MISSISSIPPI LEGISLATURE REGULAR SESSION 2003

By: Senator(s) Huggins

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2374

1 AN ACT RELATIVE TO THE MISSISSIPPI MEDICAID ASSISTANCE
2 PROGRAM; TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972, TO
3 CLARIFY ELIGIBILITY FOR MEDICAID ASSISTANCE, TO AUTHORIZE THE
4 DIVISION OF MEDICAID TO APPLY FOR APPLICABLE WAIVERS FOR BENEFITS
5 AND BUY-IN OPTIONS FOR THE DISABLED CHILDREN LIVING AT HOME AND
6 POVERTY LEVEL AGED AND DISABLED (PLADS) ELIGIBILITY CATEGORIES AND
7 TO ESTABLISH AN EXPENDITURE/ENROLLMENT CAP FOR THESE CATEGORIES;
8 TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO REDUCE
9 THE NURSING FACILITY BED DAYS ELIGIBLE FOR MEDICAID REIMBURSEMENT,
10 TO 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 CERTAIN
25 RESTRICTIONS IN THE DISEASE MANAGEMENT PROGRAM AUTHORITY, TO
26 REMOVE THE 5% REIMBURSEMENT REDUCTION FOR SERVICES UNDER THE HOME-
27 AND COMMUNITY-BASED WAIVER PROGRAM, AND TO AUTHORIZE THE DIVISION
28 TO REMOVE THE 5% REDUCTION IN REIMBURSEMENT FOR PROVIDERS WHO
29 PARTICIPATE IN THE EMERGENCY ROOM REDIRECTION PROGRAM; TO AMEND
30 SECTION 43-13-122, MISSISSIPPI CODE OF 1972, TO DELETE CERTAIN
31 OBSOLETE LANGUAGE; TO AMEND SECTION 43-13-107, MISSISSIPPI CODE OF
32 1972, TO AUTHORIZE THE DIVISION TO SUBMIT EMERGENCY DRUG ISSUES TO
33 THE PHARMACY AND THERAPEUTICS COMMITTEE WITHOUT PUBLIC COMMENT; TO
34 AMEND SECTION 43-13-145, MISSISSIPPI CODE OF 1972, TO INCREASE THE
35 PER BED ASSESSMENT LEVIED UPON NURSING FACILITIES FOR SUPPORT OF
36 THE MEDICAID PROGRAM; AND FOR RELATED PURPOSES.

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

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

40 43-13-115. Recipients of medical assistance shall be the
41 following persons only:

42 (1) Who are qualified for public assistance grants
43 under provisions of Title IV-A and E of the federal Social
44 Security Act, as amended, as determined by the State Department of

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

59 (2) Those qualified for Supplemental Security Income
60 (SSI) benefits under Title XVI of the federal Social Security Act,
61 as amended, and those who are deemed SSI eligible as contained in
62 federal statute. The eligibility of individuals covered in this
63 paragraph shall be determined by the Social Security
64 Administration and certified to the Division of Medicaid.

65 (3) Qualified pregnant women who would be eligible for
66 medical assistance as a low income family member under Section
67 1931 of the Social Security Act if her child was born.

68 (4) [Deleted]

69 (5) A child born on or after October 1, 1984, to a
70 woman eligible for and receiving medical assistance under the
71 state plan on the date of the child's birth shall be deemed to
72 have applied for medical assistance and to have been found
73 eligible for such assistance under such plan on the date of such
74 birth and will remain eligible for such assistance for a period of
75 one (1) year so long as the child is a member of the woman's
76 household and the woman remains eligible for such assistance or
77 would be eligible for assistance if pregnant. The eligibility of

78 individuals covered in this paragraph shall be determined by the
79 State Department of Human Services and certified to the Division
80 of Medicaid.

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

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

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

104 (8) Children under eighteen (18) years of age and
105 pregnant women (including those in intact families) who meet the
106 AFDC financial standards of the state plan approved under Title
107 IV-A of the federal Social Security Act, as amended. The
108 eligibility of children covered under this paragraph shall be
109 determined by the State Department of Human Services and certified
110 to the Division of Medicaid.

111 (9) Individuals who are:

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

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

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

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

127 (10) Certain disabled children age eighteen (18) or
128 under who are living at home, who would be eligible, if in a
129 medical institution, for SSI or a state supplemental payment under
130 Title XVI of the federal Social Security Act, as amended, and
131 therefore for Medicaid under the plan, and for whom the state has
132 made a determination as required under Section 1902(e)(3)(b) of
133 the federal Social Security Act, as amended. The eligibility of
134 individuals under this paragraph shall be determined by the
135 Division of Medicaid; provided, however, that the division may
136 apply to the Center for Medicare and Medicaid Services (CMS) for a
137 waiver that will allow flexibility in the benefit design for the
138 Disabled Children Living at Home eligibility category authorized
139 herein, and the division may establish an expenditure/enrollment
140 cap for this category. Nothing contained in this paragraph (10)
141 shall entitle an individual for benefits.

142 (11) Individuals who are sixty-five (65) years of age
143 or older or are disabled as determined under Section 1614(a)(3) of

144 the federal Social Security Act, as amended, and whose income does
145 not exceed one hundred thirty-five percent (135%) of the nonfarm
146 official poverty line as defined by the Office of Management and
147 Budget and revised annually, and whose resources do not exceed
148 those established by the Division of Medicaid.

149 The eligibility of individuals covered under this paragraph
150 shall be determined by the Division of Medicaid; provided,
151 however, that the division may apply to the Center for Medicare
152 and Medicaid Services (CMS) for a waiver that will allow
153 flexibility in the benefit design and buy-in options for the
154 Poverty Level Aged and Disabled (PLAD) eligibility category
155 authorized herein, and the division may establish an
156 expenditure/enrollment cap for this category. Nothing contained
157 in this paragraph (11) shall entitle an individual for benefits.

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

165 The eligibility of individuals covered under this paragraph
166 shall be determined by the Division of Medicaid, and such
167 individuals determined eligible shall receive Medicare
168 cost-sharing expenses only as more fully defined by the Medicare
169 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
170 1997.

171 (13) *** Individuals who are entitled to Medicare
172 Part A as defined in Section 4501 of the Omnibus Budget
173 Reconciliation Act of 1990, and whose income does not exceed one
174 hundred twenty percent (120%) of the nonfarm official poverty line
175 as defined by the Office of Management and Budget and revised

176 annually. Eligibility for Medicaid benefits is limited to full
177 payment of Medicare Part B premiums.
178 * * *
179 The eligibility of individuals covered under this paragraph
180 shall be determined by the Division of Medicaid.
181 (14) [Deleted]
182 (15) Disabled workers who are eligible to enroll in
183 Part A Medicare as required by Public Law 101-239, known as the
184 Omnibus Budget Reconciliation Act of 1989, and whose income does
185 not exceed two hundred percent (200%) of the federal poverty level
186 as determined in accordance with the Supplemental Security Income
187 (SSI) program. The eligibility of individuals covered under this
188 paragraph shall be determined by the Division of Medicaid and such
189 individuals shall be entitled to buy-in coverage of Medicare Part
190 A premiums only under the provisions of this paragraph (15).
191 (16) In accordance with the terms and conditions of
192 approved Title XIX waiver from the United States Department of
193 Health and Human Services, persons provided home- and
194 community-based services who are physically disabled and certified
195 by the Division of Medicaid as eligible due to applying the income
196 and deeming requirements as if they were institutionalized.
197 (17) In accordance with the terms of the federal
198 Personal Responsibility and Work Opportunity Reconciliation Act of
199 1996 (Public Law 104-193), persons who become ineligible for
200 assistance under Title IV-A of the federal Social Security Act, as
201 amended, because of increased income from or hours of employment
202 of the caretaker relative or because of the expiration of the
203 applicable earned income disregards, who were eligible for
204 Medicaid for at least three (3) of the six (6) months preceding
205 the month in which such ineligibility begins, shall be eligible
206 for Medicaid assistance for up to twelve (12) months * * *.
207 (18) Persons who become ineligible for assistance under
208 Title IV-A of the federal Social Security Act, as amended, as a

209 result, in whole or in part, of the collection or increased
210 collection of child or spousal support under Title IV-D of the
211 federal Social Security Act, as amended, who were eligible for
212 Medicaid for at least three (3) of the six (6) months immediately
213 preceding the month in which such ineligibility begins, shall be
214 eligible for Medicaid for an additional four (4) months beginning
215 with the month in which such ineligibility begins.

216 (19) Disabled workers, whose incomes are above the
217 Medicaid eligibility limits, but below two hundred fifty percent
218 (250%) of the federal poverty level, shall be allowed to purchase
219 Medicaid coverage on a sliding fee scale developed by the Division
220 of Medicaid.

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

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

238 The Division of Medicaid shall apply to the United States
239 Secretary of Health and Human Services for a federal waiver of the
240 applicable provisions of Title XIX of the federal Social Security
241 Act, as amended, and any other applicable provisions of federal

242 law as necessary to allow for the implementation of this paragraph
243 (21). The provisions of this paragraph (21) shall be implemented
244 from and after the date that the Division of Medicaid receives the
245 federal waiver.

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

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

263 *** * ***

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

270 (24) Individuals who have not attained age sixty-five
271 (65), are not otherwise covered by creditable coverage as defined
272 in the Public Health Services Act, and have been screened for
273 breast and cervical cancer under the Centers for Disease Control
274 and Prevention Breast and Cervical Cancer Early Detection Program

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

308 per diem reimbursement and will represent a reduction of costs on
309 the facility's annual cost report, and shall not exceed Ten
310 Thousand Dollars ($10,000.00) per year per recipient. This
311 subparagraph (c) shall stand repealed on July 1, 2005.
312 (2) Outpatient hospital services. Where the same
313 services are reimbursed as clinic services, the division may
314 revise the rate or methodology of outpatient reimbursement to
315 maintain consistency, efficiency, economy and quality of care.
316 (3) Laboratory and x-ray services.
317 (4) Nursing facility services.
318 (a) The division shall make full payment to
319 nursing facilities for each day, not exceeding thirty (30) days
320 per year, that a patient is absent from the facility on home
321 leave. Payment may be made for the following home leave days in
322 addition to the thirty-day limitation: Christmas, the day before
323 Christmas, the day after Christmas, Thanksgiving, the day before
324 Thanksgiving and the day after Thanksgiving.
325 (b) From and after July 1, 1997, the division
326 shall implement the integrated case-mix payment and quality
327 monitoring system, which includes the fair rental system for
328 property costs and in which recapture of depreciation is
329 eliminated. The division may reduce the payment for hospital
330 leave and therapeutic home leave days to the lower of the case-mix
331 category as computed for the resident on leave using the
332 assessment being utilized for payment at that point in time, or a
333 case-mix score of 1.000 for nursing facilities, and shall compute
334 case-mix scores of residents so that only services provided at the
335 nursing facility are considered in calculating a facility's per
336 diem.
337 During the period between May 1, 2002, and December 1, 2002,
338 the Chairmen of the Public Health and Welfare Committees of the
339 Senate and the House of Representatives may appoint a joint study
340 committee to consider the issue of setting uniform reimbursement

341 rates for nursing facilities. The study committee will consist of
342 the Chairmen of the Public Health and Welfare Committees, three
343 (3) members of the Senate and three (3) members of the House. The
344 study committee shall complete its work in not more than three (3)
345 meetings.

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

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

372 (e) The division shall develop and implement, not
373 later than January 1, 2001, a case-mix payment add-on determined

374 by time studies and other valid statistical data that will
375 reimburse a nursing facility for the additional cost of caring for
376 a resident who has a diagnosis of Alzheimer's or other related
377 dementia and exhibits symptoms that require special care. Any
378 such case-mix add-on payment shall be supported by a determination
379 of additional cost. The division shall also develop and implement
380 as part of the fair rental reimbursement system for nursing
381 facility beds, an Alzheimer's resident bed depreciation enhanced
382 reimbursement system that will provide an incentive to encourage
383 nursing facilities to convert or construct beds for residents with
384 Alzheimer's or other related dementia.

385 (f) <u>The division shall develop and implement an</u>
386 <u>assessment process for long-term care services.</u>

387 * * *

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

392 (5) Periodic screening and diagnostic services for
393 individuals under age twenty-one (21) years as are needed to
394 identify physical and mental defects and to provide health care
395 treatment and other measures designed to correct or ameliorate
396 defects and physical and mental illness and conditions discovered
397 by the screening services regardless of whether these services are
398 included in the state plan. The division may include in its
399 periodic screening and diagnostic program those discretionary
400 services authorized under the federal regulations adopted to
401 implement Title XIX of the federal Social Security Act, as
402 amended. The division, in obtaining physical therapy services,
403 occupational therapy services, and services for individuals with
404 speech, hearing and language disorders, may enter into a
405 cooperative agreement with the State Department of Education for
406 the provision of those services to handicapped students by public

407 school districts using state funds that are provided from the
408 appropriation to the Department of Education to obtain federal
409 matching funds through the division. The division, in obtaining
410 medical and psychological evaluations for children in the custody
411 of the State Department of Human Services may enter into a
412 cooperative agreement with the State Department of Human Services
413 for the provision of those services using state funds that are
414 provided from the appropriation to the Department of Human
415 Services to obtain federal matching funds through the division.
416 (6) Physician's services. The division shall allow
417 twelve (12) physician visits annually. All fees for physicians'
418 services that are covered only by Medicaid shall be reimbursed at
419 ninety percent (90%) of the rate established on January 1, 1999,
420 and as adjusted each January thereafter, under Medicare (Title
421 XVIII of the Social Security Act, as amended), and which shall in
422 no event be less than seventy percent (70%) of the rate
423 established on January 1, 1994. All fees for physicians' services
424 that are covered by both Medicare and Medicaid shall be reimbursed
425 at ten percent (10%) of the adjusted Medicare payment established
426 on January 1, 1999, and as adjusted each January thereafter, under
427 Medicare (Title XVIII of the Social Security Act, as amended), and
428 which shall in no event be less than seventy percent (70%) of the
429 adjusted Medicare payment established on January 1, 1994.
430 (7) (a) Home health services for eligible
431 persons, *** * *** not to exceed sixty (60) visits per year. All home
432 health visits must be precertified as required by the division.
433 (b) Repealed.
434 (8) Emergency medical transportation services. On
435 January 1, 1994, emergency medical transportation services shall
436 be reimbursed at seventy percent (70%) of the rate established
437 under Medicare (Title XVIII of the Social Security Act, as
438 amended). "Emergency medical transportation services" shall mean,
439 but shall not be limited to, the following services by a properly

440 permitted ambulance operated by a properly licensed provider in
441 accordance with the Emergency Medical Services Act of 1974
442 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
443 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
444 (vi) disposable supplies, (vii) similar services.

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

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

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

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

466 (b) *** * *** Payment by the division for covered
467 multiple source drugs shall be limited to the lower of the upper
468 limits established and published by the Centers for Medicare and
469 Medicaid Services (CMS) plus a dispensing fee, or the estimated
470 acquisition cost (EAC) plus a dispensing fee, or the providers'
471 usual and customary charge to the general public. *** * ***

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

476 Payment for nonlegend or over-the-counter drugs covered by
477 the division * * * shall be reimbursed at the lower of the
478 division's estimated shelf price or the providers' usual and
479 customary charge to the general public. * * *

480 The dispensing fee for each new or refill prescription,
481 including nonlegend or over-the-counter drugs covered by the
482 division, shall be Three Dollars and Ninety-one Cents ($3.91).

483 The Medicaid provider shall not prescribe, the Medicaid
484 pharmacy shall not bill, and the division shall not reimburse for
485 name brand drugs if there are equally effective generic
486 equivalents available and if the generic equivalents are the least
487 expensive.

488 * * *

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

492 * * *

493 (10) Dental care that is an adjunct to treatment of an
494 acute medical or surgical condition; services of oral surgeons and
495 dentists in connection with surgery related to the jaw or any
496 structure contiguous to the jaw or the reduction of any fracture
497 of the jaw or any facial bone; and emergency dental extractions
498 and treatment related thereto. On July 1, 1999, all fees for
499 dental care and surgery under authority of this paragraph (10)
500 shall be increased to one hundred sixty percent (160%) of the
501 amount of the reimbursement rate that was in effect on June 30,
502 1999. It is the intent of the Legislature to encourage more
503 dentists to participate in the Medicaid program.

504 (11) Eyeglasses for all Medicaid beneficiaries who have
505 (a) had surgery on the eyeball or ocular muscle that results in a
506 vision change for which eyeglasses or a change in eyeglasses is
507 medically indicated within six (6) months of the surgery and is in
508 accordance with policies established by the division, or (b) one
509 (1) pair every five (5) years and in accordance with policies
510 established by the division. In either instance, the eyeglasses
511 must be prescribed by a physician skilled in diseases of the eye
512 or an optometrist, whichever the beneficiary may select.
513 (12) Intermediate care facility services.
514 (a) The division shall make full payment to all
515 intermediate care facilities for the mentally retarded for each
516 day, not exceeding sixty (60) days per year, that a patient is
517 absent from the facility on home leave. Payment may be made for
518 the following home leave days in addition to the sixty-day
519 limitation: Christmas, the day before Christmas, the day after
520 Christmas, Thanksgiving, the day before Thanksgiving and the day
521 after Thanksgiving.
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 <u>sub</u>paragraph (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 paragraph (c)
630 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 *** * *** shall develop and
825 implement disease management programs *** * ***.
826 (48) Pediatric long-term acute care hospital services.
827 (a) Pediatric long-term acute care hospital
828 services means services provided to eligible persons under
829 twenty-one (21) years of age by a freestanding Medicare-certified
830 hospital that has an average length of inpatient stay greater than
831 twenty-five (25) days and that is primarily engaged in providing
832 chronic or long-term medical care to persons under twenty-one (21)
833 years of age.

834 (b) The services under this paragraph (48) shall
835 be reimbursed as a separate category of hospital services.
836 (49) The division shall establish copayments for all
837 Medicaid services for which copayments are allowable under federal
838 law or regulation, except for nonemergency transportation
839 services, and shall set the amount of the copayment for each of
840 those services at the maximum amount allowable under federal law
841 or regulation.
842 Notwithstanding any other provision of this article to the
843 contrary, the division shall reduce the rate of reimbursement to
844 providers for any service provided under this section by five
845 percent (5%) of the allowed amount for that service. However, the
846 reduction in the reimbursement rates required by this paragraph
847 shall not apply to inpatient hospital services, nursing facility
848 services, intermediate care facility services, psychiatric
849 residential treatment facility services, pharmacy services
850 provided under paragraph (9) of this section, or any service
851 provided by the University of Mississippi Medical Center or a
852 state agency, a state facility or a public agency that either
853 provides its own state match through intergovernmental transfer or
854 certification of funds to the division, or a service for which the
855 federal government sets the reimbursement methodology and rate.
856 In addition, the reduction in the reimbursement rates required by
857 this paragraph shall not apply to * * * home- and community-based
858 services programs * * *.
859 The division may remove the five percent (5%) reduction in
860 reimbursement for those providers who participate in the
861 division's emergency room redirection program and achieve the
862 performance measures and reduction of costs required of that
863 program.
864 Notwithstanding any provision of this article, except as
865 authorized in the following paragraph and in Section 43-13-139,
866 neither (a) the limitations on quantity or frequency of use of or

867 the fees or charges for any of the care or services available to
868 recipients under this section, nor (b) the payments or rates of
869 reimbursement to providers rendering care or services authorized
870 under this section to recipients, may be increased, decreased or
871 otherwise changed from the levels in effect on July 1, 1999,
872 unless they are authorized by an amendment to this section by the
873 Legislature. However, the restriction in this paragraph shall not
874 prevent the division from changing the payments or rates of
875 reimbursement to providers without an amendment to this section
876 whenever those changes are required by federal law or regulation,
877 or whenever those changes are necessary to correct administrative
878 errors or omissions in calculating those payments or rates of
879 reimbursement.

880 Notwithstanding any provision of this article, no new groups
881 or categories of recipients and new types of care and services may
882 be added without enabling legislation from the Mississippi
883 Legislature, except that the division may authorize those changes
884 without enabling legislation when the addition of recipients or
885 services is ordered by a court of proper authority. The executive
886 director shall keep the Governor advised on a timely basis of the
887 funds available for expenditure and the projected expenditures.
888 If current or projected expenditures of the division can be
889 reasonably anticipated to exceed the amounts appropriated for any
890 fiscal year, the Governor, after consultation with the executive
891 director, shall discontinue any or all of the payment of the types
892 of care and services as provided in this section that are deemed
893 to be optional services under Title XIX of the federal Social
894 Security Act, as amended, for any period necessary to not exceed
895 appropriated funds, and when necessary shall institute any other
896 cost containment measures on any program or programs authorized
897 under the article to the extent allowed under the federal law
898 governing that program or programs, it being the intent of the

899 Legislature that expenditures during any fiscal year shall not
900 exceed the amounts appropriated for that fiscal year.
901 Notwithstanding any other provision of this article, it shall
902 be the duty of each nursing facility, intermediate care facility
903 for the mentally retarded, psychiatric residential treatment
904 facility, and nursing facility for the severely disabled that is
905 participating in the Medicaid program to keep and maintain books,
906 documents and other records as prescribed by the Division of
907 Medicaid in substantiation of its cost reports for a period of
908 three (3) years after the date of submission to the Division of
909 Medicaid of an original cost report, or three (3) years after the
910 date of submission to the Division of Medicaid of an amended cost
911 report.
912 This section shall stand repealed on July 1, 2004.
913 **SECTION 3.** Section 43-13-107, Mississippi Code of 1972, is
914 amended as follows:
915 43-13-107. (1) The Division of Medicaid is created in the
916 Office of the Governor and established to administer this article
917 and perform such other duties as are prescribed by law.
918 (2) (a) The Governor shall appoint a full-time executive
919 director, with the advice and consent of the Senate, who shall be
920 either (i) a physician with administrative experience in a medical
921 care or health program, or (ii) a person holding a graduate degree
922 in medical care administration, public health, hospital
923 administration, or the equivalent, or (iii) a person holding a
924 bachelor's degree in business administration or hospital
925 administration, with at least ten (10) years' experience in
926 management-level administration of Medicaid programs, and who
927 shall serve at the will and pleasure of the Governor. The
928 executive director shall be the official secretary and legal
929 custodian of the records of the division; shall be the agent of
930 the division for the purpose of receiving all service of process,

931 summons and notices directed to the division; and shall perform
932 such other duties as the Governor may prescribe from time to time.
933 (b) The executive director, with the approval of the
934 Governor and subject to the rules and regulations of the State
935 Personnel Board, shall employ such professional, administrative,
936 stenographic, secretarial, clerical and technical assistance as
937 may be necessary to perform the duties required in administering
938 this article and fix the compensation therefor, all in accordance
939 with a state merit system meeting federal requirements when the
940 salary of the executive director is not set by law, that salary
941 shall be set by the State Personnel Board. No employees of the
942 Division of Medicaid shall be considered to be staff members of
943 the immediate Office of the Governor; however, the provisions of
944 Section 25-9-107(c)(xv) shall apply to the executive director and
945 other administrative heads of the division.
946 (3) (a) There is established a Medical Care Advisory
947 Committee, which shall be the committee that is required by
948 federal regulation to advise the Division of Medicaid about health
949 and medical care services.
950 (b) The advisory committee shall consist of not less
951 than eleven (11) members, as follows:
952 (i) The Governor shall appoint five (5) members,
953 one (1) from each congressional district as presently constituted;
954 (ii) The Lieutenant Governor shall appoint three
955 (3) members, one (1) from each Supreme Court district;
956 (iii) The Speaker of the House of Representatives
957 shall appoint three (3) members, one (1) from each Supreme Court
958 district.
959 All members appointed under this paragraph shall either be
960 health care providers or consumers of health care services. One
961 (1) member appointed by each of the appointing authorities shall
962 be a board certified physician.

963 (c) The respective chairmen of the House Public Health
964 and Welfare Committee, the House Appropriations Committee, the
965 Senate Public Health and Welfare Committee and the Senate
966 Appropriations Committee, or their designees, one (1) member of
967 the State Senate appointed by the Lieutenant Governor and one (1)
968 member of the House of Representatives appointed by the Speaker of
969 the House, shall serve as ex officio nonvoting members of the
970 advisory committee.
971 (d) In addition to the committee members required by
972 paragraph (b), the advisory committee shall consist of such other
973 members as are necessary to meet the requirements of the federal
974 regulation applicable to the advisory committee, who shall be
975 appointed as provided in the federal regulation.
976 (e) The chairmanship of the advisory committee shall
977 alternate for twelve-month periods between the chairmen of the
978 House and Senate Public Health and Welfare Committees, with the
979 Chairman of the House Public Health and Welfare Committee serving
980 as the first chairman.
981 (f) The members of the advisory committee specified in
982 paragraph (b) shall serve for terms that are concurrent with the
983 terms of members of the Legislature, and any member appointed
984 under paragraph (b) may be reappointed to the advisory committee.
985 The members of the advisory committee specified in paragraph (b)
986 shall serve without compensation, but shall receive reimbursement
987 to defray actual expenses incurred in the performance of committee
988 business as authorized by law. Legislators shall receive per diem
989 and expenses which may be paid from the contingent expense funds
990 of their respective houses in the same amounts as provided for
991 committee meetings when the Legislature is not in session.
992 (g) The advisory committee shall meet not less than
993 quarterly, and advisory committee members shall be furnished
994 written notice of the meetings at least ten (10) days before the
995 date of the meeting.

996 (h) The executive director shall submit to the advisory
997 committee all amendments, modifications and changes to the state
998 plan for the operation of the Medicaid program, for review by the
999 advisory committee before the amendments, modifications or changes
1000 may be implemented by the division.
1001 (i) The advisory committee, among its duties and
1002 responsibilities, shall:
1003 (i) Advise the division with respect to
1004 amendments, modifications and changes to the state plan for the
1005 operation of the Medicaid program;
1006 (ii) Advise the division with respect to issues
1007 concerning receipt and disbursement of funds and eligibility for
1008 Medicaid;
1009 (iii) Advise the division with respect to
1010 determining the quantity, quality and extent of medical care
1011 provided under this article;
1012 (iv) Communicate the views of the medical care
1013 professions to the division and communicate the views of the
1014 division to the medical care professions;
1015 (v) Gather information on reasons that medical
1016 care providers do not participate in the Medicaid program and
1017 changes that could be made in the program to encourage more
1018 providers to participate in the Medicaid program, and advise the
1019 division with respect to encouraging physicians and other medical
1020 care providers to participate in the Medicaid program;
1021 (vi) Provide a written report on or before
1022 November 30 of each year to the Governor, Lieutenant Governor and
1023 Speaker of the House of Representatives.
1024 (4) (a) There is established a Drug Use Review Board, which
1025 shall be the board that is required by federal law to:
1026 (i) Review and initiate retrospective drug use,
1027 review including ongoing periodic examination of claims data and
1028 other records in order to identify patterns of fraud, abuse, gross

1029 overuse, or inappropriate or medically unnecessary care, among
1030 physicians, pharmacists and individuals receiving Medicaid
1031 benefits or associated with specific drugs or groups of drugs.
1032 (ii) Review and initiate ongoing interventions for
1033 physicians and pharmacists, targeted toward therapy problems or
1034 individuals identified in the course of retrospective drug use
1035 reviews.
1036 (iii) On an ongoing basis, assess data on drug use
1037 against explicit predetermined standards using the compendia and
1038 literature set forth in federal law and regulations.
1039 (b) The board shall consist of not less than twelve
1040 (12) members appointed by the Governor, or his designee.
1041 (c) The board shall meet at least quarterly, and board
1042 members shall be furnished written notice of the meetings at least
1043 ten (10) days before the date of the meeting.
1044 (d) The board meetings shall be open to the public,
1045 members of the press, legislators and consumers. Additionally,
1046 all documents provided to board members shall be available to
1047 members of the Legislature in the same manner, and shall be made
1048 available to others for a reasonable fee for copying. However,
1049 patient confidentiality and provider confidentiality shall be
1050 protected by blinding patient names and provider names with
1051 numerical or other anonymous identifiers. The board meetings
1052 shall be subject to the Open Meetings Act (Section 25-41-1 et
1053 seq.). Board meetings conducted in violation of this section
1054 shall be deemed unlawful.
1055 (5) (a) There is established a Pharmacy and Therapeutics
1056 Committee, which shall be appointed by the Governor, or his
1057 designee.
1058 (b) The committee shall meet at least quarterly, and
1059 committee members shall be furnished written notice of the
1060 meetings at least ten (10) days before the date of the meeting.

1061 (c) The committee meetings shall be open to the public,
1062 members of the press, legislators and consumers. Additionally,
1063 all documents provided to committee members shall be available to
1064 members of the Legislature in the same manner, and shall be made
1065 available to others for a reasonable fee for copying. However,
1066 patient confidentiality and provider confidentiality shall be
1067 protected by blinding patient names and provider names with
1068 numerical or other anonymous identifiers. The committee meetings
1069 shall be subject to the Open Meetings Act (Section 25-41-1 et
1070 seq.). Committee meetings conducted in violation of this section
1071 shall be deemed unlawful.
1072 (d) After a thirty-day public notice, the executive
1073 director or his or her designee shall present the division's
1074 recommendation regarding prior approval for a therapeutic class of
1075 drugs to the committee. <u>However, in circumstances where the</u>
1076 <u>division deems it necessary for the health and safety of Medicaid</u>
1077 <u>beneficiaries, the division may present to the committee its</u>
1078 <u>recommendations regarding a particular drug without a thirty-day</u>
1079 <u>public notice. In making such presentation, the division shall</u>
1080 <u>state to the committee the circumstances which precipitate the</u>
1081 <u>need for the committee to review the status of a particular drug</u>
1082 <u>without a thirty-day public notice. The committee may determine</u>
1083 <u>whether or not to review the particular drug under the</u>
1084 <u>circumstances stated by the division without a thirty-day public</u>
1085 <u>notice. If the committee determines to review the status of the</u>
1086 <u>particular drug, it shall make its recommendations to the</u>
1087 <u>division, after which the division shall file such recommendations</u>
1088 <u>for a thirty-day public comment under the provisions of Section</u>
1089 <u>25-43-7(1), Mississippi Code of 1972.</u>
1090 (e) Upon reviewing the information and recommendations,
1091 the committee shall forward a written recommendation approved by a
1092 majority of the committee to the executive director or his or her
1093 designee. The decisions of the committee regarding any

1094 limitations to be imposed on any drug or its use for a specified
1095 indication shall be based on sound clinical evidence found in
1096 labeling, drug compendia, and peer reviewed clinical literature
1097 pertaining to use of the drug in the relevant population.

1098 (f) Upon reviewing and considering all recommendations
1099 including recommendation of the committee, comments, and data, the
1100 executive director shall make a final determination whether to
1101 require prior approval of a therapeutic class of drugs, or modify
1102 existing prior approval requirements for a therapeutic class of
1103 drugs.

1104 (g) At least thirty (30) days before the executive
1105 director implements new or amended prior authorization decisions,
1106 written notice of the executive director's decision shall be
1107 provided to all prescribing Medicaid providers, all Medicaid
1108 enrolled pharmacies, and any other party who has requested the
1109 notification. However, notice given under Section 25-43-7(1) will
1110 substitute for and meet the requirement for notice under this
1111 subsection.

1112 (6) This section shall stand repealed on July 1, 2004.

1113 **SECTION 4.** Section 43-13-122, Mississippi Code of 1972, is
1114 amended as follows:

1115 43-13-122. (1) The division is authorize to apply to the
1116 <u>Center for Medicare and Medicaid Services</u> of the United States
1117 Department of Health and Human Services for waivers and research
1118 and demonstration grants *** * ***.

1119 (2) The division is further authorized to accept and expend
1120 any grants, donations or contributions from any public or private
1121 organization together with any additional federal matching funds
1122 that may accrue and including, but not limited to, one hundred
1123 percent (100%) federal grant funds or funds from any governmental
1124 entity or instrumentality thereof in furthering the purposes and
1125 objectives of the Mississippi Medicaid program, provided that such
1126 receipts and expenditures are reported and otherwise handled in

1127 accordance with the General Fund Stabilization Act. The
1128 Department of Finance and Administration is authorized to transfer
1129 monies to the division from special funds in the State Treasury in
1130 amounts not exceeding the amounts authorized in the appropriation
1131 to the division.

1132 **SECTION 5.** Section 43-13-145, Mississippi Code of 1972, is
1133 amended as follows:

1134 43-13-145. (1) (a) Upon each nursing facility and each
1135 intermediate care facility for the mentally retarded licensed by
1136 the State of Mississippi, there is levied an assessment in the
1137 amount of Four Dollars ($4.00) per day for each licensed and/or
1138 certified bed of the facility. The division may apply for a
1139 waiver from the United States Secretary of Health and Human
1140 Services to exempt nonprofit, public, charitable or religious
1141 facilities from the assessment levied under this subsection, and
1142 if a waiver is granted, those facilities shall be exempt from any
1143 assessment levied under this subsection after the date that the
1144 division receives notice that the waiver has been granted.

1145 (b) A nursing facility or intermediate care facility
1146 for the mentally retarded is exempt from the assessment levied
1147 under this subsection if the facility is operated under the
1148 direction and control of:

1149 (i) The United States Veterans Administration or
1150 other agency or department of the United States government;

1151 (ii) The State Veterans Affairs Board;

1152 (iii) The University of Mississippi Medical
1153 Center; or

1154 (iv) A state agency or a state facility that
1155 either provides its own state match through intergovernmental
1156 transfer or certification of funds to the division.

1157 (2) (a) Upon each psychiatric residential treatment
1158 facility licensed by the State of Mississippi, there is levied an

1159 assessment in the amount of Three Dollars ($3.00) per day for each
1160 licensed and/or certified bed of the facility.
1161 (b) A psychiatric residential treatment facility is
1162 exempt from the assessment levied under this subsection if the
1163 facility is operated under the direction and control of:
1164 (i) The United States Veterans Administration or
1165 other agency or department of the United States government;
1166 (ii) The University of Mississippi Medical Center;
1167 (iii) A state agency or a state facility that
1168 either provides its own state match through intergovernmental
1169 transfer or certification of funds to the division.
1170 (3) (a) Upon each hospital licensed by the State of
1171 Mississippi, there is levied an assessment in the amount of One
1172 Dollar and Fifty Cents ($1.50) per day for each licensed inpatient
1173 acute care bed of the hospital.
1174 (b) A hospital is exempt from the assessment levied
1175 under this subsection if the hospital is operated under the
1176 direction and control of:
1177 (i) The United States Veterans Administration or
1178 other agency or department of the United States government;
1179 (ii) The University of Mississippi Medical Center;
1180 or
1181 (iii) A state agency or a state facility that
1182 either provides its own state match through intergovernmental
1183 transfer or certification of funds to the division.
1184 (4) Each health care facility that is subject to the
1185 provisions of this section shall keep and preserve such suitable
1186 books and records as may be necessary to determine the amount of
1187 assessment for which it is liable under this section. The books
1188 and records shall be kept and preserved for a period of not less
1189 than five (5) years, and those books and records shall be open for
1190 examination during business hours by the division, the State Tax

1191 Commission, the Office of the Attorney General and the State
1192 Department of Health.
1193 (5) The assessment levied under this section shall be
1194 collected by the division each month beginning on April 12, 2002.
1195 (6) All assessments collected under this section shall be
1196 deposited in the Medical Care Fund created by Section 43-13-143.
1197 (7) The assessment levied under this section shall be in
1198 addition to any other assessments, taxes or fees levied by law,
1199 and the assessment shall constitute a debt due the State of
1200 Mississippi from the time the assessment is due until it is paid.
1201 (8) (a) If a health care facility that is liable for
1202 payment of the assessment levied under this section does not pay
1203 the assessment when it is due, the division shall give written
1204 notice to the health care facility by certified or registered mail
1205 demanding payment of the assessment within ten (10) days from the
1206 date of delivery of the notice. If the health care facility
1207 fails or refuses to pay the assessment after receiving the notice
1208 and demand from the division, the division shall withhold from any
1209 Medicaid reimbursement payments that are due to the health care
1210 facility the amount of the unpaid assessment and a penalty of ten
1211 percent (10%) of the amount of the assessment, plus the legal rate
1212 of interest until the assessment is paid in full. If the health
1213 care facility does not participate in the Medicaid program, the
1214 division shall turn over to the Office of the Attorney General the
1215 collection of the unpaid assessment by civil action. In any such
1216 civil action, the Office of the Attorney General shall collect the
1217 amount of the unpaid assessment and a penalty of ten percent (10%)
1218 of the amount of the assessment, plus the legal rate of interest
1219 until the assessment is paid in full.
1220 (b) As an additional or alternative method for
1221 collecting unpaid assessments under this section, if a health care
1222 facility fails or refuses to pay the assessment after receiving
1223 notice and demand from the division, the division may file a

1224 notice of a tax lien with the circuit clerk of the county in which
1225 the health care facility is located, for the amount of the unpaid
1226 assessment and a penalty of ten percent (10%) of the amount of the
1227 assessment, plus the legal rate of interest until the assessment
1228 is paid in full. Immediately upon receipt of notice of the tax
1229 lien for the assessment, the circuit clerk shall enter the notice
1230 of the tax lien as a judgment upon the judgment roll and show in
1231 the appropriate columns the name of the health care facility as
1232 judgment debtor, the name of the division as judgment creditor,
1233 the amount of the unpaid assessment, and the date and time or
1234 enrollment. The judgment shall be valid as against mortgagees,
1235 pledgees, entrusters, purchasers, judgment creditors and other
1236 persons from the time of filing with the clerk. The amount of the
1237 judgment shall be a debt due the State of Mississippi and remain a
1238 lien upon the tangible property of the health care facility until
1239 the judgment is satisfied. The judgment shall be the equivalent
1240 of any enrolled judgment of a court of record and shall serve as
1241 authority for the issuance of writs of execution, writs of
1242 attachment or other remedial writs.

1243 **SECTION 6**. This act shall take effect and be in force from
1244 and after its passage.