MISSISSIPPI LEGISLATURE REGULAR SESSION 2004

By: Representatives Morris, Holland

To: Medicaid; Appropriations

HOUSE BILL NO. 1434

1 AN ACT TO BRING FORWARD SECTIONS 43-13-107, 43-13-113,
2 43-13-115, 43-13-117, 43-13-121, 43-13-141, 43-13-145 AND
3 43-13-317, MISSISSIPPI CODE OF 1972, OF THE MISSISSIPPI MEDICAID
4 LAW, FOR THE PURPOSES OF AMENDMENT; AND FOR RELATED PURPOSES.

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

6 **SECTION 1.** Section 43-13-107, Mississippi Code of 1972, is
7 brought forward as follows:

8 43-13-107. (1) The Division of Medicaid is created in the
9 Office of the Governor and established to administer this article
10 and perform such other duties as are prescribed by law.

11 (2) (a) The Governor shall appoint a full-time executive
12 director, with the advice and consent of the Senate, who shall be
13 either (i) a physician with administrative experience in a medical
14 care or health program, or (ii) a person holding a graduate degree
15 in medical care administration, public health, hospital
16 administration, or the equivalent, or (iii) a person holding a
17 bachelor's degree in business administration or hospital
18 administration, with at least ten (10) years' experience in
19 management-level administration of Medicaid programs, and who
20 shall serve at the will and pleasure of the Governor. The
21 executive director shall be the official secretary and legal
22 custodian of the records of the division; shall be the agent of
23 the division for the purpose of receiving all service of process,
24 summons and notices directed to the division; and shall perform
25 such other duties as the Governor may prescribe from time to time.

26 (b) The executive director, with the approval of the
27 Governor and subject to the rules and regulations of the State
28 Personnel Board, shall employ such professional, administrative,

29 stenographic, secretarial, clerical and technical assistance as
30 may be necessary to perform the duties required in administering
31 this article and fix the compensation therefor, all in accordance
32 with a state merit system meeting federal requirements when the
33 salary of the executive director is not set by law, that salary
34 shall be set by the State Personnel Board. No employees of the
35 Division of Medicaid shall be considered to be staff members of
36 the immediate Office of the Governor; however, the provisions of
37 Section 25-9-107(c)(xv) shall apply to the executive director and
38 other administrative heads of the division.

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

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

45 (i) The Governor shall appoint five (5) members,
46 one (1) from each congressional district and one (1) from the
47 state at large;

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

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

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

57 (c) The respective Chairmen of the House Public Health
58 and Welfare Committee, the House Appropriations Committee, the
59 Senate Public Health and Welfare Committee and the Senate
60 Appropriations Committee, or their designees, one (1) member of
61 the State Senate appointed by the Lieutenant Governor and one (1)

62 member of the House of Representatives appointed by the Speaker of
63 the House, shall serve as ex officio nonvoting members of the
64 advisory committee.

65 (d) In addition to the committee members required by
66 paragraph (b), the advisory committee shall consist of such other
67 members as are necessary to meet the requirements of the federal
68 regulation applicable to the advisory committee, who shall be
69 appointed as provided in the federal regulation.

70 (e) The chairmanship of the advisory committee shall
71 alternate for twelve-month periods between the Chairmen of the
72 House and Senate Public Health and Welfare Committees, with the
73 Chairman of the House Public Health and Welfare Committee serving
74 as the first chairman.

75 (f) The members of the advisory committee specified in
76 paragraph (b) shall serve for terms that are concurrent with the
77 terms of members of the Legislature, and any member appointed
78 under paragraph (b) may be reappointed to the advisory committee.
79 The members of the advisory committee specified in paragraph (b)
80 shall serve without compensation, but shall receive reimbursement
81 to defray actual expenses incurred in the performance of committee
82 business as authorized by law. Legislators shall receive per diem
83 and expenses which may be paid from the contingent expense funds
84 of their respective houses in the same amounts as provided for
85 committee meetings when the Legislature is not in session.

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

90 (h) The executive director shall submit to the advisory
91 committee all amendments, modifications and changes to the state
92 plan for the operation of the Medicaid program, for review by the
93 advisory committee before the amendments, modifications or changes
94 may be implemented by the division.

95 (i) The advisory committee, among its duties and
96 responsibilities, shall:
97 (i) Advise the division with respect to
98 amendments, modifications and changes to the state plan for the
99 operation of the Medicaid program;
100 (ii) Advise the division with respect to issues
101 concerning receipt and disbursement of funds and eligibility for
102 Medicaid;
103 (iii) Advise the division with respect to
104 determining the quantity, quality and extent of medical care
105 provided under this article;
106 (iv) Communicate the views of the medical care
107 professions to the division and communicate the views of the
108 division to the medical care professions;
109 (v) Gather information on reasons that medical
110 care providers do not participate in the Medicaid program and
111 changes that could be made in the program to encourage more
112 providers to participate in the Medicaid program, and advise the
113 division with respect to encouraging physicians and other medical
114 care providers to participate in the Medicaid program;
115 (vi) Provide a written report on or before
116 November 30 of each year to the Governor, Lieutenant Governor and
117 Speaker of the House of Representatives.
118 (4) (a) There is established a Drug Use Review Board, which
119 shall be the board that is required by federal law to:
120 (i) Review and initiate retrospective drug use,
121 review including ongoing periodic examination of claims data and
122 other records in order to identify patterns of fraud, abuse, gross
123 overuse, or inappropriate or medically unnecessary care, among
124 physicians, pharmacists and individuals receiving Medicaid
125 benefits or associated with specific drugs or groups of drugs.
126 (ii) Review and initiate ongoing interventions for
127 physicians and pharmacists, targeted toward therapy problems or

128 individuals identified in the course of retrospective drug use
129 reviews.
130 (iii) On an ongoing basis, assess data on drug use
131 against explicit predetermined standards using the compendia and
132 literature set forth in federal law and regulations.
133 (b) The board shall consist of not less than twelve
134 (12) members appointed by the Governor, or his designee.
135 (c) The board shall meet at least quarterly, and board
136 members shall be furnished written notice of the meetings at least
137 ten (10) days before the date of the meeting.
138 (d) The board meetings shall be open to the public,
139 members of the press, legislators and consumers. Additionally,
140 all documents provided to board members shall be available to
141 members of the Legislature in the same manner, and shall be made
142 available to others for a reasonable fee for copying. However,
143 patient confidentiality and provider confidentiality shall be
144 protected by blinding patient names and provider names with
145 numerical or other anonymous identifiers. The board meetings
146 shall be subject to the Open Meetings Act (Section 25-41-1 et
147 seq.). Board meetings conducted in violation of this section
148 shall be deemed unlawful.
149 (5) (a) There is established a Pharmacy and Therapeutics
150 Committee, which shall be appointed by the Governor, or his
151 designee.
152 (b) The committee shall meet at least quarterly, and
153 committee members shall be furnished written notice of the
154 meetings at least ten (10) days before the date of the meeting.
155 (c) The committee meetings shall be open to the public,
156 members of the press, legislators and consumers. Additionally,
157 all documents provided to committee members shall be available to
158 members of the Legislature in the same manner, and shall be made
159 available to others for a reasonable fee for copying. However,
160 patient confidentiality and provider confidentiality shall be

161 protected by blinding patient names and provider names with
162 numerical or other anonymous identifiers. The committee meetings
163 shall be subject to the Open Meetings Act (Section 25-41-1 et
164 seq.). Committee meetings conducted in violation of this section
165 shall be deemed unlawful.

166 (d) After a thirty-day public notice, the executive
167 director, or his or her designee, shall present the division's
168 recommendation regarding prior approval for a therapeutic class of
169 drugs to the committee. However, in circumstances where the
170 division deems it necessary for the health and safety of Medicaid
171 beneficiaries, the division may present to the committee its
172 recommendations regarding a particular drug without a thirty-day
173 public notice. In making such presentation, the division shall
174 state to the committee the circumstances which precipitate the
175 need for the committee to review the status of a particular drug
176 without a thirty-day public notice. The committee may determine
177 whether or not to review the particular drug under the
178 circumstances stated by the division without a thirty-day public
179 notice. If the committee determines to review the status of the
180 particular drug, it shall make its recommendations to the
181 division, after which the division shall file such recommendations
182 for a thirty-day public comment under the provisions of Section
183 25-43-7(1), Mississippi Code of 1972.

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

192 (f) Upon reviewing and considering all recommendations
193 including recommendation of the committee, comments, and data, the

194 executive director shall make a final determination whether to
195 require prior approval of a therapeutic class of drugs, or modify
196 existing prior approval requirements for a therapeutic class of
197 drugs.

198 (g) At least thirty (30) days before the executive
199 director implements new or amended prior authorization decisions,
200 written notice of the executive director's decision shall be
201 provided to all prescribing Medicaid providers, all Medicaid
202 enrolled pharmacies, and any other party who has requested the
203 notification. However, notice given under Section 25-43-7(1) will
204 substitute for and meet the requirement for notice under this
205 subsection.

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

207 **SECTION 2.** Section 43-13-113, Mississippi Code of 1972, is
208 brought forward as follows:

209 43-13-113. (1) The State Treasurer shall receive on behalf
210 of the state, and execute all instruments incidental thereto,
211 federal and other funds to be used for financing the medical
212 assistance plan or program adopted pursuant to this article, and
213 place all such funds in a special account to the credit of the
214 Governor's Office-Division of Medicaid, which funds shall be
215 expended by the division for the purposes and under the provisions
216 of this article, and shall be paid out by the State Treasurer as
217 funds appropriated to carry out the provisions of this article are
218 paid out by him.

219 The division shall issue all checks or electronic transfers
220 for administrative expenses, and for medical assistance under the
221 provisions of this article. All such checks or electronic
222 transfers shall be drawn upon funds made available to the division
223 by the State Auditor, upon requisition of the director. It is the
224 purpose of this section to provide that the State Auditor shall
225 transfer, in lump sums, amounts to the division for disbursement
226 under the regulations which shall be made by the director with the

227 approval of the Governor; however, the division, or its fiscal
228 agent in behalf of the division, shall be authorized in
229 maintaining separate accounts with a Mississippi bank to handle
230 claim payments, refund recoveries and related Medicaid program
231 financial transactions, to aggressively manage the float in these
232 accounts while awaiting clearance of checks or electronic
233 transfers and/or other disposition so as to accrue maximum
234 interest advantage of the funds in the account, and to retain all
235 earned interest on these funds to be applied to match federal
236 funds for Medicaid program operations.

237 (2) The division is authorized to obtain a line of credit
238 through the State Treasurer from the Working Cash-Stabilization
239 Fund or any other special source funds maintained in the State
240 Treasury in an amount not exceeding Ten Million Dollars
241 ($10,000,000.00) to fund shortfalls which, from time to time, may
242 occur due to decreases in state matching fund cash flow. The
243 length of indebtedness under this provision shall not carry past
244 the end of the quarter following the loan origination. Loan
245 proceeds shall be received by the State Treasurer and shall be
246 placed in a Medicaid designated special fund account. Loan
247 proceeds shall be expended only for health care services provided
248 under the Medicaid program. The division may pledge as security
249 for such interim financing future funds that will be received by
250 the division. Any such loans shall be repaid from the first
251 available funds received by the division in the manner of and
252 subject to the same terms provided in this section.

253 (3) Disbursement of funds to providers shall be made as
254 follows:

255 (a) All providers must submit all claims to the
256 Division of Medicaid's fiscal agent no later than twelve (12)
257 months from the date of service.

258 (b) The Division of Medicaid's fiscal agent must pay
259 ninety percent (90%) of all clean claims within thirty (30) days
260 of the date of receipt.
261 (c) The Division of Medicaid's fiscal agent must pay
262 ninety-nine percent (99%) of all clean claims within ninety (90)
263 days of the date of receipt.
264 (d) The Division of Medicaid's fiscal agent must pay
265 all other claims within twelve (12) months of the date of receipt.
266 (e) If a claim is neither paid nor denied for valid and
267 proper reasons by the end of the time periods as specified above,
268 the Division of Medicaid's fiscal agent must pay the provider
269 interest on the claim at the rate of one and one-half percent
270 (1-1/2%) per month on the amount of such claim until it is finally
271 settled or adjudicated.
272 (4) The date of receipt is the date the fiscal agent
273 receives the claim as indicated by its date stamp on the claim or,
274 for those claims filed electronically, the date of receipt is the
275 date of transmission.
276 (5) The date of payment is the date of the check or, for
277 those claims paid by electronic funds transfer, the date of the
278 transfer.
279 (6) The above specified time limitations do not apply in the
280 following circumstances:
281 (a) Retroactive adjustments paid to providers
282 reimbursed under a retrospective payment system;
283 (b) If a claim for payment under Medicare has been
284 filed in a timely manner, the fiscal agent may pay a Medicaid
285 claim relating to the same services within six (6) months after
286 it, or the provider, receives notice of the disposition of the
287 Medicare claim;
288 (c) Claims from providers under investigation for fraud
289 or abuse; and

290 (d) The Division of Medicaid and/or its fiscal agent
291 may make payments at any time in accordance with a court order, to
292 carry out hearing decisions or corrective actions taken to resolve
293 a dispute, or to extend the benefits of a hearing decision,
294 corrective action, or court order to others in the same situation
295 as those directly affected by it.

296 (7) Repealed.

297 (8) If sufficient funds are appropriated therefor by the
298 Legislature, the Division of Medicaid may contract with the
299 Mississippi Dental Association, or an approved designee, to
300 develop and operate a Donated Dental Services (DDS) program
301 through which volunteer dentists will treat needy disabled, aged
302 and medically-compromised individuals who are non-Medicaid
303 eligible recipients.

304 **SECTION 3.** Section 43-13-115, Mississippi Code of 1972, is
305 brought forward as follows:

306 43-13-115. Recipients of medical assistance shall be the
307 following persons only:

308 (1) Who are qualified for public assistance grants
309 under provisions of Title IV-A and E of the federal Social
310 Security Act, as amended, as determined by the State Department of
311 Human Services, including those statutorily deemed to be IV-A and
312 low-income families and children under Section 1931 of the Social
313 Security Act as determined by the State Department of Human
314 Services and certified to the Division of Medicaid, but not
315 optional groups except as specifically covered in this section.
316 For the purposes of this paragraph (1) and paragraphs (8), (17)
317 and (18) of this section, any reference to Title IV-A or to Part A
318 of Title IV of the federal Social Security Act, as amended, or the
319 state plan under Title IV-A or Part A of Title IV, shall be
320 considered as a reference to Title IV-A of the federal Social
321 Security Act, as amended, and the state plan under Title IV-A,
322 including the income and resource standards and methodologies

323 under Title IV-A and the state plan, as they existed on July 16,
324 1996.
325 (2) Those qualified for Supplemental Security Income
326 (SSI) benefits under Title XVI of the federal Social Security Act,
327 as amended, and those who are deemed SSI eligible as contained in
328 federal statute. The eligibility of individuals covered in this
329 paragraph shall be determined by the Social Security
330 Administration and certified to the Division of Medicaid.
331 (3) Qualified pregnant women who would be eligible for
332 medical assistance as a low income family member under Section
333 1931 of the Social Security Act if her child was born.
334 (4) [Deleted]
335 (5) A child born on or after October 1, 1984, to a
336 woman eligible for and receiving medical assistance under the
337 state plan on the date of the child's birth shall be deemed to
338 have applied for medical assistance and to have been found
339 eligible for such assistance under such plan on the date of such
340 birth and will remain eligible for such assistance for a period of
341 one (1) year so long as the child is a member of the woman's
342 household and the woman remains eligible for such assistance or
343 would be eligible for assistance if pregnant. The eligibility of
344 individuals covered in this paragraph shall be determined by the
345 State Department of Human Services and certified to the Division
346 of Medicaid.
347 (6) Children certified by the State Department of Human
348 Services to the Division of Medicaid of whom the state and county
349 departments of human services have custody and financial
350 responsibility, and children who are in adoptions subsidized in
351 full or part by the Department of Human Services, including
352 special needs children in non-Title IV-E adoption assistance, who
353 are approvable under Title XIX of the Medicaid program.
354 (7) (a) Persons certified by the Division of Medicaid
355 who are patients in a medical facility (nursing home, hospital,

356 tuberculosis sanatorium or institution for treatment of mental
357 diseases), and who, except for the fact that they are patients in
358 such medical facility, would qualify for grants under Title IV,
359 supplementary security income benefits under Title XVI or state
360 supplements, and those aged, blind and disabled persons who would
361 not be eligible for supplemental security income benefits under
362 Title XVI or state supplements if they were not institutionalized
363 in a medical facility but whose income is below the maximum
364 standard set by the Division of Medicaid, which standard shall not
365 exceed that prescribed by federal regulation;
366 (b) Individuals who have elected to receive
367 hospice care benefits and who are eligible using the same criteria
368 and special income limits as those in institutions as described in
369 subparagraph (a) of this paragraph (7).
370 (8) Children under eighteen (18) years of age and
371 pregnant women (including those in intact families) who meet the
372 financial standards of the state plan approved under Title IV-A of
373 the federal Social Security Act, as amended. The eligibility of
374 children covered under this paragraph shall be determined by the
375 State Department of Human Services and certified to the Division
376 of Medicaid.
377 (9) Individuals who are:
378 (a) Children born after September 30, 1983, who
379 have not attained the age of nineteen (19), with family income
380 that does not exceed one hundred percent (100%) of the nonfarm
381 official poverty line;
382 (b) Pregnant women, infants and children who have
383 not attained the age of six (6), with family income that does not
384 exceed one hundred thirty-three percent (133%) of the federal
385 poverty level; and
386 (c) Pregnant women and infants who have not
387 attained the age of one (1), with family income that does not

388 exceed one hundred eighty-five percent (185%) of the federal
389 poverty level.

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

393 (10) Certain disabled children age eighteen (18) or
394 under who are living at home, who would be eligible, if in a
395 medical institution, for SSI or a state supplemental payment under
396 Title XVI of the federal Social Security Act, as amended, and
397 therefore for Medicaid under the plan, and for whom the state has
398 made a determination as required under Section 1902(e)(3)(b) of
399 the federal Social Security Act, as amended. The eligibility of
400 individuals under this paragraph shall be determined by the
401 Division of Medicaid; provided, however, that the division may
402 apply to the Center for Medicare and Medicaid Services (CMS) for a
403 waiver that will allow flexibility in the benefit design for the
404 Disabled Children Living at Home eligibility category authorized
405 herein, and the division may establish an expenditure/enrollment
406 cap for this category. Nothing contained in this paragraph (10)
407 shall entitle an individual for benefits.

408 (11) Individuals who are sixty-five (65) years of age
409 or older or are disabled as determined under Section 1614(a)(3) of
410 the federal Social Security Act, as amended, and whose income does
411 not exceed one hundred thirty-five percent (135%) of the nonfarm
412 official poverty line as defined by the Office of Management and
413 Budget and revised annually, and whose resources do not exceed
414 those established by the Division of Medicaid.

415 The eligibility of individuals covered under this paragraph
416 shall be determined by the Division of Medicaid; provided,
417 however, that the division may apply to the Center for Medicare
418 and Medicaid Services (CMS) for a waiver that will allow
419 flexibility in the benefit design and buy-in options for the
420 Poverty Level Aged and Disabled (PLAD) eligibility category

421 authorized herein, and the division may establish an
422 expenditure/enrollment cap for this category. Nothing contained
423 in this paragraph (11) shall entitle an individual for benefits.
424 (12) Individuals who are qualified Medicare
425 beneficiaries (QMB) entitled to Part A Medicare as defined under
426 Section 301, Public Law 100-360, known as the Medicare
427 Catastrophic Coverage Act of 1988, and whose income does not
428 exceed one hundred percent (100%) of the nonfarm official poverty
429 line as defined by the Office of Management and Budget and revised
430 annually.
431 The eligibility of individuals covered under this paragraph
432 shall be determined by the Division of Medicaid, and such
433 individuals determined eligible shall receive Medicare
434 cost-sharing expenses only as more fully defined by the Medicare
435 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
436 1997.
437 (13) (a) Individuals who are entitled to Medicare Part
438 A as defined in Section 4501 of the Omnibus Budget Reconciliation
439 Act of 1990, and whose income does not exceed one hundred twenty
440 percent (120%) of the nonfarm official poverty line as defined by
441 the Office of Management and Budget and revised annually.
442 Eligibility for Medicaid benefits is limited to full payment of
443 Medicare Part B premiums.
444 (b) Individuals entitled to Part A of Medicare, with
445 income above one hundred twenty percent (120%), but less than one
446 hundred thirty-five percent (135%) of the federal poverty level,
447 and not otherwise eligible for Medicaid Eligibility for Medicaid
448 benefits is limited to full payment of Medicare Part B premiums.
449 The number of eligible individuals is limited by the availability
450 of the federal capped allocation at one hundred percent (100%) of
451 federal matching funds, as more fully defined in the Balanced
452 Budget Act of 1997.

453 The eligibility of individuals covered under this paragraph
454 shall be determined by the Division of Medicaid.
455 (14) [Deleted]
456 (15) Disabled workers who are eligible to enroll in
457 Part A Medicare as required by Public Law 101-239, known as the
458 Omnibus Budget Reconciliation Act of 1989, and whose income does
459 not exceed two hundred percent (200%) of the federal poverty level
460 as determined in accordance with the Supplemental Security Income
461 (SSI) program. The eligibility of individuals covered under this
462 paragraph shall be determined by the Division of Medicaid and such
463 individuals shall be entitled to buy-in coverage of Medicare Part
464 A premiums only under the provisions of this paragraph (15).
465 (16) In accordance with the terms and conditions of
466 approved Title XIX waiver from the United States Department of
467 Health and Human Services, persons provided home- and
468 community-based services who are physically disabled and certified
469 by the Division of Medicaid as eligible due to applying the income
470 and deeming requirements as if they were institutionalized.
471 (17) In accordance with the terms of the federal
472 Personal Responsibility and Work Opportunity Reconciliation Act of
473 1996 (Public Law 104-193), persons who become ineligible for
474 assistance under Title IV-A of the federal Social Security Act, as
475 amended, because of increased income from or hours of employment
476 of the caretaker relative or because of the expiration of the
477 applicable earned income disregards, who were eligible for
478 Medicaid for at least three (3) of the six (6) months preceding
479 the month in which such ineligibility begins, shall be eligible
480 for Medicaid assistance for up to twelve (12) months.
481 (18) Persons who become ineligible for assistance under
482 Title IV-A of the federal Social Security Act, as amended, as a
483 result, in whole or in part, of the collection or increased
484 collection of child or spousal support under Title IV-D of the
485 federal Social Security Act, as amended, who were eligible for

486 Medicaid for at least three (3) of the six (6) months immediately
487 preceding the month in which such ineligibility begins, shall be
488 eligible for Medicaid for an additional four (4) months beginning
489 with the month in which such ineligibility begins.

490 (19) Disabled workers, whose incomes are above the
491 Medicaid eligibility limits, but below two hundred fifty percent
492 (250%) of the federal poverty level, shall be allowed to purchase
493 Medicaid coverage on a sliding fee scale developed by the Division
494 of Medicaid.

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

500 (21) Women of childbearing age whose family income does
501 not exceed one hundred eighty-five percent (185%) of the federal
502 poverty level. The eligibility of individuals covered under this
503 paragraph (21) shall be determined by the Division of Medicaid,
504 and those individuals determined eligible shall only receive
505 family planning services covered under Section 43-13-117(13) and
506 not any other services covered under Medicaid. However, any
507 individual eligible under this paragraph (21) who is also eligible
508 under any other provision of this section shall receive the
509 benefits to which he or she is entitled under that other
510 provision, in addition to family planning services covered under
511 Section 43-13-117(13).

512 The Division of Medicaid shall apply to the United States
513 Secretary of Health and Human Services for a federal waiver of the
514 applicable provisions of Title XIX of the federal Social Security
515 Act, as amended, and any other applicable provisions of federal
516 law as necessary to allow for the implementation of this paragraph
517 (21). The provisions of this paragraph (21) shall be implemented

518 from and after the date that the Division of Medicaid receives the
519 federal waiver.

520 (22) Persons who are workers with a potentially severe
521 disability, as determined by the division, shall be allowed to
522 purchase Medicaid coverage. The term "worker with a potentially
523 severe disability" means a person who is at least sixteen (16)
524 years of age but under sixty-five (65) years of age, who has a
525 physical or mental impairment that is reasonably expected to cause
526 the person to become blind or disabled as defined under Section
527 1614(a) of the federal Social Security Act, as amended, if the
528 person does not receive items and services provided under
529 Medicaid.

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

537 (23) Children certified by the Mississippi Department
538 of Human Services for whom the state and county departments of
539 human services have custody and financial responsibility who are
540 in foster care on their eighteenth birthday as reported by the
541 Mississippi Department of Human Services shall be certified
542 Medicaid eligible by the Division of Medicaid until their
543 twenty-first birthday.

544 (24) Individuals who have not attained age sixty-five
545 (65), are not otherwise covered by creditable coverage as defined
546 in the Public Health Services Act, and have been screened for
547 breast and cervical cancer under the Centers for Disease Control
548 and Prevention Breast and Cervical Cancer Early Detection Program
549 established under Title XV of the Public Health Service Act in
550 accordance with the requirements of that act and who need

551 treatment for breast or cervical cancer. Eligibility of
552 individuals under this paragraph (24) shall be determined by the
553 Division of Medicaid.

554 **SECTION 4.** Section 43-13-117, Mississippi Code of 1972, is
555 brought forward as follows:

556 43-13-117. Medicaid as authorized by this article shall
557 include payment of part or all of the costs, at the discretion of
558 the division or its successor, with approval of the Governor, of
559 the following types of care and services rendered to eligible
560 applicants who have been determined to be eligible for that care
561 and services, within the limits of state appropriations and
562 federal matching funds:

563 (1) Inpatient hospital services.

564 (a) The division shall allow thirty (30) days of
565 inpatient hospital care annually for all Medicaid recipients.
566 Precertification of inpatient days must be obtained as required by
567 the division. The division may allow unlimited days in
568 disproportionate hospitals as defined by the division for eligible
569 infants under the age of six (6) years if certified as medically
570 necessary as required by the division.

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

577 (c) Hospitals will receive an additional payment
578 for the implantable programmable baclofen drug pump used to treat
579 spasticity which is implanted on an inpatient basis. The payment
580 pursuant to written invoice will be in addition to the facility's
581 per diem reimbursement and will represent a reduction of costs on
582 the facility's annual cost report, and shall not exceed Ten

583 Thousand Dollars ($10,000.00) per year per recipient. This
584 subparagraph (c) shall stand repealed on July 1, 2005.
585 (2) Outpatient hospital services. Where the same
586 services are reimbursed as clinic services, the division may
587 revise the rate or methodology of outpatient reimbursement to
588 maintain consistency, efficiency, economy and quality of care.
589 (3) Laboratory and x-ray services.
590 (4) Nursing facility services.
591 (a) The division shall make full payment to
592 nursing facilities for each day, not exceeding fifty-two (52) days
593 per year, that a patient is absent from the facility on home
594 leave. Payment may be made for the following home leave days in
595 addition to the fifty-two-day limitation: Christmas, the day
596 before Christmas, the day after Christmas, Thanksgiving, the day
597 before Thanksgiving and the day after Thanksgiving.
598 (b) From and after July 1, 1997, the division
599 shall implement the integrated case-mix payment and quality
600 monitoring system, which includes the fair rental system for
601 property costs and in which recapture of depreciation is
602 eliminated. The division may reduce the payment for hospital
603 leave and therapeutic home leave days to the lower of the case-mix
604 category as computed for the resident on leave using the
605 assessment being utilized for payment at that point in time, or a
606 case-mix score of 1.000 for nursing facilities, and shall compute
607 case-mix scores of residents so that only services provided at the
608 nursing facility are considered in calculating a facility's per
609 diem.
610 During the period between May 1, 2002, and December 1, 2002,
611 the Chairmen of the Public Health and Welfare Committees of the
612 Senate and the House of Representatives may appoint a joint study
613 committee to consider the issue of setting uniform reimbursement
614 rates for nursing facilities. The study committee will consist of
615 the Chairmen of the Public Health and Welfare Committees, three

616 (3) members of the Senate and three (3) members of the House. The
617 study committee shall complete its work in not more than three (3)
618 meetings.
619 (c) From and after July 1, 1997, all state-owned
620 nursing facilities shall be reimbursed on a full reasonable cost
621 basis.
622 (d) When a facility of a category that does not
623 require a certificate of need for construction and that could not
624 be eligible for Medicaid reimbursement is constructed to nursing
625 facility specifications for licensure and certification, and the
626 facility is subsequently converted to a nursing facility under a
627 certificate of need that authorizes conversion only and the
628 applicant for the certificate of need was assessed an application
629 review fee based on capital expenditures incurred in constructing
630 the facility, the division shall allow reimbursement for capital
631 expenditures necessary for construction of the facility that were
632 incurred within the twenty-four (24) consecutive calendar months
633 immediately preceding the date that the certificate of need
634 authorizing the conversion was issued, to the same extent that
635 reimbursement would be allowed for construction of a new nursing
636 facility under a certificate of need that authorizes that
637 construction. The reimbursement authorized in this subparagraph
638 (d) may be made only to facilities the construction of which was
639 completed after June 30, 1989. Before the division shall be
640 authorized to make the reimbursement authorized in this
641 subparagraph (d), the division first must have received approval
642 from the Health Care Financing Administration of the United States
643 Department of Health and Human Services of the change in the state
644 Medicaid plan providing for the reimbursement.
645 (e) The division shall develop and implement, not
646 later than January 1, 2001, a case-mix payment add-on determined
647 by time studies and other valid statistical data that will
648 reimburse a nursing facility for the additional cost of caring for

649 a resident who has a diagnosis of Alzheimer's or other related
650 dementia and exhibits symptoms that require special care. Any
651 such case-mix add-on payment shall be supported by a determination
652 of additional cost. The division shall also develop and implement
653 as part of the fair rental reimbursement system for nursing
654 facility beds, an Alzheimer's resident bed depreciation enhanced
655 reimbursement system that will provide an incentive to encourage
656 nursing facilities to convert or construct beds for residents with
657 Alzheimer's or other related dementia.

658 (f) The division shall develop and implement an
659 assessment process for long-term care services.

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

664 (5) Periodic screening and diagnostic services for
665 individuals under age twenty-one (21) years as are needed to
666 identify physical and mental defects and to provide health care
667 treatment and other measures designed to correct or ameliorate
668 defects and physical and mental illness and conditions discovered
669 by the screening services regardless of whether these services are
670 included in the state plan. The division may include in its
671 periodic screening and diagnostic program those discretionary
672 services authorized under the federal regulations adopted to
673 implement Title XIX of the federal Social Security Act, as
674 amended. The division, in obtaining physical therapy services,
675 occupational therapy services, and services for individuals with
676 speech, hearing and language disorders, may enter into a
677 cooperative agreement with the State Department of Education for
678 the provision of those services to handicapped students by public
679 school districts using state funds that are provided from the
680 appropriation to the Department of Education to obtain federal
681 matching funds through the division. The division, in obtaining

682 medical and psychological evaluations for children in the custody
683 of the State Department of Human Services may enter into a
684 cooperative agreement with the State Department of Human Services
685 for the provision of those services using state funds that are
686 provided from the appropriation to the Department of Human
687 Services to obtain federal matching funds through the division.
688 (6) Physician's services. The division shall allow
689 twelve (12) physician visits annually. All fees for physicians'
690 services that are covered only by Medicaid shall be reimbursed at
691 ninety percent (90%) of the rate established on January 1, 1999,
692 and as adjusted each January thereafter, under Medicare (Title
693 XVIII of the Social Security Act, as amended), and which shall in
694 no event be less than seventy percent (70%) of the rate
695 established on January 1, 1994. All fees for physicians' services
696 that are covered by both Medicare and Medicaid shall be reimbursed
697 at ten percent (10%) of the adjusted Medicare payment established
698 on January 1, 1999, and as adjusted each January thereafter, under
699 Medicare (Title XVIII of the Social Security Act, as amended), and
700 which shall in no event be less than seventy percent (70%) of the
701 adjusted Medicare payment established on January 1, 1994.
702 (7) (a) Home health services for eligible persons, not
703 to exceed in cost the prevailing cost of nursing facility
704 services, not to exceed sixty (60) visits per year. All home
705 health visits must be precertified as required by the division.
706 (b) Repealed.
707 (8) Emergency medical transportation services. On
708 January 1, 1994, emergency medical transportation services shall
709 be reimbursed at seventy percent (70%) of the rate established
710 under Medicare (Title XVIII of the Social Security Act, as
711 amended). "Emergency medical transportation services" shall mean,
712 but shall not be limited to, the following services by a properly
713 permitted ambulance operated by a properly licensed provider in
714 accordance with the Emergency Medical Services Act of 1974

715 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
716 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
717 (vi) disposable supplies, (vii) similar services.
718 (9) (a) Legend and other drugs as may be determined by
719 the division. The division may implement a program of prior
720 approval for drugs to the extent permitted by law. The division
721 shall allow seven (7) prescriptions per month for each
722 noninstitutionalized Medicaid recipient; however, after a
723 noninstitutionalized or institutionalized recipient has received
724 five (5) prescriptions in any month, each additional prescription
725 during that month must have the prior approval of the division.
726 The division shall not reimburse for any portion of a prescription
727 that exceeds a thirty-four-day supply of the drug based on the
728 daily dosage.
729 Provided, however, that until July 1, 2005, any A-typical
730 antipsychotic drug shall be included in any preferred drug list
731 developed by the Division of Medicaid and shall not require prior
732 authorization, and until July 1, 2005, any licensed physician may
733 prescribe any A-typical antipsychotic drug deemed appropriate for
734 Medicaid recipients which shall be fully eligible for Medicaid
735 reimbursement.
736 The division shall develop and implement a program of payment
737 for additional pharmacist services, with payment to be based on
738 demonstrated savings, but in no case shall the total payment
739 exceed twice the amount of the dispensing fee.
740 All claims for drugs for dually eligible Medicare/Medicaid
741 beneficiaries that are paid for by Medicare must be submitted to
742 Medicare for payment before they may be processed by the
743 division's on-line payment system.
744 The division shall develop a pharmacy policy in which drugs
745 in tamper-resistant packaging that are prescribed for a resident
746 of a nursing facility but are not dispensed to the resident shall

747 be returned to the pharmacy and not billed to Medicaid, in
748 accordance with guidelines of the State Board of Pharmacy.
749 (b) Payment by the division for covered multiple
750 source drugs shall be limited to the lower of the upper limits
751 established and published by the Centers for Medicare and Medicaid
752 Services (CMS) plus a dispensing fee, or the estimated acquisition
753 cost (EAC) plus a dispensing fee, or the providers' usual and
754 customary charge to the general public.
755 Payment for other covered drugs, other than multiple source
756 drugs with CMS upper limits, shall not exceed the lower of the
757 estimated acquisition cost plus a dispensing fee or the providers'
758 usual and customary charge to the general public.
759 Payment for nonlegend or over-the-counter drugs covered by
760 the division shall be reimbursed at the lower of the division's
761 estimated shelf price or the providers' usual and customary charge
762 to the general public.
763 The dispensing fee for each new or refill prescription,
764 including nonlegend or over-the-counter drugs covered by the
765 division, shall be Three Dollars and Ninety-one Cents ($3.91).
766 The Medicaid provider shall not prescribe, the Medicaid
767 pharmacy shall not bill, and the division shall not reimburse for
768 name brand drugs if there are equally effective generic
769 equivalents available and if the generic equivalents are the least
770 expensive.
771 As used in this paragraph (9), "estimated acquisition cost"
772 means twelve percent (12%) less than the average wholesale price
773 for a drug.
774 (10) Dental care that is an adjunct to treatment of an
775 acute medical or surgical condition; services of oral surgeons and
776 dentists in connection with surgery related to the jaw or any
777 structure contiguous to the jaw or the reduction of any fracture
778 of the jaw or any facial bone; and emergency dental extractions
779 and treatment related thereto. On July 1, 1999, all fees for

780 dental care and surgery under authority of this paragraph (10)
781 shall be increased to one hundred sixty percent (160%) of the
782 amount of the reimbursement rate that was in effect on June 30,
783 1999. It is the intent of the Legislature to encourage more
784 dentists to participate in the Medicaid program.

785 (11) Eyeglasses for all Medicaid beneficiaries who have
786 (a) had surgery on the eyeball or ocular muscle that results in a
787 vision change for which eyeglasses or a change in eyeglasses is
788 medically indicated within six (6) months of the surgery and is in
789 accordance with policies established by the division, or (b) one
790 (1) pair every five (5) years and in accordance with policies
791 established by the division. In either instance, the eyeglasses
792 must be prescribed by a physician skilled in diseases of the eye
793 or an optometrist, whichever the beneficiary may select.

794 (12) Intermediate care facility services.

795 (a) The division shall make full payment to all
796 intermediate care facilities for the mentally retarded for each
797 day, not exceeding eighty-four (84) days per year, that a patient
798 is absent from the facility on home leave. Payment may be made
799 for the following home leave days in addition to the
800 eighty-four-day limitation: Christmas, the day before Christmas,
801 the day after Christmas, Thanksgiving, the day before Thanksgiving
802 and the day after Thanksgiving.

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

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

809 (14) Clinic services. Such diagnostic, preventive,
810 therapeutic, rehabilitative or palliative services furnished to an
811 outpatient by or under the supervision of a physician or dentist
812 in a facility that is not a part of a hospital but that is

813 organized and operated to provide medical care to outpatients.
814 Clinic services shall include any services reimbursed as
815 outpatient hospital services that may be rendered in such a
816 facility, including those that become so after July 1, 1991. On
817 July 1, 1999, all fees for physicians' services reimbursed under
818 authority of this paragraph (14) shall be reimbursed at ninety
819 percent (90%) of the rate established on January 1, 1999, and as
820 adjusted each January thereafter, under Medicare (Title XVIII of
821 the Social Security Act, as amended), and which shall in no event
822 be less than seventy percent (70%) of the rate established on
823 January 1, 1994. All fees for physicians' services that are
824 covered by both Medicare and Medicaid shall be reimbursed at ten
825 percent (10%) of the adjusted Medicare payment established on
826 January 1, 1999, and as adjusted each January thereafter, under
827 Medicare (Title XVIII of the Social Security Act, as amended), and
828 which shall in no event be less than seventy percent (70%) of the
829 adjusted Medicare payment established on January 1, 1994. On July
830 1, 1999, all fees for dentists' services reimbursed under
831 authority of this paragraph (14) shall be increased to one hundred
832 sixty percent (160%) of the amount of the reimbursement rate that
833 was in effect on June 30, 1999.
834 (15) Home- and community-based services for the elderly
835 and disabled, as provided under Title XIX of the federal Social
836 Security Act, as amended, under waivers, subject to the
837 availability of funds specifically appropriated therefor by the
838 Legislature.
839 (16) Mental health services. Approved therapeutic and
840 case management services (a) provided by an approved regional
841 mental health/retardation center established under Sections
842 41-19-31 through 41-19-39, or by another community mental health
843 service provider meeting the requirements of the Department of
844 Mental Health to be an approved mental health/retardation center
845 if determined necessary by the Department of Mental Health, using

846 state funds that are provided from the appropriation to the State
847 Department of Mental Health and/or funds transferred to the
848 department by a political subdivision or instrumentality of the
849 state and used to match federal funds under a cooperative
850 agreement between the division and the department, or (b) provided
851 by a facility that is certified by the State Department of Mental
852 Health to provide therapeutic and case management services, to be
853 reimbursed on a fee for service basis, or (c) provided in the
854 community by a facility or program operated by the Department of
855 Mental Health. Any such services provided by a facility described
856 in subparagraph (b) must have the prior approval of the division
857 to be reimbursable under this section. After June 30, 1997,
858 mental health services provided by regional mental
859 health/retardation centers established under Sections 41-19-31
860 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
861 and/or their subsidiaries and divisions, or by psychiatric
862 residential treatment facilities as defined in Section 43-11-1, or
863 by another community mental health service provider meeting the
864 requirements of the Department of Mental Health to be an approved
865 mental health/retardation center if determined necessary by the
866 Department of Mental Health, shall not be included in or provided
867 under any capitated managed care pilot program provided for under
868 paragraph (24) of this section.
869 (17) Durable medical equipment services and medical
870 supplies. Precertification of durable medical equipment and
871 medical supplies must be obtained as required by the division.
872 The Division of Medicaid may require durable medical equipment
873 providers to obtain a surety bond in the amount and to the
874 specifications as established by the Balanced Budget Act of 1997.
875 (18) (a) Notwithstanding any other provision of this
876 section to the contrary, the division shall make additional
877 reimbursement to hospitals that serve a disproportionate share of
878 low-income patients and that meet the federal requirements for

879 those payments as provided in Section 1923 of the federal Social
880 Security Act and any applicable regulations. However, from and
881 after January 1, 1999, no public hospital shall participate in the
882 Medicaid disproportionate share program unless the public hospital
883 participates in an intergovernmental transfer program as provided
884 in Section 1903 of the federal Social Security Act and any
885 applicable regulations. Administration and support for
886 participating hospitals shall be provided by the Mississippi
887 Hospital Association.
888 (b) The division shall establish a Medicare Upper
889 Payment Limits Program, as defined in Section 1902(a)(30) of the
890 federal Social Security Act and any applicable federal
891 regulations, for hospitals, and may establish a Medicare Upper
892 Payments Limits Program for nursing facilities. The division
893 shall assess each hospital and, if the program is established for
894 nursing facilities, shall assess each nursing facility, for the
895 sole purpose of financing the state portion of the Medicare Upper
896 Payment Limits Program. This assessment shall be based on
897 Medicaid utilization, or other appropriate method consistent with
898 federal regulations, and will remain in effect as long as the
899 state participates in the Medicare Upper Payment Limits Program.
900 The division shall make additional reimbursement to hospitals and,
901 if the program is established for nursing facilities, shall make
902 additional reimbursement to nursing facilities, for the Medicare
903 Upper Payment Limits, as defined in Section 1902(a)(30) of the
904 federal Social Security Act and any applicable federal
905 regulations. This subparagraph (b) shall stand repealed from and
906 after July 1, 2005.
907 (c) The division shall contract with the
908 Mississippi Hospital Association to provide administrative support
909 for the operation of the disproportionate share hospital program
910 and the Medicare Upper Payment Limits Program. This subparagraph
911 (c) shall stand repealed from and after July 1, 2005.

912 (19) (a) Perinatal risk management services. The
913 division shall promulgate regulations to be effective from and
914 after October 1, 1988, to establish a comprehensive perinatal
915 system for risk assessment of all pregnant and infant Medicaid
916 recipients and for management, education and follow-up for those
917 who are determined to be at risk. Services to be performed
918 include case management, nutrition assessment/counseling,
919 psychosocial assessment/counseling and health education. The
920 division shall set reimbursement rates for providers in
921 conjunction with the State Department of Health.
922 (b) Early intervention system services. The
923 division shall cooperate with the State Department of Health,
924 acting as lead agency, in the development and implementation of a
925 statewide system of delivery of early intervention services, under
926 Part C of the Individuals with Disabilities Education Act (IDEA).
927 The State Department of Health shall certify annually in writing
928 to the executive director of the division the dollar amount of
929 state early intervention funds available that will be utilized as
930 a certified match for Medicaid matching funds. Those funds then
931 shall be used to provide expanded targeted case management
932 services for Medicaid eligible children with special needs who are
933 eligible for the state's early intervention system.
934 Qualifications for persons providing service coordination shall be
935 determined by the State Department of Health and the Division of
936 Medicaid.
937 (20) Home- and community-based services for physically
938 disabled approved services as allowed by a waiver from the United
939 States Department of Health and Human Services for home- and
940 community-based services for physically disabled people using
941 state funds that are provided from the appropriation to the State
942 Department of Rehabilitation Services and used to match federal
943 funds under a cooperative agreement between the division and the
944 department, provided that funds for these services are

945 specifically appropriated to the Department of Rehabilitation
946 Services.
947 (21) Nurse practitioner services. Services furnished
948 by a registered nurse who is licensed and certified by the
949 Mississippi Board of Nursing as a nurse practitioner, including,
950 but not limited to, nurse anesthetists, nurse midwives, family
951 nurse practitioners, family planning nurse practitioners,
952 pediatric nurse practitioners, obstetrics-gynecology nurse
953 practitioners and neonatal nurse practitioners, under regulations
954 adopted by the division. Reimbursement for those services shall
955 not exceed ninety percent (90%) of the reimbursement rate for
956 comparable services rendered by a physician.
957 (22) Ambulatory services delivered in federally
958 qualified health centers, rural health centers and clinics of the
959 local health departments of the State Department of Health for
960 individuals eligible for Medicaid under this article based on
961 reasonable costs as determined by the division.
962 (23) Inpatient psychiatric services. Inpatient
963 psychiatric services to be determined by the division for
964 recipients under age twenty-one (21) that are provided under the
965 direction of a physician in an inpatient program in a licensed
966 acute care psychiatric facility or in a licensed psychiatric
967 residential treatment facility, before the recipient reaches age
968 twenty-one (21) or, if the recipient was receiving the services
969 immediately before he reached age twenty-one (21), before the
970 earlier of the date he no longer requires the services or the date
971 he reaches age twenty-two (22), as provided by federal
972 regulations. Precertification of inpatient days and residential
973 treatment days must be obtained as required by the division.
974 (24) [Deleted]
975 (25) [Deleted]
976 (26) Hospice care. As used in this paragraph, the term
977 "hospice care" means a coordinated program of active professional

978 medical attention within the home and outpatient and inpatient
979 care that treats the terminally ill patient and family as a unit,
980 employing a medically directed interdisciplinary team. The
981 program provides relief of severe pain or other physical symptoms
982 and supportive care to meet the special needs arising out of
983 physical, psychological, spiritual, social and economic stresses
984 that are experienced during the final stages of illness and during
985 dying and bereavement and meets the Medicare requirements for
986 participation as a hospice as provided in federal regulations.
987 (27) Group health plan premiums and cost sharing if it
988 is cost effective as defined by the Secretary of Health and Human
989 Services.
990 (28) Other health insurance premiums that are cost
991 effective as defined by the Secretary of Health and Human
992 Services. Medicare eligible must have Medicare Part B before
993 other insurance premiums can be paid.
994 (29) The Division of Medicaid may apply for a waiver
995 from the Department of Health and Human Services for home- and
996 community-based services for developmentally disabled people using
997 state funds that are provided from the appropriation to the State
998 Department of Mental Health and/or funds transferred to the
999 department by a political subdivision or instrumentality of the
1000 state and used to match federal funds under a cooperative
1001 agreement between the division and the department, provided that
1002 funds for these services are specifically appropriated to the
1003 Department of Mental Health and/or transferred to the department
1004 by a political subdivision or instrumentality of the state.
1005 (30) Pediatric skilled nursing services for eligible
1006 persons under twenty-one (21) years of age.
1007 (31) Targeted case management services for children
1008 with special needs, under waivers from the United States
1009 Department of Health and Human Services, using state funds that
1010 are provided from the appropriation to the Mississippi Department

1011 of Human Services and used to match federal funds under a
1012 cooperative agreement between the division and the department.
1013 (32) Care and services provided in Christian Science
1014 Sanatoria listed and certified by the Commission for Accreditation
1015 of Christian Science Nursing Organizations/Facilities, Inc.,
1016 rendered in connection with treatment by prayer or spiritual means
1017 to the extent that those services are subject to reimbursement
1018 under Section 1903 of the Social Security Act.
1019 (33) Podiatrist services.
1020 (34) Assisted living services as provided through home-
1021 and community-based services under Title XIX of the Social
1022 Security Act, as amended, subject to the availability of funds
1023 specifically appropriated therefor by the Legislature.
1024 (35) Services and activities authorized in Sections
1025 43-27-101 and 43-27-103, using state funds that are provided from
1026 the appropriation to the State Department of Human Services and
1027 used to match federal funds under a cooperative agreement between
1028 the division and the department.
1029 (36) Nonemergency transportation services for
1030 Medicaid-eligible persons, to be provided by the Division of
1031 Medicaid. The division may contract with additional entities to
1032 administer nonemergency transportation services as it deems
1033 necessary. All providers shall have a valid driver's license,
1034 vehicle inspection sticker, valid vehicle license tags and a
1035 standard liability insurance policy covering the vehicle. The
1036 division may pay providers a flat fee based on mileage tiers, or
1037 in the alternative, may reimburse on actual miles traveled. The
1038 division may apply to the Center for Medicare and Medicaid
1039 Services (CMS) for a waiver to draw federal matching funds for
1040 nonemergency transportation services as a covered service instead
1041 of an administrative cost.
1042 (37) [Deleted]

1043 (38) Chiropractic services. A chiropractor's manual
1044 manipulation of the spine to correct a subluxation, if x-ray
1045 demonstrates that a subluxation exists and if the subluxation has
1046 resulted in a neuromusculoskeletal condition for which
1047 manipulation is appropriate treatment, and related spinal x-rays
1048 performed to document these conditions. Reimbursement for
1049 chiropractic services shall not exceed Seven Hundred Dollars
1050 ($700.00) per year per beneficiary.
1051 (39) Dually eligible Medicare/Medicaid beneficiaries.
1052 The division shall pay the Medicare deductible and coinsurance
1053 amounts for services available under Medicare, as determined by
1054 the division.
1055 (40) [Deleted]
1056 (41) Services provided by the State Department of
1057 Rehabilitation Services for the care and rehabilitation of persons
1058 with spinal cord injuries or traumatic brain injuries, as allowed
1059 under waivers from the United States Department of Health and
1060 Human Services, using up to seventy-five percent (75%) of the
1061 funds that are appropriated to the Department of Rehabilitation
1062 Services from the Spinal Cord and Head Injury Trust Fund
1063 established under Section 37-33-261 and used to match federal
1064 funds under a cooperative agreement between the division and the
1065 department.
1066 (42) Notwithstanding any other provision in this
1067 article to the contrary, the division may develop a population
1068 health management program for women and children health services
1069 through the age of one (1) year. This program is primarily for
1070 obstetrical care associated with low birth weight and pre-term
1071 babies. The division may apply to the federal Centers for
1072 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
1073 any other waivers that may enhance the program. In order to
1074 effect cost savings, the division may develop a revised payment
1075 methodology that may include at-risk capitated payments, and may

1076 require member participation in accordance with the terms and
1077 conditions of an approved federal waiver.
1078 (43) The division shall provide reimbursement,
1079 according to a payment schedule developed by the division, for
1080 smoking cessation medications for pregnant women during their
1081 pregnancy and other Medicaid-eligible women who are of
1082 child-bearing age.
1083 (44) Nursing facility services for the severely
1084 disabled.
1085 (a) Severe disabilities include, but are not
1086 limited to, spinal cord injuries, closed head injuries and
1087 ventilator dependent patients.
1088 (b) Those services must be provided in a long-term
1089 care nursing facility dedicated to the care and treatment of
1090 persons with severe disabilities, and shall be reimbursed as a
1091 separate category of nursing facilities.
1092 (45) Physician assistant services. Services furnished
1093 by a physician assistant who is licensed by the State Board of
1094 Medical Licensure and is practicing with physician supervision
1095 under regulations adopted by the board, under regulations adopted
1096 by the division. Reimbursement for those services shall not
1097 exceed ninety percent (90%) of the reimbursement rate for
1098 comparable services rendered by a physician.
1099 (46) The division shall make application to the federal
1100 Centers for Medicare and Medicaid Services (CMS) for a waiver to
1101 develop and provide services for children with serious emotional
1102 disturbances as defined in Section 43-14-1(1), which may include
1103 home- and community-based services, case management services or
1104 managed care services through mental health providers certified by
1105 the Department of Mental Health. The division may implement and
1106 provide services under this waivered program only if funds for
1107 these services are specifically appropriated for this purpose by

1108 the Legislature, or if funds are voluntarily provided by affected
1109 agencies.
1110 (47) (a) Notwithstanding any other provision in this
1111 article to the contrary, the division, in conjunction with the
1112 State Department of Health, shall develop and implement disease
1113 management programs for individuals with asthma, diabetes or
1114 hypertension, including the use of grants, waivers, demonstrations
1115 or other projects as necessary.
1116 (b) Participation in any disease management
1117 program implemented under this paragraph (47) is optional with the
1118 individual. An individual must affirmatively elect to participate
1119 in the disease management program in order to participate.
1120 (c) An individual who participates in the disease
1121 management program has the option of participating in the
1122 prescription drug home delivery component of the program at any
1123 time while participating in the program. An individual must
1124 affirmatively elect to participate in the prescription drug home
1125 delivery component in order to participate.
1126 (d) An individual who participates in the disease
1127 management program may elect to discontinue participation in the
1128 program at any time. An individual who participates in the
1129 prescription drug home delivery component may elect to discontinue
1130 participation in the prescription drug home delivery component at
1131 any time.
1132 (e) The division shall send written notice to all
1133 individuals who participate in the disease management program
1134 informing them that they may continue using their local pharmacy
1135 or any other pharmacy of their choice to obtain their prescription
1136 drugs while participating in the program.
1137 (f) Prescription drugs that are provided to
1138 individuals under the prescription drug home delivery component
1139 shall be limited only to those drugs that are used for the
1140 treatment, management or care of asthma, diabetes or hypertension.

1141 (48) Pediatric long-term acute care hospital services.
1142 (a) Pediatric long-term acute care hospital
1143 services means services provided to eligible persons under
1144 twenty-one (21) years of age by a freestanding Medicare-certified
1145 hospital that has an average length of inpatient stay greater than
1146 twenty-five (25) days and that is primarily engaged in providing
1147 chronic or long-term medical care to persons under twenty-one (21)
1148 years of age.
1149 (b) The services under this paragraph (48) shall
1150 be reimbursed as a separate category of hospital services.
1151 (49) The division shall establish copayments for all
1152 Medicaid services for which copayments are allowable under federal
1153 law or regulation, except for nonemergency transportation
1154 services, and shall set the amount of the copayment for each of
1155 those services at the maximum amount allowable under federal law
1156 or regulation.
1157 (50) Services provided by the State Department of
1158 Rehabilitation Services for the care and rehabilitation of persons
1159 who are deaf and blind, as allowed under waivers from the United
1160 States Department of Health and Human Services to provide home-
1161 and community-based services using state funds which are provided
1162 from the appropriation to the State Department of Rehabilitation
1163 Services or if funds are voluntarily provided by another agency.
1164 Notwithstanding any other provision of this article to the
1165 contrary, the division shall reduce the rate of reimbursement to
1166 providers for any service provided under this section by five
1167 percent (5%) of the allowed amount for that service. However, the
1168 reduction in the reimbursement rates required by this paragraph
1169 shall not apply to inpatient hospital services, nursing facility
1170 services, intermediate care facility services, psychiatric
1171 residential treatment facility services, pharmacy services
1172 provided under paragraph (9) of this section, or any service
1173 provided by the University of Mississippi Medical Center or a

1174 state agency, a state facility or a public agency that either
1175 provides its own state match through intergovernmental transfer or
1176 certification of funds to the division, or a service for which the
1177 federal government sets the reimbursement methodology and rate.
1178 In addition, the reduction in the reimbursement rates required by
1179 this paragraph shall not apply to case management services
1180 provided under the home- and community-based services program for
1181 the elderly and disabled by a planning and development district
1182 (PDD). Planning and development districts participating in the
1183 home- and community-based services program for the elderly and
1184 disabled as case management providers shall be reimbursed for case
1185 management services at the maximum rate approved by the Centers
1186 for Medicare and Medicaid Services (CMS). PDDs shall transfer to
1187 the division state match from public funds (not federal) in an
1188 amount equal to the difference between the maximum case management
1189 reimbursement rate approved by CMS and a five percent (5%)
1190 reduction in that rate. The division shall invoice each PDD
1191 fifteen (15) days after the end of each quarter for the
1192 intergovernmental transfer based on payments made for Medicaid
1193 home- and community-based case management services during the
1194 quarter.

1195 The division may pay to those providers who participate in
1196 and accept patient referrals from the division's emergency room
1197 redirection program a percentage, as determined by the division,
1198 of savings achieved according to the performance measures and
1199 reduction of costs required of that program.

1200 Notwithstanding any provision of this article, except as
1201 authorized in the following paragraph and in Section 43-13-139,
1202 neither (a) the limitations on quantity or frequency of use of or
1203 the fees or charges for any of the care or services available to
1204 recipients under this section, nor (b) the payments or rates of
1205 reimbursement to providers rendering care or services authorized
1206 under this section to recipients, may be increased, decreased or

1207 otherwise changed from the levels in effect on July 1, 1999,
1208 unless they are authorized by an amendment to this section by the
1209 Legislature. However, the restriction in this paragraph shall not
1210 prevent the division from changing the payments or rates of
1211 reimbursement to providers without an amendment to this section
1212 whenever those changes are required by federal law or regulation,
1213 or whenever those changes are necessary to correct administrative
1214 errors or omissions in calculating those payments or rates of
1215 reimbursement.

1216 Notwithstanding any provision of this article, no new groups
1217 or categories of recipients and new types of care and services may
1218 be added without enabling legislation from the Mississippi
1219 Legislature, except that the division may authorize those changes
1220 without enabling legislation when the addition of recipients or
1221 services is ordered by a court of proper authority. The executive
1222 director shall keep the Governor advised on a timely basis of the
1223 funds available for expenditure and the projected expenditures.
1224 If current or projected expenditures of the division can be
1225 reasonably anticipated to exceed the amounts appropriated for any
1226 fiscal year, the Governor, after consultation with the executive
1227 director, shall discontinue any or all of the payment of the types
1228 of care and services as provided in this section that are deemed
1229 to be optional services under Title XIX of the federal Social
1230 Security Act, as amended, for any period necessary to not exceed
1231 appropriated funds, and when necessary shall institute any other
1232 cost containment measures on any program or programs authorized
1233 under the article to the extent allowed under the federal law
1234 governing that program or programs, it being the intent of the
1235 Legislature that expenditures during any fiscal year shall not
1236 exceed the amounts appropriated for that fiscal year.

1237 Notwithstanding any other provision of this article, it shall
1238 be the duty of each nursing facility, intermediate care facility
1239 for the mentally retarded, psychiatric residential treatment

1240 facility, and nursing facility for the severely disabled that is
1241 participating in the Medicaid program to keep and maintain books,
1242 documents and other records as prescribed by the Division of
1243 Medicaid in substantiation of its cost reports for a period of
1244 three (3) years after the date of submission to the Division of
1245 Medicaid of an original cost report, or three (3) years after the
1246 date of submission to the Division of Medicaid of an amended cost
1247 report.

1248 This section shall stand repealed on July 1, 2004.

1249 **SECTION 5.** Section 43-13-121, Mississippi Code of 1972, is
1250 brought forward as follows:

1251 43-13-121. (1) The division shall administer the Medicaid
1252 program under the provisions of this article, and may do the
1253 following:

1254 (a) Adopt and promulgate reasonable rules, regulations
1255 and standards, with approval of the Governor, and in accordance
1256 with the Administrative Procedures Law, Section 25-43-1 et seq.:

1257 (i) Establishing methods and procedures as may be
1258 necessary for the proper and efficient administration of this
1259 article;

1260 (ii) Providing Medicaid to all qualified
1261 recipients under the provisions of this article as the division
1262 may determine and within the limits of appropriated funds;

1263 (iii) Establishing reasonable fees, charges and
1264 rates for medical services and drugs; in doing so, the division
1265 shall fix all of those fees, charges and rates at the minimum
1266 levels absolutely necessary to provide the medical assistance
1267 authorized by this article, and shall not change any of those
1268 fees, charges or rates except as may be authorized in Section
1269 43-13-117;

1270 (iv) Providing for fair and impartial hearings;

1271 (v) Providing safeguards for preserving the
1272 confidentiality of records; and

1273 (vi) For detecting and processing fraudulent
1274 practices and abuses of the program;
1275 (b) Receive and expend state, federal and other funds
1276 in accordance with court judgments or settlements and agreements
1277 between the State of Mississippi and the federal government, the
1278 rules and regulations promulgated by the division, with the
1279 approval of the Governor, and within the limitations and
1280 restrictions of this article and within the limits of funds
1281 available for that purpose;
1282 (c) Subject to the limits imposed by this article, to
1283 submit a Medicaid plan to the federal Department of Health and
1284 Human Services for approval under the provisions of the Social
1285 Security Act, to act for the state in making negotiations relative
1286 to the submission and approval of that plan, to make such
1287 arrangements, not inconsistent with the law, as may be required by
1288 or under federal law to obtain and retain that approval and to
1289 secure for the state the benefits of the provisions of that law.
1290 No agreements, specifically including the general plan for
1291 the operation of the Medicaid program in this state, shall be made
1292 by and between the division and the Department of Health and Human
1293 Services unless the Attorney General of the State of Mississippi
1294 has reviewed the agreements, specifically including the
1295 operational plan, and has certified in writing to the Governor and
1296 to the executive director of the division that the agreements,
1297 including the plan of operation, have been drawn strictly in
1298 accordance with the terms and requirements of this article;
1299 (d) In accordance with the purposes and intent of this
1300 article and in compliance with its provisions, provide for aged
1301 persons otherwise eligible for the benefits provided under Title
1302 XVIII of the federal Social Security Act by expenditure of funds
1303 available for those purposes;
1304 (e) To make reports to the federal Department of Health
1305 and Human Services as from time to time may be required by that

1306 federal department and to the Mississippi Legislature as provided
1307 in this section;
1308 (f) Define and determine the scope, duration and amount
1309 of Medicaid that may be provided in accordance with this article
1310 and establish priorities therefor in conformity with this article;
1311 (g) Cooperate and contract with other state agencies
1312 for the purpose of coordinating Medicaid provided under this
1313 article and eliminating duplication and inefficiency in the
1314 Medicaid program;
1315 (h) Adopt and use an official seal of the division;
1316 (i) Sue in its own name on behalf of the State of
1317 Mississippi and employ legal counsel on a contingency basis with
1318 the approval of the Attorney General;
1319 (j) To recover any and all payments incorrectly made by
1320 the division or by the Medicaid Commission to a recipient or
1321 provider from the recipient or provider receiving the payments;
1322 (k) To recover any and all payments by the division or
1323 by the Medicaid Commission fraudulently obtained by a recipient or
1324 provider. Additionally, if recovery of any payments fraudulently
1325 obtained by a recipient or provider is made in any court, then,
1326 upon motion of the Governor, the judge of the court may award
1327 twice the payments recovered as damages;
1328 (l) Have full, complete and plenary power and authority
1329 to conduct such investigations as it may deem necessary and
1330 requisite of alleged or suspected violations or abuses of the
1331 provisions of this article or of the regulations adopted under
1332 this article, including, but not limited to, fraudulent or
1333 unlawful act or deed by applicants for Medicaid or other benefits,
1334 or payments made to any person, firm or corporation under the
1335 terms, conditions and authority of this article, to suspend or
1336 disqualify any provider of services, applicant or recipient for
1337 gross abuse, fraudulent or unlawful acts for such periods,
1338 including permanently, and under such conditions as the division

1339 deems proper and just, including the imposition of a legal rate of
1340 interest on the amount improperly or incorrectly paid. Recipients
1341 who are found to have misused or abused Medicaid benefits may be
1342 locked into one (1) physician and/or one (1) pharmacy of the
1343 recipient's choice for a reasonable amount of time in order to
1344 educate and promote appropriate use of medical services, in
1345 accordance with federal regulations. If an administrative hearing
1346 becomes necessary, the division may, if the provider does not
1347 succeed in his defense, tax the costs of the administrative
1348 hearing, including the costs of the court reporter or stenographer
1349 and transcript, to the provider. The convictions of a recipient
1350 or a provider in a state or federal court for abuse, fraudulent or
1351 unlawful acts under this chapter shall constitute an automatic
1352 disqualification of the recipient or automatic disqualification of
1353 the provider from participation under the Medicaid program.

1354 A conviction, for the purposes of this chapter, shall include
1355 a judgment entered on a plea of nolo contendere or a
1356 nonadjudicated guilty plea and shall have the same force as a
1357 judgment entered pursuant to a guilty plea or a conviction
1358 following trial. A certified copy of the judgment of the court of
1359 competent jurisdiction of the conviction shall constitute prima
1360 facie evidence of the conviction for disqualification purposes;

1361 (m) Establish and provide such methods of
1362 administration as may be necessary for the proper and efficient
1363 operation of the Medicaid program, fully utilizing computer
1364 equipment as may be necessary to oversee and control all current
1365 expenditures for purposes of this article, and to closely monitor
1366 and supervise all recipient payments and vendors rendering
1367 services under this article;

1368 (n) To cooperate and contract with the federal
1369 government for the purpose of providing Medicaid to Vietnamese and
1370 Cambodian refugees, under the provisions of Public Law 94-23 and
1371 Public Law 94-24, including any amendments to those laws, only to

1372 the extent that the Medicaid assistance and the administrative
1373 cost related thereto are one hundred percent (100%) reimbursable
1374 by the federal government. For the purposes of Section 43-13-117,
1375 persons receiving Medicaid under Public Law 94-23 and Public Law
1376 94-24, including any amendments to those laws, shall not be
1377 considered a new group or category of recipient; and
1378 (o) The division shall impose penalties upon Medicaid
1379 only, Title XIX participating long-term care facilities found to
1380 be in noncompliance with division and certification standards in
1381 accordance with federal and state regulations, including interest
1382 at the same rate calculated by the Department of Health and Human
1383 Services and/or the Centers for Medicare and Medicaid Services
1384 (CMS) under federal regulations.
1385 (2) The division also shall exercise such additional powers
1386 and perform such other duties as may be conferred upon the
1387 division by act of the Legislature.
1388 (3) The division, and the State Department of Health as the
1389 agency for licensure of health care facilities and certification
1390 and inspection for the Medicaid and/or Medicare programs, shall
1391 contract for or otherwise provide for the consolidation of on-site
1392 inspections of health care facilities that are necessitated by the
1393 respective programs and functions of the division and the
1394 department.
1395 (4) The division and its hearing officers shall have power
1396 to preserve and enforce order during hearings; to issue subpoenas
1397 for, to administer oaths to and to compel the attendance and
1398 testimony of witnesses, or the production of books, papers,
1399 documents and other evidence, or the taking of depositions before
1400 any designated individual competent to administer oaths; to
1401 examine witnesses; and to do all things conformable to law that
1402 may be necessary to enable them effectively to discharge the
1403 duties of their office. In compelling the attendance and
1404 testimony of witnesses, or the production of books, papers,

1405 documents and other evidence, or the taking of depositions, as
1406 authorized by this section, the division or its hearing officers
1407 may designate an individual employed by the division or some other
1408 suitable person to execute and return that process, whose action
1409 in executing and returning that process shall be as lawful as if
1410 done by the sheriff or some other proper officer authorized to
1411 execute and return process in the county where the witness may
1412 reside. In carrying out the investigatory powers under the
1413 provisions of this article, the executive director or other
1414 designated person or persons may examine, obtain, copy or
1415 reproduce the books, papers, documents, medical charts,
1416 prescriptions and other records relating to medical care and
1417 services furnished by the provider to a recipient or designated
1418 recipients of Medicaid services under investigation. In the
1419 absence of the voluntary submission of the books, papers,
1420 documents, medical charts, prescriptions and other records, the
1421 Governor, the executive director, or other designated person may
1422 issue and serve subpoenas instantly upon the provider, his agent,
1423 servant or employee for the production of the books, papers,
1424 documents, medical charts, prescriptions or other records during
1425 an audit or investigation of the provider. If any provider or his
1426 agent, servant or employee refuses to produce the records after
1427 being duly subpoenaed, the executive director may certify those
1428 facts and institute contempt proceedings in the manner, time and
1429 place as authorized by law for administrative proceedings. As an
1430 additional remedy, the division may recover all amounts paid to
1431 the provider covering the period of the audit or investigation,
1432 inclusive of a legal rate of interest and a reasonable attorney's
1433 fee and costs of court if suit becomes necessary. Division staff
1434 shall have immediate access to the provider's physical location,
1435 facilities, records, documents, books, and any other records
1436 relating to medical care and services rendered to recipients
1437 during regular business hours.

1438 (5) If any person in proceedings before the division
1439 disobeys or resists any lawful order or process, or misbehaves
1440 during a hearing or so near the place thereof as to obstruct the
1441 same, or neglects to produce, after having been ordered to do so,
1442 any pertinent book, paper or document, or refuses to appear after
1443 having been subpoenaed, or upon appearing refuses to take the oath
1444 as a witness, or after having taken the oath refuses to be
1445 examined according to law, the executive director shall certify
1446 the facts to any court having jurisdiction in the place in which
1447 it is sitting, and the court shall thereupon, in a summary manner,
1448 hear the evidence as to the acts complained of, and if the
1449 evidence so warrants, punish that person in the same manner and to
1450 the same extent as for a contempt committed before the court, or
1451 commit that person upon the same condition as if the doing of the
1452 forbidden act had occurred with reference to the process of, or in
1453 the presence of, the court.
1454 (6) In suspending or terminating any provider from
1455 participation in the Medicaid program, the division shall preclude
1456 the provider from submitting claims for payment, either personally
1457 or through any clinic, group, corporation or other association to
1458 the division or its fiscal agents for any services or supplies
1459 provided under the Medicaid program except for those services or
1460 supplies provided before the suspension or termination. No
1461 clinic, group, corporation or other association that is a provider
1462 of services shall submit claims for payment to the division or its
1463 fiscal agents for any services or supplies provided by a person
1464 within that organization who has been suspended or terminated from
1465 participation in the Medicaid program except for those services or
1466 supplies provided before the suspension or termination. When this
1467 provision is violated by a provider of services that is a clinic,
1468 group, corporation or other association, the division may suspend
1469 or terminate that organization from participation. Suspension may
1470 be applied by the division to all known affiliates of a provider,

1471 provided that each decision to include an affiliate is made on a
1472 case-by-case basis after giving due regard to all relevant facts
1473 and circumstances. The violation, failure or inadequacy of
1474 performance may be imputed to a person with whom the provider is
1475 affiliated where that conduct was accomplished within the course
1476 of his official duty or was effectuated by him with the knowledge
1477 or approval of that person.
1478 (7) The division may deny or revoke enrollment in the
1479 Medicaid program to a provider if any of the following are found
1480 to be applicable to the provider, his agent, a managing employee
1481 or any person having an ownership interest equal to five percent
1482 (5%) or greater in the provider:
1483 (a) Failure to truthfully or fully disclose any and all
1484 information required, or the concealment of any and all
1485 information required, on a claim, a provider application or a
1486 provider agreement, or the making of a false or misleading
1487 statement to the division relative to the Medicaid program.
1488 (b) Previous or current exclusion, suspension,
1489 termination from or the involuntary withdrawing from participation
1490 in the Medicaid program, any other state's Medicaid program,
1491 Medicare or any other public or private health or health insurance
1492 program. If the division ascertains that a provider has been
1493 convicted of a felony under federal or state law for an offense
1494 that the division determines is detrimental to the best interest
1495 of the program or of Medicaid beneficiaries, the division may
1496 refuse to enter into an agreement with that provider, or may
1497 terminate or refuse to renew an existing agreement.
1498 (c) Conviction under federal or state law of a criminal
1499 offense relating to the delivery of any goods, services or
1500 supplies, including the performance of management or
1501 administrative services relating to the delivery of the goods,
1502 services or supplies, under the Medicaid program, any other

1503 state's Medicaid program, Medicare or any other public or private
1504 health or health insurance program.
1505 (d) Conviction under federal or state law of a criminal
1506 offense relating to the neglect or abuse of a patient in
1507 connection with the delivery of any goods, services or supplies.
1508 (e) Conviction under federal or state law of a criminal
1509 offense relating to the unlawful manufacture, distribution,
1510 prescription or dispensing of a controlled substance.
1511 (f) Conviction under federal or state law of a criminal
1512 offense relating to fraud, theft, embezzlement, breach of
1513 fiduciary responsibility or other financial misconduct.
1514 (g) Conviction under federal or state law of a criminal
1515 offense punishable by imprisonment of a year or more that involves
1516 moral turpitude, or acts against the elderly, children or infirm.
1517 (h) Conviction under federal or state law of a criminal
1518 offense in connection with the interference or obstruction of any
1519 investigation into any criminal offense listed in paragraphs (c)
1520 through (i) of this subsection.
1521 (i) Sanction for a violation of federal or state laws
1522 or rules relative to the Medicaid program, any other state's
1523 Medicaid program, Medicare or any other public health care or
1524 health insurance program.
1525 (j) Revocation of license or certification.
1526 (k) Failure to pay recovery properly assessed or
1527 pursuant to an approved repayment schedule under the Medicaid
1528 program.
1529 (l) Failure to meet any condition of enrollment.
1530 **SECTION 6.** Section 43-13-141, Mississippi Code of 1972, is
1531 brought forward as follows:
1532 43-13-141. (1) There is levied an assessment equal to
1533 fifteen percent (15%) of the amount of that portion of the
1534 Medicaid reimbursement payments made by the Division of Medicaid
1535 to each provider participating in the Mississippi Medicaid Program

1536 that is derived from state general funds, regardless of where the
1537 provider is located. The division shall deduct the assessment
1538 from the Medicaid reimbursement payments at the time that the
1539 payments are made to the Medicaid providers, and shall deposit the
1540 proceeds of the assessment into a special fund that is created in
1541 the State Treasury to be known as the "Medical Care Assessments
1542 Fund." The division shall begin deducting the assessment levied
1543 under this section as soon after April 25, 1991, as the division
1544 has made the computer program modifications and other
1545 administrative changes that are necessary to begin deducting the
1546 assessment, but not later than August 1, 1991. If the division is
1547 prepared to deduct the assessment before August 1, 1991, it shall
1548 not begin deducting the assessment until at least one (1) month
1549 after it has given written notification to all Medicaid providers
1550 of its intention to begin deducting the assessment. The division
1551 shall furnish to each Medicaid provider at least once each year a
1552 record of the amount of the assessment that has been deducted from
1553 the reimbursement payments made to the provider. The assessment
1554 provided for by this section shall not be levied or deducted from
1555 any Medicaid reimbursement payments after September 30, 1992.
1556 (2) The assessment levied under this section shall be in
1557 addition to any other assessments, taxes or fees levied by law.
1558 (3) The assessment levied under this section shall not be
1559 applicable to and shall not be deducted from Medicaid
1560 reimbursement payments made:
1561 (a) To state-owned nursing facilities;
1562 (b) For pharmaceutical ingredients; and
1563 (c) For ambulatory services delivered in federally
1564 qualified health centers and in clinics of the local health
1565 departments of the State Department of Health.
1566 (4) The monies in the Medical Care Assessments Fund shall be
1567 expended only for health care services, and may be expended only
1568 upon appropriation by the Legislature. Unexpended monies

1569 remaining in the fund at the end of a fiscal year shall not lapse
1570 into the State General Fund, and any interest earned on monies in
1571 the fund shall be deposited to the credit of the fund.
1572 **SECTION 7.** Section 43-13-145, Mississippi Code of 1972, is
1573 brought forward as follows:
1574 43-13-145. (1) (a) Upon each nursing facility and each
1575 intermediate care facility for the mentally retarded licensed by
1576 the State of Mississippi, there is levied an assessment in the
1577 amount of Four Dollars ($4.00) per day for each licensed and/or
1578 certified bed of the facility. The division may apply for a
1579 waiver from the United States Secretary of Health and Human
1580 Services to exempt nonprofit, public, charitable or religious
1581 facilities from the assessment levied under this subsection, and
1582 if a waiver is granted, those facilities shall be exempt from any
1583 assessment levied under this subsection after the date that the
1584 division receives notice that the waiver has been granted.
1585 (b) A nursing facility or intermediate care facility
1586 for the mentally retarded is exempt from the assessment levied
1587 under this subsection if the facility is operated under the
1588 direction and control of:
1589 (i) The United States Veterans Administration or
1590 other agency or department of the United States government;
1591 (ii) The State Veterans Affairs Board;
1592 (iii) The University of Mississippi Medical
1593 Center; or
1594 (iv) A state agency or a state facility that
1595 either provides its own state match through intergovernmental
1596 transfer or certification of funds to the division.
1597 (2) (a) Upon each psychiatric residential treatment
1598 facility licensed by the State of Mississippi, there is levied an
1599 assessment in the amount of Three Dollars ($3.00) per day for each
1600 licensed and/or certified bed of the facility.

1601 (b) A psychiatric residential treatment facility is
1602 exempt from the assessment levied under this subsection if the
1603 facility is operated under the direction and control of:
1604 (i) The United States Veterans Administration or
1605 other agency or department of the United States government;
1606 (ii) The University of Mississippi Medical Center;
1607 (iii) A state agency or a state facility that
1608 either provides its own state match through intergovernmental
1609 transfer or certification of funds to the division.
1610 (3) (a) Upon each hospital licensed by the State of
1611 Mississippi, there is levied an assessment in the amount of One
1612 Dollar and Fifty Cents ($1.50) per day for each licensed inpatient
1613 acute care bed of the hospital.
1614 (b) A hospital is exempt from the assessment levied
1615 under this subsection if the hospital is operated under the
1616 direction and control of:
1617 (i) The United States Veterans Administration or
1618 other agency or department of the United States government;
1619 (ii) The University of Mississippi Medical Center;
1620 or
1621 (iii) A state agency or a state facility that
1622 either provides its own state match through intergovernmental
1623 transfer or certification of funds to the division.
1624 (4) Each health care facility that is subject to the
1625 provisions of this section shall keep and preserve such suitable
1626 books and records as may be necessary to determine the amount of
1627 assessment for which it is liable under this section. The books
1628 and records shall be kept and preserved for a period of not less
1629 than five (5) years, and those books and records shall be open for
1630 examination during business hours by the division, the State Tax
1631 Commission, the Office of the Attorney General and the State
1632 Department of Health.

1633 (5) The assessment levied under this section shall be
1634 collected by the division each month beginning on April 12, 2002.
1635 (6) All assessments collected under this section shall be
1636 deposited in the Medical Care Fund created by Section 43-13-143.
1637 (7) The assessment levied under this section shall be in
1638 addition to any other assessments, taxes or fees levied by law,
1639 and the assessment shall constitute a debt due the State of
1640 Mississippi from the time the assessment is due until it is paid.
1641 (8) (a) If a health care facility that is liable for
1642 payment of the assessment levied under this section does not pay
1643 the assessment when it is due, the division shall give written
1644 notice to the health care facility by certified or registered mail
1645 demanding payment of the assessment within ten (10) days from the
1646 date of delivery of the notice. If the health care facility
1647 fails or refuses to pay the assessment after receiving the notice
1648 and demand from the division, the division shall withhold from any
1649 Medicaid reimbursement payments that are due to the health care
1650 facility the amount of the unpaid assessment and a penalty of ten
1651 percent (10%) of the amount of the assessment, plus the legal rate
1652 of interest until the assessment is paid in full. If the health
1653 care facility does not participate in the Medicaid program, the
1654 division shall turn over to the Office of the Attorney General the
1655 collection of the unpaid assessment by civil action. In any such
1656 civil action, the Office of the Attorney General shall collect the
1657 amount of the unpaid assessment and a penalty of ten percent (10%)
1658 of the amount of the assessment, plus the legal rate of interest
1659 until the assessment is paid in full.
1660 (b) As an additional or alternative method for
1661 collecting unpaid assessments under this section, if a health care
1662 facility fails or refuses to pay the assessment after receiving
1663 notice and demand from the division, the division may file a
1664 notice of a tax lien with the circuit clerk of the county in which
1665 the health care facility is located, for the amount of the unpaid

1666 assessment and a penalty of ten percent (10%) of the amount of the
1667 assessment, plus the legal rate of interest until the assessment
1668 is paid in full. Immediately upon receipt of notice of the tax
1669 lien for the assessment, the circuit clerk shall enter the notice
1670 of the tax lien as a judgment upon the judgment roll and show in
1671 the appropriate columns the name of the health care facility as
1672 judgment debtor, the name of the division as judgment creditor,
1673 the amount of the unpaid assessment, and the date and time of
1674 enrollment. The judgment shall be valid as against mortgagees,
1675 pledgees, entrusters, purchasers, judgment creditors and other
1676 persons from the time of filing with the clerk. The amount of the
1677 judgment shall be a debt due the State of Mississippi and remain a
1678 lien upon the tangible property of the health care facility until
1679 the judgment is satisfied. The judgment shall be the equivalent
1680 of any enrolled judgment of a court of record and shall serve as
1681 authority for the issuance of writs of execution, writs of
1682 attachment or other remedial writs.
1683 **SECTION 8.** Section 43-13-317, Mississippi Code of 1972, is
1684 brought forward as follows:
1685 43-13-317. (1) In accordance with applicable federal law
1686 and rules and regulations, including those under Title XIX of the
1687 Social Security Act, the division may seek recovery of payments
1688 for nursing facility services, home- and community-based services,
1689 and related hospital and prescription drug services from the
1690 estate of a deceased Medicaid recipient who was fifty-five (55)
1691 years of age or older when he received the assistance. The
1692 division shall be noticed as an identified creditor against the
1693 estate of the deceased Medicaid recipient pursuant to Section
1694 91-7-145, Mississippi Code of 1972.
1695 (2) The claim shall be waived by the division (a) if there
1696 is a surviving spouse; or (b) if there is a surviving dependent
1697 who is under the age of twenty-one (21) years or who is blind or
1698 disabled; or (c) as provided by federal law and regulation, if it

1699 is determined by the division or by court order that there is
1700 undue hardship.
1701 **SECTION 9.** This act shall take effect and be in force from
1702 and after July 1, 2004.