not to exceed sixty (60) visits per year. All home health visits must be precertified as required by the division.

(b) Repealed.

(8) Emergency medical transportation services. On January 1, 1994, emergency medical transportation services shall be reimbursed at seventy percent (70%) of the rate established under Medicare (Title XVIII of the Social Security Act, as amended). "Emergency medical transportation services" shall mean, but shall not be limited to, the following services by a properly permitted ambulance operated by a properly licensed provider in accordance with the Emergency Medical Services Act of 1974 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi) disposable supplies, (vii) similar services.

(9) Legend and other drugs as may be determined by the division. The division may implement a program of prior approval for drugs to the extent permitted by law. Payment by the division for covered multiple source drugs shall be limited to the lower of the upper limits established and published by the Centers for Medicare and Medicaid Services (CMS) plus a dispensing fee * * *, or the estimated acquisition cost (EAC) * * * plus a dispensing fee * * *, or the providers' usual and customary charge to the general public. The division shall allow seven (7) prescriptions per month for each Medicaid recipient; however, after a recipient has received five (5) prescriptions in any month, each additional prescription during that month must have the prior approval of the division. The division shall not reimburse for any portion of a prescription that exceeds a thirty-four-day supply of the drug based on the daily dosage.

Payment for other covered drugs, other than multiple source drugs with CMS upper limits, shall not exceed the lower of the estimated acquisition cost * * * plus a dispensing fee * * * or the providers' usual and customary charge to the general public.

Payment for nonlegend or over-the-counter drugs covered on the division's formulary shall be reimbursed at the lower of the

division's estimated shelf price or the providers' usual and customary charge to the general public. No dispensing fee shall be paid.

The dispensing fee for each new or refill prescription shall be Three Dollars and Ninety-one Cents ($3.91).

If a generic drug is available for a prescription, the division shall reimburse for that prescription as if it had been filled with the generic drug, regardless of whether the prescription was written for or filled with that generic drug or a patented or trademarked drug.

The division shall develop and implement a program of payment for additional pharmacist services, with payment to be based on demonstrated savings, but in no case shall the total payment exceed twice the amount of the dispensing fee.

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

Any drugs packaged as unit doses or in blister packs that were prescribed for a resident of a nursing facility, that were originally billed to Medicaid but are not used by the resident, shall be returned to the billing pharmacy for credit to Medicaid, in accordance with guidelines of the State Board of Pharmacy.

As used in this paragraph (9), "estimated acquisition cost" means thirteen and one-half percent (13-1/2%) less than the average wholesale price for a drug * * *.

(10) Dental care that is an adjunct to treatment of an acute medical or surgical condition; services of oral surgeons and dentists in connection with surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone; and emergency dental extractions and treatment related thereto. On July 1, 1999, all fees for dental care and surgery under authority of this paragraph (10)

shall be increased to one hundred sixty percent (160%) of the amount of the reimbursement rate that was in effect on June 30, 1999. It is the intent of the Legislature to encourage more dentists to participate in the Medicaid program.

(11) Eyeglasses necessitated by reason of eye surgery, and as prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the patient may select, or one (1) pair every five (5) years as prescribed by a physician or an optometrist, whichever the patient may select.

(12) Intermediate care facility services.

(a) The division shall make full payment to all intermediate care facilities for the mentally retarded for each day, not exceeding eighty-four (84) 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 eighty-four-day limitation: Christmas, the day before Christmas, the day after Christmas, Thanksgiving, the day before Thanksgiving and the day after Thanksgiving.

(b) All state-owned intermediate care facilities for the mentally retarded shall be reimbursed on a full reasonable cost basis.

(13) Family planning services, including drugs, supplies and devices, when those services are under the supervision of a physician.

(14) Clinic services. Such diagnostic, preventive, therapeutic, rehabilitative or palliative services furnished to an outpatient by or under the supervision of a physician or dentist in a facility that is not a part of a hospital but that is organized and operated to provide medical care to outpatients. Clinic services shall include any services reimbursed as outpatient hospital services that may be rendered in such a facility, including those that become so after July 1, 1991. On July 1, 1999, all fees for physicians' services reimbursed under

authority of this paragraph (14) shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act, as amended), and which shall in no event be less than seventy percent (70%) of the rate established on January 1, 1994. All fees for physicians' services that are covered by both Medicare and Medicaid shall be reimbursed at ten percent (10%) of the adjusted Medicare payment established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act, as amended), and which shall in no event be less than seventy percent (70%) of the adjusted Medicare payment established on January 1, 1994. On July 1, 1999, all fees for dentists' services reimbursed under authority of this paragraph (14) shall be increased to one hundred sixty percent (160%) of the amount of the reimbursement rate that was in effect on June 30, 1999.

(15) Home- and community-based services, as provided under Title XIX of the federal Social Security Act, as amended, under waivers, subject to the availability of funds specifically appropriated therefor by the Legislature. Payment for those services shall be limited to individuals who would be eligible for and would otherwise require the level of care provided in a nursing facility. The home- and community-based services authorized under this paragraph shall be expanded over a five-year period beginning July 1, 1999. The division shall certify case management agencies to provide case management services and provide for home- and community-based services for eligible individuals under this paragraph. The home- and community-based services under this paragraph and the activities performed by certified case management agencies under this paragraph shall be funded using state funds that are provided from the appropriation to the Division of Medicaid and used to match federal funds.

(16) Mental health services. Approved therapeutic and case management services provided by (a) an approved regional mental health/retardation 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/retardation center if determined necessary by the Department of Mental Health, using state funds that are provided from the appropriation to the State Department of Mental Health and used to match federal funds under a cooperative agreement between the division and the department, or (b) 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. Any such services provided by a facility described in paragraph (b) must have the prior approval of the division to be reimbursable under this section. After June 30, 1997, mental health services provided by regional mental health/retardation centers established under Sections 41-19-31 through 41-19-39, or by hospitals as defined in Section 41-9-3(a) and/or their subsidiaries and divisions, or by psychiatric residential treatment facilities as defined in Section 43-11-1, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/retardation center if determined necessary by the Department of Mental Health, shall not be included in or provided under any capitated managed care pilot program provided for under paragraph (24) of 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.

(18) (a) Notwithstanding any other provision of this section to the contrary, the division shall make additional reimbursement to hospitals that serve a disproportionate share of low-income patients and that meet the federal requirements for such payments as provided in Section 1923 of the federal Social Security Act and any applicable regulations. However, from and after January 1, 2000, no public hospital shall participate in the Medicaid disproportionate share program unless the public hospital participates in an intergovernmental transfer program as provided in Section 1903 of the federal Social Security Act and any applicable regulations. Administration and support for participating hospitals shall be provided by the Mississippi Hospital Association.

(b) The division shall establish a Medicare Upper Payment Limits Program as defined in Section 1902(a)(30) of the federal Social Security Act and any applicable federal regulations. The division shall assess each hospital for the sole purpose of financing the state portion of the Medicare Upper Payment Limits Program. This assessment shall be based on Medicaid utilization, or other appropriate method consistent with federal regulations, and will remain in effect as long as the state participates in the Medicare Upper Payment Limits Program. The division shall make additional reimbursement to hospitals for the Medicare Upper Payment Limits as defined in Section 1902(a)(30) of the federal Social Security Act and any applicable federal regulations. This paragraph (b) shall stand repealed from and after July 1, 2005.

(c) The division shall contract with the Mississippi Hospital Association to provide administrative support for the operation of the disproportionate share hospital program and the Medicare Upper Payment Limits Program. This paragraph (c) shall stand repealed from and after July 1, 2005.

(19) (a) Perinatal risk management services. The division shall promulgate regulations to be effective from and after October 1, 1988, to establish a comprehensive perinatal system for risk assessment of all pregnant and infant Medicaid recipients and for management, education and follow-up for those who are determined to be at risk. Services to be performed include case management, nutrition assessment/counseling, psychosocial assessment/counseling and health education. The division shall set reimbursement rates for providers in conjunction with the State Department of Health.

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

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

specifically appropriated to the Department of Rehabilitation Services.

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

(22) Ambulatory services delivered in federally qualified health centers and in clinics of the local health departments of the State Department of Health for individuals eligible for medical assistance under this article based on reasonable costs as determined by the division.

(23) Inpatient psychiatric services. Inpatient psychiatric services to be determined by the division for recipients under age twenty-one (21) that are provided under the direction of a physician in an inpatient program in a licensed acute care psychiatric facility or in a licensed psychiatric residential treatment facility, before the recipient reaches age twenty-one (21) or, if the recipient was receiving the services immediately before he reached age twenty-one (21), before the earlier of the date he no longer requires the services or the date he reaches age twenty-two (22), as provided by federal regulations. Precertification of inpatient days and residential treatment days must be obtained as required by the division.

(24) * * *

(25) Birthing center services.

(26) Hospice care. As used in this paragraph, the term "hospice care" means a coordinated program of active professional

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

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

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

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

(30) Pediatric skilled nursing services for eligible persons under twenty-one (21) years of age.

(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 operated by or listed and certified by The First Church of Christ Scientist, Boston, Massachusetts, 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 Social Security Act.

(33) Podiatrist services.

(34) The division shall make application to the United States Health Care Financing Administration for a waiver to develop a program of services to personal care and assisted living homes in Mississippi. This waiver shall be completed by December 1, 1999.

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

(36) Nonemergency transportation services for Medicaid-eligible persons, to be provided by the Division of Medicaid. The division may contract with additional entities to administer nonemergency transportation services as it deems necessary. All providers shall have a valid driver's license, vehicle inspection sticker, valid vehicle license tags and a standard liability insurance policy covering the vehicle.

(37) [Deleted]

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

(39) Dually eligible Medicare/Medicaid beneficiaries. The division shall pay the Medicare deductible and ten percent (10%) coinsurance amounts for services available under Medicare for the duration and scope of services otherwise available under the Medicaid program.

(40) [Deleted]

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

(42) Notwithstanding any other provision in this article to the contrary, the division may develop a population health management program for women and children health services through the age of two (2) years. This program is primarily for obstetrical care associated with low birth weight and pre-term babies. In order to effect cost savings, the division may develop a revised payment methodology that may include at-risk capitated payments.

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

(44) Nursing facility services for the severely disabled.

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

(b) Those services must be provided in a long-term care nursing facility dedicated to the care and treatment of persons with severe disabilities, and shall be reimbursed as a separate category of nursing facilities.

(45) Physician assistant services. Services furnished by a physician assistant who is licensed by the State Board of Medical Licensure and is practicing with physician supervision under regulations adopted by the board, under regulations adopted by the division. Reimbursement for those services shall not exceed ninety percent (90%) of the reimbursement rate for comparable services rendered by a physician.

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

(47) Notwithstanding any other provision in this article to the contrary, the division shall develop and implement disease management programs statewide for individuals with asthma, diabetes or hypertension, including the use of grants, waivers, demonstrations or other projects as necessary.

(48) The division shall establish copayments for all Medicaid services for which copayments are allowable under federal law or regulation, and shall set the amount of the copayment for

each of those services at the maximum amount allowable under federal law or regulation.

Notwithstanding any other provision of this article to the contrary, the division shall reduce the rate of reimbursement to providers for any service provided under this section by five percent (5%) of the reimbursement rate for that service that was in effect on January 1, 2002. However, the reduction in the reimbursement rates required by this paragraph shall not apply to any service provided under paragraph (9) of this section or any service provided by a state agency or the University of Mississippi Medical Center.

Notwithstanding any provision of this article, except as authorized in the following paragraph and in Section 43-13-139, neither (a) the limitations on quantity or frequency of use of or the fees or charges for any of the care or services available to recipients under this section, nor (b) the payments or rates of reimbursement to providers rendering care or services authorized under this section to recipients, may be increased, decreased or otherwise changed from the levels in effect on July 1, 1999, unless they are authorized by an amendment to this section by the Legislature. However, the restriction in this paragraph shall not prevent the division from changing the payments or rates of reimbursement to providers without an amendment to this section whenever those changes are required by federal law or regulation, or whenever those changes are necessary to correct administrative errors or omissions in calculating those payments or rates of reimbursement.

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. The executive

director shall keep the Governor advised on a timely basis of the funds available for expenditure and the projected expenditures. If current or projected expenditures of the division can be reasonably anticipated to exceed the amounts appropriated for any fiscal year, the Governor, after consultation with the executive director, shall discontinue any or all of the payment of the types of care and services as provided in this section that are deemed to be optional services under Title XIX of the federal Social Security Act, as amended, for any period necessary to not exceed appropriated funds, and when necessary shall institute any other cost containment measures on any program or programs authorized under the article to the extent allowed under the federal law governing that program or programs, it being the intent of the Legislature that expenditures during any fiscal year shall not exceed the amounts appropriated for that fiscal year.

Notwithstanding any other provision of this article, it shall be the duty of each nursing facility, intermediate care facility for the mentally retarded, psychiatric residential treatment facility, and nursing facility for the severely disabled that is participating in the Medicaid program to keep and maintain books, documents, and other records as prescribed by the Division of Medicaid in substantiation of its cost reports for a period of three (3) years after the date of submission to the Division of Medicaid of an original cost report, or three (3) years after the date of submission to the Division of Medicaid of an amended cost report.

This section shall stand repealed on July 1, 2004.

SECTION 2. Section 43-13-407, Mississippi Code of 1972, is amended as follows:

43-13-407. (1) In accordance with the purposes of this article, there is established in the State Treasury the Health Care Expendable Fund, into which shall be transferred from the Health Care Trust Fund the following sums:

(a) In fiscal year 2000, Fifty Million Dollars ($50,000,000.00);

(b) In fiscal year 2001, Fifty-five Million Dollars ($55,000,000.00);

(c) In fiscal year 2002, Sixty Million Five Hundred Thousand Dollars ($60,500,000.00);

(d) In fiscal year 2003, Sixty-six Million Five Hundred Fifty Thousand Dollars ($66,550,000.00);

(e) In fiscal year 2004 and each subsequent fiscal year, a sum equal to the average annual amount of the income from the investment of the funds in the Health Care Trust Fund since July 1, 1999.

(2) In any fiscal year in which interest and dividends from the investment of the funds in the Health Care Trust Fund are not sufficient to fund the full amount of the annual transfer into the Health Care Expendable Fund as required in subsection (1) of this section, the State Treasurer shall transfer from tobacco settlement installment payments an amount that is sufficient to fully fund the amount of the annual transfer.

(3) (a) On the effective date of House Bill No. 1200, 2002 Regular Session, the State Treasurer shall transfer the sum of Eighty-seven Million Dollars ($87,000,000.00) from the Health Care Trust Fund into the Health Care Expendable Fund. In addition, at the time the State of Mississippi receives the 2002 calendar year tobacco settlement installment payment, the State Treasurer shall deposit the full amount of that installment payment into the Health Care Expendable Fund.

(b) If during any fiscal year after the effective date of House Bill No. 1200, 2002 Regular Session, the general fund revenues received by the state exceed the general fund revenues received during the previous fiscal year by more than five percent (5%), the Legislature shall repay to the Health Care Trust Fund one-third (1/3) of the amount of the general fund revenues that

exceed the five percent (5%) growth in general fund revenues. The repayment required by this paragraph shall continue in each fiscal year in which there is more than five percent (5%) growth in general fund revenues, until the full amount of the funds that were transferred and deposited into the Health Care Expendable Fund under the provisions of paragraph (a) of this subsection have been repaid to the Health Care Trust Fund.

(4) All income from the investment of the funds in the Health Care Expendable Fund shall be credited to the account of the Health Care Expendable Fund. Any funds in the Health Care Expendable Fund at the end of a fiscal year shall not lapse into the State General Fund.

(5) The funds in the Health Care Expendable Fund shall be available for expenditure under specific appropriation by the Legislature beginning in fiscal year 2000, and shall be expended exclusively for health care purposes.

(6) Subsections (1), (2), (4) and (5) of this section shall stand repealed on July 1, 2004.

SECTION 3. Section 43-13-405, Mississippi Code of 1972, is amended as follows:

43-13-405. (1) In accordance with the purposes of this article, there is established in the State Treasury the Health Care Trust Fund, into which shall be deposited Two Hundred Eighty Million Dollars ($280,000,000.00) of the funds received by the State of Mississippi as a result of the tobacco settlement as of the end of fiscal year 1999, and all tobacco settlement installment payments made in subsequent years for which the use or purpose for expenditure is not restricted by the terms of the settlement, except as otherwise provided in Section 43-13-407(2) and (3). All income from the investment of the funds in the Health Care Trust Fund shall be credited to the account of the Health Care Trust Fund. The funds in the Health Care Trust Fund

at the end of a fiscal year shall not lapse into the State General Fund.

(2) The Health Care Trust Fund shall remain inviolate and shall never be expended, except as provided in this article. The Legislature shall appropriate from the Health Care Trust Fund such sums as are necessary to recoup any funds lost as a result of any of the following actions:

(a) The federal Centers for Medicare and Medicaid Services, or other agency of the federal government, is successful in recouping tobacco settlement funds from the State of Mississippi;

(b) The federal share of funds for the support of the Mississippi Medicaid Program is reduced directly or indirectly as a result of the tobacco settlement;

(c) Federal funding for any other program is reduced as a result of the tobacco settlement; or

(d) Tobacco cessation programs are mandated by the federal government or court order.

(3) This section shall stand repealed on July 1, 2004.

SECTION 4. Section 43-13-105, Mississippi Code of 1972, is brought forward as follows:

43-13-105. When used in this article, the following definitions shall apply, unless the context requires otherwise:

(a) "Administering agency" means the Division of Medicaid in the Office of the Governor as created by this article.

(b) "Division" or "Division of Medicaid" means the Division of Medicaid in the Office of the Governor.

(c) "Medical assistance" means payment of part or all of the costs of medical and remedial care provided under the terms of this article and in accordance with provisions of Titles XIX and XXI of the Social Security Act, as amended.

(d) "Applicant" means a person who applies for assistance under Titles IV, XVI, XIX or XXI of the Social Security Act, as amended, and under the terms of this article.

(e) "Recipient" means a person who is eligible for assistance under Title XIX or XXI of the Social Security Act, as amended and under the terms of this article.

(f) "State health agency" shall mean any agency, department, institution, board or commission of the State of Mississippi, except the University Medical School, which is supported in whole or in part by any public funds, including funds directly appropriated from the State Treasury, funds derived by taxes, fees levied or collected by statutory authority, or any other funds used by "state health agencies" derived from federal sources, when any funds available to such agency are expended either directly or indirectly in connection with, or in support of, any public health, hospital, hospitalization or other public programs for the preventive treatment or actual medical treatment of persons who are physically or mentally ill or mentally retarded.

(g) "Mississippi Medicaid Commission" or "Medicaid Commission" wherever they appear in the laws of the State of Mississippi, shall mean the Division of Medicaid in the Office of the Governor.

SECTION 5. Section 43-13-107, Mississippi Code of 1972, is brought forward as follows:

43-13-107. (1) The Division of Medicaid is created in the Office of the Governor and established to administer this article and perform such other duties as are prescribed by law.

(2) The Governor shall appoint a full-time director, with the advice and consent of the Senate, who shall be either (a) a physician with administrative experience in a medical care or health program, or (b) a person holding a graduate degree in medical care administration, public health, hospital

administration, or the equivalent, or (c) a person holding a bachelor's degree in business administration or hospital administration, with at least ten (10) years' experience in management-level administration of Medicaid programs, and who shall serve at the will and pleasure of the Governor. The director shall be the official secretary and legal custodian of the records of the division; shall be the agent of the division for the purpose of receiving all service of process, summons and notices directed to the division; and shall perform such other duties as the Governor shall, from time to time, prescribe. The director, with the approval of the Governor and the rules and regulations of the State Personnel Board, shall employ such professional, administrative, stenographic, secretarial, clerical and technical assistance as may be necessary to perform the duties required in administering this article and fix the compensation therefor, all in accordance with a state merit system meeting federal requirements, except that when the salary of the director is not set by law, such salary shall be set by the State Personnel Board. No employees of the Division of Medicaid shall be considered to be staff members of the immediate Office of the Governor; however, the provisions of Section 25-9-107 (c) (xv) shall apply to the director and other administrative heads of the division.

(3) (a) There is established a Medical Care Advisory Committee, which shall be the committee that is required by federal regulation to advise the Division of Medicaid about health and medical care services.

(b) The committee shall consist of not less than eleven (11) members, as follows:

(i) The Governor shall appoint five (5) members, one (1) from each congressional district as presently constituted;

(ii) The Lieutenant Governor shall appoint three (3) members, one (1) from each Supreme Court district;

(iii) The Speaker of the House of Representatives shall appoint three (3) members, one (1) from each Supreme Court district.

All members appointed under this paragraph shall either be health care providers or consumers of health care services. One (1) member appointed by each of the appointing authorities shall be a board certified physician.

(c) The respective chairmen of the House Public Health and Welfare Committee, the House Appropriations Committee, the Senate Public Health and Welfare Committee and the Senate Appropriations Committee, or their designees, one (1) member of the State Senate appointed by the Lieutenant Governor and one (1) member of the House of Representatives appointed by the Speaker of the House, shall serve as ex officio nonvoting members.

(d) In addition to the committee members required by paragraph (b), the committee shall consist of such other members as are necessary to meet the requirements of the federal regulation applicable to the Medical Care Advisory Committee, who shall be appointed as provided in the federal regulation.

(e) The chairmanship of the Medical Care Advisory Committee shall alternate for twelve-month periods between the chairmen of the House and Senate Public Health and Welfare Committees, with the Chairman of the House Public Health and Welfare Committee serving as the first chairman.

(f) The members of the committee specified in paragraph (b) shall serve for terms that are concurrent with the terms of members of the Legislature, and any member appointed under paragraph (b) may be reappointed to the committee. The members of the committee specified in paragraph (b) shall serve without compensation, but shall receive reimbursement to defray actual expenses incurred in the performance of committee business as authorized by law. Legislators shall receive per diem and expenses which may be paid from the contingent expense funds of

their respective houses in the same amounts as provided for committee meetings when the Legislature is not in session.

(g) The committee shall meet not less than quarterly, and committee members shall be furnished written notice of the meetings at least ten (10) days before the date of the meeting.

(h) The Executive Director of the Division of Medicaid shall submit to the committee all amendments, modifications and changes to the state plan for the operation of the Medicaid program, for review by the committee before the amendments, modifications or changes may be implemented by the division.

(i) The committee, among its duties and responsibilities, shall:

(i) Advise the division with respect to amendments, modifications and changes to the state plan for the operation of the Medicaid program;

(ii) Advise the division with respect to issues concerning receipt and disbursement of funds and eligibility for medical assistance;

(iii) Advise the division with respect to determining the quantity, quality and extent of medical care provided under this article;

(iv) Communicate the views of the medical care professions to the division and communicate the views of the division to the medical care professions;

(v) Gather information on reasons that medical care providers do not participate in the Medicaid program and changes that could be made in the program to encourage more providers to participate in the Medicaid program, and advise the division with respect to encouraging physicians and other medical care providers to participate in the Medicaid program;

(vi) Provide a written report on or before November 30 of each year to the Governor, Lieutenant Governor and Speaker of the House of Representatives.

SECTION 6. Section 43-13-115, Mississippi Code of 1972, is brought forward as follows:

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

(1) Who are qualified for public assistance grants under provisions of Title IV-A and E of the federal Social Security Act, as amended, as determined by the State Department of Human Services, including those statutorily deemed to be IV-A and low-income families and children under Section 1931 of the Social Security Act as determined by the State Department of Human Services and certified to the Division of Medicaid, but not optional groups except as specifically covered in this section. For the purposes of this paragraph (1) and paragraphs (8), (17) and (18) of this section, any reference to Title IV-A or to Part A of Title IV of the federal Social Security Act, as amended, or the state plan under Title IV-A or Part A of Title IV, shall be considered as a reference to Title IV-A of the federal Social Security Act, as amended, and the state plan under Title IV-A, including the income and resource standards and methodologies under Title IV-A and the state plan, as they existed on July 16, 1996.

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

(3) [Deleted]

(4) [Deleted]

(5) A child born on or after October 1, 1984, to a woman eligible for and receiving medical assistance under the state plan on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such

birth and will remain eligible for such assistance for a period of one (1) year so long as the child is a member of the woman's household and the woman remains eligible for such assistance or would be eligible for assistance if pregnant. The eligibility of individuals covered in this paragraph shall be determined by the State Department of Human Services and certified to the Division of Medicaid.

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

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

(b) Individuals who have elected to receive hospice care benefits and who are eligible using the same criteria and special income limits as those in institutions as described in subparagraph (a) of this paragraph (7).

(8) Children under eighteen (18) years of age and pregnant women (including those in intact families) who meet the AFDC financial standards of the state plan approved under Title

IV-A of the federal Social Security Act, as amended. The eligibility of children covered under this paragraph shall be determined by the State Department of Human Services and certified to the Division of Medicaid.

(9) Individuals who are:

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

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

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

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

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

(11) Individuals who are sixty-five (65) years of age or older or are disabled as determined under Section 1614(a)(3) of the federal Social Security Act, as amended, and whose income does not exceed one hundred thirty-five percent (135%) of the nonfarm

official poverty line as defined by the Office of Management and Budget and revised annually, and whose resources do not exceed those established by the Division of Medicaid.

The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid, and such individuals determined eligible shall receive the same Medicaid services as other categorical eligible individuals.

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

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

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

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

availability of the federal capped allocation at one hundred percent (100%) of federal matching funds, as more fully defined in the Balanced Budget Act of 1997.

(c) Individuals entitled to Part A of Medicare, with income of at least one hundred thirty-five percent (135%), but not exceeding one hundred seventy-five percent (175%) of the federal poverty level, and not otherwise eligible for Medicaid. Eligibility for Medicaid benefits is limited to partial payment of Medicare Part B premiums. The number of eligible individuals is limited by the availability of the federal capped allocation of one hundred percent (100%) federal matching funds, as more fully defined in the Balanced Budget Act of 1997.

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

(14) [Deleted]

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

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

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

assistance under Title IV-A of the federal Social Security Act, as amended, because of increased income from or hours of employment of the caretaker relative or because of the expiration of the applicable earned income disregards, who were eligible for Medicaid for at least three (3) of the six (6) months preceding the month in which such ineligibility begins, shall be eligible for Medicaid assistance for up to twenty-four (24) months; however, Medicaid assistance for more than twelve (12) months may be provided only if a federal waiver is obtained to provide such assistance for more than twelve (12) months and federal and state funds are available to provide such assistance.

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

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

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

(21) Women of childbearing age whose family income does not exceed one hundred eighty-five percent (185%) of the federal poverty level. The eligibility of individuals covered under this

paragraph (21) shall be determined by the Division of Medicaid, and those individuals determined eligible shall only receive family planning services covered under Section 43-13-117(13) and not any other services covered under Medicaid. However, any individual eligible under this paragraph (21) who is also eligible under any other provision of this section shall receive the benefits to which he or she is entitled under that other provision, in addition to family planning services covered under Section 43-13-117(13).

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

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

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

covered under this paragraph (22) shall be determined by the Division of Medicaid.

The Division of Medicaid shall apply to the United States Secretary of Health and Human Services for a federal waiver of the applicable provisions of Title XIX of the federal Social Security Act, as amended, and any other applicable provisions of federal law as necessary to allow for the implementation of this paragraph (22). The provisions of this paragraph (22) shall be implemented from and after the date that the Division of Medicaid receives the federal waiver.

(23) Children certified by the Mississippi Department of Human Services for whom the state and county human services agency has custody and financial responsibility who are in foster care on their eighteenth birthday as reported by the Mississippi Department of Human Services shall be certified Medicaid eligible by the Division of Medicaid until their twenty-first birthday.

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

(25) Individuals who would be eligible for services in a nursing home but who live in a noninstitutional setting, whose income does not exceed the amount prescribed by federal regulation for nursing home care, and who regularly expend more than fifty percent (50%) of their monthly income on prescription drugs and over-the-counter drugs.

The eligibility of individuals covered under this paragraph (25) shall be determined by the Division of Medicaid. The individuals determined eligible shall be eligible only for prescription drugs and over-the-counter drugs covered under Section 43-13-117(9) and not for any other services covered under Section 43-13-117.

The Division of Medicaid shall apply to the United States Secretary of Health and Human Services for a federal waiver of the applicable provisions of Title XIX of the federal Social Security Act, as amended, and any other applicable provisions of federal law as necessary to allow for the implementation of this paragraph (25). The provisions of this paragraph (25) shall be implemented from and after the date that the Division of Medicaid receives the federal waiver.

SECTION 7. Section 43-13-115.1, Mississippi Code of 1972, is brought forward as follows:

43-13-115.1. There will be presumptive eligibility under this article for children under nineteen (19) years of age, in accordance with the following provisions:

(a) A child will be deemed to be presumptively eligible for covered benefits and services under this article if a qualified entity as defined under federal law (42 USCS Section 1396r-1a) determines, on the basis of preliminary information, that the family income of the child does not exceed the applicable income level of eligibility under the state Medicaid plan.

(b) A child will be presumptively eligible under this article from the date that the qualified entity determines that the child is presumptively eligible until the earlier of either:

(i) The date on which a determination is made with respect to the eligibility of the child for covered benefits and services under this article, or

(ii) The last day of the month following the month in which presumptive eligibility is determined, if an application has not been filed on behalf of the child by that day.

(c) For the period during which a child is presumptively eligible under this article, the child will be eligible to receive all covered benefits and services under this article.

(d) If a child is determined to be presumptively eligible under this article, the child's parent, guardian or caretaker relative must submit a completed application for Medicaid assistance no later than the last day of the month following the month in which presumptive eligibility is determined. The qualified entity shall inform the parent, guardian or caretaker relative of this requirement at the time the qualified entity makes the determination of presumptive eligibility.

(e) The qualified entity shall notify the Division of Medicaid of the determination of presumptive eligibility within five (5) working days after the date on which the determination is made.

(f) The Division of Medicaid shall provide qualified entities with such forms as are necessary for an application to be made on behalf of a child for eligibility under this article. The Division of Medicaid shall make those application forms and the application process itself as simple as possible.

SECTION 8. Section 43-13-121, Mississippi Code of 1972, is brought forward as follows:

43-13-121. (1) The division is authorized and empowered to administer a program of medical assistance under the provisions of this article, and to do the following:

(a) Adopt and promulgate reasonable rules, regulations and standards, with approval of the Governor, and in accordance with the Administrative Procedures Law, Section 25-43-1 et seq.:

(i) Establishing methods and procedures as may be necessary for the proper and efficient administration of this article;

(ii) Providing medical assistance to all qualified recipients under the provisions of this article as the division may determine and within the limits of appropriated funds;

(iii) Establishing reasonable fees, charges and rates for medical services and drugs; and in doing so shall fix all such fees, charges and rates at the minimum levels absolutely necessary to provide the medical assistance authorized by this article, and shall not change any such fees, charges or rates except as may be authorized in Section 43-13-117;

(iv) Providing for fair and impartial hearings;

(v) Providing safeguards for preserving the confidentiality of records; and

(vi) For detecting and processing fraudulent practices and abuses of the program;

(b) Receive and expend state, federal and other funds in accordance with court judgments or settlements and agreements between the State of Mississippi and the federal government, the rules and regulations promulgated by the division, with the approval of the Governor, and within the limitations and restrictions of this article and within the limits of funds available for such purpose;

(c) Subject to the limits imposed by this article, to submit a plan for medical assistance to the federal Department of Health and Human Services for approval pursuant to the provisions of the Social Security Act, to act for the state in making negotiations relative to the submission and approval of such plan, to make such arrangements, not inconsistent with the law, as may be required by or pursuant to federal law to obtain and retain such approval and to secure for the state the benefits of the provisions of such law;

No agreements, specifically including the general plan for the operation of the Medicaid program in this state, shall be made by and between the division and the Department of Health and Human Services unless the Attorney General of the State of Mississippi has reviewed the agreements, specifically including the operational plan, and has certified in writing to the Governor and to the director of the division that the agreements, including the plan of operation, have been drawn strictly in accordance with the terms and requirements of this article;

(d) Pursuant to the purposes and intent of this article and in compliance with its provisions, provide for aged persons otherwise eligible for the benefits provided under Title XVIII of the federal Social Security Act by expenditure of funds available for such purposes;

(e) To make reports to the federal Department of Health and Human Services as from time to time may be required by such federal department and to the Mississippi Legislature as hereinafter provided;

(f) Define and determine the scope, duration and amount of medical assistance which may be provided in accordance with this article and establish priorities therefor in conformity with this article;

(g) Cooperate and contract with other state agencies for the purpose of coordinating medical assistance rendered under this article and eliminating duplication and inefficiency in the program;

(h) Adopt and use an official seal of the division;

(i) Sue in its own name on behalf of the State of Mississippi and employ legal counsel on a contingency basis with the approval of the Attorney General;

(j) To recover any and all payments incorrectly made by the division or by the Medicaid Commission to a recipient or provider from the recipient or provider receiving the payments;

(k) To recover any and all payments by the division or by the Medicaid Commission fraudulently obtained by a recipient or provider. Additionally, if recovery of any payments fraudulently obtained by a recipient or provider is made in any court, then, upon motion of the Governor, the judge of the court may award twice the payments recovered as damages;

(l) Have full, complete and plenary power and authority to conduct such investigations as it may deem necessary and requisite of alleged or suspected violations or abuses of the provisions of this article or of the regulations adopted hereunder including, but not limited to, fraudulent or unlawful act or deed by applicants for medical assistance or other benefits, or payments made to any person, firm or corporation under the terms, conditions and authority of this article, to suspend or disqualify any provider of services, applicant or recipient for gross abuse, fraudulent or unlawful acts for such periods, including permanently, and under such conditions as the division may deem proper and just, including the imposition of a legal rate of interest on the amount improperly or incorrectly paid. Recipients who are found to have misused or abused medical assistance benefits may be locked into one (1) physician and/or one (1) pharmacy of the recipient's choice for a reasonable amount of time in order to educate and promote appropriate use of medical services, in accordance with federal regulations. Should an administrative hearing become necessary, the division shall be authorized, should the provider not succeed in his defense, in taxing the costs of the administrative hearing, including the costs of the court reporter or stenographer and transcript, to the provider. The convictions of a recipient or a provider in a state or federal court for abuse, fraudulent or unlawful acts under this chapter shall constitute an automatic disqualification of the recipient or automatic disqualification of the provider from participation under the Medicaid program.

A conviction, for the purposes of this chapter, shall include a judgment entered on a plea of nolo contendere or a nonadjudicated guilty plea and shall have the same force as a judgment entered pursuant to a guilty plea or a conviction following trial. A certified copy of the judgment of the court of competent jurisdiction of such conviction shall constitute prima facie evidence of such conviction for disqualification purposes;

(m) Establish and provide such methods of administration as may be necessary for the proper and efficient operation of the program, fully utilizing computer equipment as may be necessary to oversee and control all current expenditures for purposes of this article, and to closely monitor and supervise all recipient payments and vendors rendering such services hereunder;

(n) To cooperate and contract with the federal government for the purpose of providing medical assistance to Vietnamese and Cambodian refugees, pursuant to the provisions of Public Law 94-23 and Public Law 94-24, including any amendments thereto, only to the extent that such assistance and the administrative cost related thereto are one hundred percent (100%) reimbursable by the federal government. For the purposes of Section 43-13-117, persons receiving medical assistance pursuant to Public Law 94-23 and Public Law 94-24, including any amendments thereto, shall not be considered a new group or category of recipient; and

(o) The division shall impose penalties upon Medicaid only, Title XIX participating long-term care facilities found to be in noncompliance with division and certification standards in accordance with federal and state regulations, including interest at the same rate calculated by the Department of Health and Human Services and/or the Health Care Financing Administration under federal regulations.

(2) The division also shall exercise such additional powers and perform such other duties as may be conferred upon the division by act of the Legislature hereafter.

(3) The division, and the State Department of Health as the agency for licensure of health care facilities and certification and inspection for the Medicaid and/or Medicare programs, shall contract for or otherwise provide for the consolidation of on-site inspections of health care facilities which are necessitated by the respective programs and functions of the division and the department.

(4) The division and its hearing officers shall have power to preserve and enforce order during hearings; to issue subpoenas for, to administer oaths to and to compel the attendance and testimony of witnesses, or the production of books, papers, documents and other evidence, or the taking of depositions before any designated individual competent to administer oaths; to examine witnesses; and to do all things conformable to law which may be necessary to enable them effectively to discharge the duties of their office. In compelling the attendance and testimony of witnesses, or the production of books, papers, documents and other evidence, or the taking of depositions, as authorized by this section, the division or its hearing officers may designate an individual employed by the division or some other suitable person to execute and return such process, whose action in executing and returning such process shall be as lawful as if done by the sheriff or some other proper officer authorized to execute and return process in the county where the witness may reside. In carrying out the investigatory powers under the provisions of this article, the director or other designated person or persons shall be authorized to examine, obtain, copy or reproduce the books, papers, documents, medical charts, prescriptions and other records relating to medical care and services furnished by the provider to a recipient or designated

recipients of Medicaid services under investigation. In the absence of the voluntary submission of the books, papers, documents, medical charts, prescriptions and other records, the Governor, the director, or other designated person shall be authorized to issue and serve subpoenas instantly upon such provider, his agent, servant or employee for the production of the books, papers, documents, medical charts, prescriptions or other records during an audit or investigation of the provider. If any provider or his agent, servant or employee should refuse to produce the records after being duly subpoenaed, the director shall be authorized to certify such facts and institute contempt proceedings in the manner, time, and place as authorized by law for administrative proceedings. As an additional remedy, the division shall be authorized to recover all amounts paid to the provider covering the period of the audit or investigation, inclusive of a legal rate of interest and a reasonable attorney's fee and costs of court if suit becomes necessary. Division staff shall have immediate access to the provider's physical location, facilities, records, documents, books, and any other records relating to medical care and services rendered to recipients during regular business hours.

(5) If any person in proceedings before the division disobeys or resists any lawful order or process, or misbehaves during a hearing or so near the place thereof as to obstruct the same, or neglects to produce, after having been ordered to do so, any pertinent book, paper or document, or refuses to appear after having been subpoenaed, or upon appearing refuses to take the oath as a witness, or after having taken the oath refuses to be examined according to law, the director shall certify the facts to any court having jurisdiction in the place in which it is sitting, and the court shall thereupon, in a summary manner, hear the evidence as to the acts complained of, and if the evidence so warrants, punish such person in the same manner and to the same

extent as for a contempt committed before the court, or commit such person upon the same condition as if the doing of the forbidden act had occurred with reference to the process of, or in the presence of, the court.

(6) In suspending or terminating any provider from participation in the Medicaid program, the division shall preclude such provider from submitting claims for payment, either personally or through any clinic, group, corporation or other association to the division or its fiscal agents for any services or supplies provided under the Medicaid program except for those services or supplies provided prior to the suspension or termination. No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the division or its fiscal agents for any services or supplies provided by a person within such organization who has been suspended or terminated from participation in the Medicaid program except for those services or supplies provided prior to the suspension or termination. When this provision is violated by a provider of services which is a clinic, group, corporation or other association, the division may suspend or terminate such organization from participation. Suspension may be applied by the division to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the provider is affiliated where such conduct was accomplished with the course of his official duty or was effectuated by him with the knowledge or approval of such person.

(7) If the division ascertains that a provider has been convicted of a felony under federal or state law for an offense which the division determines is detrimental to the best interests of the program or of Medicaid recipients, the division may refuse

to enter into an agreement with such provider, or may terminate or refuse to renew an existing agreement.

SECTION 9. Section 43-13-125, Mississippi Code of 1972, is brought forward as follows:

43-13-125. (1) If medical assistance is provided to a recipient under this article for injuries, disease or sickness caused under circumstances creating a cause of action in favor of the recipient against any person, firm or corporation, then the division shall be entitled to recover the proceeds that may result from the exercise of any rights of recovery which the recipient may have against any such person, firm or corporation to the extent of the Division of Medicaid's interest on behalf of the recipient. The recipient shall execute and deliver instruments and papers to do whatever is necessary to secure such rights and shall do nothing after the medical assistance is provided to prejudice the subrogation rights of the division. Court orders or agreements for reimbursement of Medicaid's interest shall direct such payments to the Division of Medicaid, which shall be authorized to endorse any and all, including, but not limited to, multi-payee checks, drafts, money orders, or other negotiable instruments representing Medicaid payment recoveries that are received. In accordance with Section 43-13-305, endorsement of multi-payee checks, drafts, money orders or other negotiable instruments by the Division of Medicaid shall be deemed endorsed by the recipient.

The division, with the approval of the Governor, may compromise or settle any such claim and execute a release of any claim it has by virtue of this section.

(2) The acceptance of medical assistance under this article or the making of a claim thereunder shall not affect the right of a recipient or his legal representative to recover Medicaid's interest as an element of special damages in any action at law; however, a copy of the pleadings shall be certified to the

division at the time of the institution of suit, and proof of such notice shall be filed of record in such action. The division may, at any time before the trial on the facts, join in such action or may intervene therein. Any amount recovered by a recipient or his legal representative shall be applied as follows:

(a) The reasonable costs of the collection, including attorney's fees, as approved and allowed by the court in which such action is pending, or in case of settlement without suit, by the legal representative of the division;

(b) The amount of Medicaid's interest on behalf of the recipient; or such pro rata amount as may be arrived at by the legal representative of the division and the recipient's attorney, or as set by the court having jurisdiction; and

(c) Any excess shall be awarded to the recipient.

(3) No compromise of any claim by the recipient or his legal representative shall be binding upon or affect the rights of the division against the third party unless the division, with the approval of the Governor, has entered into the compromise. Any compromise effected by the recipient or his legal representative with the third party in the absence of advance notification to and approved by the division shall constitute conclusive evidence of the liability of the third party, and the division, in litigating its claim against the third party, shall be required only to prove the amount and correctness of its claim relating to such injury, disease or sickness. It is further provided that should the recipient or his legal representative fail to notify the division of the institution of legal proceedings against a third party for which the division has a cause of action, the facts relating to negligence and the liability of the third party, if judgment is rendered for the recipient, shall constitute conclusive evidence of liability in a subsequent action maintained by the division and only the amount and correctness of the division's claim relating to injuries, disease or sickness shall be tried before the court.

The division shall be authorized in bringing such action against the third party and his insurer jointly or against the insurer alone.

(4) Nothing herein shall be construed to diminish or otherwise restrict the subrogation rights of the Division of Medicaid against a third party for medical assistance provided by the Division of Medicaid to the recipient as a result of injuries, disease or sickness caused under circumstances creating a cause of action in favor of the recipient against such a third party.

(5) Any amounts recovered by the division under this section shall, by the division, be placed to the credit of the funds appropriated for benefits under this article proportionate to the amounts provided by the state and federal governments respectively.

SECTION 10. Section 41-86-15, Mississippi Code of 1972, is brought forward as follows:

41-86-15. (1) Persons eligible to receive covered benefits under Sections 41-86-5 through 41-86-17 shall be low-income children who meet the eligibility standards set forth in the plan. Any person who is eligible for benefits under the Mississippi Medicaid Law, Section 43-13-101 et seq., shall not be eligible to receive benefits under Sections 41-86-5 through 41-86-17. A person who is without insurance coverage at the time of application for the program and who meets the other eligibility criteria in the plan shall be eligible to receive covered benefits under the program, if federal approval is obtained to allow eligibility with no waiting period of being without insurance coverage. If federal approval is not obtained for the preceding provision, the Division of Medicaid shall seek federal approval to allow eligibility after the shortest waiting period of being without insurance coverage for which approval can be obtained. After federal approval is obtained to allow eligibility after a certain waiting period of being without insurance coverage, a

person who has been without insurance coverage for the approved waiting period and who meets the other eligibility criteria in the plan shall be eligible to receive covered benefits under the program. If the plan includes any waiting period of being without insurance coverage before eligibility, the State and School Employees Health Insurance Management Board shall adopt regulations to provide exceptions to the waiting period for families who have lost insurance coverage for good cause or through no fault of their own.

(2) The eligibility of children for covered benefits under the program shall be determined annually by the same agency or entity that determines eligibility under Section 43-13-115(9) and shall cover twelve (12) continuous months under the program.

(3) There will be presumptive eligibility under this chapter for children under nineteen (19) years of age, in accordance with the following provisions:

(a) A child will be deemed to be presumptively eligible for covered benefits and services under this chapter if a qualified entity as defined under federal law (42 USCS Section 1396r-1a) determines, on the basis of preliminary information, that the family income of the child does not exceed the applicable income level of eligibility under the plan.

(b) A child will be presumptively eligible under this chapter from the date that the qualified entity determines that the child is presumptively eligible until the earlier of either:

(i) The date on which a determination is made with respect to the eligibility of the child for covered benefits and services under this chapter, or

(ii) The last day of the month following the month in which presumptive eligibility is determined, if an application has not been filed on behalf of the child by that day.

(c) For the period during which a child is presumptively eligible under this chapter, the child will be

eligible to receive all covered benefits and services under this chapter.

(d) If a child is determined to be presumptively eligible under this chapter, the child's parent, guardian or caretaker relative must submit a completed application for assistance under the program no later than the last day of the month following the month in which presumptive eligibility is determined. The qualified entity shall inform the parent, guardian or caretaker relative of this requirement at the time the qualified entity makes the determination of presumptive eligibility.

(e) The qualified entity shall notify the Division of Medicaid of the determination of presumptive eligibility within five (5) working days after the date on which the determination is made.

(f) The Division of Medicaid shall provide qualified entities with such forms as are necessary for an application to be made on behalf of a child for eligibility under this chapter. The Division of Medicaid shall make those application forms and the application process itself as simple as possible.

SECTION 11. This act shall take effect and be in force from and after its passage.