

By: Representatives Moody, Holland

To: Public Health and  
Welfare

## HOUSE BILL NO. 1888

1 AN ACT TO AMEND SECTIONS 43-13-107, 43-13-116 AND 43-13-117,  
2 MISSISSIPPI CODE OF 1972, TO PROVIDE FOR THE APPOINTMENT OF A  
3 JOINT LEGISLATIVE COMMITTEE THAT WILL MEET WITH THE EXECUTIVE  
4 DIRECTOR OF THE DIVISION OF MEDICAID TO DEVELOP A STRATEGY FOR  
5 ADDRESSING THE GROWING COSTS OF THE MEDICAID PROGRAM; TO REQUIRE  
6 THE DIVISION OF MEDICAID TO VERIFY THE ELIGIBILITY OF APPLICANTS  
7 FOR AND RECIPIENTS OF MEDICAID; TO PROVIDE THE GOVERNOR AND THE  
8 EXECUTIVE DIRECTOR OF THE DIVISION OF MEDICAID WITH MORE  
9 FLEXIBILITY TO ADMINISTER THE MEDICAID PROGRAM, BY AUTHORIZING THE  
10 DIVISION TO ESTABLISH THE TYPES OF CARE AND SERVICES TO BE  
11 AVAILABLE TO ELIGIBLE APPLICANTS FOR AND RECIPIENTS OF MEDICAID,  
12 WHICH INCLUDES DETERMINING THE QUANTITY OR FREQUENCY OF USE OF  
13 SERVICES, CHARGES FOR SERVICES AND THE SETTING OF PROVIDER  
14 REIMBURSEMENT RATES; AND FOR RELATED PURPOSES.

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

16 **SECTION 1.** Section 43-13-107, Mississippi Code of 1972, as  
17 amended by House Bill No. 1200, 2002 Regular Session, is amended  
18 as follows:

19 43-13-107. (1) The Division of Medicaid is created in the  
20 Office of the Governor and established to administer this article  
21 and perform such other duties as are prescribed by law.

22 (2) (a) The Governor shall appoint a full-time executive  
23 director, with the advice and consent of the Senate, who shall be  
24 either (i) a physician with administrative experience in a medical  
25 care or health program, or (ii) a person holding a graduate degree  
26 in medical care administration, public health, hospital  
27 administration, or the equivalent, or (iii) a person holding a  
28 bachelor's degree in business administration or hospital  
29 administration, with at least ten (10) years' experience in  
30 management-level administration of Medicaid programs, and who  
31 shall serve at the will and pleasure of the Governor. The  
32 executive director shall be the official secretary and legal  
33 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 may prescribe from time to time.

(b) The executive director, with the approval of the Governor and subject to 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 when the salary of the executive director is not set by law, that 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 executive 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 advisory 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.



67                   (c) The respective chairmen of the House Public Health  
68 and Welfare Committee, the House Appropriations Committee, the  
69 Senate Public Health and Welfare Committee and the Senate  
70 Appropriations Committee, or their designees, one (1) member of  
71 the State Senate appointed by the Lieutenant Governor and one (1)  
72 member of the House of Representatives appointed by the Speaker of  
73 the House, shall serve as ex officio nonvoting members of the  
74 advisory committee.

75                   (d) In addition to the committee members required by  
76 paragraph (b), the advisory committee shall consist of such other  
77 members as are necessary to meet the requirements of the federal  
78 regulation applicable to the advisory committee, who shall be  
79 appointed as provided in the federal regulation.

80                   (e) The chairmanship of the advisory committee shall  
81 alternate for twelve-month periods between the chairmen of the  
82 House and Senate Public Health and Welfare Committees, with the  
83 Chairman of the House Public Health and Welfare Committee serving  
84 as the first chairman.

85                   (f) The members of the advisory committee specified in  
86 paragraph (b) shall serve for terms that are concurrent with the  
87 terms of members of the Legislature, and any member appointed  
88 under paragraph (b) may be reappointed to the advisory committee.  
89 The members of the advisory committee specified in paragraph (b)  
90 shall serve without compensation, but shall receive reimbursement  
91 to defray actual expenses incurred in the performance of committee  
92 business as authorized by law. Legislators shall receive per diem  
93 and expenses which may be paid from the contingent expense funds  
94 of their respective houses in the same amounts as provided for  
95 committee meetings when the Legislature is not in session.

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



100           (h) The executive director shall submit to the advisory  
101 committee all amendments, modifications and changes to the state  
102 plan for the operation of the Medicaid program, for review by the  
103 advisory committee before the amendments, modifications or changes  
104 may be implemented by the division.

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

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

110               (ii) Advise the division with respect to issues  
111 concerning receipt and disbursement of funds and eligibility for  
112 Medicaid;

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

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

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

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

128           (4) (a) There is established a Drug Use Review Board, which  
129 shall be the board that is required by federal law to:

130               (i) Review and initiate retrospective drug use,  
131 review including ongoing periodic examination of claims data and  
132 other records in order to identify patterns of fraud, abuse, gross



overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists and individuals receiving Medicaid benefits or associated with specific drugs or groups of drugs.

(ii) Review and initiate ongoing interventions for physicians and pharmacists, targeted toward therapy problems or individuals identified in the course of retrospective drug use reviews.

(iii) On an ongoing basis, assess data on drug use against explicit predetermined standards using the compendia and literature set forth in federal law and regulations.

(b) The board shall consist of not less than twelve (12) members appointed by the Governor or his designee.

(c) The board shall meet at least quarterly, and board members shall be furnished written notice of the meetings at least ten (10) days before the date of the meeting.

(d) The board meetings shall be open to the public, members of the press, legislators and consumers. Additionally, all documents provided to board members shall be available to members of the Legislature in the same manner, and shall be made available to others for a reasonable fee for copying. However, patient confidentiality and provider confidentiality shall be protected by blinding patient names and provider names with numerical or other anonymous identifiers. The board meetings shall be subject to the Open Meetings Act (Section 25-41-1 et seq.). Board meetings conducted in violation of this section shall be deemed unlawful.

(5) (a) There is established a Pharmacy and Therapeutics Committee, which shall be appointed by the Governor or his designee.

(b) The committee shall meet at least quarterly, and committee members shall be furnished written notice of the meetings at least ten (10) days before the date of the meeting.



165 (c) The committee meetings shall be open to the public,  
166 members of the press, legislators and consumers. Additionally,  
167 all documents provided to committee members shall be available to  
168 members of the Legislature in the same manner, and shall be made  
169 available to others for a reasonable fee for copying. However,  
170 patient confidentiality and provider confidentiality shall be  
171 protected by blinding patient names and provider names with  
172 numerical or other anonymous identifiers. The committee meetings  
173 shall be subject to the Open Meetings Act (Section 25-41-1 et  
174 seq.). Committee meetings conducted in violation of this section  
175 shall be deemed unlawful.

176 (d) After a thirty-day public notice, the executive  
177 director or his or her designee shall present the division's  
178 recommendation regarding prior approval for a therapeutic class of  
179 drugs to the committee.

180 (e) Upon reviewing the information and recommendations,  
181 the committee shall forward a written recommendation approved by a  
182 majority of the committee to the executive director or his or her  
183 designee. The decisions of the committee regarding any  
184 limitations to be imposed on any drug or its use for a specified  
185 indication shall be based on sound clinical evidence found in  
186 labeling, drug compendia, and peer reviewed clinical literature  
187 pertaining to use of the drug in the relevant population.

188 (f) Upon reviewing and considering all recommendations  
189 including recommendation of the committee, comments, and data, the  
190 executive director shall make a final determination whether to  
191 require prior approval of a therapeutic class of drugs, or modify  
192 existing prior approval requirements for a therapeutic class of  
193 drugs.

194 (g) At least thirty (30) days before the executive  
195 director implements new or amended prior authorization decisions,  
196 written notice of the executive director's decision shall be  
197 provided to all prescribing Medicaid providers, all Medicaid



enrolled pharmacies, and any other party who has requested the notification. However, notice given under Section 25-43-7(1) will substitute for and meet the requirement for notice under this subsection.

(6) (a) The Speaker of the House of Representatives and the Lieutenant Governor shall appoint a joint legislative committee to meet with the Executive Director of the Division of Medicaid for the purpose of developing a sound strategy for addressing the increasing costs of the Medicaid program. The goal of the strategy shall be to ensure that the division will be able to administer the program within the amount of appropriated funds and avoid large deficits before the end of the fiscal year, while being as fair and equitable as possible to the recipients and providers of Medicaid services.

(b) The committee shall consist of the Chairmen of the Public Health and Welfare Committees of the House and Senate, the Chairmen of the Appropriations Committees of the House and Senate, and such other members of the House as may be appointed by the Speaker, and such other members of the Senate as may be appointed by the Lieutenant Governor. The appointed members of the committee shall be appointed not later than seven (7) days after the effective date of House Bill No. 1888, 2002 Regular Session.

(c) This subsection shall stand repealed on July 1, 2002.

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

**SECTION 2.** Section 43-13-116, Mississippi Code of 1972, is amended as follows:

43-13-116. (1) \* \* \* The Division of Medicaid shall fully implement and carry out the administrative functions of determining the eligibility of those persons who qualify for Medicaid under Section 43-13-115. The division shall verify the eligibility of applicants for and recipients of Medicaid services in cases where the determination of eligibility is being made by



231 another agency or is being made on the basis of information  
232 provided by another agency or entity.

233       (2) In determining Medicaid eligibility, the Division of  
234 Medicaid may enter into an agreement with the Secretary of the  
235 Department of Health and Human Services for the purpose of  
236 securing the transfer of eligibility information from the Social  
237 Security Administration on those individuals receiving  
238 Supplemental Security Income (SSI) benefits under the federal  
239 Social Security Act and any other information necessary in  
240 determining Medicaid eligibility. In addition, the Division of  
241 Medicaid may enter into contractual arrangements with its fiscal  
242 agent or with the State Department of Human Services in securing  
243 electronic data processing support as may be necessary.

244       (3) Administrative hearings shall be available to any  
245 applicant who requests it because his or her claim of eligibility  
246 for services is denied or is not acted upon with reasonable  
247 promptness or by any recipient who requests it because he or she  
248 believes the agency has erroneously taken action to deny, reduce,  
249 or terminate benefits. The agency need not grant a hearing if the  
250 sole issue is a federal or state law requiring an automatic change  
251 adversely affecting some or all recipients. Eligibility  
252 determinations that are made by other agencies and certified to  
253 the Division of Medicaid under Section 43-13-115 are not subject  
254 to the administrative hearing procedures of the Division of  
255 Medicaid, but are subject to the administrative hearing procedures  
256 of the agency that determined eligibility.

257       (a) A request may be made either for a local regional  
258 office hearing or a state office hearing when the local regional  
259 office has made the initial decision that the claimant seeks to  
260 appeal or when the regional office has not acted with reasonable  
261 promptness in making a decision on a claim for eligibility or  
262 services. The only exception to requesting a local hearing is  
263 when the issue under appeal involves either (i) a disability or





blindness denial, or termination, or (ii) a level of care denial or termination for a disabled child living at home. An appeal involving disability, blindness or level of care must be handled as a state level hearing. The decision from the local hearing may be appealed to the state office for a state hearing. A decision to deny, reduce or terminate benefits that is initially made at the state office may be appealed by requesting a state hearing.

(b) A request for a hearing, either state or local, must be made in writing by the claimant or claimant's legal representative. "Legal representative" includes the claimant's authorized representative, an attorney retained by the claimant or claimant's family to represent the claimant, a paralegal representative with a legal aid services, a parent of a minor child if the claimant is a child, a legal guardian or conservator or an individual with power of attorney for the claimant. The claimant may also be represented by anyone that he or she so designates but must give the designation to the Medicaid regional office or state office in writing, if the person is not the legal representative, legal guardian, or authorized representative.

(c) The claimant may make a request for a hearing in person at the regional office but an oral request must be put into written form. Regional office staff will determine from the claimant if a local or state hearing is requested and assist the claimant in completing and signing the appropriate form. Regional office staff may forward a state hearing request to the appropriate division in the state office or the claimant may mail the form to the address listed on the form. The claimant may make a written request for a hearing by letter. A simple statement requesting a hearing that is signed by the claimant or legal representative is sufficient; however, if possible, the claimant should state the reason for the request. The letter may be mailed to the regional office or it may be mailed to the state office. If the letter does not specify the type of hearing desired, local



or state, Medicaid staff will attempt to contact the claimant to determine the level of hearing desired. If contact cannot be made within three (3) days of receipt of the request, the request will be assumed to be for a local hearing and scheduled accordingly. A hearing will not be scheduled until either a letter or the appropriate form is received by the regional or state office.

(d) When both members of a couple wish to appeal an action or inaction by the agency that affects both applications or cases similarly and arose from the same issue, one or both may file the request for hearing, both may present evidence at the hearing, and the agency's decision will be applicable to both. If both file a request for hearing, two (2) hearings will be registered but they will be conducted on the same day and in the same place, either consecutively or jointly, as the couple wishes. If they so desire, only one of the couple need attend the hearing.

(e) The procedure for administrative hearings shall be as follows:

(i) The claimant has thirty (30) days from the date the agency mails the appropriate notice to the claimant of its decision regarding eligibility, services, or benefits to request either a state or local hearing. This time period may be extended if the claimant can show good cause for not filing within thirty (30) days. Good cause includes, but may not be limited to, illness, failure to receive the notice, being out of state, or some other reasonable explanation. If good cause can be shown, a late request may be accepted provided the facts in the case remain the same. If a claimant's circumstances have changed or if good cause for filing a request beyond thirty (30) days is not shown, a hearing request will not be accepted. If the claimant wishes to have eligibility reconsidered, he or she may reapply.

(ii) If a claimant or representative requests a hearing in writing during the advance notice period before benefits are reduced or terminated, benefits must be continued or



reinstated to the benefit level in effect before the effective date of the adverse action. Benefits will continue at the original level until the final hearing decision is rendered. Any hearing requested after the advance notice period will not be accepted as a timely request in order for continuation of benefits to apply.

(iii) Upon receipt of a written request for a hearing, the request will be acknowledged in writing within twenty (20) days and a hearing scheduled. The claimant or representative will be given at least five (5) days' advance notice of the hearing date. The local and/or state level hearings will be held by telephone unless, at the hearing officer's discretion, it is determined that an in-person hearing is necessary. If a local hearing is requested, the regional office will notify the claimant or representative in writing of the time of the local hearing. If a state hearing is requested, the state office will notify the claimant or representative in writing of the time of the state hearing. If an in-person hearing is necessary, local hearings will be held at the regional office and state hearings will be held at the state office unless other arrangements are necessitated by the claimant's inability to travel.

(iv) All persons attending a hearing will attend for the purpose of giving information on behalf of the claimant or rendering the claimant assistance in some other way, or for the purpose of representing the Division of Medicaid.

(v) A state or local hearing request may be withdrawn at any time before the scheduled hearing, or after the hearing is held but before a decision is rendered. The withdrawal must be in writing and signed by the claimant or representative. A hearing request will be considered abandoned if the claimant or representative fails to appear at a scheduled hearing without good cause. If no one appears for a hearing, the appropriate office will notify the claimant in writing that the hearing is dismissed



unless good cause is shown for not attending. The proposed agency action will be taken on the case following failure to appear for a hearing if the action has not already been effected.

(vi) The claimant or his representative has the following rights in connection with a local or state hearing:

(A) The right to examine at a reasonable time before the date of the hearing and during the hearing the content of the claimant's case record;

(B) The right to have legal representation at the hearing and to bring witnesses;

(C) The right to produce documentary evidence and establish all facts and circumstances concerning eligibility, services, or benefits;

(D) The right to present an argument without undue interference;

(E) The right to question or refute any testimony or evidence including an opportunity to confront and cross-examine adverse witnesses.

(vii) When a request for a local hearing is received by the regional office or if the regional office is notified by the state office that a local hearing has been requested, the Medicaid specialist supervisor in the regional office will review the case record, reexamine the action taken on the case, and determine if policy and procedures have been followed. If any adjustments or corrections should be made, the Medicaid specialist supervisor will ensure that corrective action is taken. If the request for hearing was timely made such that continuation of benefits applies, the Medicaid specialist supervisor will ensure that benefits continue at the level before the proposed adverse action that is the subject of the appeal. The Medicaid specialist supervisor will also ensure that all needed information, verification, and evidence is in the case record for the hearing.



(viii) When a state hearing is requested that appeals the action or inaction of a regional office, the regional office will prepare copies of the case record and forward it to the appropriate division in the state office no later than five (5) days after receipt of the request for a state hearing. The original case record will remain in the regional office. Either the original case record in the regional office or the copy forwarded to the state office will be available for inspection by the claimant or claimant's representative a reasonable time before the date of the hearing.

(ix) The Medicaid specialist supervisor will serve as the hearing officer for a local hearing unless the Medicaid specialist supervisor actually participated in the eligibility, benefits, or services decision under appeal, in which case the Medicaid specialist supervisor must appoint a Medicaid specialist in the regional office who did not actually participate in the decision under appeal to serve as hearing officer. The local hearing will be an informal proceeding in which the claimant or representative may present new or additional information, may question the action taken on the client's case, and will hear an explanation from agency staff as to the regulations and requirements that were applied to claimant's case in making the decision.

(x) After the hearing, the hearing officer will prepare a written summary of the hearing procedure and file it with the case record. The hearing officer will consider the facts presented at the local hearing in reaching a decision. The claimant will be notified of the local hearing decision on the appropriate form that will state clearly the reason for the decision, the policy that governs the decision, the claimant's right to appeal the decision to the state office, and, if the original adverse action is upheld, the new effective date of the reduction or termination of benefits or services if continuation



of benefits applied during the hearing process. The new effective date of the reduction or termination of benefits or services must be at the end of the fifteen-day advance notice period from the mailing date of the notice of hearing decision. The notice to claimant will be made part of the case record.

(xi) The claimant has the right to appeal a local hearing decision by requesting a state hearing in writing within fifteen (15) days of the mailing date of the notice of local hearing decision. The state hearing request should be made to the regional office. If benefits have been continued pending the local hearing process, then benefits will continue throughout the fifteen-day advance notice period for an adverse local hearing decision. If a state hearing is timely requested within the fifteen-day period, then benefits will continue pending the state hearing process. State hearings requested after the fifteen-day local hearing advance notice period will not be accepted unless the initial thirty-day period for filing a hearing request has not expired because the local hearing was held early, in which case a state hearing request will be accepted as timely within the number of days remaining of the unexpired initial thirty-day period in addition to the fifteen-day time period. Continuation of benefits during the state hearing process, however, will only apply if the state hearing request is received within the fifteen-day advance notice period.

(xii) When a request for a state hearing is received in the regional office, the request will be made part of the case record and the regional office will prepare the case record and forward it to the appropriate division in the state office within five (5) days of receipt of the state hearing request. A request for a state hearing received in the state office will be forwarded to the regional office for inclusion in the case record and the regional office will prepare the case record and forward it to the appropriate division in the state



office within five (5) days of receipt of the state hearing request.

(xiii) Upon receipt of the hearing record, an impartial hearing officer will be assigned to hear the case either by the Executive Director of the Division of Medicaid or his or her designee. Hearing officers will be individuals with appropriate expertise employed by the division and who have not been involved in any way with the action or decision on appeal in the case. The hearing officer will review the case record and if the review shows that an error was made in the action of the agency or in the interpretation of policy, or that a change of policy has been made, the hearing officer will discuss these matters with the appropriate agency personnel and request that an appropriate adjustment be made. Appropriate agency personnel will discuss the matter with the claimant and if the claimant is agreeable to the adjustment of the claim, then agency personnel will request in writing dismissal of the hearing and the reason therefor, to be placed in the case record. If the hearing is to go forward, it shall be scheduled by the hearing officer in the manner set forth in subparagraph (iii) of this paragraph (e).

(xiv) In conducting the hearing, the state hearing officer will inform those present of the following:

(A) That the hearing will be recorded on tape and that a transcript of the proceedings will be typed for the record;

(B) The action taken by the agency which prompted the appeal;

(C) An explanation of the claimant's rights during the hearing as outlined in subparagraph (vi) of this paragraph (e);

(D) That the purpose of the hearing is for the claimant to express dissatisfaction and present additional information or evidence;



495 (E) That the case record is available for  
496 review by the claimant or representative during the hearing;

497 (F) That the final hearing decision will be  
498 rendered by the Executive Director of the Division of Medicaid on  
499 the basis of facts presented at the hearing and the case record  
500 and that the claimant will be notified by letter of the final  
501 decision.

502 (xv) During the hearing, the claimant and/or  
503 representative will be allowed an opportunity to make a full  
504 statement concerning the appeal and will be assisted, if  
505 necessary, in disclosing all information on which the claim is  
506 based. All persons representing the claimant and those  
507 representing the Division of Medicaid will have the opportunity to  
508 state all facts pertinent to the appeal. The hearing officer may  
509 recess or continue the hearing for a reasonable time should  
510 additional information or facts be required or if some change in  
511 the claimant's circumstances occurs during the hearing process  
512 which impacts the appeal. When all information has been  
513 presented, the hearing officer will close the hearing and stop the  
514 recorder.

515 (xvi) Immediately following the hearing the  
516 hearing tape will be transcribed and a copy of the transcription  
517 forwarded to the regional office for filing in the case record.  
518 As soon as possible, the hearing officer shall review the evidence  
519 and record of the proceedings, testimony, exhibits, and other  
520 supporting documents, prepare a written summary of the facts as  
521 the hearing officer finds them, and prepare a written  
522 recommendation of action to be taken by the agency, citing  
523 appropriate policy and regulations that govern the recommendation.  
524 The decision cannot be based on any material, oral or written, not  
525 available to the claimant before or during the hearing. The  
526 hearing officer's recommendation will become part of the case





527 record which will be submitted to the Executive Director of the  
528 Division of Medicaid for further review and decision.

529                   (xvii) The Executive Director of the Division of  
530 Medicaid, upon review of the recommendation, proceedings and the  
531 record, may sustain the recommendation of the hearing officer,  
532 reject the same, or remand the matter to the hearing officer to  
533 take additional testimony and evidence, in which case, the hearing  
534 officer thereafter shall submit to the executive director a new  
535 recommendation. The executive director shall prepare a written  
536 decision summarizing the facts and identifying policies and  
537 regulations that support the decision, which shall be mailed to  
538 the claimant and the representative, with a copy to the regional  
539 office if appropriate, as soon as possible after submission of a  
540 recommendation by the hearing officer. The decision notice will  
541 specify any action to be taken by the agency, specify any revised  
542 eligibility dates or, if continuation of benefits applies, will  
543 notify the claimant of the new effective date of reduction or  
544 termination of benefits or services, which will be fifteen (15)  
545 days from the mailing date of the notice of decision. The  
546 decision rendered by the Executive Director of the Division of  
547 Medicaid is final and binding. The claimant is entitled to seek  
548 judicial review in a court of proper jurisdiction.

549                   (xviii) The Division of Medicaid must take final  
550 administrative action on a hearing, whether state or local, within  
551 ninety (90) days from the date of the initial request for a  
552 hearing.

553                   (xix) A group hearing may be held for a number of  
554 claimants under the following circumstances:

555                   (A) The Division of Medicaid may consolidate  
556 the cases and conduct a single group hearing when the only issue  
557 involved is one (1) of a single law or agency policy;



558 (B) The claimants may request a group hearing  
559 when there is one (1) issue of agency policy common to all of  
560 them.

561 In all group hearings, whether initiated by the Division of  
562 Medicaid or by the claimants, the policies governing fair hearings  
563 must be followed. Each claimant in a group hearing must be  
564 permitted to present his or her own case and be represented by his  
565 or her own representative, or to withdraw from the group hearing  
566 and have his or her appeal heard individually. As in individual  
567 hearings, the hearing will be conducted only on the issue being  
568 appealed, and each claimant will be expected to keep individual  
569 testimony within a reasonable time frame as a matter of  
570 consideration to the other claimants involved.

571 (xx) Any specific matter necessitating an  
572 administrative hearing not otherwise provided under this article  
573 or agency policy shall be afforded under the hearing procedures as  
574 outlined above. If the specific time frames of such a unique  
575 matter relating to requesting, granting, and concluding of the  
576 hearing is contrary to the time frames as set out in the hearing  
577 procedures above, the specific time frames will govern over the  
578 time frames as set out within these procedures.

579 (4) The Executive Director of the Division of Medicaid, with  
580 the approval of the Governor, shall be authorized to employ  
581 eligibility, technical, clerical and supportive staff as may be  
582 required in carrying out and fully implementing the determination  
583 of Medicaid eligibility, including conducting quality control  
584 reviews and the investigation of the improper receipt of  
585 Medicaid. Staffing needs will be set forth in the annual  
586 appropriation act for the division. Additional office space as  
587 needed in performing eligibility, quality control and  
588 investigative functions shall be obtained by the division.



589           **SECTION 3.** Section 43-13-117, Mississippi Code of 1972, as  
590 amended by House Bill No. 1200, Senate Bill No. 3060 and Senate  
591 Bill No. 2189, 2002 Regular Session, is amended as follows:

592           43-13-117. Medicaid as authorized by this article shall  
593 include payment of part or all of the costs, at the discretion of  
594 the division or its successor, with approval of the Governor, of  
595 the following types of care and services rendered to eligible  
596 applicants who have been determined to be eligible for that care  
597 and services, within the limits of state appropriations and  
598 federal matching funds:

599           (1) Inpatient hospital services.

600           (a) The division shall allow thirty (30) days of  
601 inpatient hospital care annually for all Medicaid recipients.  
602 Precertification of inpatient days must be obtained as required by  
603 the division. The division may allow unlimited days in  
604 disproportionate hospitals as defined by the division for eligible  
605 infants under the age of six (6) years if certified as medically  
606 necessary as required by the division.

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

613           (c) Hospitals will receive an additional payment  
614 for the implantable programmable baclofen drug pump used to treat  
615 spasticity which is implanted on an inpatient basis. The payment  
616 pursuant to written invoice will be in addition to the facility's  
617 per diem reimbursement and will represent a reduction of costs on  
618 the facility's annual cost report, and shall not exceed Ten  
619 Thousand Dollars (\$10,000.00) per year per recipient. This  
620 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.

During the period between May 1, 2002, and December 1, 2002, the Chairmen of the Public Health and Welfare Committees of the Senate and the House of Representatives may appoint a joint study committee to consider the issue of setting uniform reimbursement rates for nursing facilities. The study committee will consist of the Chairmen of the Public Health and Welfare Committees, three (3) members of the Senate and three (3) members of the House. The



653 study committee shall complete its work in not more than three (3)  
654 meetings.

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

658 (d) When a facility of a category that does not  
659 require a certificate of need for construction and that could not  
660 be eligible for Medicaid reimbursement is constructed to nursing  
661 facility specifications for licensure and certification, and the  
662 facility is subsequently converted to a nursing facility under a  
663 certificate of need that authorizes conversion only and the  
664 applicant for the certificate of need was assessed an application  
665 review fee based on capital expenditures incurred in constructing  
666 the facility, the division shall allow reimbursement for capital  
667 expenditures necessary for construction of the facility that were  
668 incurred within the twenty-four (24) consecutive calendar months  
669 immediately preceding the date that the certificate of need  
670 authorizing the conversion was issued, to the same extent that  
671 reimbursement would be allowed for construction of a new nursing  
672 facility under a certificate of need that authorizes that  
673 construction. The reimbursement authorized in this subparagraph  
674 (d) may be made only to facilities the construction of which was  
675 completed after June 30, 1989. Before the division shall be  
676 authorized to make the reimbursement authorized in this  
677 subparagraph (d), the division first must have received approval  
678 from the Health Care Financing Administration of the United States  
679 Department of Health and Human Services of the change in the state  
680 Medicaid plan providing for the reimbursement.

681 (e) The division shall develop and implement, not  
682 later than January 1, 2001, a case-mix payment add-on determined  
683 by time studies and other valid statistical data that will  
684 reimburse a nursing facility for the additional cost of caring for  
685 a resident who has a diagnosis of Alzheimer's or other related



686 dementia and exhibits symptoms that require special care. Any  
687 such case-mix add-on payment shall be supported by a determination  
688 of additional cost. The division shall also develop and implement  
689 as part of the fair rental reimbursement system for nursing  
690 facility beds, an Alzheimer's resident bed depreciation enhanced  
691 reimbursement system that will provide an incentive to encourage  
692 nursing facilities to convert or construct beds for residents with  
693 Alzheimer's or other related dementia.

694 (f) The Division of Medicaid shall develop and  
695 implement a referral process for long-term care alternatives for  
696 Medicaid beneficiaries and applicants. No Medicaid beneficiary  
697 shall be admitted to a Medicaid-certified nursing facility unless  
698 a licensed physician certifies that nursing facility care is  
699 appropriate for that person on a standardized form to be prepared  
700 and provided to nursing facilities by the Division of Medicaid.  
701 The physician shall forward a copy of that certification to the  
702 Division of Medicaid within twenty-four (24) hours after it is  
703 signed by the physician. Any physician who fails to forward the  
704 certification to the Division of Medicaid within the time period  
705 specified in this paragraph shall be ineligible for Medicaid  
706 reimbursement for any physician's services performed for the  
707 applicant. The Division of Medicaid shall determine, through an  
708 assessment of the applicant conducted within two (2) business days  
709 after receipt of the physician's certification, whether the  
710 applicant also could live appropriately and cost-effectively at  
711 home or in some other community-based setting if home- or  
712 community-based services were available to the applicant. The  
713 time limitation prescribed in this paragraph shall be waived in  
714 cases of emergency. If the Division of Medicaid determines that a  
715 home- or other community-based setting is appropriate and  
716 cost-effective, the division shall:



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

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

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

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

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

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

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

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



750           (5) Periodic screening and diagnostic services for  
751 individuals under age twenty-one (21) years as are needed to  
752 identify physical and mental defects and to provide health care  
753 treatment and other measures designed to correct or ameliorate  
754 defects and physical and mental illness and conditions discovered  
755 by the screening services regardless of whether these services are  
756 included in the state plan. The division may include in its  
757 periodic screening and diagnostic program those discretionary  
758 services authorized under the federal regulations adopted to  
759 implement Title XIX of the federal Social Security Act, as  
760 amended. The division, in obtaining physical therapy services,  
761 occupational therapy services, and services for individuals with  
762 speech, hearing and language disorders, may enter into a  
763 cooperative agreement with the State Department of Education for  
764 the provision of those services to handicapped students by public  
765 school districts using state funds that are provided from the  
766 appropriation to the Department of Education to obtain federal  
767 matching funds through the division. The division, in obtaining  
768 medical and psychological evaluations for children in the custody  
769 of the State Department of Human Services may enter into a  
770 cooperative agreement with the State Department of Human Services  
771 for the provision of those services using state funds that are  
772 provided from the appropriation to the Department of Human  
773 Services to obtain federal matching funds through the division.

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





783 at ten percent (10%) of the adjusted Medicare payment established  
784 on January 1, 1999, and as adjusted each January thereafter, under  
785 Medicare (Title XVIII of the Social Security Act, as amended), and  
786 which shall in no event be less than seventy percent (70%) of the  
787 adjusted Medicare payment established on January 1, 1994.

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

792 (b) Repealed.

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

804 (9) (a) Legend and other drugs as may be determined by  
805 the division. The division shall opt out of the federal drug  
806 rebate program and shall create a closed drug formulary as soon as  
807 practicable after the effective date of Senate Bill No. 2189, 2002  
808 Regular Session. Drugs included on the formulary will be those  
809 with the lowest and best price as determined through a bidding  
810 process. The division may implement a program of prior approval  
811 for drugs to the extent permitted by law. The division shall  
812 allow seven (7) prescriptions per month for each  
813 noninstitutionalized Medicaid recipient; however, after a  
814 noninstitutionalized or institutionalized recipient has received  
815 five (5) prescriptions in any month, each additional prescription



816 during that month must have the prior approval of the division.  
817 The division shall not reimburse for any portion of a prescription  
818 that exceeds a thirty-four-day supply of the drug based on the  
819 daily dosage.

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

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

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

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

835 (b) Legend and other drugs as may be determined by  
836 the division. The division may implement a program of prior  
837 approval for drugs to the extent permitted by law. Payment by the  
838 division for covered multiple source drugs shall be limited to the  
839 lower of the upper limits established and published by the Centers  
840 for Medicare and Medicaid Services (CMS) plus a dispensing fee, or  
841 the estimated acquisition cost (EAC) plus a dispensing fee, or the  
842 providers' usual and customary charge to the general public. The  
843 division shall allow seven (7) prescriptions per month for each  
844 noninstitutionalized Medicaid recipient; however, after a  
845 noninstitutionalized or institutionalized recipient has received  
846 five (5) prescriptions in any month, each additional prescription  
847 during that month must have the prior approval of the division.  
848 The division shall not reimburse for any portion of a prescription



849 that exceeds a thirty-four-day supply of the drug based on the  
850 daily dosage.

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

855 Payment for nonlegend or over-the-counter drugs covered on  
856 the division's formulary shall be reimbursed at the lower of the  
857 division's estimated shelf price or the providers' usual and  
858 customary charge to the general public. No dispensing fee shall  
859 be paid.

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

862 The Medicaid provider shall not prescribe, the Medicaid  
863 pharmacy shall not bill, and the division shall not reimburse for  
864 name brand drugs if there are equally effective generic  
865 equivalents available and if the generic equivalents are the least  
866 expensive.

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

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

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



880           As used in this paragraph (9), "estimated acquisition cost"  
881 means twelve percent (12%) less than the average wholesale price  
882 for a drug.

883                       (c) The division may operate the drug program  
884 under the provisions of subparagraph (b) until the closed drug  
885 formulary required by subparagraph (a) is established and  
886 implemented. Subparagraph (a) of this paragraph (9) shall stand  
887 repealed on July 1, 2003.

888                       (10) Dental care that is an adjunct to treatment of an  
889 acute medical or surgical condition; services of oral surgeons and  
890 dentists in connection with surgery related to the jaw or any  
891 structure contiguous to the jaw or the reduction of any fracture  
892 of the jaw or any facial bone; and emergency dental extractions  
893 and treatment related thereto. On July 1, 1999, all fees for  
894 dental care and surgery under authority of this paragraph (10)  
895 shall be increased to one hundred sixty percent (160%) of the  
896 amount of the reimbursement rate that was in effect on June 30,  
897 1999. It is the intent of the Legislature to encourage more  
898 dentists to participate in the Medicaid program.

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

908                       (12) Intermediate care facility services.

909                       (a) The division shall make full payment to all  
910 intermediate care facilities for the mentally retarded for each  
911 day, not exceeding eighty-four (84) days per year, that a patient  
912 is absent from the facility on home leave. Payment may be made



913 for the following home leave days in addition to the  
914 eighty-four-day limitation: Christmas, the day before Christmas,  
915 the day after Christmas, Thanksgiving, the day before Thanksgiving  
916 and the day after Thanksgiving.

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

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

923 (14) Clinic services. Such diagnostic, preventive,  
924 therapeutic, rehabilitative or palliative services furnished to an  
925 outpatient by or under the supervision of a physician or dentist  
926 in a facility that is not a part of a hospital but that is  
927 organized and operated to provide medical care to outpatients.  
928 Clinic services shall include any services reimbursed as  
929 outpatient hospital services that may be rendered in such a  
930 facility, including those that become so after July 1, 1991. On  
931 July 1, 1999, all fees for physicians' services reimbursed under  
932 authority of this paragraph (14) shall be reimbursed at ninety  
933 percent (90%) of the rate established on January 1, 1999, and as  
934 adjusted each January thereafter, under Medicare (Title XVIII of  
935 the Social Security Act, as amended), and which shall in no event  
936 be less than seventy percent (70%) of the rate established on  
937 January 1, 1994. All fees for physicians' services that are  
938 covered by both Medicare and Medicaid shall be reimbursed at ten  
939 percent (10%) of the adjusted Medicare payment established on  
940 January 1, 1999, and as adjusted each January thereafter, under  
941 Medicare (Title XVIII of the Social Security Act, as amended), and  
942 which shall in no event be less than seventy percent (70%) of the  
943 adjusted Medicare payment established on January 1, 1994. On July  
944 1, 1999, all fees for dentists' services reimbursed under  
945 authority of this paragraph (14) shall be increased to one hundred



946 sixty percent (160%) of the amount of the reimbursement rate that  
947 was in effect on June 30, 1999.

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

964 (16) Mental health services. Approved therapeutic and  
965 case management services (a) provided by an approved regional  
966 mental health/retardation center established under Sections  
967 41-19-31 through 41-19-39, or by another community mental health  
968 service provider meeting the requirements of the Department of  
969 Mental Health to be an approved mental health/retardation center  
970 if determined necessary by the Department of Mental Health, using  
971 state funds that are provided from the appropriation to the State  
972 Department of Mental Health and/or funds transferred to the  
973 department by a political subdivision or instrumentality of the  
974 state and used to match federal funds under a cooperative  
975 agreement between the division and the department, or (b) provided  
976 by a facility that is certified by the State Department of Mental  
977 Health to provide therapeutic and case management services, to be  
978 reimbursed on a fee for service basis, or (c) provided in the



community by a facility or program operated by the Department of Mental Health. Any such services provided by a facility described in 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 those payments as provided in Section 1923 of the federal Social Security Act and any applicable regulations. However, from and after January 1, 1999, 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



1011 participating hospitals shall be provided by the Mississippi  
1012 Hospital Association.

1013                   (b) The division shall establish a Medicare Upper  
1014 Payment Limits Program, as defined in Section 1902(a)(30) of the  
1015 federal Social Security Act and any applicable federal  
1016 regulations, for hospitals, and may establish a Medicare Upper  
1017 Payments Limits Program for nursing facilities. The division  
1018 shall assess each hospital and, if the program is established for  
1019 nursing facilities, shall assess each nursing facility, for the  
1020 sole purpose of financing the state portion of the Medicare Upper  
1021 Payment Limits Program. This assessment shall be based on  
1022 Medicaid utilization, or other appropriate method consistent with  
1023 federal regulations, and will remain in effect as long as the  
1024 state participates in the Medicare Upper Payment Limits Program.  
1025 The division shall make additional reimbursement to hospitals and,  
1026 if the program is established for nursing facilities, shall make  
1027 additional reimbursement to nursing facilities, for the Medicare  
1028 Upper Payment Limits, as defined in Section 1902(a)(30) of the  
1029 federal Social Security Act and any applicable federal  
1030 regulations. This paragraph (b) shall stand repealed from and  
1031 after July 1, 2005.

1032                   (c) The division shall contract with the  
1033 Mississippi Hospital Association to provide administrative support  
1034 for the operation of the disproportionate share hospital program  
1035 and the Medicare Upper Payment Limits Program. This paragraph (c)  
1036 shall stand repealed from and after July 1, 2005.

1037                   (19) (a) Perinatal risk management services. The  
1038 division shall promulgate regulations to be effective from and  
1039 after October 1, 1988, to establish a comprehensive perinatal  
1040 system for risk assessment of all pregnant and infant Medicaid  
1041 recipients and for management, education and follow-up for those  
1042 who are determined to be at risk. Services to be performed  
1043 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, under Part C of the Individuals with Disabilities Education Act (IDEA). The State Department of Health shall certify annually in writing to the executive director of the division the dollar amount of state early intervention funds available that will be utilized as a certified match for Medicaid matching funds. Those funds then shall be used to provide expanded targeted case management services for Medicaid eligible children with special needs who are eligible for the state's early intervention system. Qualifications for persons providing service coordination shall be determined by the State Department of Health and the Division of Medicaid.

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

(21) Nurse practitioner services. Services furnished by a registered nurse who is licensed and certified by the Mississippi Board of Nursing as a nurse practitioner, including, but not limited to, nurse anesthetists, nurse midwives, family nurse practitioners, family planning nurse practitioners,



1077 pediatric nurse practitioners, obstetrics-gynecology nurse  
1078 practitioners and neonatal nurse practitioners, under regulations  
1079 adopted by the division. Reimbursement for those services shall  
1080 not exceed ninety percent (90%) of the reimbursement rate for  
1081 comparable services rendered by a physician.

1082           (22) Ambulatory services delivered in federally  
1083 qualified health centers, rural health centers and clinics of the  
1084 local health departments of the State Department of Health for  
1085 individuals eligible for Medicaid under this article based on  
1086 reasonable costs as determined by the division.

1087           (23) Inpatient psychiatric services. Inpatient  
1088 psychiatric services to be determined by the division for  
1089 recipients under age twenty-one (21) that are provided under the  
1090 direction of a physician in an inpatient program in a licensed  
1091 acute care psychiatric facility or in a licensed psychiatric  
1092 residential treatment facility, before the recipient reaches age  
1093 twenty-one (21) or, if the recipient was receiving the services  
1094 immediately before he reached age twenty-one (21), before the  
1095 earlier of the date he no longer requires the services or the date  
1096 he reaches age twenty-two (22), as provided by federal  
1097 regulations. Precertification of inpatient days and residential  
1098 treatment days must be obtained as required by the division.

1099           (24) [Deleted]

1100           (25) Birthing center services.

1101           (26) Hospice care. As used in this paragraph, the term  
1102 "hospice care" means a coordinated program of active professional  
1103 medical attention within the home and outpatient and inpatient  
1104 care that treats the terminally ill patient and family as a unit,  
1105 employing a medically directed interdisciplinary team. The  
1106 program provides relief of severe pain or other physical symptoms  
1107 and supportive care to meet the special needs arising out of  
1108 physical, psychological, spiritual, social and economic stresses  
1109 that are experienced during the final stages of illness and during



1110 dying and bereavement and meets the Medicare requirements for  
1111 participation as a hospice as provided in federal regulations.

1112           (27) Group health plan premiums and cost sharing if it  
1113 is cost effective as defined by the Secretary of Health and Human  
1114 Services.

1115           (28) Other health insurance premiums that are cost  
1116 effective as defined by the Secretary of Health and Human  
1117 Services. Medicare eligible must have Medicare Part B before  
1118 other insurance premiums can be paid.

1119           (29) The Division of Medicaid may apply for a waiver  
1120 from the Department of Health and Human Services for home- and  
1121 community-based services for developmentally disabled people using  
1122 state funds that are provided from the appropriation to the State  
1123 Department of Mental Health and/or funds transferred to the  
1124 department by a political subdivision or instrumentality of the  
1125 state and used to match federal funds under a cooperative  
1126 agreement between the division and the department, provided that  
1127 funds for these services are specifically appropriated to the  
1128 Department of Mental Health and/or transferred to the department  
1129 by a political subdivision or instrumentality of the state.

1130           (30) Pediatric skilled nursing services for eligible  
1131 persons under twenty-one (21) years of age.

1132           (31) Targeted case management services for children  
1133 with special needs, under waivers from the United States  
1134 Department of Health and Human Services, using state funds that  
1135 are provided from the appropriation to the Mississippi Department  
1136 of Human Services and used to match federal funds under a  
1137 cooperative agreement between the division and the department.

1138           (32) Care and services provided in Christian Science  
1139 Sanatoria listed and certified by the Commission for Accreditation  
1140 of Christian Science Nursing Organizations/Facilities, Inc.,  
1141 rendered in connection with treatment by prayer or spiritual means



1142 to the extent that those services are subject to reimbursement  
1143 under Section 1903 of the Social Security Act.

1144 (33) Podiatrist services.

1145 (34) The division shall make application to the United  
1146 States Health Care Financing Administration for a waiver to  
1147 develop a program of services to personal care and assisted living  
1148 homes in Mississippi. This waiver shall be completed by December  
1149 1, 1999.

1150 (35) Services and activities authorized in Sections  
1151 43-27-101 and 43-27-103, using state funds that are provided from  
1152 the appropriation to the State Department of Human Services and  
1153 used to match federal funds under a cooperative agreement between  
1154 the division and the department.

1155 (36) Nonemergency transportation services for  
1156 Medicaid-eligible persons, to be provided by the Division of  
1157 Medicaid. The division may contract with additional entities to  
1158 administer nonemergency transportation services as it deems  
1159 necessary. All providers shall have a valid driver's license,  
1160 vehicle inspection sticker, valid vehicle license tags and a  
1161 standard liability insurance policy covering the vehicle.

1162 (37) [Deleted]

1163 (38) Chiropractic services. A chiropractor's manual  
1164 manipulation of the spine to correct a subluxation, if x-ray  
1165 demonstrates that a subluxation exists and if the subluxation has  
1166 resulted in a neuromusculoskeletal condition for which  
1167 manipulation is appropriate treatment, and related spinal x-rays  
1168 performed to document these conditions. Reimbursement for  
1169 chiropractic services shall not exceed Seven Hundred Dollars  
1170 (\$700.00) per year per beneficiary.

1171 (39) Dually eligible Medicare/Medicaid beneficiaries.  
1172 The division shall pay the Medicare deductible and ten percent  
1173 (10%) coinsurance amounts for services available under Medicare



1174 for the duration and scope of services otherwise available under  
1175 the Medicaid program.

1176 (40) [Deleted]

1177 (41) Services provided by the State Department of  
1178 Rehabilitation Services for the care and rehabilitation of persons  
1179 with spinal cord injuries or traumatic brain injuries, as allowed  
1180 under waivers from the United States Department of Health and  
1181 Human Services, using up to seventy-five percent (75%) of the  
1182 funds that are appropriated to the Department of Rehabilitation  
1183 Services from the Spinal Cord and Head Injury Trust Fund  
1184 established under Section 37-33-261 and used to match federal  
1185 funds under a cooperative agreement between the division and the  
1186 department.

1187 (42) Notwithstanding any other provision in this  
1188 article to the contrary, the division may develop a population  
1189 health management program for women and children health services  
1190 through the age of two (2) years. This program is primarily for  
1191 obstetrical care associated with low birth weight and pre-term  
1192 babies. The division may apply to the federal Centers for  
1193 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or  
1194 any other waivers that may enhance the program. In order to  
1195 effect cost savings, the division may develop a revised payment  
1196 methodology that may include at-risk capitated payments, and may  
1197 require member participation in accordance with the terms and  
1198 conditions of an approved federal waiver.

1199 (43) The division shall provide reimbursement,  
1200 according to a payment schedule developed by the division, for  
1201 smoking cessation medications for pregnant women during their  
1202 pregnancy and other Medicaid-eligible women who are of  
1203 child-bearing age.

1204 (44) Nursing facility services for the severely  
1205 disabled.



1206                   (a) Severe disabilities include, but are not  
1207 limited to, spinal cord injuries, closed head injuries and  
1208 ventilator dependent patients.

1209                   (b) Those services must be provided in a long-term  
1210 care nursing facility dedicated to the care and treatment of  
1211 persons with severe disabilities, and shall be reimbursed as a  
1212 separate category of nursing facilities.

1213                   (45) Physician assistant services. Services furnished  
1214 by a physician assistant who is licensed by the State Board of  
1215 Medical Licensure and is practicing with physician supervision  
1216 under regulations adopted by the board, under regulations adopted  
1217 by the division. Reimbursement for those services shall not  
1218 exceed ninety percent (90%) of the reimbursement rate for  
1219 comparable services rendered by a physician.

1220                   (46) The division shall make application to the federal  
1221 Centers for Medicare and Medicaid Services (CMS) for a waiver to  
1222 develop and provide services for children with serious emotional  
1223 disturbances as defined in Section 43-14-1(1), which may include  
1224 home- and community-based services, case management services or  
1225 managed care services through mental health providers certified by  
1226 the Department of Mental Health. The division may implement and  
1227 provide services under this waived program only if funds for  
1228 these services are specifically appropriated for this purpose by  
1229 the Legislature, or if funds are voluntarily provided by affected  
1230 agencies.

1231                   (47) Notwithstanding any other provision in this  
1232 article to the contrary, the division, in conjunction with the  
1233 State Department of Health, shall develop and implement disease  
1234 management programs statewide for individuals with asthma,  
1235 diabetes or hypertension, including the use of grants, waivers,  
1236 demonstrations or other projects as necessary.

1237                   (48) Pediatric long-term acute care hospital services.



1238                   (a) Pediatric long-term acute care hospital  
1239 services means services provided to eligible persons under  
1240 twenty-one (21) years of age by a freestanding Medicare-certified  
1241 hospital that has an average length of inpatient stay greater than  
1242 twenty-five (25) days and that is primarily engaged in providing  
1243 chronic or long-term medical care to persons under twenty-one (21)  
1244 years of age.

1245                   (b) The services under this paragraph (48) shall  
1246 be reimbursed as a separate category of hospital services.

1247                   (49) The division shall establish copayments for all  
1248 Medicaid services for which copayments are allowable under federal  
1249 law or regulation, except for nonemergency transportation  
1250 services, and shall set the amount of the copayment for each of  
1251 those services at the maximum amount allowable under federal law  
1252 or regulation.

1253           Notwithstanding any other provision of this article to the  
1254 contrary, the division shall reduce the rate of reimbursement to  
1255 providers for any service provided under this section by five  
1256 percent (5%) of the allowed amount for that service. However, the  
1257 reduction in the reimbursement rates required by this paragraph  
1258 shall not apply to inpatient hospital services, nursing facility  
1259 services, intermediate care facility services, psychiatric  
1260 residential treatment facility services, pharmacy services  
1261 provided under paragraph (9) of this section, or any service  
1262 provided by the University of Mississippi Medical Center or a  
1263 state agency, a state facility or a public agency that either  
1264 provides its own state match through intergovernmental transfer or  
1265 certification of funds to the division, or a service for which the  
1266 federal government sets the reimbursement methodology and rate.  
1267 In addition, the reduction in the reimbursement rates required by  
1268 this paragraph shall not apply to case management services and  
1269 home delivered meal services provided under the home- and  
1270 community-based services program for the elderly and disabled by a



1271 planning and development district, if the planning and development  
1272 district transfers to the division a sum equal to the amount of  
1273 the reduction in reimbursement that would otherwise be made for  
1274 those services under this paragraph.

1275         Notwithstanding any provision of this article, except as  
1276 authorized in the following paragraph and in Section 43-13-139,  
1277 neither (a) the limitations on quantity or frequency of use of or  
1278 the fees or charges for any of the care or services available to  
1279 recipients under this section, nor (b) the payments or rates of  
1280 reimbursement to providers rendering care or services authorized  
1281 under this section to recipients, may be increased, decreased or  
1282 otherwise changed from the levels in effect on July 1, 1999,  
1283 unless they are authorized by an amendment to this section by the  
1284 Legislature. However, the restriction in this paragraph shall not  
1285 prevent the division from changing the payments or rates of  
1286 reimbursement to providers without an amendment to this section  
1287 whenever those changes are required by federal law or regulation,  
1288 or whenever those changes are necessary to correct administrative  
1289 errors or omissions in calculating those payments or rates of  
1290 reimbursement.

1291         Notwithstanding any provision of this article, no new groups  
1292 or categories of recipients and new types of care and services may  
1293 be added without enabling legislation from the Mississippi  
1294 Legislature, except that the division may authorize those changes  
1295 without enabling legislation when the addition of recipients or  
1296 services is ordered by a court of proper authority. The executive  
1297 director shall keep the Governor advised on a timely basis of the  
1298 funds available for expenditure and the projected expenditures.  
1299 If current or projected expenditures of the division can be  
1300 reasonably anticipated to exceed the amounts appropriated for any  
1301 fiscal year, the Governor, after consultation with the executive  
1302 director, shall discontinue any or all of the payment of the types  
1303 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, from May 1, 2002, through June 30, 2004, the Governor is authorized, by means of an executive order and in consultation with the executive director of the division, to adopt and administer a state plan for medical assistance in accordance with Titles XIX and XXI of the federal Social Security Act, as amended, provided that the state plan is administered within the amount of funds appropriated to the division by the Legislature. In adopting and administering the state plan, the division is authorized (a) to establish the types of care and services to be available to eligible applicants for and recipients of Medicaid; (b) to establish the amount, duration, scope and terms and conditions of the care and services for recipients, including the quantity or frequency of use of, and the fees or charges for, any of the care or services available to recipients; (c) to set the payments or rates of reimbursement to providers rendering care or services to recipients; (d) to establish such rules and regulations as may be necessary or desirable for implementation of the state plan; and (e) to take such actions as necessary to secure the maximum amount of federal financial participation available for the program.

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,



1337 documents and other records as prescribed by the Division of  
1338 Medicaid in substantiation of its cost reports for a period of  
1339 three (3) years after the date of submission to the Division of  
1340 Medicaid of an original cost report, or three (3) years after the  
1341 date of submission to the Division of Medicaid of an amended cost  
1342 report.

1343 This section shall stand repealed on July 1, 2004.

1344 **SECTION 4.** It is the intent of the Legislature that the  
1345 amendments to Section 43-13-117, Mississippi Code of 1972,  
1346 contained in this House Bill No. 1888, 2002 Regular Session, shall  
1347 supersede the amendments to that section contained in House Bill  
1348 No. 1200, Senate Bill No. 3060 and Senate Bill No. 2189, 2002  
1349 Regular Session.

1350 **SECTION 5.** This act shall take effect and be in force from  
1351 and after its passage.

