

**Adopted
COMMITTEE AMENDMENT NO 1 PROPOSED TO**

Senate Bill No. 2436

BY: Committee

**Amend by striking all after the enacting clause and inserting
in lieu thereof the following:**

64 **SECTION 1.** Section 43-13-107, Mississippi Code of 1972, is
65 amended as follows:
66 43-13-107. (1) The Division of Medicaid is created in the
67 Office of the Governor and established to administer this article
68 and perform such other duties as are prescribed by law.
69 (2) (a) The Governor shall appoint a full-time executive
70 director, with the advice and consent of the Senate, who shall be
71 either (i) a physician with administrative experience in a medical
72 care or health program, or (ii) a person holding a graduate degree
73 in medical care administration, public health, hospital
74 administration, or the equivalent, or (iii) a person holding a
75 bachelor's degree in business administration or hospital
76 administration, with at least ten (10) years' experience in
77 management-level administration of Medicaid programs, and who
78 shall serve at the will and pleasure of the Governor. The
79 executive director shall be the official secretary and legal
80 custodian of the records of the division; shall be the agent of
81 the division for the purpose of receiving all service of process,

82 summons and notices directed to the division; and shall perform
83 such other duties as the Governor may prescribe from time to time.

84 (b) The executive director, with the approval of the
85 Governor and subject to the rules and regulations of the State
86 Personnel Board, shall employ such professional, administrative,
87 stenographic, secretarial, clerical and technical assistance as
88 may be necessary to perform the duties required in administering
89 this article and fix the compensation for those persons, all in
90 accordance with a state merit system meeting federal requirements.
91 When the salary of the executive director is not set by law, that
92 salary shall be set by the State Personnel Board. No employees of
93 the Division of Medicaid shall be considered to be staff members
94 of the immediate Office of the Governor; however, the provisions
95 of Section 25-9-107(c)(xv) shall apply to the executive director
96 and other administrative heads of the division.

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

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

103 (i) The Governor shall appoint five (5) members,
104 one (1) from each congressional district and one (1) from the
105 state at large;

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

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

111 All members appointed under this paragraph shall either be
112 health care providers or consumers of health care services. One

113 (1) member appointed by each of the appointing authorities shall
114 be a board certified physician.

115 (c) The respective Chairmen of the House Medicaid
116 Committee, the House Public Health and Human Services Committee,
117 the House Appropriations Committee, the Senate Public Health and
118 Welfare Committee and the Senate Appropriations Committee, or
119 their designees, one (1) member of the State Senate appointed by
120 the Lieutenant Governor and one (1) member of the House of
121 Representatives appointed by the Speaker of the House, shall serve
122 as ex officio nonvoting members of the advisory committee.

123 (d) In addition to the committee members required by
124 paragraph (b), the advisory committee shall consist of such other
125 members as are necessary to meet the requirements of the federal
126 regulation applicable to the advisory committee, who shall be
127 appointed as provided in the federal regulation.

128 (e) The chairmanship of the advisory committee shall
129 alternate for twelve-month periods between the Chairmen of the
130 House Medicaid Committee and the Senate Public Health and Welfare
131 Committee.

132 (f) The members of the advisory committee specified in
133 paragraph (b) shall serve for terms that are concurrent with the
134 terms of members of the Legislature, and any member appointed
135 under paragraph (b) may be reappointed to the advisory committee.
136 The members of the advisory committee specified in paragraph (b)
137 shall serve without compensation, but shall receive reimbursement
138 to defray actual expenses incurred in the performance of committee
139 business as authorized by law. Legislators shall receive per diem
140 and expenses, which may be paid from the contingent expense funds
141 of their respective houses in the same amounts as provided for
142 committee meetings when the Legislature is not in session.

143 (g) The advisory committee shall meet not less than
144 quarterly, and advisory committee members shall be furnished

145 written notice of the meetings at least ten (10) days before the
146 date of the meeting.

147 (h) The executive director shall submit to the advisory
148 committee all amendments, modifications and changes to the state
149 plan for the operation of the Medicaid program, for review by the
150 advisory committee before the amendments, modifications or changes
151 may be implemented by the division.

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

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

157 (ii) Advise the division with respect to issues
158 concerning receipt and disbursement of funds and eligibility for
159 Medicaid;

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

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

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

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

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

177 (i) Review and initiate retrospective drug use,
178 review including ongoing periodic examination of claims data and
179 other records in order to identify patterns of fraud, abuse, gross
180 overuse, or inappropriate or medically unnecessary care, among
181 physicians, pharmacists and individuals receiving Medicaid
182 benefits or associated with specific drugs or groups of drugs.

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

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

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

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

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

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

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

212 (c) The committee meetings shall be open to the public,
213 members of the press, legislators and consumers. Additionally,
214 all documents provided to committee members shall be available to
215 members of the Legislature in the same manner, and shall be made
216 available to others for a reasonable fee for copying. However,
217 patient confidentiality and provider confidentiality shall be
218 protected by blinding patient names and provider names with
219 numerical or other anonymous identifiers. The committee meetings
220 shall be subject to the Open Meetings Act (Section 25-41-1 et
221 seq.). Committee meetings conducted in violation of this section
222 shall be deemed unlawful.

223 (d) After a thirty-day public notice, the executive
224 director, or his or her designee, shall present the division's
225 recommendation regarding prior approval for a therapeutic class of
226 drugs to the committee. However, in circumstances where the
227 division deems it necessary for the health and safety of Medicaid
228 beneficiaries, the division may present to the committee its
229 recommendations regarding a particular drug without a thirty-day
230 public notice. In making that presentation, the division shall
231 state to the committee the circumstances that precipitate the need
232 for the committee to review the status of a particular drug
233 without a thirty-day public notice. The committee may determine
234 whether or not to review the particular drug under the
235 circumstances stated by the division without a thirty-day public
236 notice. If the committee determines to review the status of the
237 particular drug, it shall make its recommendations to the
238 division, after which the division shall file those
239 recommendations for a thirty-day public comment under the
240 provisions of Section 25-43-7(1).

241 (e) Upon reviewing the information and recommendations,
242 the committee shall forward a written recommendation approved by a
243 majority of the committee to the executive director or his or her
244 designee. The decisions of the committee regarding any
245 limitations to be imposed on any drug or its use for a specified
246 indication shall be based on sound clinical evidence found in
247 labeling, drug compendia, and peer reviewed clinical literature
248 pertaining to use of the drug in the relevant population.

249 (f) Upon reviewing and considering all recommendations
250 including recommendation of the committee, comments, and data, the
251 executive director shall make a final determination whether to
252 require prior approval of a therapeutic class of drugs, or modify
253 existing prior approval requirements for a therapeutic class of
254 drugs.

255 (g) At least thirty (30) days before the executive
256 director implements new or amended prior authorization decisions,
257 written notice of the executive director's decision shall be
258 provided to all prescribing Medicaid providers, all Medicaid
259 enrolled pharmacies, and any other party who has requested the
260 notification. However, notice given under Section 25-43-7(1) will
261 substitute for and meet the requirement for notice under this
262 subsection.

263 (6) This section shall stand repealed on July 1, 2006.

264 **SECTION 2.** Section 43-13-113, Mississippi Code of 1972, is
265 amended as follows:

266 43-13-113. (1) The State Treasurer shall receive on behalf
267 of the state, and execute all instruments incidental thereto,
268 federal and other funds to be used for financing the Medicaid plan
269 or program adopted under this article, and place all those funds
270 in a special account to the credit of the Governor's
271 Office-Division of Medicaid, which funds shall be expended by the
272 division for the purposes and under the provisions of this

273 article, and shall be paid out by the State Treasurer as funds
274 appropriated to carry out the provisions of this article are paid
275 out by the Treasurer.

276 The division shall issue all checks or electronic transfers
277 for administrative expenses, and for medical assistance under the
278 provisions of this article. All those checks or electronic
279 transfers shall be drawn upon funds made available to the division
280 by the State Fiscal Officer, upon requisition of the executive
281 director. It is the purpose of this section to provide that the
282 State Fiscal Officer shall transfer, in lump sums, amounts to the
283 division for disbursement under * * * regulations * * * made by
284 the executive director with the approval of the Governor; however,
285 the division, or its fiscal agent in behalf of the division, shall
286 be authorized in maintaining separate accounts with a Mississippi
287 bank to handle claim payments, refund recoveries and related
288 Medicaid program financial transactions, to aggressively manage
289 the float in these accounts while awaiting clearance of checks or
290 electronic transfers and/or other disposition so as to accrue
291 maximum interest advantage of the funds in the account, and to
292 retain all earned interest on these funds to be applied to match
293 federal funds for Medicaid program operations.

294 (2) The division is authorized to obtain a line of credit
295 through the State Treasurer from the Working Cash-Stabilization
296 Fund or any other special source funds maintained in the State
297 Treasury in an amount not exceeding One Hundred Fifty Million
298 Dollars (\$150,000,000.00) to fund shortfalls that, from time to
299 time, may occur due to decreases in state matching fund cash flow.
300 The length of indebtedness under this provision shall not carry
301 past the end of the quarter following the loan origination. Loan
302 proceeds shall be received by the State Treasurer and shall be
303 placed in a Medicaid designated special fund account. Loan
304 proceeds shall be expended only for health care services provided

305 under the Medicaid program. The division may pledge as security
306 for that interim financing future funds that will be received by
307 the division. Any such loans shall be repaid from the first
308 available funds received by the division in the manner of and
309 subject to the same terms provided in this section.

310 (3) Disbursement of funds to providers shall be made as
311 follows:

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

315 (b) The Division of Medicaid's fiscal agent must pay
316 ninety percent (90%) of all clean claims within thirty (30) days
317 of the date of receipt.

318 (c) The Division of Medicaid's fiscal agent must pay
319 ninety-nine percent (99%) of all clean claims within ninety (90)
320 days of the date of receipt.

321 (d) The Division of Medicaid's fiscal agent must pay
322 all other claims within twelve (12) months of the date of receipt.

323 (e) If a claim is neither paid nor denied for valid and
324 proper reasons by the end of the time periods as specified in the
325 preceding paragraphs, the Division of Medicaid's fiscal agent must
326 pay the provider interest on the claim at the rate of one and
327 one-half percent (1-1/2%) per month on the amount of the claim
328 until it is finally settled or adjudicated.

329 (4) The date of receipt is the date the fiscal agent
330 receives the claim as indicated by its date stamp on the claim or,
331 for those claims filed electronically, the date of receipt is the
332 date of transmission.

333 (5) The date of payment is the date of the check or, for
334 those claims paid by electronic funds transfer, the date of the
335 transfer.

336 (6) The above specified time limitations do not apply in the
337 following circumstances:

338 (a) Retroactive adjustments paid to providers
339 reimbursed under a retrospective payment system;

340 (b) If a claim for payment under Medicare has been
341 filed in a timely manner, the fiscal agent may pay a Medicaid
342 claim relating to the same services within six (6) months after
343 it, or the provider, receives notice of the disposition of the
344 Medicare claim;

345 (c) Claims from providers under investigation for fraud
346 or abuse; and

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

353 (7) Repealed.

354 (8) If sufficient funds are appropriated for that purpose by
355 the Legislature, the Division of Medicaid may contract with the
356 Mississippi Dental Association, or an approved designee, to
357 develop and operate a Donated Dental Services (DDS) program
358 through which volunteer dentists will treat needy disabled, aged
359 and medically-compromised individuals who are non-Medicaid
360 eligible recipients.

361 **SECTION 3.** Section 43-13-115, Mississippi Code of 1972, is
362 amended as follows:

363 43-13-115. Recipients of Medicaid shall be the following
364 persons only:

365 (1) Those who are qualified for public assistance
366 grants under provisions of Title IV-A and E of the federal Social
367 Security Act, as amended, * * * including those statutorily deemed

368 to be IV-A and low income families and children under Section 1931
369 of the federal Social Security Act * * *. For the purposes of
370 this paragraph (1) and paragraphs (8), (17) and (18) of this
371 section, any reference to Title IV-A or to Part A of Title IV of
372 the federal Social Security Act, as amended, or the state plan
373 under Title IV-A or Part A of Title IV, shall be considered as a
374 reference to Title IV-A of the federal Social Security Act, as
375 amended, and the state plan under Title IV-A, including the income
376 and resource standards and methodologies under Title IV-A and the
377 state plan, as they existed on July 16, 1996. The Department of
378 Human Services shall determine Medicaid eligibility for children
379 receiving public assistance grants under Title IV-E. The division
380 shall determine eligibility for low income families under Section
381 1931 of the federal Social Security Act and shall redetermine
382 eligibility for those continuing under Title IV-A grants.

383 (2) Those qualified for Supplemental Security Income
384 (SSI) benefits under Title XVI of the federal Social Security Act,
385 as amended, and those who are deemed SSI eligible as contained in
386 federal statute. The eligibility of individuals covered in this
387 paragraph shall be determined by the Social Security
388 Administration and certified to the Division of Medicaid.

389 (3) Qualified pregnant women who would be eligible for
390 Medicaid as a low income family member under Section 1931 of the
391 federal Social Security Act if her child were born. The
392 eligibility of the individuals covered under this paragraph shall
393 be determined by the division.

394 (4) [Deleted]

395 (5) A child born on or after October 1, 1984, to a
396 woman eligible for and receiving Medicaid under the state plan on
397 the date of the child's birth shall be deemed to have applied for
398 Medicaid and to have been found eligible for Medicaid under the
399 plan on the date of that birth, and will remain eligible for

400 Medicaid for a period of one (1) year so long as the child is a
401 member of the woman's household and the woman remains eligible for
402 Medicaid or would be eligible for Medicaid if pregnant. The
403 eligibility of individuals covered in this paragraph shall be
404 determined by * * * the Division of Medicaid.

405 (6) Children certified by the State Department of Human
406 Services to the Division of Medicaid of whom the state and county
407 departments of human services have custody and financial
408 responsibility, and children who are in adoptions subsidized in
409 full or part by the Department of Human Services, including
410 special needs children in non-Title IV-E adoption assistance, who
411 are approvable under Title XIX of the Medicaid program. The
412 eligibility of the children covered under this paragraph shall be
413 determined by the State Department of Human Services.

414 (7) (a) Persons certified by the Division of Medicaid
415 who are patients in a medical facility (nursing home, hospital,
416 tuberculosis sanatorium or institution for treatment of mental
417 diseases), and who, except for the fact that they are patients in
418 that medical facility, would qualify for grants under Title IV,
419 Supplementary Security Income (SSI) benefits under Title XVI or
420 state supplements, and those aged, blind and disabled persons who
421 would not be eligible for Supplemental Security Income (SSI)
422 benefits under Title XVI or state supplements if they were not
423 institutionalized in a medical facility but whose income is below
424 the maximum standard set by the Division of Medicaid, which
425 standard shall not exceed that prescribed by federal regulation;

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

430 (8) Children under eighteen (18) years of age and
431 pregnant women (including those in intact families) who meet the

432 financial standards of the state plan approved under Title IV-A of
433 the federal Social Security Act, as amended. The eligibility of
434 children covered under this paragraph shall be determined by * * *
435 the Division of Medicaid.

436 (9) Individuals who are:

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

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

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

449 The eligibility of individuals covered in (a), (b) and (c) of
450 this paragraph shall be determined by the division.

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

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

464 official poverty level as defined by the Office of Management and
465 Budget and revised annually, and whose resources do not exceed
466 those established by the Division of Medicaid. The eligibility of
467 individuals covered under this paragraph shall be determined by
468 the Division of Medicaid * * *.

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

476 The eligibility of individuals covered under this paragraph
477 shall be determined by the Division of Medicaid, and those
478 individuals determined eligible shall receive Medicare
479 cost-sharing expenses only as more fully defined by the Medicare
480 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
481 1997.

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

489 (b) Individuals entitled to Part A of Medicare, with
490 income above one hundred twenty percent (120%), but less than one
491 hundred thirty-five percent (135%) of the federal poverty level,
492 and not otherwise eligible for Medicaid Eligibility for Medicaid
493 benefits is limited to full payment of Medicare Part B premiums.
494 The number of eligible individuals is limited by the availability
495 of the federal capped allocation at one hundred percent (100%) of

496 federal matching funds, as more fully defined in the Balanced
497 Budget Act of 1997.

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

500 (14) [Deleted]

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

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

516 (17) In accordance with the terms of the federal
517 Personal Responsibility and Work Opportunity Reconciliation Act of
518 1996 (Public Law 104-193), persons who become ineligible for
519 assistance under Title IV-A of the federal Social Security Act, as
520 amended, because of increased income from or hours of employment
521 of the caretaker relative or because of the expiration of the
522 applicable earned income disregards, who were eligible for
523 Medicaid for at least three (3) of the six (6) months preceding
524 the month in which the ineligibility begins, shall be eligible for
525 Medicaid * * * for up to twelve (12) months. The eligibility of
526 the individuals covered under this paragraph shall be determined
527 by the division.

528 (18) Persons who become ineligible for assistance under
529 Title IV-A of the federal Social Security Act, as amended, as a
530 result, in whole or in part, of the collection or increased
531 collection of child or spousal support under Title IV-D of the
532 federal Social Security Act, as amended, who were eligible for
533 Medicaid for at least three (3) of the six (6) months immediately
534 preceding the month in which the ineligibility begins, shall be
535 eligible for Medicaid for an additional four (4) months beginning
536 with the month in which the ineligibility begins. The eligibility
537 of the individuals covered under this paragraph shall be
538 determined by the division.

539 (19) Disabled workers, whose incomes are above the
540 Medicaid eligibility limits, but below two hundred fifty percent
541 (250%) of the federal poverty level, shall be allowed to purchase
542 Medicaid coverage on a sliding fee scale developed by the Division
543 of Medicaid.

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

549 (21) Women of childbearing age whose family income does
550 not exceed one hundred eighty-five percent (185%) of the federal
551 poverty level. The eligibility of individuals covered under this
552 paragraph (21) shall be determined by the Division of Medicaid,
553 and those individuals determined eligible shall only receive
554 family planning services covered under Section 43-13-117(13) and
555 not any other services covered under Medicaid. However, any
556 individual eligible under this paragraph (21) who is also eligible
557 under any other provision of this section shall receive the
558 benefits to which he or she is entitled under that other

559 provision, in addition to family planning services covered under
560 Section 43-13-117(13).

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

569 (22) Persons who are workers with a potentially severe
570 disability, as determined by the division, shall be allowed to
571 purchase Medicaid coverage. The term "worker with a potentially
572 severe disability" means a person who is at least sixteen (16)
573 years of age but under sixty-five (65) years of age, who has a
574 physical or mental impairment that is reasonably expected to cause
575 the person to become blind or disabled as defined under Section
576 1614(a) of the federal Social Security Act, as amended, if the
577 person does not receive items and services provided under
578 Medicaid.

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

586 (23) Children certified by the Mississippi Department
587 of Human Services for whom the state and county departments of
588 human services have custody and financial responsibility who are
589 in foster care on their eighteenth birthday as reported by the
590 Mississippi Department of Human Services shall be certified

591 Medicaid eligible by the Division of Medicaid until their
592 twenty-first birthday.

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

603 The division shall redetermine eligibility for all categories
604 of recipients described in each paragraph of this section not less
605 frequently than required by federal law.

606 **SECTION 4.** Section 43-13-117, Mississippi Code of 1972, is
607 amended as follows:

608 43-13-117. Medicaid as authorized by this article shall
609 include payment of part or all of the costs, at the discretion of
610 the division * * *, with approval of the Governor, of the
611 following types of care and services rendered to eligible
612 applicants who have been determined to be eligible for that care
613 and services, within the limits of state appropriations and
614 federal matching funds:

615 (1) Inpatient hospital services.

616 (a) The division shall allow thirty (30) days of
617 inpatient hospital care annually for all Medicaid recipients.
618 Precertification of inpatient days must be obtained as required by
619 the division. The division may allow unlimited days in
620 disproportionate hospitals as defined by the division for eligible
621 infants under the age of six (6) years if certified as medically
622 necessary as required by the division.

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

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

637 (2) Outpatient hospital services. Where the same
638 services are reimbursed as clinic services, the division may
639 revise the rate or methodology of outpatient reimbursement to
640 maintain consistency, efficiency, economy and quality of care.

641 (3) Laboratory and x-ray services.

642 (4) Nursing facility services.

643 (a) The division shall make full payment to
644 nursing facilities for each day, not exceeding fifty-two (52) days
645 per year, that a patient is absent from the facility on home
646 leave. Payment may be made for the following home leave days in
647 addition to the fifty-two-day limitation: Christmas, the day
648 before Christmas, the day after Christmas, Thanksgiving, the day
649 before Thanksgiving and the day after Thanksgiving.

650 (b) From and after July 1, 1997, the division
651 shall implement the integrated case-mix payment and quality
652 monitoring system, which includes the fair rental system for
653 property costs and in which recapture of depreciation is
654 eliminated. The division may reduce the payment for hospital

655 leave and therapeutic home leave days to the lower of the case-mix
656 category as computed for the resident on leave using the
657 assessment being utilized for payment at that point in time, or a
658 case-mix score of 1.000 for nursing facilities, and shall compute
659 case-mix scores of residents so that only services provided at the
660 nursing facility are considered in calculating a facility's per
661 diem.

662 * * *

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

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

686 from the Centers for Medicare and Medicaid Services (CMS) of the
687 change in the state Medicaid plan providing for the reimbursement.

688 (e) The division shall develop and implement, not
689 later than January 1, 2001, a case-mix payment add-on determined
690 by time studies and other valid statistical data that will
691 reimburse a nursing facility for the additional cost of caring for
692 a resident who has a diagnosis of Alzheimer's or other related
693 dementia and exhibits symptoms that require special care. Any
694 such case-mix add-on payment shall be supported by a determination
695 of additional cost. The division shall also develop and implement
696 as part of the fair rental reimbursement system for nursing
697 facility beds, an Alzheimer's resident bed depreciation enhanced
698 reimbursement system that will provide an incentive to encourage
699 nursing facilities to convert or construct beds for residents with
700 Alzheimer's or other related dementia.

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

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

707 (5) Periodic screening and diagnostic services for
708 individuals under age twenty-one (21) years as are needed to
709 identify physical and mental defects and to provide health care
710 treatment and other measures designed to correct or ameliorate
711 defects and physical and mental illness and conditions discovered
712 by the screening services, regardless of whether these services
713 are included in the state plan. The division may include in its
714 periodic screening and diagnostic program those discretionary
715 services authorized under the federal regulations adopted to
716 implement Title XIX of the federal Social Security Act, as
717 amended. The division, in obtaining physical therapy services,

718 occupational therapy services, and services for individuals with
719 speech, hearing and language disorders, may enter into a
720 cooperative agreement with the State Department of Education for
721 the provision of those services to handicapped students by public
722 school districts using state funds that are provided from the
723 appropriation to the Department of Education to obtain federal
724 matching funds through the division. The division, in obtaining
725 medical and psychological evaluations for children in the custody
726 of the State Department of Human Services may enter into a
727 cooperative agreement with the State Department of Human Services
728 for the provision of those services using state funds that are
729 provided from the appropriation to the Department of Human
730 Services to obtain federal matching funds through the division.

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

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

743 (b) Repealed.

744 (8) Emergency medical transportation services. On
745 January 1, 1994, emergency medical transportation services shall
746 be reimbursed at seventy percent (70%) of the rate established
747 under Medicare (Title XVIII of the federal Social Security Act, as
748 amended). "Emergency medical transportation services" shall mean,
749 but shall not be limited to, the following services by a properly

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

755 (9) (a) Legend and other drugs as may be determined by
756 the division. The division shall establish a mandatory preferred
757 drug list. Drugs not on the mandatory preferred drug list shall
758 be made available by utilizing prior authorization procedures
759 established by the division. The division may seek to establish
760 relationships with other states or Canada in order to lower
761 acquisition costs of prescription drugs to include named brands or
762 generics. The division shall allow for a combination of named
763 brand and generic prescriptions to meet the needs of the
764 beneficiaries, not to exceed four (4) named brand prescriptions
765 per month for each noninstitutionalized Medicaid beneficiary. The
766 division shall allow for unlimited generic drugs. The voluntary
767 preferred drug list shall be expanded to function in the interim
768 in order to have a manageable prior authorization system, thereby
769 minimizing disruption of service to beneficiaries. The division
770 shall not reimburse for any portion of a prescription that exceeds
771 a thirty-four-day supply of the drug based on the daily dosage.

772 * * * However, * * * until July 1, 2005, any A-typical
773 antipsychotic drug shall be included in any preferred drug list
774 developed by the Division of Medicaid and shall not require prior
775 authorization, and until July 1, 2005, any licensed physician may
776 prescribe any A-typical antipsychotic drug deemed appropriate for
777 Medicaid recipients, which shall be fully eligible for Medicaid
778 reimbursement. In addition, antiretroviral and fusion inhibitor
779 medications, including, but not limited to, protease inhibitors,
780 nonnucleoside reverse transcriptase inhibitors, nucleoside reverse
781 transcriptase inhibitors, antivirals and fusion inhibitors, shall

782 be included in any preferred drug list developed by the Division
783 of Medicaid.

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

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

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

797 (b) Payment by the division for covered
798 multisource drugs shall be limited to the lower of the upper
799 limits established and published by the Centers for Medicare and
800 Medicaid Services (CMS) plus a dispensing fee, or the estimated
801 acquisition cost (EAC) as determined by the division, plus a
802 dispensing fee, or the providers' usual and customary charge to
803 the general public.

804 Payment for other covered drugs, other than multisource drugs
805 with CMS upper limits, shall not exceed the lower of the estimated
806 acquisition cost as determined by the division, plus a dispensing
807 fee or the providers' usual and customary charge to the general
808 public.

809 Payment for nonlegend or over-the-counter drugs covered by
810 the division shall be reimbursed at the lower of the division's
811 estimated shelf price or the providers' usual and customary charge
812 to the general public.

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

816 * * * The division shall not reimburse for name brand drugs
817 if there are equally effective generic equivalents available and
818 if the generic equivalents are the least expensive.

819 * * *

820 The division shall develop and implement a program that
821 requires Medicaid providers who prescribe drugs to use a
822 counterfeit-proof prescription pad for Medicaid prescriptions for
823 controlled substances; however, this shall not prevent the filling
824 of prescriptions for controlled substances by means of electronic
825 communications between a prescriber and pharmacist as allowed by
826 federal law.

827 (10) Dental care that is an adjunct to treatment of an
828 acute medical or surgical condition; services of oral surgeons and
829 dentists in connection with surgery related to the jaw or any
830 structure contiguous to the jaw or the reduction of any fracture
831 of the jaw or any facial bone; and emergency dental extractions
832 and treatment related thereto. On July 1, 1999, all fees for
833 dental care and surgery under authority of this paragraph (10)
834 shall be increased to one hundred sixty percent (160%) of the
835 amount of the reimbursement rate that was in effect on June 30,
836 1999. It is the intent of the Legislature to encourage more
837 dentists to participate in the Medicaid program.

838 (11) Eyeglasses for all Medicaid beneficiaries who have
839 (a) had surgery on the eyeball or ocular muscle that results in a
840 vision change for which eyeglasses or a change in eyeglasses is
841 medically indicated within six (6) months of the surgery and is in
842 accordance with policies established by the division, or (b) one
843 (1) pair every five (5) years and in accordance with policies
844 established by the division. In either instance, the eyeglasses

845 must be prescribed by a physician skilled in diseases of the eye
846 or an optometrist, whichever the beneficiary may select.

847 (12) Intermediate care facility services.

848 (a) The division shall make full payment to all
849 intermediate care facilities for the mentally retarded for each
850 day, not exceeding eighty-four (84) days per year, that a patient
851 is absent from the facility on home leave. Payment may be made
852 for the following home leave days in addition to the
853 eighty-four-day limitation: Christmas, the day before Christmas,
854 the day after Christmas, Thanksgiving, the day before Thanksgiving
855 and the day after Thanksgiving.

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

859 (13) Family planning services, including drugs,
860 supplies and devices, when those services are under the
861 supervision of a physician or nurse practitioner.

862 (14) Clinic services. Such diagnostic, preventive,
863 therapeutic, rehabilitative or palliative services furnished to an
864 outpatient by or under the supervision of a physician or dentist
865 in a facility that is not a part of a hospital but that is
866 organized and operated to provide medical care to outpatients.
867 Clinic services shall include any services reimbursed as
868 outpatient hospital services that may be rendered in such a
869 facility, including those that become so after July 1, 1991. On
870 July 1, 1999, all fees for physicians' services reimbursed under
871 authority of this paragraph (14) shall be reimbursed at ninety
872 percent (90%) of the rate established on January 1, 1999, and as
873 adjusted each January thereafter, under Medicare (Title XVIII of
874 the federal Social Security Act, as amended), and which shall in
875 no event be less than seventy percent (70%) of the rate
876 established on January 1, 1994. * * * On July 1, 1999, all fees

877 for dentists' services reimbursed under authority of this
878 paragraph (14) shall be increased to one hundred sixty percent
879 (160%) of the amount of the reimbursement rate that was in effect
880 on June 30, 1999.

881 (15) Home- and community-based services for the elderly
882 and disabled, as provided under Title XIX of the federal Social
883 Security Act, as amended, under waivers, subject to the
884 availability of funds specifically appropriated for that purpose
885 by the Legislature.

886 (16) Mental health services. Approved therapeutic and
887 case management services (a) provided by an approved regional
888 mental health/retardation center established under Sections
889 41-19-31 through 41-19-39, or by another community mental health
890 service provider meeting the requirements of the Department of
891 Mental Health to be an approved mental health/retardation center
892 if determined necessary by the Department of Mental Health, using
893 state funds that are provided from the appropriation to the State
894 Department of Mental Health and/or funds transferred to the
895 department by a political subdivision or instrumentality of the
896 state and used to match federal funds under a cooperative
897 agreement between the division and the department, or (b) provided
898 by a facility that is certified by the State Department of Mental
899 Health to provide therapeutic and case management services, to be
900 reimbursed on a fee for service basis, or (c) provided in the
901 community by a facility or program operated by the Department of
902 Mental Health. Any such services provided by a facility described
903 in subparagraph (b) must have the prior approval of the division
904 to be reimbursable under this section. After June 30, 1997,
905 mental health services provided by regional mental
906 health/retardation centers established under Sections 41-19-31
907 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
908 and/or their subsidiaries and divisions, or by psychiatric

909 residential treatment facilities as defined in Section 43-11-1, or
910 by another community mental health service provider meeting the
911 requirements of the Department of Mental Health to be an approved
912 mental health/retardation center if determined necessary by the
913 Department of Mental Health, shall not be included in or provided
914 under any capitated managed care pilot program provided for under
915 paragraph (24) of this section.

916 (17) Durable medical equipment services and medical
917 supplies. Precertification of durable medical equipment and
918 medical supplies must be obtained as required by the division.
919 The Division of Medicaid may require durable medical equipment
920 providers to obtain a surety bond in the amount and to the
921 specifications as established by the Balanced Budget Act of 1997.

922 (18) (a) Notwithstanding any other provision of this
923 section to the contrary, the division shall make additional
924 reimbursement to hospitals that serve a disproportionate share of
925 low-income patients and that meet the federal requirements for
926 those payments as provided in Section 1923 of the federal Social
927 Security Act and any applicable regulations. However, from and
928 after January 1, 1999, no public hospital shall participate in the
929 Medicaid disproportionate share program unless the public hospital
930 participates in an intergovernmental transfer program as provided
931 in Section 1903 of the federal Social Security Act and any
932 applicable regulations. * * *

933 (b) The division shall establish a Medicare Upper
934 Payment Limits Program, as defined in Section 1902(a)(30) of the
935 federal Social Security Act and any applicable federal
936 regulations, for hospitals, and may establish a Medicare Upper
937 Payments Limits Program for nursing facilities. The division
938 shall assess each hospital and, if the program is established for
939 nursing facilities, shall assess each nursing facility, for the
940 sole purpose of financing the state portion of the Medicare Upper

941 Payment Limits Program. This assessment shall be based on
942 Medicaid utilization, or other appropriate method consistent with
943 federal regulations, and will remain in effect as long as the
944 state participates in the Medicare Upper Payment Limits Program.
945 The division shall make additional reimbursement to hospitals and,
946 if the program is established for nursing facilities, shall make
947 additional reimbursement to nursing facilities, for the Medicare
948 Upper Payment Limits, as defined in Section 1902(a)(30) of the
949 federal Social Security Act and any applicable federal
950 regulations. This subparagraph (b) shall stand repealed from and
951 after July 1, 2005.

952 * * *

953 (19) (a) Perinatal risk management services. The
954 division shall promulgate regulations to be effective from and
955 after October 1, 1988, to establish a comprehensive perinatal
956 system for risk assessment of all pregnant and infant Medicaid
957 recipients and for management, education and follow-up for those
958 who are determined to be at risk. Services to be performed
959 include case management, nutrition assessment/counseling,
960 psychosocial assessment/counseling and health education. * * *

961 (b) Early intervention system services. The
962 division shall cooperate with the State Department of Health,
963 acting as lead agency, in the development and implementation of a
964 statewide system of delivery of early intervention services, under
965 Part C of the Individuals with Disabilities Education Act (IDEA).
966 The State Department of Health shall certify annually in writing
967 to the executive director of the division the dollar amount of
968 state early intervention funds available that will be utilized as
969 a certified match for Medicaid matching funds. Those funds then
970 shall be used to provide expanded targeted case management
971 services for Medicaid eligible children with special needs who are
972 eligible for the state's early intervention system.

973 Qualifications for persons providing service coordination shall be
974 determined by the State Department of Health and the Division of
975 Medicaid.

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

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

996 (22) Ambulatory services delivered in federally
997 qualified health centers, rural health centers and clinics of the
998 local health departments of the State Department of Health for
999 individuals eligible for Medicaid under this article based on
1000 reasonable costs as determined by the division.

1001 (23) Inpatient psychiatric services. Inpatient
1002 psychiatric services to be determined by the division for
1003 recipients under age twenty-one (21) that are provided under the
1004 direction of a physician in an inpatient program in a licensed

1005 acute care psychiatric facility or in a licensed psychiatric
1006 residential treatment facility, before the recipient reaches age
1007 twenty-one (21) or, if the recipient was receiving the services
1008 immediately before he or she reached age twenty-one (21), before
1009 the earlier of the date he or she no longer requires the services
1010 or the date he or she reaches age twenty-two (22), as provided by
1011 federal regulations. Precertification of inpatient days and
1012 residential treatment days must be obtained as required by the
1013 division.

1014 (24) [Deleted]

1015 (25) [Deleted]

1016 (26) Hospice care. As used in this paragraph, the term
1017 "hospice care" means a coordinated program of active professional
1018 medical attention within the home and outpatient and inpatient
1019 care that treats the terminally ill patient and family as a unit,
1020 employing a medically directed interdisciplinary team. The
1021 program provides relief of severe pain or other physical symptoms
1022 and supportive care to meet the special needs arising out of
1023 physical, psychological, spiritual, social and economic stresses
1024 that are experienced during the final stages of illness and during
1025 dying and bereavement and meets the Medicare requirements for
1026 participation as a hospice as provided in federal regulations.

1027 (27) Group health plan premiums and cost sharing if it
1028 is cost effective as defined by the United States Secretary of
1029 Health and Human Services.

1030 (28) Other health insurance premiums that are cost
1031 effective as defined by the United States Secretary of Health and
1032 Human Services. Medicare eligible must have Medicare Part B
1033 before other insurance premiums can be paid.

1034 (29) The Division of Medicaid may apply for a waiver
1035 from the United States Department of Health and Human Services for
1036 home- and community-based services for developmentally disabled

1037 people using state funds that are provided from the appropriation
1038 to the State Department of Mental Health and/or funds transferred
1039 to the department by a political subdivision or instrumentality of
1040 the state and used to match federal funds under a cooperative
1041 agreement between the division and the department, provided that
1042 funds for these services are specifically appropriated to the
1043 Department of Mental Health and/or transferred to the department
1044 by a political subdivision or instrumentality of the state.

1045 (30) Pediatric skilled nursing services for eligible
1046 persons under twenty-one (21) years of age.

1047 (31) Targeted case management services for children
1048 with special needs, under waivers from the United States
1049 Department of Health and Human Services, using state funds that
1050 are provided from the appropriation to the Mississippi Department
1051 of Human Services and used to match federal funds under a
1052 cooperative agreement between the division and the department.

1053 (32) Care and services provided in Christian Science
1054 Sanatoria listed and certified by the Commission for Accreditation
1055 of Christian Science Nursing Organizations/Facilities, Inc.,
1056 rendered in connection with treatment by prayer or spiritual means
1057 to the extent that those services are subject to reimbursement
1058 under Section 1903 of the federal Social Security Act.

1059 (33) Podiatrist services.

1060 (34) Assisted living services as provided through home-
1061 and community-based services under Title XIX of the federal Social
1062 Security Act, as amended, subject to the availability of funds
1063 specifically appropriated for that purpose by the Legislature.

1064 (35) Services and activities authorized in Sections
1065 43-27-101 and 43-27-103, using state funds that are provided from
1066 the appropriation to the State Department of Human Services and
1067 used to match federal funds under a cooperative agreement between
1068 the division and the department.

1069 (36) Nonemergency transportation services for
1070 Medicaid-eligible persons, to be provided by the Division of
1071 Medicaid. The division may contract with additional entities to
1072 administer nonemergency transportation services as it deems
1073 necessary. All providers shall have a valid driver's license,
1074 vehicle inspection sticker, valid vehicle license tags and a
1075 standard liability insurance policy covering the vehicle. The
1076 division may pay providers a flat fee based on mileage tiers, or
1077 in the alternative, may reimburse on actual miles traveled. The
1078 division may apply to the Center for Medicare and Medicaid
1079 Services (CMS) for a waiver to draw federal matching funds for
1080 nonemergency transportation services as a covered service instead
1081 of an administrative cost.

1082 (37) [Deleted]

1083 (38) Chiropractic services. A chiropractor's manual
1084 manipulation of the spine to correct a subluxation, if x-ray
1085 demonstrates that a subluxation exists and if the subluxation has
1086 resulted in a neuromusculoskeletal condition for which
1087 manipulation is appropriate treatment, and related spinal x-rays
1088 performed to document these conditions. Reimbursement for
1089 chiropractic services shall not exceed Seven Hundred Dollars
1090 (\$700.00) per year per beneficiary.

1091 (39) Dually eligible Medicare/Medicaid beneficiaries.
1092 The division shall pay the Medicare deductible and coinsurance
1093 amounts for services available under Medicare, as determined by
1094 the division.

1095 (40) [Deleted]

1096 (41) Services provided by the State Department of
1097 Rehabilitation Services for the care and rehabilitation of persons
1098 with spinal cord injuries or traumatic brain injuries, as allowed
1099 under waivers from the United States Department of Health and
1100 Human Services, using up to seventy-five percent (75%) of the

1101 funds that are appropriated to the Department of Rehabilitation
1102 Services from the Spinal Cord and Head Injury Trust Fund
1103 established under Section 37-33-261 and used to match federal
1104 funds under a cooperative agreement between the division and the
1105 department.

1106 (42) Notwithstanding any other provision in this
1107 article to the contrary, the division may develop a population
1108 health management program for women and children health services
1109 through the age of one (1) year. This program is primarily for
1110 obstetrical care associated with low birth weight and pre-term
1111 babies. The division may apply to the federal Centers for
1112 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
1113 any other waivers that may enhance the program. In order to
1114 effect cost savings, the division may develop a revised payment
1115 methodology that may include at-risk capitated payments, and may
1116 require member participation in accordance with the terms and
1117 conditions of an approved federal waiver.

1118 (43) The division shall provide reimbursement,
1119 according to a payment schedule developed by the division, for
1120 smoking cessation medications for pregnant women during their
1121 pregnancy and other Medicaid-eligible women who are of
1122 child-bearing age.

1123 (44) Nursing facility services for the severely
1124 disabled.

1125 (a) Severe disabilities include, but are not
1126 limited to, spinal cord injuries, closed head injuries and
1127 ventilator dependent patients.

1128 (b) Those services must be provided in a long-term
1129 care nursing facility dedicated to the care and treatment of
1130 persons with severe disabilities, and shall be reimbursed as a
1131 separate category of nursing facilities.

1132 (45) Physician assistant services. Services furnished
1133 by a physician assistant who is licensed by the State Board of
1134 Medical Licensure and is practicing with physician supervision
1135 under regulations adopted by the board, under regulations adopted
1136 by the division. Reimbursement for those services shall not
1137 exceed ninety percent (90%) of the reimbursement rate for
1138 comparable services rendered by a physician.

1139 (46) The division shall make application to the federal
1140 Centers for Medicare and Medicaid Services (CMS) for a waiver to
1141 develop and provide services for children with serious emotional
1142 disturbances as defined in Section 43-14-1(1), which may include
1143 home- and community-based services, case management services or
1144 managed care services through mental health providers certified by
1145 the Department of Mental Health. The division may implement and
1146 provide services under this waived program only if funds for
1147 these services are specifically appropriated for this purpose by
1148 the Legislature, or if funds are voluntarily provided by affected
1149 agencies.

1150 (47) (a) Notwithstanding any other provision in this
1151 article to the contrary, the division, in conjunction with the
1152 State Department of Health, shall develop and implement disease
1153 management programs for individuals with asthma, diabetes or
1154 hypertension, including the use of grants, waivers, demonstrations
1155 or other projects as necessary.

1156 (b) Participation in any disease management
1157 program implemented under this paragraph (47) is optional with the
1158 individual. An individual must affirmatively elect to participate
1159 in the disease management program in order to participate.

1160 (c) An individual who participates in the disease
1161 management program has the option of participating in the
1162 prescription drug home delivery component of the program at any
1163 time while participating in the program. An individual must

1164 affirmatively elect to participate in the prescription drug home
1165 delivery component in order to participate.

1166 (d) An individual who participates in the disease
1167 management program may elect to discontinue participation in the
1168 program at any time. An individual who participates in the
1169 prescription drug home delivery component may elect to discontinue
1170 participation in the prescription drug home delivery component at
1171 any time.

1172 (e) The division shall send written notice to all
1173 individuals who participate in the disease management program
1174 informing them that they may continue using their local pharmacy
1175 or any other pharmacy of their choice to obtain their prescription
1176 drugs while participating in the program.

1177 (f) Prescription drugs that are provided to
1178 individuals under the prescription drug home delivery component
1179 shall be limited only to those drugs that are used for the
1180 treatment, management or care of asthma, diabetes or hypertension.

1181 (48) Pediatric long-term acute care hospital services.

1182 (a) Pediatric long-term acute care hospital
1183 services means services provided to eligible persons under
1184 twenty-one (21) years of age by a freestanding Medicare-certified
1185 hospital that has an average length of inpatient stay greater than
1186 twenty-five (25) days and that is primarily engaged in providing
1187 chronic or long-term medical care to persons under twenty-one (21)
1188 years of age.

1189 (b) The services under this paragraph (48) shall
1190 be reimbursed as a separate category of hospital services.

1191 (49) The division shall establish co-payments and/or
1192 coinsurance for all Medicaid services for which co-payments and/or
1193 coinsurance are allowable under federal law or regulation, except
1194 for nonemergency transportation services, and shall set the amount

1195 of the co-payment and/or coinsurance for each of those services at
1196 the maximum amount allowable under federal law or regulation.

1197 (50) Services provided by the State Department of
1198 Rehabilitation Services for the care and rehabilitation of persons
1199 who are deaf and blind, as allowed under waivers from the United
1200 States Department of Health and Human Services to provide home-
1201 and community-based services using state funds that are provided
1202 from the appropriation to the State Department of Rehabilitation
1203 Services or if funds are voluntarily provided by another agency.

1204 (51) Upon determination of Medicaid eligibility and in
1205 association with annual redetermination of Medicaid eligibility,
1206 beneficiaries shall be encouraged to undertake a physical
1207 examination that will establish a base-line level of health and
1208 identification of a usual and customary source of care (a medical
1209 home) to aid utilization of disease management tools. This
1210 physical examination and utilization of these disease management
1211 tools shall be consistent with current United States Preventive
1212 Services Task Force or other recognized authority recommendations.

1213 Notwithstanding any other provision of this article to the
1214 contrary, the division shall reduce the rate of reimbursement to
1215 providers for any service provided under this section by five
1216 percent (5%) of the allowed amount for that service. However, the
1217 reduction in the reimbursement rates required by this paragraph
1218 shall not apply to inpatient hospital services, nursing facility
1219 services, intermediate care facility services, psychiatric
1220 residential treatment facility services, pharmacy services
1221 provided under paragraph (9) of this section, or any service
1222 provided by the University of Mississippi Medical Center or a
1223 state agency, a state facility or a public agency that either
1224 provides its own state match through intergovernmental transfer or
1225 certification of funds to the division, or a service for which the
1226 federal government sets the reimbursement methodology and rate.

1227 In addition, the reduction in the reimbursement rates required by
1228 this paragraph shall not apply to case management services
1229 provided under the home- and community-based services program for
1230 the elderly and disabled by a planning and development district
1231 (PDD). Planning and development districts participating in the
1232 home- and community-based services program for the elderly and
1233 disabled as case management providers shall be reimbursed for case
1234 management services at the maximum rate approved by the Centers
1235 for Medicare and Medicaid Services (CMS). PDDs shall transfer to
1236 the division state match from public funds (not federal) in an
1237 amount equal to the difference between the maximum case management
1238 reimbursement rate approved by CMS and a five percent (5%)
1239 reduction in that rate. The division shall invoice each PDD
1240 fifteen (15) days after the end of each quarter for the
1241 intergovernmental transfer based on payments made for Medicaid
1242 home- and community-based case management services during the
1243 quarter.

1244 The division may pay to those providers who participate in
1245 and accept patient referrals from the division's emergency room
1246 redirection program a percentage, as determined by the division,
1247 of savings achieved according to the performance measures and
1248 reduction of costs required of that program.

1249 Notwithstanding any provision of this article, except as
1250 authorized in the following paragraph and in Section 43-13-139,
1251 neither (a) the limitations on quantity or frequency of use of or
1252 the fees or charges for any of the care or services available to
1253 recipients under this section, nor (b) the payments or rates of
1254 reimbursement to providers rendering care or services authorized
1255 under this section to recipients, may be increased, decreased or
1256 otherwise changed from the levels in effect on July 1, 1999,
1257 unless they are authorized by an amendment to this section by the
1258 Legislature. However, the restriction in this paragraph shall not

1259 prevent the division from changing the payments or rates of
1260 reimbursement to providers without an amendment to this section
1261 whenever those changes are required by federal law or regulation,
1262 or whenever those changes are necessary to correct administrative
1263 errors or omissions in calculating those payments or rates of
1264 reimbursement.

1265 Notwithstanding any provision of this article, no new groups
1266 or categories of recipients and new types of care and services may
1267 be added without enabling legislation from the Mississippi
1268 Legislature, except that the division may authorize those changes
1269 without enabling legislation when the addition of recipients or
1270 services is ordered by a court of proper authority. The executive
1271 director shall keep the Governor advised on a timely basis of the
1272 funds available for expenditure and the projected expenditures.
1273 If current or projected expenditures of the division can be
1274 reasonably anticipated to exceed the amounts appropriated for any
1275 fiscal year, the Governor, after consultation with the executive
1276 director, shall discontinue any or all of the payment of the types
1277 of care and services as provided in this section that are deemed
1278 to be optional services under Title XIX of the federal Social
1279 Security Act, as amended, for any period necessary to not exceed
1280 appropriated funds, and when necessary shall institute any other
1281 cost containment measures on any program or programs authorized
1282 under the article to the extent allowed under the federal law
1283 governing that program or programs, it being the intent of the
1284 Legislature that expenditures during any fiscal year shall not
1285 exceed the amounts appropriated for that fiscal year.

1286 Notwithstanding any other provision of this article, it shall
1287 be the duty of each nursing facility, intermediate care facility
1288 for the mentally retarded, psychiatric residential treatment
1289 facility, and nursing facility for the severely disabled that is
1290 participating in the Medicaid program to keep and maintain books,

1291 documents and other records as prescribed by the Division of
1292 Medicaid in substantiation of its cost reports for a period of
1293 three (3) years after the date of submission to the Division of
1294 Medicaid of an original cost report, or three (3) years after the
1295 date of submission to the Division of Medicaid of an amended cost
1296 report.

1297 This section shall stand repealed on July 1, 2006.

1298 **SECTION 5.** Section 43-13-121, Mississippi Code of 1972, is
1299 amended as follows:

1300 43-13-121. (1) The division shall administer the Medicaid
1301 program under the provisions of this article, and may do the
1302 following:

1303 (a) Adopt and promulgate reasonable rules, regulations
1304 and standards, with approval of the Governor, and in accordance
1305 with the Administrative Procedures Law, Section 25-43-1 et seq.:

1306 (i) Establishing methods and procedures as may be
1307 necessary for the proper and efficient administration of this
1308 article;

1309 (ii) Providing Medicaid to all qualified
1310 recipients under the provisions of this article as the division
1311 may determine and within the limits of appropriated funds;

1312 (iii) Establishing reasonable fees, charges and
1313 rates for medical services and drugs; in doing so, the division
1314 shall fix all of those fees, charges and rates at the minimum
1315 levels absolutely necessary to provide the medical assistance
1316 authorized by this article, and shall not change any of those
1317 fees, charges or rates except as may be authorized in Section
1318 43-13-117;

1319 (iv) Providing for fair and impartial hearings;

1320 (v) Providing safeguards for preserving the
1321 confidentiality of records; and

1322 (vi) For detecting and processing fraudulent
1323 practices and abuses of the program;

1324 (b) Receive and expend state, federal and other funds
1325 in accordance with court judgments or settlements and agreements
1326 between the State of Mississippi and the federal government, the
1327 rules and regulations promulgated by the division, with the
1328 approval of the Governor, and within the limitations and
1329 restrictions of this article and within the limits of funds
1330 available for that purpose;

1331 (c) Subject to the limits imposed by this article, to
1332 submit a Medicaid plan to the United States Department of Health
1333 and Human Services for approval under the provisions of the
1334 federal Social Security Act, to act for the state in making
1335 negotiations relative to the submission and approval of that plan,
1336 to make such arrangements, not inconsistent with the law, as may
1337 be required by or under federal law to obtain and retain that
1338 approval and to secure for the state the benefits of the
1339 provisions of that law.

1340 No agreements, specifically including the general plan for
1341 the operation of the Medicaid program in this state, shall be made
1342 by and between the division and the United States Department of
1343 Health and Human Services unless the Attorney General of the State
1344 of Mississippi has reviewed the agreements, specifically including
1345 the operational plan, and has certified in writing to the Governor
1346 and to the executive director of the division that the agreements,
1347 including the plan of operation, have been drawn strictly in
1348 accordance with the terms and requirements of this article;

1349 (d) In accordance with the purposes and intent of this
1350 article and in compliance with its provisions, provide for aged
1351 persons otherwise eligible for the benefits provided under Title
1352 XVIII of the federal Social Security Act by expenditure of funds
1353 available for those purposes;

1354 (e) To make reports to the United States Department of
1355 Health and Human Services as from time to time may be required by
1356 that federal department and to the Mississippi Legislature as
1357 provided in this section;

1358 (f) Define and determine the scope, duration and amount
1359 of Medicaid that may be provided in accordance with this article
1360 and establish priorities therefor in conformity with this article;

1361 (g) Cooperate and contract with other state agencies
1362 for the purpose of coordinating Medicaid provided under this
1363 article and eliminating duplication and inefficiency in the
1364 Medicaid program;

1365 (h) Adopt and use an official seal of the division;

1366 (i) Sue in its own name on behalf of the State of
1367 Mississippi and employ legal counsel on a contingency basis with
1368 the approval of the Attorney General;

1369 (j) To recover any and all payments incorrectly made by
1370 the division * * * to a recipient or provider from the recipient
1371 or provider receiving the payments. The division shall report to
1372 the State Tax Commission the name of any current or former
1373 Medicaid recipient who has received medical services rendered
1374 during a period of established Medicaid ineligibility, or a
1375 Medicaid provider that has received reimbursement(s) for medical
1376 services rendered to an ineligible individual, and who has not
1377 reimbursed the division for the related medical service payment(s)
1378 or reimbursement(s). The State Tax Commission shall withhold from
1379 the state tax refund of the individual or the provider, and pay to
1380 the division, the amount of the payment(s) for medical services
1381 rendered to the ineligible individual, or the amount of the
1382 reimbursement(s) made to the provider for medical services
1383 rendered to an ineligible individual, that have not been
1384 reimbursed to the division for the related medical service
1385 payment(s) or reimbursements(s);

1386 (k) To recover any and all payments by the
1387 division * * * fraudulently obtained by a recipient or provider.
1388 Additionally, if recovery of any payments fraudulently obtained by
1389 a recipient or provider is made in any court, then, upon motion of
1390 the Governor, the judge of the court may award twice the payments
1391 recovered as damages;

1392 (1) Have full, complete and plenary power and authority
1393 to conduct such investigations as it may deem necessary and
1394 requisite of alleged or suspected violations or abuses of the
1395 provisions of this article or of the regulations adopted under
1396 this article, including, but not limited to, fraudulent or
1397 unlawful act or deed by applicants for Medicaid or other benefits,
1398 or payments made to any person, firm or corporation under the
1399 terms, conditions and authority of this article, to suspend or
1400 disqualify any provider of services, applicant or recipient for
1401 gross abuse, fraudulent or unlawful acts for such periods,
1402 including permanently, and under such conditions as the division
1403 deems proper and just, including the imposition of a legal rate of
1404 interest on the amount improperly or incorrectly paid. Recipients
1405 who are found to have misused or abused Medicaid benefits may be
1406 locked into one (1) physician and/or one (1) pharmacy of the
1407 recipient's choice for a reasonable amount of time in order to
1408 educate and promote appropriate use of medical services, in
1409 accordance with federal regulations. If an administrative hearing
1410 becomes necessary, the division may, if the provider does not
1411 succeed in his or her defense, tax the costs of the administrative
1412 hearing, including the costs of the court reporter or stenographer
1413 and transcript, to the provider. The convictions of a recipient
1414 or a provider in a state or federal court for abuse, fraudulent or
1415 unlawful acts under this chapter shall constitute an automatic
1416 disqualification of the recipient or automatic disqualification of
1417 the provider from participation under the Medicaid program.

1418 A conviction, for the purposes of this chapter, shall include
1419 a judgment entered on a plea of nolo contendere or a
1420 nonadjudicated guilty plea and shall have the same force as a
1421 judgment entered pursuant to a guilty plea or a conviction
1422 following trial. A certified copy of the judgment of the court of
1423 competent jurisdiction of the conviction shall constitute prima
1424 facie evidence of the conviction for disqualification purposes;

1425 (m) Establish and provide such methods of
1426 administration as may be necessary for the proper and efficient
1427 operation of the Medicaid program, fully utilizing computer
1428 equipment as may be necessary to oversee and control all current
1429 expenditures for purposes of this article, and to closely monitor
1430 and supervise all recipient payments and vendors rendering
1431 services under this article;

1432 (n) To cooperate and contract with the federal
1433 government for the purpose of providing Medicaid to Vietnamese and
1434 Cambodian refugees, under the provisions of Public Law 94-23 and
1435 Public Law 94-24, including any amendments to those laws, only to
1436 the extent that the Medicaid assistance and the administrative
1437 cost related thereto are one hundred percent (100%) reimbursable
1438 by the federal government. For the purposes of Section 43-13-117,
1439 persons receiving Medicaid under Public Law 94-23 and Public Law
1440 94-24, including any amendments to those laws, shall not be
1441 considered a new group or category of recipient; and

1442 (o) The division shall impose penalties upon Medicaid
1443 only, Title XIX participating long-term care facilities found to
1444 be in noncompliance with division and certification standards in
1445 accordance with federal and state regulations, including interest
1446 at the same rate calculated by the United States Department of
1447 Health and Human Services and/or the Centers for Medicare and
1448 Medicaid Services (CMS) under federal regulations.

1449 (2) The division also shall exercise such additional powers
1450 and perform such other duties as may be conferred upon the
1451 division by act of the Legislature.

1452 (3) The division, and the State Department of Health as the
1453 agency for licensure of health care facilities and certification
1454 and inspection for the Medicaid and/or Medicare programs, shall
1455 contract for or otherwise provide for the consolidation of on-site
1456 inspections of health care facilities that are necessitated by the
1457 respective programs and functions of the division and the
1458 department.

1459 (4) The division and its hearing officers shall have power
1460 to preserve and enforce order during hearings; to issue subpoenas
1461 for, to administer oaths to and to compel the attendance and
1462 testimony of witnesses, or the production of books, papers,
1463 documents and other evidence, or the taking of depositions before
1464 any designated individual competent to administer oaths; to
1465 examine witnesses; and to do all things conformable to law that
1466 may be necessary to enable them effectively to discharge the
1467 duties of their office. In compelling the attendance and
1468 testimony of witnesses, or the production of books, papers,
1469 documents and other evidence, or the taking of depositions, as
1470 authorized by this section, the division or its hearing officers
1471 may designate an individual employed by the division or some other
1472 suitable person to execute and return that process, whose action
1473 in executing and returning that process shall be as lawful as if
1474 done by the sheriff or some other proper officer authorized to
1475 execute and return process in the county where the witness may
1476 reside. In carrying out the investigatory powers under the
1477 provisions of this article, the executive director or other
1478 designated person or persons may examine, obtain, copy or
1479 reproduce the books, papers, documents, medical charts,
1480 prescriptions and other records relating to medical care and

1481 services furnished by the provider to a recipient or designated
1482 recipients of Medicaid services under investigation. In the
1483 absence of the voluntary submission of the books, papers,
1484 documents, medical charts, prescriptions and other records, the
1485 Governor, the executive director, or other designated person may
1486 issue and serve subpoenas instantly upon the provider, his or her
1487 agent, servant or employee for the production of the books,
1488 papers, documents, medical charts, prescriptions or other records
1489 during an audit or investigation of the provider. If any provider
1490 or his or her agent, servant or employee refuses to produce the
1491 records after being duly subpoenaed, the executive director may
1492 certify those facts and institute contempt proceedings in the
1493 manner, time and place as authorized by law for administrative
1494 proceedings. As an additional remedy, the division may recover
1495 all amounts paid to the provider covering the period of the audit
1496 or investigation, inclusive of a legal rate of interest and a
1497 reasonable attorney's fee and costs of court if suit becomes
1498 necessary. Division staff shall have immediate access to the
1499 provider's physical location, facilities, records, documents,
1500 books, and any other records relating to medical care and services
1501 rendered to recipients during regular business hours.

1502 (5) If any person in proceedings before the division
1503 disobeys or resists any lawful order or process, or misbehaves
1504 during a hearing or so near the place thereof as to obstruct the
1505 hearing, or neglects to produce, after having been ordered to do
1506 so, any pertinent book, paper or document, or refuses to appear
1507 after having been subpoenaed, or upon appearing refuses to take
1508 the oath as a witness, or after having taken the oath refuses to
1509 be examined according to law, the executive director shall certify
1510 the facts to any court having jurisdiction in the place in which
1511 it is sitting, and the court shall thereupon, in a summary manner,
1512 hear the evidence as to the acts complained of, and if the

1513 evidence so warrants, punish that person in the same manner and to
1514 the same extent as for a contempt committed before the court, or
1515 commit that person upon the same condition as if the doing of the
1516 forbidden act had occurred with reference to the process of, or in
1517 the presence of, the court.

1518 (6) In suspending or terminating any provider from
1519 participation in the Medicaid program, the division shall preclude
1520 the provider from submitting claims for payment, either personally
1521 or through any clinic, group, corporation or other association to
1522 the division or its fiscal agents for any services or supplies
1523 provided under the Medicaid program except for those services or
1524 supplies provided before the suspension or termination. No
1525 clinic, group, corporation or other association that is a provider
1526 of services shall submit claims for payment to the division or its
1527 fiscal agents for any services or supplies provided by a person
1528 within that organization who has been suspended or terminated from
1529 participation in the Medicaid program except for those services or
1530 supplies provided before the suspension or termination. When this
1531 provision is violated by a provider of services that is a clinic,
1532 group, corporation or other association, the division may suspend
1533 or terminate that organization from participation. Suspension may
1534 be applied by the division to all known affiliates of a provider,
1535 provided that each decision to include an affiliate is made on a
1536 case-by-case basis after giving due regard to all relevant facts
1537 and circumstances. The violation, failure or inadequacy of
1538 performance may be imputed to a person with whom the provider is
1539 affiliated where that conduct was accomplished within the course
1540 of his or her official duty or was effectuated by him or her with
1541 the knowledge or approval of that person.

1542 (7) The division may deny or revoke enrollment in the
1543 Medicaid program to a provider if any of the following are found
1544 to be applicable to the provider, his or her agent, a managing

1545 employee or any person having an ownership interest equal to five
1546 percent (5%) or greater in the provider:

1547 (a) Failure to truthfully or fully disclose any and all
1548 information required, or the concealment of any and all
1549 information required, on a claim, a provider application or a
1550 provider agreement, or the making of a false or misleading
1551 statement to the division relative to the Medicaid program.

1552 (b) Previous or current exclusion, suspension,
1553 termination from or the involuntary withdrawing from participation
1554 in the Medicaid program, any other state's Medicaid program,
1555 Medicare or any other public or private health or health insurance
1556 program. If the division ascertains that a provider has been
1557 convicted of a felony under federal or state law for an offense
1558 that the division determines is detrimental to the best interest
1559 of the program or of Medicaid beneficiaries, the division may
1560 refuse to enter into an agreement with that provider, or may
1561 terminate or refuse to renew an existing agreement.

1562 (c) Conviction under federal or state law of a criminal
1563 offense relating to the delivery of any goods, services or
1564 supplies, including the performance of management or
1565 administrative services relating to the delivery of the goods,
1566 services or supplies, under the Medicaid program, any other
1567 state's Medicaid program, Medicare or any other public or private
1568 health or health insurance program.

1569 (d) Conviction under federal or state law of a criminal
1570 offense relating to the neglect or abuse of a patient in
1571 connection with the delivery of any goods, services or supplies.

1572 (e) Conviction under federal or state law of a criminal
1573 offense relating to the unlawful manufacture, distribution,
1574 prescription or dispensing of a controlled substance.

1575 (f) Conviction under federal or state law of a criminal
1576 offense relating to fraud, theft, embezzlement, breach of
1577 fiduciary responsibility or other financial misconduct.

1578 (g) Conviction under federal or state law of a criminal
1579 offense punishable by imprisonment of a year or more that involves
1580 moral turpitude, or acts against the elderly, children or infirm.

1581 (h) Conviction under federal or state law of a criminal
1582 offense in connection with the interference or obstruction of any
1583 investigation into any criminal offense listed in paragraphs (c)
1584 through (i) of this subsection.

1585 (i) Sanction for a violation of federal or state laws
1586 or rules relative to the Medicaid program, any other state's
1587 Medicaid program, Medicare or any other public health care or
1588 health insurance program.

1589 (j) Revocation of license or certification.

1590 (k) Failure to pay recovery properly assessed or
1591 pursuant to an approved repayment schedule under the Medicaid
1592 program.

1593 (l) Failure to meet any condition of enrollment.

1594 **SECTION 6.** Section 43-13-125, Mississippi Code of 1972, is
1595 amended as follows:

1596 43-13-125. (1) If Medicaid is provided to a recipient under
1597 this article for injuries, disease or sickness caused under
1598 circumstances creating a cause of action in favor of the recipient
1599 against any person, firm or corporation, then the division shall
1600 be entitled to recover the proceeds that may result from the
1601 exercise of any rights of recovery that the recipient may have
1602 against any such person, firm or corporation to the extent of the
1603 Division of Medicaid's interest on behalf of the recipient. The
1604 recipient shall execute and deliver instruments and papers to do
1605 whatever is necessary to secure those rights and shall do nothing
1606 after Medicaid is provided to prejudice the subrogation rights of

1607 the division. Court orders or agreements for reimbursement of
1608 Medicaid's interest shall direct those payments to the Division of
1609 Medicaid, which shall be authorized to endorse any and all,
1610 including, but not limited to, multi-payee checks, drafts, money
1611 orders, or other negotiable instruments representing Medicaid
1612 payment recoveries that are received. In accordance with Section
1613 43-13-305, endorsement of multi-payee checks, drafts, money orders
1614 or other negotiable instruments by the Division of Medicaid shall
1615 be deemed endorsed by the recipient.

1616 The division, with the approval of the Governor, may
1617 compromise or settle any such claim and execute a release of any
1618 claim it has by virtue of this section.

1619 (2) The acceptance of Medicaid under this article or the
1620 making of a claim under this article shall not affect the right of
1621 a recipient or his or her legal representative to recover
1622 Medicaid's interest as an element of * * * damages in any action
1623 at law; however, a copy of the pleadings shall be certified to the
1624 division at the time of the institution of suit, and proof of
1625 that notice shall be filed of record in that action. The division
1626 may, at any time before the trial on the facts, join in that
1627 action or may intervene in that action. Any amount recovered by a
1628 recipient or his or her legal representative shall be applied as
1629 follows:

1630 (a) The reasonable costs of the collection, including
1631 attorney's fees, as approved and allowed by the court in which
1632 that action is pending, or in case of settlement without suit, by
1633 the legal representative of the division;

1634 (b) The amount of Medicaid's interest on behalf of the
1635 recipient; or such pro rata amount as may be arrived at by the
1636 legal representative of the division and the recipient's attorney,
1637 or as set by the court having jurisdiction; and

1638 (c) Any excess shall be awarded to the recipient.

1639 (3) No compromise of any claim by the recipient or his or
1640 her legal representative shall be binding upon or affect the
1641 rights of the division against the third party unless the
1642 division, with the approval of the Governor, has entered into the
1643 compromise. Any compromise effected by the recipient or his or
1644 her legal representative with the third party in the absence of
1645 advance notification to and approved by the division shall
1646 constitute conclusive evidence of the liability of the third
1647 party, and the division, in litigating its claim against the third
1648 party, shall be required only to prove the amount and correctness
1649 of its claim relating to the injury, disease or sickness. If the
1650 recipient or his or her legal representative fails to notify the
1651 division of the institution of legal proceedings against a third
1652 party for which the division has a cause of action, the facts
1653 relating to negligence and the liability of the third party, if
1654 judgment is rendered for the recipient, shall constitute
1655 conclusive evidence of liability in a subsequent action maintained
1656 by the division and only the amount and correctness of the
1657 division's claim relating to injuries, disease or sickness shall
1658 be tried before the court. The division shall be authorized in
1659 bringing that action against the third party and his or her
1660 insurer jointly or against the insurer alone.

1661 (4) Nothing in this section shall be construed to diminish
1662 or otherwise restrict the subrogation rights of the Division of
1663 Medicaid against a third party for Medicaid provided by the
1664 Division of Medicaid to the recipient as a result of injuries,
1665 disease or sickness caused under circumstances creating a cause of
1666 action in favor of the recipient against such a third party.

1667 (5) Any amounts recovered by the division under this section
1668 shall, by the division, be placed to the credit of the funds
1669 appropriated for benefits under this article proportionate to the

1670 amounts provided by the state and federal governments
1671 respectively.

1672 **SECTION 7.** Section 43-13-145, Mississippi Code of 1972, is
1673 amended as follows:

1674 43-13-145. (1) (a) Upon each nursing facility and each
1675 intermediate care facility for the mentally retarded licensed by
1676 the State of Mississippi, there is levied an assessment in the
1677 amount of Six Dollars (\$6.00) per day for each licensed and/or
1678 certified bed of the facility. * * *

1679 (b) A nursing facility or intermediate care facility
1680 for the mentally retarded is exempt from the assessment levied
1681 under this subsection if the facility is operated under the
1682 direction and control of:

1683 (i) The United States Veterans Administration or
1684 other agency or department of the United States government;

1685 (ii) The State Veterans Affairs Board;

1686 (iii) The University of Mississippi Medical
1687 Center; or

1688 (iv) A state agency or a state facility that
1689 either provides its own state match through intergovernmental
1690 transfer or certification of funds to the division.

1691 (2) (a) Upon each psychiatric residential treatment
1692 facility licensed by the State of Mississippi, there is levied an
1693 assessment in the amount of Six Dollars (\$6.00) per day for each
1694 licensed and/or certified bed of the facility.

1695 (b) A psychiatric residential treatment facility is
1696 exempt from the assessment levied under this subsection if the
1697 facility is operated under the direction and control of:

1698 (i) The United States Veterans Administration or
1699 other agency or department of the United States government;

1700 (ii) The University of Mississippi Medical Center;

1701 (iii) A state agency or a state facility that
1702 either provides its own state match through intergovernmental
1703 transfer or certification of funds to the division.

1704 (3) (a) Upon each hospital licensed by the State of
1705 Mississippi, there is levied an assessment in the amount of One
1706 Dollar and Fifty Cents (\$1.50) per day for each licensed inpatient
1707 acute care bed of the hospital.

1708 (b) A hospital is exempt from the assessment levied
1709 under this subsection if the hospital is operated under the
1710 direction and control of:

1711 (i) The United States Veterans Administration or
1712 other agency or department of the United States government;

1713 (ii) The University of Mississippi Medical Center;
1714 or

1715 (iii) A state agency or a state facility that
1716 either provides its own state match through intergovernmental
1717 transfer or certification of funds to the division.

1718 (4) Each health care facility that is subject to the
1719 provisions of this section shall keep and preserve such suitable
1720 books and records as may be necessary to determine the amount of
1721 assessment for which it is liable under this section. The books
1722 and records shall be kept and preserved for a period of not less
1723 than five (5) years, and those books and records shall be open for
1724 examination during business hours by the division, the State Tax
1725 Commission, the Office of the Attorney General and the State
1726 Department of Health.

1727 (5) The assessment levied under this section shall be
1728 collected by the division each month beginning on April 12, 2002.

1729 (6) All assessments collected under this section shall be
1730 deposited in the Medical Care Fund created by Section 43-13-143.

1731 (7) The assessment levied under this section shall be in
1732 addition to any other assessments, taxes or fees levied by law,

1733 and the assessment shall constitute a debt due the State of
1734 Mississippi from the time the assessment is due until it is paid.

1735 (8) (a) If a health care facility that is liable for
1736 payment of the assessment levied under this section does not pay
1737 the assessment when it is due, the division shall give written
1738 notice to the health care facility by certified or registered mail
1739 demanding payment of the assessment within ten (10) days from the
1740 date of delivery of the notice. If the health care facility
1741 fails or refuses to pay the assessment after receiving the notice
1742 and demand from the division, the division shall withhold from any
1743 Medicaid reimbursement payments that are due to the health care
1744 facility the amount of the unpaid assessment and a penalty of ten
1745 percent (10%) of the amount of the assessment, plus the legal rate
1746 of interest until the assessment is paid in full. If the health
1747 care facility does not participate in the Medicaid program, the
1748 division shall turn over to the Office of the Attorney General the
1749 collection of the unpaid assessment by civil action. In any such
1750 civil action, the Office of the Attorney General shall collect the
1751 amount of the unpaid assessment and a penalty of ten percent (10%)
1752 of the amount of the assessment, plus the legal rate of interest
1753 until the assessment is paid in full.

1754 (b) As an additional or alternative method for
1755 collecting unpaid assessments under this section, if a health care
1756 facility fails or refuses to pay the assessment after receiving
1757 notice and demand from the division, the division may file a
1758 notice of a tax lien with the circuit clerk of the county in which
1759 the health care facility is located, for the amount of the unpaid
1760 assessment and a penalty of ten percent (10%) of the amount of the
1761 assessment, plus the legal rate of interest until the assessment
1762 is paid in full. Immediately upon receipt of notice of the tax
1763 lien for the assessment, the circuit clerk shall enter the notice
1764 of the tax lien as a judgment upon the judgment roll and show in

1765 the appropriate columns the name of the health care facility as
1766 judgment debtor, the name of the division as judgment creditor,
1767 the amount of the unpaid assessment, and the date and time of
1768 enrollment. The judgment shall be valid as against mortgagees,
1769 pledgees, entrusters, purchasers, judgment creditors and other
1770 persons from the time of filing with the clerk. The amount of the
1771 judgment shall be a debt due the State of Mississippi and remain a
1772 lien upon the tangible property of the health care facility until
1773 the judgment is satisfied. The judgment shall be the equivalent
1774 of any enrolled judgment of a court of record and shall serve as
1775 authority for the issuance of writs of execution, writs of
1776 attachment or other remedial writs.

1777 **SECTION 8.** Section 43-13-317, Mississippi Code of 1972, is
1778 amended as follows:

1779 43-13-317. (1) * * * The division shall be noticed as an
1780 identified creditor against the estate of any deceased Medicaid
1781 recipient under Section 91-7-145.

1782 (2) In accordance with applicable federal law and rules and
1783 regulations, including those under Title XIX of the federal Social
1784 Security Act, the division may seek recovery of payments for
1785 nursing facility services, home- and community-based services and
1786 related hospital and prescription drug services from the estate of
1787 a deceased Medicaid recipient who was fifty-five (55) years of age
1788 or older when he or she received the assistance. The claim shall
1789 be waived by the division (a) if there is a surviving spouse; or
1790 (b) if there is a surviving dependent who is under the age of
1791 twenty-one (21) years or who is blind or disabled; or (c) as
1792 provided by federal law and regulation, if it is determined by the
1793 division or by court order that there is undue hardship.

1794 **SECTION 9.** Section 43-13-141, Mississippi Code of 1972,
1795 which provides for an assessment upon certain Medicaid

1796 reimbursement payments to be paid into the Medical Care Assessment
1797 Fund, is repealed.

1798 **SECTION 10.** This act shall take effect and be in force from
1799 and after July 1, 2004.

**Further, amend by striking the title in its entirety and
inserting in lieu thereof the following:**

1 AN ACT TO AMEND SECTION 43-13-107, MISSISSIPPI CODE OF 1972,
2 WHICH CREATES THE DIVISION OF MEDICAID, PRESCRIBES ITS DUTIES AND
3 RESPONSIBILITIES, PROVIDES FOR THE APPOINTMENT OF AN EXECUTIVE
4 DIRECTOR OF THE DIVISION, PROVIDES FOR THE AUTHORITY AND
5 RESPONSIBILITIES OF THE EXECUTIVE DIRECTOR, PROVIDES FOR A MEDICAL
6 CARE ADVISORY COMMITTEE, PROVIDES FOR A DRUG USE REVIEW BOARD AND
7 PROVIDES FOR THE PHARMACY AND THERAPEUTICS COMMITTEE, TO EXTEND
8 THE AUTOMATIC REPEALER ON THAT SECTION; TO ADD THE CHAIRMAN OF THE
9 HOUSE MEDICAID COMMITTEE AS A MEMBER OF THE MEDICAL CARE ADVISORY
10 COMMITTEE; TO AMEND SECTION 43-13-113, MISSISSIPPI CODE OF 1972,
11 TO INCREASE THE AUTHORIZED LINE OF CREDIT FOR THE DIVISION TO USE
12 FOR BUDGET SHORTFALLS; TO AMEND SECTION 43-13-115, MISSISSIPPI
13 CODE OF 1972, TO REQUIRE THE DIVISION TO REDETERMINE ELIGIBILITY
14 FOR ALL CATEGORIES OF MEDICAID RECIPIENTS NOT LESS FREQUENTLY THAN
15 REQUIRED BY FEDERAL LAW; TO DEFINE THE RESPONSIBILITY OF THE
16 DIVISION AND THE DEPARTMENT OF HUMAN SERVICES REGARDING
17 ELIGIBILITY DETERMINATION; TO AMEND SECTION 43-13-117, MISSISSIPPI
18 CODE OF 1972, TO DELETE THE REIMBURSEMENT RATE FOR PHYSICIANS
19 SERVICES AND CLINIC SERVICES TO RECIPIENTS THAT ARE DUALY
20 ELIGIBLE UNDER MEDICAID AND MEDICARE; TO DIRECT THE DIVISION TO
21 ESTABLISH A MANDATORY PREFERRED DRUG LIST FOR MEDICAID
22 REIMBURSEMENT; TO PROVIDE THAT DRUGS NOT ON THE MANDATORY
23 PREFERRED DRUG LIST SHALL BE MADE AVAILABLE BY UTILIZING PRIOR
24 AUTHORIZATION PROCEDURES; TO AUTHORIZE AGREEMENTS WITH OTHER
25 STATES TO LOWER THE ACQUISITION COSTS OF PRESCRIPTION DRUGS; TO
26 AUTHORIZE A COMBINATION OF NAMED BRAND AND GENERIC PRESCRIPTIONS
27 WITH MONTHLY LIMITATIONS; TO ALLOW UNLIMITED GENERIC DRUGS; TO
28 DELETE THE MONTHLY LIMITATION FOR DRUG PRESCRIPTIONS WITHOUT PRIOR
29 AUTHORIZATION; TO REQUIRE THE DIVISION TO INCLUDE ANTIRETROVIRAL
30 AND FUSION INHIBITOR MEDICATIONS IN ANY PREFERRED DRUG LIST
31 DEVELOPED BY THE DIVISION; TO AUTHORIZE REIMBURSEMENT FOR
32 MULTISOURCE DRUGS AT THE ESTIMATED ACQUISITION COST AS DETERMINED
33 BY THE DIVISION; TO REQUIRE MEDICAID PROVIDERS TO USE
34 COUNTERFEIT-PROOF PRESCRIPTION PADS FOR MEDICAID PRESCRIPTIONS FOR
35 CONTROLLED SUBSTANCES; TO DELETE THE AUTHORITY FOR THE DIVISION TO
36 CONTRACT WITH THE MISSISSIPPI HOSPITAL ASSOCIATION TO PROVIDE
37 ADMINISTRATIVE SUPPORT FOR THE DISPROPORTIONATE SHARE HOSPITAL
38 PROGRAM AND MEDICARE UPPER PAYMENT LIMITS PROGRAM; TO DELETE THE
39 AUTHORITY OF THE DIVISION TO SET REIMBURSEMENT RATES FOR PERINATAL
40 RISK MANAGEMENT SERVICES IN CONJUNCTION WITH THE STATE DEPARTMENT
41 OF HEALTH; TO AUTHORIZE MEDICAID REIMBURSEMENT FOR ANNUAL PHYSICAL
42 EXAMINATIONS TO ESTABLISH A BASE-LINE LEVEL OF HEALTH AND TO
43 IDENTIFY A USUAL SOURCE OF CARE IN CONJUNCTION WITH THE ANNUAL
44 REDETERMINATION OF MEDICAID ELIGIBILITY; TO EXTEND THE AUTOMATIC
45 REPEALER ON THAT SECTION; TO AMEND SECTION 43-13-121, MISSISSIPPI
46 CODE OF 1972, TO DIRECT THE STATE TAX COMMISSION TO WITHHOLD
47 UNREIMBURSED FUNDS FROM THE STATE TAX REFUND OF AN INELIGIBLE
48 MEDICAID RECIPIENT OR A PROVIDER OF SERVICES TO AN INELIGIBLE
49 INDIVIDUAL AND PAY THOSE AMOUNTS TO THE DIVISION; TO AMEND SECTION
50 43-13-125, MISSISSIPPI CODE OF 1972, TO CLARIFY THE RECOVERY OF
51 MEDICAID PAYMENTS FROM THIRD PARTIES AS AN ELEMENT OF DAMAGES; TO

52 AMEND SECTION 43-13-145, MISSISSIPPI CODE OF 1972, TO INCREASE THE
53 ASSESSMENT LEVIED UPON BEDS OF NURSING FACILITIES, ICF-MR
54 FACILITIES AND PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES FOR
55 THE SUPPORT OF THE MEDICAID PROGRAM; TO DELETE THE WAIVER
56 AUTHORITY FOR CERTAIN NONPROFIT CHARITABLE INSTITUTIONS; TO AMEND
57 SECTION 43-13-317, MISSISSIPPI CODE OF 1972, TO CLARIFY THE
58 PROCEDURES FOR RECOVERY OF MEDICAID PAYMENTS FROM THE ESTATE OF A
59 DECEASED RECIPIENT; TO REPEAL SECTION 43-13-141, MISSISSIPPI CODE
60 OF 1972, WHICH PROVIDES FOR AN ASSESSMENT UPON CERTAIN MEDICAID
61 REIMBURSEMENT PAYMENTS TO BE PAID INTO THE MEDICAL CARE ASSESSMENT
62 FUND; AND FOR RELATED PURPOSES.