MISSISSIPPI LEGISLATURE REGULAR SESSION 2003

By: Representatives Moody, Holland

To: Public Health and Welfare; Appropriations

HOUSE BILL NO. 897
(As Passed the House)

1 AN ACT RELATIVE TO THE MISSISSIPPI MEDICAID PROGRAM; TO AMEND
2 SECTION 43-13-115, MISSISSIPPI CODE OF 1972, TO CLARIFY
3 ELIGIBILITY FOR MEDICAID; TO AUTHORIZE THE DIVISION OF MEDICAID TO
4 APPLY FOR APPLICABLE WAIVERS FOR BENEFITS AND BUY-IN OPTIONS FOR
5 THE DISABLED CHILDREN LIVING AT HOME AND POVERTY LEVEL AGED AND
6 DISABLED (PLADS) ELIGIBILITY CATEGORIES AND TO ESTABLISH AN
7 EXPENDITURE/ENROLLMENT CAP FOR THESE CATEGORIES; TO AMEND SECTION
8 43-13-117, MISSISSIPPI CODE OF 1972, TO REDUCE THE NURSING
9 FACILITY BED DAYS ELIGIBLE FOR MEDICAID REIMBURSEMENT; TO
10 AUTHORIZE THE DIVISION TO DEVELOP AN ASSESSMENT PROCESS FOR
11 LONG-TERM CARE SERVICES AND DELETE THE REFERRAL PHYSICIAN
12 CERTIFICATION PROCESS; TO DELETE THE NECESSITY TO COMPARE HOME
13 HEALTH COSTS TO NURSING FACILITY SERVICES FOR REIMBURSEMENT; TO
14 DELETE AUTHORITY FOR THE DIVISION TO OPT OUT OF THE FEDERAL DRUG
15 REBATE PROGRAM AND CREATE A CLOSED DRUG FORMULARY; TO DELETE PRIOR
16 APPROVAL OF MONTHLY DRUG PRESCRIPTIONS OVER FIVE; TO ALLOW A
17 DISPENSING FEE FOR OVER-THE-COUNTER DRUGS; TO REDUCE THE ICF/MR
18 BED DAYS ELIGIBLE FOR REIMBURSEMENT; TO DELETE CERTAIN
19 RESTRICTIONS ON THE HOME- AND COMMUNITY-BASED SERVICES WAIVER
20 PROGRAM; TO DELETE THE AUTHORITY FOR REIMBURSEMENT FOR BIRTHING
21 CENTER SERVICES; TO CLARIFY THE ASSISTED LIVING SERVICES WAIVER
22 PROVISION; TO GIVE THE DIVISION DISCRETION IN PAYING MEDICARE
23 COINSURANCE AMOUNTS; TO AUTHORIZE CHILDREN UP TO TWO YEARS OF AGE
24 FOR THE OBSTETRICAL CARE WAIVER PROGRAM; TO DELETE THE REQUIREMENT
25 THAT DISEASE MANAGEMENT PROGRAMS BE IMPLEMENTED STATEWIDE; TO
26 REQUIRE DISEASE MANAGEMENT SERVICES TO BE PROVIDED TO
27 PARTICIPATING INDIVIDUALS IN PERSON; TO REQUIRE THE DIVISION TO
28 REPORT TO THE LEGISLATURE ON THE DEMONSTRATED AMOUNT OF SAVINGS TO
29 THE STATE AS A RESULT OF DISEASE MANAGEMENT PROGRAMS IMPLEMENTED
30 BY THE DIVISION; TO REMOVE THE FIVE PERCENT REIMBURSEMENT
31 REDUCTION FOR CASE MANAGEMENT SERVICES PROVIDED UNDER THE HOME-
32 AND COMMUNITY-BASED SERVICES PROGRAM BY A PLANNING AND DEVELOPMENT
33 DISTRICT; TO AUTHORIZE THE DIVISION TO REMOVE THE FIVE PERCENT
34 REDUCTION IN REIMBURSEMENT FOR PROVIDERS WHO PARTICIPATE IN THE
35 EMERGENCY ROOM REDIRECTION PROGRAM; TO AMEND SECTION 43-13-122,
36 MISSISSIPPI CODE OF 1972, TO DELETE CERTAIN OBSOLETE LANGUAGE; TO
37 AMEND SECTION 43-13-107, MISSISSIPPI CODE OF 1972, TO AUTHORIZE
38 THE DIVISION TO SUBMIT EMERGENCY DRUG ISSUES TO THE PHARMACY AND
39 THERAPEUTICS COMMITTEE WITHOUT PUBLIC COMMENT; TO AMEND SECTION
40 43-13-145, MISSISSIPPI CODE OF 1972, TO INCREASE THE PER BED
41 ASSESSMENT LEVIED UPON NURSING FACILITIES FOR SUPPORT OF THE
42 MEDICAID PROGRAM; AND FOR RELATED PURPOSES.

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

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

46 43-13-115. Recipients of Medicaid shall be the following
47 persons only:

48 (1) Who are qualified for public assistance grants
49 under provisions of Title IV-A and E of the federal Social
50 Security Act, as amended, as determined by the State Department of
51 Human Services, including those statutorily deemed to be IV-A and
52 low-income families and children under Section 1931 of the Social
53 Security Act as determined by the State Department of Human
54 Services and certified to the Division of Medicaid, but not
55 optional groups except as specifically covered in this section.
56 For the purposes of this paragraph (1) and paragraphs (8), (17)
57 and (18) of this section, any reference to Title IV-A or to Part A
58 of Title IV of the federal Social Security Act, as amended, or the
59 state plan under Title IV-A or Part A of Title IV, shall be
60 considered as a reference to Title IV-A of the federal Social
61 Security Act, as amended, and the state plan under Title IV-A,
62 including the income and resource standards and methodologies
63 under Title IV-A and the state plan, as they existed on July 16,
64 1996.

65 (2) Those qualified for Supplemental Security Income
66 (SSI) benefits under Title XVI of the federal Social Security Act,
67 as amended, and those who are deemed SSI eligible as contained in
68 federal statute. The eligibility of individuals covered in this
69 paragraph shall be determined by the Social Security
70 Administration and certified to the Division of Medicaid.

71 (3) Qualified pregnant women who would be eligible for
72 Medicaid as a low income family member under Section 1931 of the
73 Social Security Act if her child was born.

74 (4) [Deleted]

75 (5) A child born on or after October 1, 1984, to a
76 woman eligible for and receiving Medicaid under the state plan on
77 the date of the child's birth shall be deemed to have applied for
78 Medicaid and to have been found eligible for Medicaid under the
79 plan on the date of that birth and will remain eligible for
80 Medicaid for a period of one (1) year so long as the child is a

81 member of the woman's household and the woman remains eligible for
82 Medicaid or would be eligible for Medicaid if pregnant. The
83 eligibility of individuals covered in this paragraph shall be
84 determined by the State Department of Human Services and certified
85 to the Division of Medicaid.

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

93 (7) (a) Persons certified by the Division of Medicaid
94 who are patients in a medical facility (nursing home, hospital,
95 tuberculosis sanatorium or institution for treatment of mental
96 diseases), and who, except for the fact that they are patients in
97 that medical facility, would qualify for grants under Title IV,
98 Supplementary Security Income (SSI) benefits under Title XVI or
99 state supplements, and those aged, blind and disabled persons who
100 would not be eligible for Supplemental Security Income (SSI)
101 benefits under Title XVI or state supplements if they were not
102 institutionalized in a medical facility but whose income is below
103 the maximum standard set by the Division of Medicaid, which
104 standard shall not exceed that prescribed by federal regulation;

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

109 (8) Children under eighteen (18) years of age and
110 pregnant women (including those in intact families) who meet
111 the * * * financial standards of the state plan approved under
112 Title IV-A of the federal Social Security Act, as amended. The
113 eligibility of children covered under this paragraph shall be

114 determined by the State Department of Human Services and certified
115 to the Division of Medicaid.
116 (9) Individuals who are:
117 (a) Children born after September 30, 1983, who
118 have not attained the age of nineteen (19), with family income
119 that does not exceed one hundred percent (100%) of the nonfarm
120 official poverty level;
121 (b) Pregnant women, infants and children who have
122 not attained the age of six (6), with family income that does not
123 exceed one hundred thirty-three percent (133%) of the federal
124 poverty level; and
125 (c) Pregnant women and infants who have not
126 attained the age of one (1), with family income that does not
127 exceed one hundred eighty-five percent (185%) of the federal
128 poverty level.
129 The eligibility of individuals covered in (a), (b) and (c) of
130 this paragraph shall be determined by the Department of Human
131 Services.
132 (10) Certain disabled children age eighteen (18) or
133 under who are living at home, who would be eligible, if in a
134 medical institution, for SSI or a state supplemental payment under
135 Title XVI of the federal Social Security Act, as amended, and
136 therefore for Medicaid under the plan, and for whom the state has
137 made a determination as required under Section 1902(e)(3)(b) of
138 the federal Social Security Act, as amended. The eligibility of
139 individuals under this paragraph shall be determined by the
140 Division of Medicaid; however, the division may apply to the
141 federal Centers for Medicare and Medicaid Services (CMS) for a
142 waiver that will allow flexibility in the benefit design for the
143 Disabled Children Living at Home eligibility category authorized
144 in this paragraph (10), and the division may establish an
145 expenditure/enrollment cap for this category. Nothing contained
146 in this paragraph (10) shall entitle an individual to benefits.

147 (11) Individuals who are sixty-five (65) years of age
148 or older or are disabled as determined under Section 1614(a)(3) of
149 the federal Social Security Act, as amended, and whose income does
150 not exceed one hundred thirty-five percent (135%) of the nonfarm
151 official poverty level as defined by the Office of Management and
152 Budget and revised annually, and whose resources do not exceed
153 those established by the Division of Medicaid.
154 The eligibility of individuals covered under this paragraph
155 shall be determined by the Division of Medicaid; however, the
156 division may apply to the federal Centers for Medicare and
157 Medicaid Services (CMS) for a waiver that will allow flexibility
158 in the benefit design and buy-in options for the Poverty Level
159 Aged and Disabled (PLAD) eligibility category authorized in this
160 paragraph (11), and the division may establish an
161 expenditure/enrollment cap for this category. Nothing contained
162 in this paragraph (11) shall entitle an individual to benefits.
163 (12) Individuals who are qualified Medicare
164 beneficiaries (QMB) entitled to Part A Medicare as defined under
165 Section 301, Public Law 100-360, known as the Medicare
166 Catastrophic Coverage Act of 1988, and whose income does not
167 exceed one hundred percent (100%) of the nonfarm official poverty
168 level as defined by the Office of Management and Budget and
169 revised annually.
170 The eligibility of individuals covered under this paragraph
171 shall be determined by the Division of Medicaid, and those
172 individuals determined eligible shall receive Medicare
173 cost-sharing expenses only as more fully defined by the Medicare
174 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
175 1997.
176 (13) *** * *** Individuals who are entitled to Medicare
177 Part A as defined in Section 4501 of the Omnibus Budget
178 Reconciliation Act of 1990, and whose income does not exceed one
179 hundred twenty percent (120%) of the nonfarm official poverty

180 level as defined by the Office of Management and Budget and
181 revised annually. Eligibility for Medicaid benefits is limited to
182 full payment of Medicare Part B premiums.
183 * * *
184 The eligibility of individuals covered under this paragraph
185 shall be determined by the Division of Medicaid.
186 (14) [Deleted]
187 (15) Disabled workers who are eligible to enroll in
188 Part A Medicare as required by Public Law 101-239, known as the
189 Omnibus Budget Reconciliation Act of 1989, and whose income does
190 not exceed two hundred percent (200%) of the federal poverty level
191 as determined in accordance with the Supplemental Security Income
192 (SSI) program. The eligibility of individuals covered under this
193 paragraph shall be determined by the Division of Medicaid and
194 those individuals shall be entitled to buy-in coverage of Medicare
195 Part A premiums only under the provisions of this paragraph (15).
196 (16) In accordance with the terms and conditions of
197 approved Title XIX waiver from the United States Department of
198 Health and Human Services, persons provided home- and
199 community-based services who are physically disabled and certified
200 by the Division of Medicaid as eligible due to applying the income
201 and deeming requirements as if they were institutionalized.
202 (17) In accordance with the terms of the federal
203 Personal Responsibility and Work Opportunity Reconciliation Act of
204 1996 (Public Law 104-193), persons who become ineligible for
205 assistance under Title IV-A of the federal Social Security Act, as
206 amended, because of increased income from or hours of employment
207 of the caretaker relative or because of the expiration of the
208 applicable earned income disregards, who were eligible for
209 Medicaid for at least three (3) of the six (6) months preceding
210 the month in which the ineligibility begins, shall be eligible for
211 Medicaid * * * for up to twelve (12) months * * *.

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

221 (19) Disabled workers, whose incomes are above the
222 Medicaid eligibility limits, but below two hundred fifty percent
223 (250%) of the federal poverty level, shall be allowed to purchase
224 Medicaid coverage on a sliding fee scale developed by the Division
225 of Medicaid.

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

231 (21) Women of childbearing age whose family income does
232 not exceed one hundred eighty-five percent (185%) of the federal
233 poverty level. The eligibility of individuals covered under this
234 paragraph (21) shall be determined by the Division of Medicaid,
235 and those individuals determined eligible shall only receive
236 family planning services covered under Section 43-13-117(13) and
237 not any other services covered under Medicaid. However, any
238 individual eligible under this paragraph (21) who is also eligible
239 under any other provision of this section shall receive the
240 benefits to which he or she is entitled under that other
241 provision, in addition to family planning services covered under
242 Section 43-13-117(13).

243 The Division of Medicaid shall apply to the United States
244 Secretary of Health and Human Services for a federal waiver of the

245 applicable provisions of Title XIX of the federal Social Security
246 Act, as amended, and any other applicable provisions of federal
247 law as necessary to allow for the implementation of this paragraph
248 (21). The provisions of this paragraph (21) shall be implemented
249 from and after the date that the Division of Medicaid receives the
250 federal waiver.

251 (22) Persons who are workers with a potentially severe
252 disability, as determined by the division, shall be allowed to
253 purchase Medicaid coverage. The term "worker with a potentially
254 severe disability" means a person who is at least sixteen (16)
255 years of age but under sixty-five (65) years of age, who has a
256 physical or mental impairment that is reasonably expected to cause
257 the person to become blind or disabled as defined under Section
258 1614(a) of the federal Social Security Act, as amended, if the
259 person does not receive items and services provided under
260 Medicaid.

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

268 *** * ***

269 (23) Children certified by the Mississippi Department
270 of Human Services for whom the state and county <u>departments of</u>
271 <u>human services</u> <u>have</u> custody and financial responsibility who are
272 in foster care on their eighteenth birthday as reported by the
273 Mississippi Department of Human Services shall be certified
274 Medicaid eligible by the Division of Medicaid until their
275 twenty-first birthday.

276 (24) Individuals who have not attained age sixty-five
277 (65), are not otherwise covered by creditable coverage as defined

278 in the Public Health Services Act, and have been screened for
279 breast and cervical cancer under the Centers for Disease Control
280 and Prevention Breast and Cervical Cancer Early Detection Program
281 established under Title XV of the Public Health Service Act in
282 accordance with the requirements of that act and who need
283 treatment for breast or cervical cancer. Eligibility of
284 individuals under this paragraph (24) shall be determined by the
285 Division of Medicaid.
286 ***
287 **SECTION 2.** Section 43-13-117, Mississippi Code of 1972, is
288 amended as follows:
289 43-13-117. Medicaid as authorized by this article shall
290 include payment of part or all of the costs, at the discretion of
291 the division or its successor, with approval of the Governor, of
292 the following types of care and services rendered to eligible
293 applicants who have been determined to be eligible for that care
294 and services, within the limits of state appropriations and
295 federal matching funds:
296 (1) Inpatient hospital services.
297 (a) The division shall allow thirty (30) days of
298 inpatient hospital care annually for all Medicaid recipients.
299 Precertification of inpatient days must be obtained as required by
300 the division. The division may allow unlimited days in
301 disproportionate hospitals as defined by the division for eligible
302 infants under the age of six (6) years if certified as medically
303 necessary as required by the division.
304 (b) From and after July 1, 1994, the Executive
305 Director of the Division of Medicaid shall amend the Mississippi
306 Title XIX Inpatient Hospital Reimbursement Plan to remove the
307 occupancy rate penalty from the calculation of the Medicaid
308 Capital Cost Component utilized to determine total hospital costs
309 allocated to the Medicaid program.

310 (c) Hospitals will receive an additional payment
311 for the implantable programmable baclofen drug pump used to treat
312 spasticity which is implanted on an inpatient basis. The payment
313 pursuant to written invoice will be in addition to the facility's
314 per diem reimbursement and will represent a reduction of costs on
315 the facility's annual cost report, and shall not exceed Ten
316 Thousand Dollars ($10,000.00) per year per recipient. This
317 subparagraph (c) shall stand repealed on July 1, 2005.
318 (2) Outpatient hospital services. Where the same
319 services are reimbursed as clinic services, the division may
320 revise the rate or methodology of outpatient reimbursement to
321 maintain consistency, efficiency, economy and quality of care.
322 (3) Laboratory and x-ray services.
323 (4) Nursing facility services.
324 (a) The division shall make full payment to
325 nursing facilities for each day, not exceeding fifty-two (52) days
326 per year, that a patient is absent from the facility on home
327 leave. * * *
328 (b) From and after July 1, 1997, the division
329 shall implement the integrated case-mix payment and quality
330 monitoring system, which includes the fair rental system for
331 property costs and in which recapture of depreciation is
332 eliminated. The division may reduce the payment for hospital
333 leave and therapeutic home leave days to the lower of the case-mix
334 category as computed for the resident on leave using the
335 assessment being utilized for payment at that point in time, or a
336 case-mix score of 1.000 for nursing facilities, and shall compute
337 case-mix scores of residents so that only services provided at the
338 nursing facility are considered in calculating a facility's per
339 diem.
340 During the period between May 1, 2002, and December 1, 2002,
341 the Chairmen of the Public Health and Welfare Committees of the
342 Senate and the House of Representatives may appoint a joint study

343 committee to consider the issue of setting uniform reimbursement
344 rates for nursing facilities. The study committee will consist of
345 the Chairmen of the Public Health and Welfare Committees, three
346 (3) members of the Senate and three (3) members of the House. The
347 study committee shall complete its work in not more than three (3)
348 meetings.

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

352 (d) When a facility of a category that does not
353 require a certificate of need for construction and that could not
354 be eligible for Medicaid reimbursement is constructed to nursing
355 facility specifications for licensure and certification, and the
356 facility is subsequently converted to a nursing facility under a
357 certificate of need that authorizes conversion only and the
358 applicant for the certificate of need was assessed an application
359 review fee based on capital expenditures incurred in constructing
360 the facility, the division shall allow reimbursement for capital
361 expenditures necessary for construction of the facility that were
362 incurred within the twenty-four (24) consecutive calendar months
363 immediately preceding the date that the certificate of need
364 authorizing the conversion was issued, to the same extent that
365 reimbursement would be allowed for construction of a new nursing
366 facility under a certificate of need that authorizes that
367 construction. The reimbursement authorized in this subparagraph
368 (d) may be made only to facilities the construction of which was
369 completed after June 30, 1989. Before the division shall be
370 authorized to make the reimbursement authorized in this
371 subparagraph (d), the division first must have received approval
372 from the Health Care Financing Administration of the United States
373 Department of Health and Human Services of the change in the state
374 Medicaid plan providing for the reimbursement.

375 (e) The division shall develop and implement, not
376 later than January 1, 2001, a case-mix payment add-on determined
377 by time studies and other valid statistical data that will
378 reimburse a nursing facility for the additional cost of caring for
379 a resident who has a diagnosis of Alzheimer's or other related
380 dementia and exhibits symptoms that require special care. Any
381 such case-mix add-on payment shall be supported by a determination
382 of additional cost. The division shall also develop and implement
383 as part of the fair rental reimbursement system for nursing
384 facility beds, an Alzheimer's resident bed depreciation enhanced
385 reimbursement system that will provide an incentive to encourage
386 nursing facilities to convert or construct beds for residents with
387 Alzheimer's or other related dementia.
388 (f) The division shall develop and implement an
389 assessment process for long-term care services.
390 * * *
391 The division shall apply for necessary federal waivers to
392 assure that additional services providing alternatives to nursing
393 facility care are made available to applicants for nursing
394 facility care.
395 (5) Periodic screening and diagnostic services for
396 individuals under age twenty-one (21) years as are needed to
397 identify physical and mental defects and to provide health care
398 treatment and other measures designed to correct or ameliorate
399 defects and physical and mental illness and conditions discovered
400 by the screening services regardless of whether these services are
401 included in the state plan. The division may include in its
402 periodic screening and diagnostic program those discretionary
403 services authorized under the federal regulations adopted to
404 implement Title XIX of the federal Social Security Act, as
405 amended. The division, in obtaining physical therapy services,
406 occupational therapy services, and services for individuals with
407 speech, hearing and language disorders, may enter into a

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

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

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

437 (b) Repealed.

438 (8) Emergency medical transportation services. On
439 January 1, 1994, emergency medical transportation services shall
440 be reimbursed at seventy percent (70%) of the rate established

441 under Medicare (Title XVIII of the Social Security Act, as
442 amended). "Emergency medical transportation services" shall mean,
443 but shall not be limited to, the following services by a properly
444 permitted ambulance operated by a properly licensed provider in
445 accordance with the Emergency Medical Services Act of 1974
446 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
447 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
448 (vi) disposable supplies, (vii) similar services.

449 (9) (a) Legend and other drugs as may be determined by
450 the division. *** * *** The division may implement a program of prior
451 approval for drugs to the extent permitted by law. The division
452 shall allow seven (7) prescriptions per month for each
453 noninstitutionalized Medicaid recipient *** * ***. The division shall
454 not reimburse for any portion of a prescription that exceeds a
455 thirty-four-day supply of the drug based on the daily dosage.
456 *** * ***

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

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

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

470 (b) *** * *** Payment by the division for covered
471 multiple source drugs shall be limited to the lower of the upper
472 limits established and published by the Centers for Medicare and
473 Medicaid Services (CMS) plus a dispensing fee, or the estimated

474 acquisition cost (EAC) plus a dispensing fee, or the providers'
475 usual and customary charge to the general public. *** * ***
476 Payment for other covered drugs, other than multiple source
477 drugs with CMS upper limits, shall not exceed the lower of the
478 estimated acquisition cost plus a dispensing fee or the providers'
479 usual and customary charge to the general public.
480 Payment for nonlegend or over-the-counter drugs covered <u>by</u>
481 the <u>division</u> shall be reimbursed at the lower of the division's
482 estimated shelf price or the providers' usual and customary charge
483 to the general public. *** * ***
484 The dispensing fee for each new or refill prescription<u>,</u>
485 <u>including nonlegend or over-the-counter drugs covered by the</u>
486 <u>division,</u> shall be Three Dollars and Ninety-one Cents ($3.91).
487 The Medicaid provider shall not prescribe, the Medicaid
488 pharmacy shall not bill, and the division shall not reimburse for
489 name brand drugs if there are equally effective generic
490 equivalents available and if the generic equivalents are the least
491 expensive.
492 *** * ***
493 As used in this paragraph (9), "estimated acquisition cost"
494 means twelve percent (12%) less than the average wholesale price
495 for a drug.
496 *** * ***
497 (10) Dental care that is an adjunct to treatment of an
498 acute medical or surgical condition; services of oral surgeons and
499 dentists in connection with surgery related to the jaw or any
500 structure contiguous to the jaw or the reduction of any fracture
501 of the jaw or any facial bone; and emergency dental extractions
502 and treatment related thereto. On July 1, 1999, all fees for
503 dental care and surgery under authority of this paragraph (10)
504 shall be increased to one hundred sixty percent (160%) of the
505 amount of the reimbursement rate that was in effect on June 30,

506 1999. It is the intent of the Legislature to encourage more
507 dentists to participate in the Medicaid program.
508 (11) Eyeglasses for all Medicaid beneficiaries who have
509 (a) had surgery on the eyeball or ocular muscle that results in a
510 vision change for which eyeglasses or a change in eyeglasses is
511 medically indicated within six (6) months of the surgery and is in
512 accordance with policies established by the division, or (b) one
513 (1) pair every five (5) years and in accordance with policies
514 established by the division. In either instance, the eyeglasses
515 must be prescribed by a physician skilled in diseases of the eye
516 or an optometrist, whichever the beneficiary may select.
517 (12) Intermediate care facility services.
518 (a) The division shall make full payment to all
519 intermediate care facilities for the mentally retarded for each
520 day, not exceeding eighty-four (84) days per year, that a patient
521 is absent from the facility on home leave. *** * ***
522 (b) All state-owned intermediate care facilities
523 for the mentally retarded shall be reimbursed on a full reasonable
524 cost basis.
525 (13) Family planning services, including drugs,
526 supplies and devices, when those services are under the
527 supervision of a physician.
528 (14) Clinic services. Such diagnostic, preventive,
529 therapeutic, rehabilitative or palliative services furnished to an
530 outpatient by or under the supervision of a physician or dentist
531 in a facility that is not a part of a hospital but that is
532 organized and operated to provide medical care to outpatients.
533 Clinic services shall include any services reimbursed as
534 outpatient hospital services that may be rendered in such a
535 facility, including those that become so after July 1, 1991. On
536 July 1, 1999, all fees for physicians' services reimbursed under
537 authority of this paragraph (14) shall be reimbursed at ninety
538 percent (90%) of the rate established on January 1, 1999, and as

539 adjusted each January thereafter, under Medicare (Title XVIII of
540 the Social Security Act, as amended), and which shall in no event
541 be less than seventy percent (70%) of the rate established on
542 January 1, 1994. All fees for physicians' services that are
543 covered by both Medicare and Medicaid shall be reimbursed at ten
544 percent (10%) of the adjusted Medicare payment established on
545 January 1, 1999, and as adjusted each January thereafter, under
546 Medicare (Title XVIII of the Social Security Act, as amended), and
547 which shall in no event be less than seventy percent (70%) of the
548 adjusted Medicare payment established on January 1, 1994. On July
549 1, 1999, all fees for dentists' services reimbursed under
550 authority of this paragraph (14) shall be increased to one hundred
551 sixty percent (160%) of the amount of the reimbursement rate that
552 was in effect on June 30, 1999.
553 (15) Home- and community-based services for the elderly
554 and disabled, as provided under Title XIX of the federal Social
555 Security Act, as amended, under waivers, subject to the
556 availability of funds specifically appropriated therefor by the
557 Legislature. *** * ***
558 (16) Mental health services. Approved therapeutic and
559 case management services (a) provided by an approved regional
560 mental health/retardation center established under Sections
561 41-19-31 through 41-19-39, or by another community mental health
562 service provider meeting the requirements of the Department of
563 Mental Health to be an approved mental health/retardation center
564 if determined necessary by the Department of Mental Health, using
565 state funds that are provided from the appropriation to the State
566 Department of Mental Health and/or funds transferred to the
567 department by a political subdivision or instrumentality of the
568 state and used to match federal funds under a cooperative
569 agreement between the division and the department, or (b) provided
570 by a facility that is certified by the State Department of Mental
571 Health to provide therapeutic and case management services, to be

572 reimbursed on a fee for service basis, or (c) provided in the
573 community by a facility or program operated by the Department of
574 Mental Health. Any such services provided by a facility described
575 in subparagraph (b) must have the prior approval of the division
576 to be reimbursable under this section. After June 30, 1997,
577 mental health services provided by regional mental
578 health/retardation centers established under Sections 41-19-31
579 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
580 and/or their subsidiaries and divisions, or by psychiatric
581 residential treatment facilities as defined in Section 43-11-1, or
582 by another community mental health service provider meeting the
583 requirements of the Department of Mental Health to be an approved
584 mental health/retardation center if determined necessary by the
585 Department of Mental Health, shall not be included in or provided
586 under any capitated managed care pilot program provided for under
587 paragraph (24) of this section.

588 (17) Durable medical equipment services and medical
589 supplies. Precertification of durable medical equipment and
590 medical supplies must be obtained as required by the division.
591 The Division of Medicaid may require durable medical equipment
592 providers to obtain a surety bond in the amount and to the
593 specifications as established by the Balanced Budget Act of 1997.

594 (18) (a) Notwithstanding any other provision of this
595 section to the contrary, the division shall make additional
596 reimbursement to hospitals that serve a disproportionate share of
597 low-income patients and that meet the federal requirements for
598 those payments as provided in Section 1923 of the federal Social
599 Security Act and any applicable regulations. However, from and
600 after January 1, 1999, no public hospital shall participate in the
601 Medicaid disproportionate share program unless the public hospital
602 participates in an intergovernmental transfer program as provided
603 in Section 1903 of the federal Social Security Act and any
604 applicable regulations. Administration and support for

605 participating hospitals shall be provided by the Mississippi
606 Hospital Association.
607 (b) The division shall establish a Medicare Upper
608 Payment Limits Program, as defined in Section 1902(a)(30) of the
609 federal Social Security Act and any applicable federal
610 regulations, for hospitals, and may establish a Medicare Upper
611 Payments Limits Program for nursing facilities. The division
612 shall assess each hospital and, if the program is established for
613 nursing facilities, shall assess each nursing facility, for the
614 sole purpose of financing the state portion of the Medicare Upper
615 Payment Limits Program. This assessment shall be based on
616 Medicaid utilization, or other appropriate method consistent with
617 federal regulations, and will remain in effect as long as the
618 state participates in the Medicare Upper Payment Limits Program.
619 The division shall make additional reimbursement to hospitals and,
620 if the program is established for nursing facilities, shall make
621 additional reimbursement to nursing facilities, for the Medicare
622 Upper Payment Limits, as defined in Section 1902(a)(30) of the
623 federal Social Security Act and any applicable federal
624 regulations. This subparagraph (b) shall stand repealed from and
625 after July 1, 2005.
626 (c) The division shall contract with the
627 Mississippi Hospital Association to provide administrative support
628 for the operation of the disproportionate share hospital program
629 and the Medicare Upper Payment Limits Program. This subparagraph
630 (c) shall stand repealed from and after July 1, 2005.
631 (19) (a) Perinatal risk management services. The
632 division shall promulgate regulations to be effective from and
633 after October 1, 1988, to establish a comprehensive perinatal
634 system for risk assessment of all pregnant and infant Medicaid
635 recipients and for management, education and follow-up for those
636 who are determined to be at risk. Services to be performed
637 include case management, nutrition assessment/counseling,

638 psychosocial assessment/counseling and health education. The
639 division shall set reimbursement rates for providers in
640 conjunction with the State Department of Health.
641 (b) Early intervention system services. The
642 division shall cooperate with the State Department of Health,
643 acting as lead agency, in the development and implementation of a
644 statewide system of delivery of early intervention services, under
645 Part C of the Individuals with Disabilities Education Act (IDEA).
646 The State Department of Health shall certify annually in writing
647 to the executive director of the division the dollar amount of
648 state early intervention funds available that will be utilized as
649 a certified match for Medicaid matching funds. Those funds then
650 shall be used to provide expanded targeted case management
651 services for Medicaid eligible children with special needs who are
652 eligible for the state's early intervention system.
653 Qualifications for persons providing service coordination shall be
654 determined by the State Department of Health and the Division of
655 Medicaid.
656 (20) Home- and community-based services for physically
657 disabled approved services as allowed by a waiver from the United
658 States Department of Health and Human Services for home- and
659 community-based services for physically disabled people using
660 state funds that are provided from the appropriation to the State
661 Department of Rehabilitation Services and used to match federal
662 funds under a cooperative agreement between the division and the
663 department, provided that funds for these services are
664 specifically appropriated to the Department of Rehabilitation
665 Services.
666 (21) Nurse practitioner services. Services furnished
667 by a registered nurse who is licensed and certified by the
668 Mississippi Board of Nursing as a nurse practitioner, including,
669 but not limited to, nurse anesthetists, nurse midwives, family
670 nurse practitioners, family planning nurse practitioners,

671 pediatric nurse practitioners, obstetrics-gynecology nurse
672 practitioners and neonatal nurse practitioners, under regulations
673 adopted by the division. Reimbursement for those services shall
674 not exceed ninety percent (90%) of the reimbursement rate for
675 comparable services rendered by a physician.
676 (22) Ambulatory services delivered in federally
677 qualified health centers, rural health centers and clinics of the
678 local health departments of the State Department of Health for
679 individuals eligible for Medicaid under this article based on
680 reasonable costs as determined by the division.
681 (23) Inpatient psychiatric services. Inpatient
682 psychiatric services to be determined by the division for
683 recipients under age twenty-one (21) that are provided under the
684 direction of a physician in an inpatient program in a licensed
685 acute care psychiatric facility or in a licensed psychiatric
686 residential treatment facility, before the recipient reaches age
687 twenty-one (21) or, if the recipient was receiving the services
688 immediately before he reached age twenty-one (21), before the
689 earlier of the date he no longer requires the services or the date
690 he reaches age twenty-two (22), as provided by federal
691 regulations. Precertification of inpatient days and residential
692 treatment days must be obtained as required by the division.
693 (24) [Deleted]
694 (25) [Deleted]
695 (26) Hospice care. As used in this paragraph, the term
696 "hospice care" means a coordinated program of active professional
697 medical attention within the home and outpatient and inpatient
698 care that treats the terminally ill patient and family as a unit,
699 employing a medically directed interdisciplinary team. The
700 program provides relief of severe pain or other physical symptoms
701 and supportive care to meet the special needs arising out of
702 physical, psychological, spiritual, social and economic stresses
703 that are experienced during the final stages of illness and during

704 dying and bereavement and meets the Medicare requirements for
705 participation as a hospice as provided in federal regulations.
706 (27) Group health plan premiums and cost sharing if it
707 is cost effective as defined by the Secretary of Health and Human
708 Services.
709 (28) Other health insurance premiums that are cost
710 effective as defined by the Secretary of Health and Human
711 Services. Medicare eligible must have Medicare Part B before
712 other insurance premiums can be paid.
713 (29) The Division of Medicaid may apply for a waiver
714 from the Department of Health and Human Services for home- and
715 community-based services for developmentally disabled people using
716 state funds that are provided from the appropriation to the State
717 Department of Mental Health and/or funds transferred to the
718 department by a political subdivision or instrumentality of the
719 state and used to match federal funds under a cooperative
720 agreement between the division and the department, provided that
721 funds for these services are specifically appropriated to the
722 Department of Mental Health and/or transferred to the department
723 by a political subdivision or instrumentality of the state.
724 (30) Pediatric skilled nursing services for eligible
725 persons under twenty-one (21) years of age.
726 (31) Targeted case management services for children
727 with special needs, under waivers from the United States
728 Department of Health and Human Services, using state funds that
729 are provided from the appropriation to the Mississippi Department
730 of Human Services and used to match federal funds under a
731 cooperative agreement between the division and the department.
732 (32) Care and services provided in Christian Science
733 Sanatoria listed and certified by the Commission for Accreditation
734 of Christian Science Nursing Organizations/Facilities, Inc.,
735 rendered in connection with treatment by prayer or spiritual means

736 to the extent that those services are subject to reimbursement
737 under Section 1903 of the Social Security Act.
738 (33) Podiatrist services.
739 (34) Assisted living services as provided through home-
740 and community-based services under Title XIX of the Social
741 Security Act, as amended, subject to the availability of funds
742 specifically appropriated therefor by the Legislature.
743 (35) Services and activities authorized in Sections
744 43-27-101 and 43-27-103, using state funds that are provided from
745 the appropriation to the State Department of Human Services and
746 used to match federal funds under a cooperative agreement between
747 the division and the department.
748 (36) Nonemergency transportation services for
749 Medicaid-eligible persons, to be provided by the Division of
750 Medicaid. The division may contract with additional entities to
751 administer nonemergency transportation services as it deems
752 necessary. All providers shall have a valid driver's license,
753 vehicle inspection sticker, valid vehicle license tags and a
754 standard liability insurance policy covering the vehicle.
755 (37) [Deleted]
756 (38) Chiropractic services. A chiropractor's manual
757 manipulation of the spine to correct a subluxation, if x-ray
758 demonstrates that a subluxation exists and if the subluxation has
759 resulted in a neuromusculoskeletal condition for which
760 manipulation is appropriate treatment, and related spinal x-rays
761 performed to document these conditions. Reimbursement for
762 chiropractic services shall not exceed Seven Hundred Dollars
763 ($700.00) per year per beneficiary.
764 (39) Dually eligible Medicare/Medicaid beneficiaries.
765 The division shall pay the Medicare deductible and *** * ***
766 coinsurance amounts for services available under Medicare, as
767 determined by the division.
768 (40) [Deleted]

769 (41) Services provided by the State Department of
770 Rehabilitation Services for the care and rehabilitation of persons
771 with spinal cord injuries or traumatic brain injuries, as allowed
772 under waivers from the United States Department of Health and
773 Human Services, using up to seventy-five percent (75%) of the
774 funds that are appropriated to the Department of Rehabilitation
775 Services from the Spinal Cord and Head Injury Trust Fund
776 established under Section 37-33-261 and used to match federal
777 funds under a cooperative agreement between the division and the
778 department.
779 (42) Notwithstanding any other provision in this
780 article to the contrary, the division may develop a population
781 health management program for women and children health services
782 through the age of one (1) year. This program is primarily for
783 obstetrical care associated with low birth weight and pre-term
784 babies. The division may apply to the federal Centers for
785 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
786 any other waivers that may enhance the program. In order to
787 effect cost savings, the division may develop a revised payment
788 methodology that may include at-risk capitated payments, and may
789 require member participation in accordance with the terms and
790 conditions of an approved federal waiver.
791 (43) The division shall provide reimbursement,
792 according to a payment schedule developed by the division, for
793 smoking cessation medications for pregnant women during their
794 pregnancy and other Medicaid-eligible women who are of
795 child-bearing age.
796 (44) Nursing facility services for the severely
797 disabled.
798 (a) Severe disabilities include, but are not
799 limited to, spinal cord injuries, closed head injuries and
800 ventilator dependent patients.

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

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

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

823 *(47) Notwithstanding any other provision in this*
824 *article to the contrary, the division, in conjunction with the*
825 *State Department of Health, shall develop and implement disease*
826 *management programs* *** * * *** *for individuals with asthma, diabetes or*
827 *hypertension, including the use of grants, waivers, demonstrations*
828 *or other projects as necessary.* Disease management services for
829 individuals participating in a disease management program must be
830 provided to the individual in person, not by mail or on the
831 telephone. Not later than July 1, 2003, the division shall report
832 to the Chairmen of the Public Health and Welfare Committees of the
833 House of Representatives and the Senate on the demonstrated amount

834 of savings to the State of Mississippi as a result of disease
835 management programs implemented by the division since March 6,
836 2002.

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

838 (a) Pediatric long-term acute care hospital
839 services means services provided to eligible persons under
840 twenty-one (21) years of age by a freestanding Medicare-certified
841 hospital that has an average length of inpatient stay greater than
842 twenty-five (25) days and that is primarily engaged in providing
843 chronic or long-term medical care to persons under twenty-one (21)
844 years of age.

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

847 (49) The division shall establish copayments for all
848 Medicaid services for which copayments are allowable under federal
849 law or regulation, except for nonemergency transportation
850 services, and shall set the amount of the copayment for each of
851 those services at the maximum amount allowable under federal law
852 or regulation.

853 Notwithstanding any other provision of this article to the
854 contrary, the division shall reduce the rate of reimbursement to
855 providers for any service provided under this section by five
856 percent (5%) of the allowed amount for that service. However, the
857 reduction in the reimbursement rates required by this paragraph
858 shall not apply to inpatient hospital services, nursing facility
859 services, intermediate care facility services, psychiatric
860 residential treatment facility services, pharmacy services
861 provided under paragraph (9) of this section, or any service
862 provided by the University of Mississippi Medical Center or a
863 state agency, a state facility or a public agency that either
864 provides its own state match through intergovernmental transfer or
865 certification of funds to the division, or a service for which the
866 federal government sets the reimbursement methodology and rate.

867 In addition, the reduction in the reimbursement rates required by
868 this paragraph shall not apply to case management services * * *
869 provided under the home- and community-based services program for
870 the elderly and disabled by a planning and development district
871 (PDD). PDDs participating in the home- and community-based
872 services program for the elderly and disabled as case management
873 providers shall be reimbursed for case management services at the
874 maximum rate approved by the federal Centers for Medicare and
875 Medicaid Services (CMS). PDDs shall transfer to the division the
876 state match from nonfederal public funds in an amount equal to the
877 difference between the maximum case management reimbursement rate
878 approved by CMS and a five percent (5%) reduction in that rate.
879 The division shall invoice each PDD fifteen (15) days after the
880 end of each quarter for the intergovernmental transfer based on
881 the number of Medicaid home- and community-based clients that the
882 PDD served during the quarter. The division may remove the five
883 percent (5%) reduction in reimbursement for those providers who
884 participate in the division's emergency room redirection program
885 and achieve the performance measures and reduction of costs
886 required of that program.
887 Notwithstanding any provision of this article, except as
888 authorized in the following paragraph and in Section 43-13-139,
889 neither (a) the limitations on quantity or frequency of use of or
890 the fees or charges for any of the care or services available to
891 recipients under this section, nor (b) the payments or rates of
892 reimbursement to providers rendering care or services authorized
893 under this section to recipients, may be increased, decreased or
894 otherwise changed from the levels in effect on July 1, 1999,
895 unless they are authorized by an amendment to this section by the
896 Legislature. However, the restriction in this paragraph shall not
897 prevent the division from changing the payments or rates of
898 reimbursement to providers without an amendment to this section
899 whenever those changes are required by federal law or regulation,

900 or whenever those changes are necessary to correct administrative
901 errors or omissions in calculating those payments or rates of
902 reimbursement.

903 Notwithstanding any provision of this article, no new groups
904 or categories of recipients and new types of care and services may
905 be added without enabling legislation from the Mississippi
906 Legislature, except that the division may authorize those changes
907 without enabling legislation when the addition of recipients or
908 services is ordered by a court of proper authority. The executive
909 director shall keep the Governor advised on a timely basis of the
910 funds available for expenditure and the projected expenditures.
911 If current or projected expenditures of the division can be
912 reasonably anticipated to exceed the amounts appropriated for any
913 fiscal year, the Governor, after consultation with the executive
914 director, shall discontinue any or all of the payment of the types
915 of care and services as provided in this section that are deemed
916 to be optional services under Title XIX of the federal Social
917 Security Act, as amended, for any period necessary to not exceed
918 appropriated funds, and when necessary shall institute any other
919 cost containment measures on any program or programs authorized
920 under the article to the extent allowed under the federal law
921 governing that program or programs, it being the intent of the
922 Legislature that expenditures during any fiscal year shall not
923 exceed the amounts appropriated for that fiscal year.

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

933 date of submission to the Division of Medicaid of an amended cost
934 report.
935 This section shall stand repealed on July 1, 2004.
936 **SECTION 3.** Section 43-13-107, Mississippi Code of 1972, is
937 amended as follows:
938 43-13-107. (1) The Division of Medicaid is created in the
939 Office of the Governor and established to administer this article
940 and perform such other duties as are prescribed by law.
941 (2) (a) The Governor shall appoint a full-time executive
942 director, with the advice and consent of the Senate, who shall be
943 either (i) a physician with administrative experience in a medical
944 care or health program, or (ii) a person holding a graduate degree
945 in medical care administration, public health, hospital
946 administration, or the equivalent, or (iii) a person holding a
947 bachelor's degree in business administration or hospital
948 administration, with at least ten (10) years' experience in
949 management-level administration of Medicaid programs, and who
950 shall serve at the will and pleasure of the Governor. The
951 executive director shall be the official secretary and legal
952 custodian of the records of the division; shall be the agent of
953 the division for the purpose of receiving all service of process,
954 summons and notices directed to the division; and shall perform
955 such other duties as the Governor may prescribe from time to time.
956 (b) The executive director, with the approval of the
957 Governor and subject to the rules and regulations of the State
958 Personnel Board, shall employ such professional, administrative,
959 stenographic, secretarial, clerical and technical assistance as
960 may be necessary to perform the duties required in administering
961 this article and fix the compensation therefor, all in accordance
962 with a state merit system meeting federal requirements when the
963 salary of the executive director is not set by law, that salary
964 shall be set by the State Personnel Board. No employees of the
965 Division of Medicaid shall be considered to be staff members of

966 the immediate Office of the Governor; however, the provisions of
967 Section 25-9-107(c)(xv) shall apply to the executive director and
968 other administrative heads of the division.

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

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

975 (i) The Governor shall appoint five (5) members,
976 one (1) from each congressional district <u>and one (1) from the</u>
977 <u>state at large</u>;

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

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

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

987 (c) The respective chairmen of the House Public Health
988 and Welfare Committee, the House Appropriations Committee, the
989 Senate Public Health and Welfare Committee and the Senate
990 Appropriations Committee, or their designees, one (1) member of
991 the State Senate appointed by the Lieutenant Governor and one (1)
992 member of the House of Representatives appointed by the Speaker of
993 the House, shall serve as ex officio nonvoting members of the
994 advisory committee.

995 (d) In addition to the committee members required by
996 paragraph (b), the advisory committee shall consist of such other
997 members as are necessary to meet the requirements of the federal

998 regulation applicable to the advisory committee, who shall be
999 appointed as provided in the federal regulation.
1000 (e) The chairmanship of the advisory committee shall
1001 alternate for twelve-month periods between the chairmen of the
1002 House and Senate Public Health and Welfare Committees, with the
1003 Chairman of the House Public Health and Welfare Committee serving
1004 as the first chairman.
1005 (f) The members of the advisory committee specified in
1006 paragraph (b) shall serve for terms that are concurrent with the
1007 terms of members of the Legislature, and any member appointed
1008 under paragraph (b) may be reappointed to the advisory committee.
1009 The members of the advisory committee specified in paragraph (b)
1010 shall serve without compensation, but shall receive reimbursement
1011 to defray actual expenses incurred in the performance of committee
1012 business as authorized by law. Legislators shall receive per diem
1013 and expenses which may be paid from the contingent expense funds
1014 of their respective houses in the same amounts as provided for
1015 committee meetings when the Legislature is not in session.
1016 (g) The advisory committee shall meet not less than
1017 quarterly, and advisory committee members shall be furnished
1018 written notice of the meetings at least ten (10) days before the
1019 date of the meeting.
1020 (h) The executive director shall submit to the advisory
1021 committee all amendments, modifications and changes to the state
1022 plan for the operation of the Medicaid program, for review by the
1023 advisory committee before the amendments, modifications or changes
1024 may be implemented by the division.
1025 (i) The advisory committee, among its duties and
1026 responsibilities, shall:
1027 (i) Advise the division with respect to
1028 amendments, modifications and changes to the state plan for the
1029 operation of the Medicaid program;

1030 (ii) Advise the division with respect to issues
1031 concerning receipt and disbursement of funds and eligibility for
1032 Medicaid;
1033 (iii) Advise the division with respect to
1034 determining the quantity, quality and extent of medical care
1035 provided under this article;
1036 (iv) Communicate the views of the medical care
1037 professions to the division and communicate the views of the
1038 division to the medical care professions;
1039 (v) Gather information on reasons that medical
1040 care providers do not participate in the Medicaid program and
1041 changes that could be made in the program to encourage more
1042 providers to participate in the Medicaid program, and advise the
1043 division with respect to encouraging physicians and other medical
1044 care providers to participate in the Medicaid program;
1045 (vi) Provide a written report on or before
1046 November 30 of each year to the Governor, Lieutenant Governor and
1047 Speaker of the House of Representatives.
1048 (4) (a) There is established a Drug Use Review Board, which
1049 shall be the board that is required by federal law to:
1050 (i) Review and initiate retrospective drug use,
1051 review including ongoing periodic examination of claims data and
1052 other records in order to identify patterns of fraud, abuse, gross
1053 overuse, or inappropriate or medically unnecessary care, among
1054 physicians, pharmacists and individuals receiving Medicaid
1055 benefits or associated with specific drugs or groups of drugs.
1056 (ii) Review and initiate ongoing interventions for
1057 physicians and pharmacists, targeted toward therapy problems or
1058 individuals identified in the course of retrospective drug use
1059 reviews.
1060 (iii) On an ongoing basis, assess data on drug use
1061 against explicit predetermined standards using the compendia and
1062 literature set forth in federal law and regulations.

1063 (b) The board shall consist of not less than twelve
1064 (12) members appointed by the Governor, or his designee.
1065 (c) The board shall meet at least quarterly, and board
1066 members shall be furnished written notice of the meetings at least
1067 ten (10) days before the date of the meeting.
1068 (d) The board meetings shall be open to the public,
1069 members of the press, legislators and consumers. Additionally,
1070 all documents provided to board members shall be available to
1071 members of the Legislature in the same manner, and shall be made
1072 available to others for a reasonable fee for copying. However,
1073 patient confidentiality and provider confidentiality shall be
1074 protected by blinding patient names and provider names with
1075 numerical or other anonymous identifiers. The board meetings
1076 shall be subject to the Open Meetings Act (Section 25-41-1 et
1077 seq.). Board meetings conducted in violation of this section
1078 shall be deemed unlawful.
1079 (5) (a) There is established a Pharmacy and Therapeutics
1080 Committee, which shall be appointed by the Governor, or his
1081 designee.
1082 (b) The committee shall meet at least quarterly, and
1083 committee members shall be furnished written notice of the
1084 meetings at least ten (10) days before the date of the meeting.
1085 (c) The committee meetings shall be open to the public,
1086 members of the press, legislators and consumers. Additionally,
1087 all documents provided to committee members shall be available to
1088 members of the Legislature in the same manner, and shall be made
1089 available to others for a reasonable fee for copying. However,
1090 patient confidentiality and provider confidentiality shall be
1091 protected by blinding patient names and provider names with
1092 numerical or other anonymous identifiers. The committee meetings
1093 shall be subject to the Open Meetings Act (Section 25-41-1 et
1094 seq.). Committee meetings conducted in violation of this section
1095 shall be deemed unlawful.

1096 (d) After a thirty-day public notice, the executive
1097 director or his or her designee shall present the division's
1098 recommendation regarding prior approval for a therapeutic class of
1099 drugs to the committee. <u>However, in circumstances where the</u>
1100 <u>division deems it necessary for the health and safety of Medicaid</u>
1101 <u>beneficiaries, the division may present to the committee its</u>
1102 <u>recommendations regarding a particular drug without a thirty-day</u>
1103 <u>public notice. In making the presentation, the division shall</u>
1104 <u>state to the committee the circumstances that precipitate the need</u>
1105 <u>for the committee to review the status of a particular drug</u>
1106 <u>without a thirty-day public notice. The committee may determine</u>
1107 <u>whether or not to review the particular drug under the</u>
1108 <u>circumstances stated by the division without a thirty-day public</u>
1109 <u>notice. If the committee determines to review the status of the</u>
1110 <u>particular drug, it shall make its recommendations to the</u>
1111 <u>division, after which the division shall file the recommendations</u>
1112 <u>for a thirty-day public comment under the provisions of Section</u>
1113 <u>25-43-7(1).</u>
1114 (e) Upon reviewing the information and recommendations,
1115 the committee shall forward a written recommendation approved by a
1116 majority of the committee to the executive director or his or her
1117 designee. The decisions of the committee regarding any
1118 limitations to be imposed on any drug or its use for a specified
1119 indication shall be based on sound clinical evidence found in
1120 labeling, drug compendia, and peer reviewed clinical literature
1121 pertaining to use of the drug in the relevant population.
1122 (f) Upon reviewing and considering all recommendations
1123 including recommendation of the committee, comments, and data, the
1124 executive director shall make a final determination whether to
1125 require prior approval of a therapeutic class of drugs, or modify
1126 existing prior approval requirements for a therapeutic class of
1127 drugs.

1128 (g) At least thirty (30) days before the executive
1129 director implements new or amended prior authorization decisions,
1130 written notice of the executive director's decision shall be
1131 provided to all prescribing Medicaid providers, all Medicaid
1132 enrolled pharmacies, and any other party who has requested the
1133 notification. However, notice given under Section 25-43-7(1) will
1134 substitute for and meet the requirement for notice under this
1135 subsection.
1136 (6) This section shall stand repealed on July 1, 2004.
1137 **SECTION 4.** Section 43-13-122, Mississippi Code of 1972, is
1138 amended as follows:
1139 43-13-122. (1) The division may apply to the federal
1140 Centers for Medicare and Medicaid Services (CMS) of the United
1141 States Department of Health and Human Services for waivers and
1142 research and demonstration grants *** * ***.
1143 (2) The division may accept and expend any grants, donations
1144 or contributions from any public or private organization, together
1145 with any additional federal matching funds that may accrue and
1146 including, but not limited to, one hundred percent (100%) federal
1147 grant funds or funds from any governmental entity or
1148 instrumentality thereof in furthering the purposes and objectives
1149 of the Mississippi Medicaid program, provided that those receipts
1150 and expenditures are reported and otherwise handled in accordance
1151 with the General Fund Stabilization Act. The Department of
1152 Finance and Administration may transfer monies to the division
1153 from special funds in the State Treasury in amounts not exceeding
1154 the amounts authorized in the appropriation to the division.
1155 **SECTION 5.** Section 43-13-145, Mississippi Code of 1972, is
1156 amended as follows:
1157 43-13-145. (1) (a) Upon each nursing facility and each
1158 intermediate care facility for the mentally retarded licensed by
1159 the State of Mississippi, there is levied an assessment in the
1160 amount of Four Dollars ($4.00) per day for each licensed and/or

1161 certified bed of the facility. The division may apply for a
1162 waiver from the United States Secretary of Health and Human
1163 Services to exempt nonprofit, public, charitable or religious
1164 facilities from the assessment levied under this subsection, and
1165 if a waiver is granted, those facilities shall be exempt from any
1166 assessment levied under this subsection after the date that the
1167 division receives notice that the waiver has been granted.
1168 (b) A nursing facility or intermediate care facility
1169 for the mentally retarded is exempt from the assessment levied
1170 under this subsection if the facility is operated under the
1171 direction and control of:
1172 (i) The United States Veterans Administration or
1173 other agency or department of the United States government;
1174 (ii) The State Veterans Affairs Board;
1175 (iii) The University of Mississippi Medical
1176 Center; or
1177 (iv) A state agency or a state facility that
1178 either provides its own state match through intergovernmental
1179 transfer or certification of funds to the division.
1180 (2) (a) Upon each psychiatric residential treatment
1181 facility licensed by the State of Mississippi, there is levied an
1182 assessment in the amount of Three Dollars ($3.00) per day for each
1183 licensed and/or certified bed of the facility.
1184 (b) A psychiatric residential treatment facility is
1185 exempt from the assessment levied under this subsection if the
1186 facility is operated under the direction and control of:
1187 (i) The United States Veterans Administration or
1188 other agency or department of the United States government;
1189 (ii) The University of Mississippi Medical Center;
1190 (iii) A state agency or a state facility that
1191 either provides its own state match through intergovernmental
1192 transfer or certification of funds to the division.

1193 (3) (a) Upon each hospital licensed by the State of
1194 Mississippi, there is levied an assessment in the amount of One
1195 Dollar and Fifty Cents ($1.50) per day for each licensed inpatient
1196 acute care bed of the hospital.
1197 (b) A hospital is exempt from the assessment levied
1198 under this subsection if the hospital is operated under the
1199 direction and control of:
1200 (i) The United States Veterans Administration or
1201 other agency or department of the United States government;
1202 (ii) The University of Mississippi Medical Center;
1203 or
1204 (iii) A state agency or a state facility that
1205 either provides its own state match through intergovernmental
1206 transfer or certification of funds to the division.
1207 (4) Each health care facility that is subject to the
1208 provisions of this section shall keep and preserve such suitable
1209 books and records as may be necessary to determine the amount of
1210 assessment for which it is liable under this section. The books
1211 and records shall be kept and preserved for a period of not less
1212 than five (5) years, and those books and records shall be open for
1213 examination during business hours by the division, the State Tax
1214 Commission, the Office of the Attorney General and the State
1215 Department of Health.
1216 (5) The assessment levied under this section shall be
1217 collected by the division each month beginning on April 12, 2002.
1218 (6) All assessments collected under this section shall be
1219 deposited in the Medical Care Fund created by Section 43-13-143.
1220 (7) The assessment levied under this section shall be in
1221 addition to any other assessments, taxes or fees levied by law,
1222 and the assessment shall constitute a debt due the State of
1223 Mississippi from the time the assessment is due until it is paid.
1224 (8) (a) If a health care facility that is liable for
1225 payment of the assessment levied under this section does not pay

1226 the assessment when it is due, the division shall give written
1227 notice to the health care facility by certified or registered mail
1228 demanding payment of the assessment within ten (10) days from the
1229 date of delivery of the notice. If the health care facility
1230 fails or refuses to pay the assessment after receiving the notice
1231 and demand from the division, the division shall withhold from any
1232 Medicaid reimbursement payments that are due to the health care
1233 facility the amount of the unpaid assessment and a penalty of ten
1234 percent (10%) of the amount of the assessment, plus the legal rate
1235 of interest until the assessment is paid in full. If the health
1236 care facility does not participate in the Medicaid program, the
1237 division shall turn over to the Office of the Attorney General the
1238 collection of the unpaid assessment by civil action. In any such
1239 civil action, the Office of the Attorney General shall collect the
1240 amount of the unpaid assessment and a penalty of ten percent (10%)
1241 of the amount of the assessment, plus the legal rate of interest
1242 until the assessment is paid in full.

1243 (b) As an additional or alternative method for
1244 collecting unpaid assessments under this section, if a health care
1245 facility fails or refuses to pay the assessment after receiving
1246 notice and demand from the division, the division may file a
1247 notice of a tax lien with the circuit clerk of the county in which
1248 the health care facility is located, for the amount of the unpaid
1249 assessment and a penalty of ten percent (10%) of the amount of the
1250 assessment, plus the legal rate of interest until the assessment
1251 is paid in full. Immediately upon receipt of notice of the tax
1252 lien for the assessment, the circuit clerk shall enter the notice
1253 of the tax lien as a judgment upon the judgment roll and show in
1254 the appropriate columns the name of the health care facility as
1255 judgment debtor, the name of the division as judgment creditor,
1256 the amount of the unpaid assessment, and the date and time or
1257 enrollment. The judgment shall be valid as against mortgagees,
1258 pledgees, entrusters, purchasers, judgment creditors and other

1259 persons from the time of filing with the clerk. The amount of the
1260 judgment shall be a debt due the State of Mississippi and remain a
1261 lien upon the tangible property of the health care facility until
1262 the judgment is satisfied. The judgment shall be the equivalent
1263 of any enrolled judgment of a court of record and shall serve as
1264 authority for the issuance of writs of execution, writs of
1265 attachment or other remedial writs.

1266 **SECTION 6**. This act shall take effect and be in force from
1267 and after its passage.