MISSISSIPPI LEGISLATURE REGULAR SESSION 2005

By: Senator(s) Nunnelee, Burton

To: Public Health and Welfare; Appropriations

COMMITTEE SUBSTITUTE
FOR
SENATE BILL NO. 2745

AN ACT RELATING TO THE MISSISSIPPI MEDICAID PROGRAM; TO AMEND SECTION 43-13-107, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT THE EXECUTIVE DIRECTOR AND THE DEPUTY DIRECTOR OF THE DIVISION OF MEDICAID SHALL SERVE AT THE WILL AND PLEASURE OF THE GOVERNOR; TO CONFORM THE OPERATION OF THE MEDICAID PHARMACY AND THERAPEUTICS COMMITTEE WITH FEDERAL CONFIDENTIALITY REGULATIONS AND TO CONFORM COMMITTEE MEETING REQUIREMENTS WITH THE MISSISSIPPI ADMINISTRATIVE PROCEDURES ACT; TO PROVIDE FOR PUBLIC INPUT AT SUCH COMMITTEE MEETINGS; TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972, TO REINSTATE MEDICAID ELIGIBILITY FOR THE POVERTY-LEVEL, AGED OR DISABLED GROUP (PLADS) UNTIL JANUARY 1, 2006, AND TO PROVIDE THAT ELIGIBILITY FOR THAT GROUP SHALL BE DETERMINED BY THE DIVISION OF MEDICAID; TO DEFINE MEDICAID ELIGIBILITY FOR INDIVIDUALS PURSUANT TO MEDICARE PART D; TO DELETE A CATEGORY OF ELIGIBILITY RELATING TO HOSPICE CARE; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO PROVIDE A LIMIT ON INPATIENT HOSPITAL DAYS REIMBURSABLE UNDER MEDICAID; TO ESTABLISH A CO-PAYMENT REQUIREMENT FOR INPATIENT HOSPITAL SERVICES; TO DEFINE THE AGE LIMITATION FOR UNLIMITED DAYS IN DISPROPORTIONATE SHARE HOSPITALS; TO ESTABLISH A REIMBURSEMENT LIMIT FOR EMERGENCY ROOM VISITS; TO ESTABLISH A CO-PAYMENT REQUIREMENT FOR NONEMERGENCY VISITS TO AN EMERGENCY ROOM; TO PROVIDE FOR NONEMERGENCY OUTPATIENT HOSPITAL SERVICES REIMBURSABLE UNDER MEDICAID; TO ESTABLISH A CO-PAYMENT REQUIREMENT FOR PHYSICIAN AND SPECIALIST VISITS; TO DELETE CERTAIN RESTRICTIONS ON THE REIMBURSEMENT RATE FOR PHYSICIAN SERVICES; TO PROVIDE A LIMIT ON HOME HEALTH SERVICE VISITS REIMBURSABLE UNDER MEDICAID; TO ESTABLISH A CO-PAYMENT REQUIREMENT FOR HOME HEALTH SERVICE VISITS; TO ESTABLISH A CO-PAYMENT REQUIREMENT FOR PRESCRIPTION DRUGS REIMBURSABLE UNDER MEDICAID; TO PROVIDE A MONTHLY LIMIT ON PRESCRIPTION DRUGS REIMBURSABLE UNDER MEDICAID AND TO DELETE THE AUTHORITY FOR UNLIMITED PRESCRIPTIONS FOR GENERIC DRUGS; TO REVISE THE DRUG SUPPLY REIMBURSABLE UNDER MEDICAID; TO PROVIDE FOR TRUE UNIT DOSES OF DRUGS PRESCRIBED FOR LONG-TERM CARE FACILITY RESIDENTS; TO PROVIDE FOR THE CONFIDENTIALITY OF INFORMATION REGARDING THE DRUG PROGRAM; TO PROVIDE AN ANNUAL LIMIT ON REIMBURSEMENT FOR DENTAL SERVICES; TO ESTABLISH A CO-PAYMENT REQUIREMENT FOR CLINIC SERVICES REIMBURSABLE UNDER MEDICAID; TO DELETE THE LIMITATION ON THE REIMBURSEMENT RATE FOR CLINIC SERVICES UNDER MEDICAID; TO ESTABLISH A CO-PAYMENT REQUIREMENT FOR DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES; TO DELETE THE AUTOMATIC REPEALER ON THE MEDICARE UPPER PAYMENT LIMITS PROGRAM; TO AUTHORIZE THE DIVISION TO ESTABLISH A MANAGED CARE SERVICES PROGRAM UTILIZING A PUBLIC OR PRIVATE PROVIDER FOR THE RESPONSIBLE CONTAINMENT OF COSTS; TO PROVIDE A LIMIT ON NONEMERGENCY TRANSPORTATION SERVICES REIMBURSABLE UNDER MEDICAID; TO ESTABLISH A CO-PAYMENT REQUIREMENT FOR CHIROPRACTIC SERVICES UNDER MEDICAID; TO CLARIFY THE DISEASES AND CONDITIONS ELIGIBLE FOR THE DISEASE MANAGEMENT PROGRAM UNDER MEDICAID; TO AUTHORIZE THE DIVISION TO PROVIDE TARGETED CASE MANAGEMENT SERVICES FOR CERTAIN HIGH-COST CASES; TO REVISE THE AUTHORITY OF THE GOVERNOR TO DISCONTINUE PAYMENT FOR SERVICES AND TAKE COST CONTAINMENT MEASURES WHEN DIVISION EXPENDITURES ARE

ABOVE THE AMOUNT OF FUNDS APPROPRIATED; TO AMEND SECTION 43-13-145, MISSISSIPPI CODE OF 1972, TO INCREASE THE PER BED PER DAY ASSESSMENT LEVIED UPON CERTAIN HEALTH CARE FACILITIES TO THE MAXIMUM AMOUNT ALLOWABLE UNDER FEDERAL REGULATION AND TO REMOVE CERTAIN EXCEPTIONS; TO AMEND SECTIONS 25-9-107 AND 25-9-127, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT FOR A PERIOD OF ONE YEAR, THE PERSONNEL ACTIONS OF ALL EXECUTIVE AGENCIES SHALL BE EXEMPT FROM CERTAIN STATE PERSONNEL BOARD PROCEDURES AND TO SUSPEND EMPLOYMENT RIGHTS FOR SUCH EMPLOYEES DURING THAT PERIOD; AND FOR RELATED PURPOSES.

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

SECTION 1. Section 43-13-107, Mississippi Code of 1972, is amended as follows:

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

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

(b) The Governor shall appoint a full-time Deputy Director of Administration, with the advice and consent of the Senate, who shall have at least a bachelor's degree from an accredited college or university, and/or shall possess a special knowledge of Medicaid as pertaining to the State of Mississippi. The Deputy Director of Administration may perform those duties of

the executive director that the executive director has not expressly retained for himself. * * * The Deputy Director of Administration shall serve at the will and pleasure of the Governor * * *. In the event of a vacancy, the same shall be filled by the Governor. * * *

(c) The executive director and the Deputy Director of Administration of the Division of Medicaid shall perform all other duties that are now or may be imposed upon them by law.

(d) The executive director and the Deputy Director of Administration shall, before entering upon the discharge of the duties of their offices, take and subscribe to the oath of office prescribed by the Mississippi Constitution and shall file the same in the Office of the Secretary of State, and each shall execute a bond in some surety company authorized to do business in the state in the penal sum of One Hundred Thousand Dollars ($100,000.00), conditioned for the faithful and impartial discharge of the duties of their offices. The premium on those bonds shall be paid as provided by law out of funds appropriated to the Division of Medicaid for contractual services.

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

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

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

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

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

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

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

(c) The respective Chairmen of the House Medicaid Committee, the House Public Health and Human Services Committee, the House Appropriations Committee, the Senate Public Health and Welfare Committee and the Senate Appropriations Committee, or their designees, two (2) members of the State Senate appointed by the Lieutenant Governor and one (1) member of the House of Representatives appointed by the Speaker of the House, shall serve as ex officio nonvoting members of the advisory committee.

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

(e) The chairmanship of the advisory committee shall alternate for twelve-month periods between the Chairmen of the

House Medicaid Committee and the Senate Public Health and Welfare Committee.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) The committee meetings shall be open to the public, members of the press, legislators and consumers. Additionally, all documents provided to committee members shall be available to members of the Legislature in the same manner, and shall be made available to others for a reasonable fee for copying. However, patient confidentiality and provider confidentiality shall be protected by blinding patient names and provider names with numerical or other anonymous identifiers in accordance with the standards found at 45 CFR Parts 160 and 164, other federal law, or state law, whichever is more stringent. The committee meetings shall be subject to the Open Meetings Act (Section 25-41-1 et seq.). Committee meetings conducted in violation of this section shall be deemed unlawful. The committee shall receive public input in the form of an open public comment session during Pharmacy and Therapeutics Committee meetings on drugs scheduled for review for the drug formulary. Public input shall be received

after the product discussion by the committee and before the decision-making process. The committee shall also accept written evidence supporting the inclusion of a drug on the drug formulary before the Pharmacy and Therapeutics Committee meeting.

(d) After a twenty-five-day public notice, the executive director, or his or her designee, shall present the division's recommendation regarding prior approval for a therapeutic class of drugs to the committee. However, in circumstances where the division deems it necessary for the health and safety of Medicaid beneficiaries, the division may present to the committee its recommendations regarding a particular drug without a twenty-five-day public notice. In making that presentation, the division shall state to the committee the circumstances that precipitate the need for the committee to review the status of a particular drug without a twenty-five-day public notice. The committee may determine whether or not to review the particular drug under the circumstances stated by the division without a twenty-five-day public notice. If the committee determines to review the status of the particular drug, it shall make its recommendations to the division * * *.

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

(f) Upon reviewing and considering all recommendations including recommendation of the committee, comments, and data, the executive director shall make a final determination whether to require prior approval of a therapeutic class of drugs, or modify

existing prior approval requirements for a therapeutic class of drugs.

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

(h) Members of the committee shall dispose of matters before the committee in an unbiased and professional manner. If a matter being considered by the committee presents a real or apparent conflict of interest for any member of the committee, that member shall disclose the conflict in writing to the committee chair and recuse himself or herself from any discussions and/or actions on the matter.

(6) This section shall stand repealed on July 1, 2007.

SECTION 2. Section 43-13-115, Mississippi Code of 1972, is amended as follows:

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

(1) Those who are qualified for public assistance grants under provisions of Title IV-A and E of the federal Social Security Act, as amended, including those statutorily deemed to be IV-A and low-income families and children under Section 1931 of the federal Social Security Act. For the purposes of this paragraph (1) and paragraphs (8), (17) and (18) of this section, any reference to Title IV-A or to Part A of Title IV of the federal Social Security Act, as amended, or the state plan under Title IV-A or Part A of Title IV, shall be considered as a reference to Title IV-A of the federal Social Security Act, as amended, and the state plan under Title IV-A, including the income

and resource standards and methodologies under Title IV-A and the state plan, as they existed on July 16, 1996. The Department of Human Services shall determine Medicaid eligibility for children receiving public assistance grants under Title IV-E. The division shall determine eligibility for low-income families under Section 1931 of the federal Social Security Act and shall redetermine eligibility for those continuing under Title IV-A grants.

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

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

(4) [Deleted]

(5) A child born on or after October 1, 1984, to a woman eligible for and receiving Medicaid under the state plan on the date of the child's birth shall be deemed to have applied for Medicaid and to have been found eligible for Medicaid under the plan on the date of that birth, and will remain eligible for Medicaid for a period of one (1) year so long as the child is a member of the woman's household and the woman remains eligible for Medicaid or would be eligible for Medicaid if pregnant. The eligibility of individuals covered in this paragraph shall be determined by the Division of Medicaid.

(6) Children certified by the State Department of Human Services to the Division of Medicaid of whom the state and county departments of human services have custody and financial responsibility, and children who are in adoptions subsidized in

full or part by the Department of Human Services, including special needs children in non-Title IV-E adoption assistance, who are approvable under Title XIX of the Medicaid program. The eligibility of the children covered under this paragraph shall be determined by the State Department of Human Services.

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

* * *

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

(9) Individuals who are:

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

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

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

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

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

(11) Until the end of the day on December 31, 2005, individuals who are sixty-five (65) years of age or older or are disabled as determined under Section 1614(a)(3) of the federal Social Security Act, as amended, and whose income does not exceed one hundred thirty-five percent (135%) of the nonfarm official poverty level as defined by the Office of Management and Budget and revised annually, and whose resources do not exceed those established by the Division of Medicaid. The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid. After December 31, 2005, only those individuals covered under the 1115(c) Healthier Mississippi waiver will be covered under this category.

(12) Individuals who are qualified Medicare beneficiaries (QMB) entitled to Part A Medicare as defined under Section 301, Public Law 100-360, known as the Medicare Catastrophic Coverage Act of 1988, and whose income does not exceed one hundred percent (100%) of the nonfarm official poverty

level as defined by the Office of Management and Budget and revised annually.

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

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

(b) Individuals entitled to Part A of Medicare, with income above one hundred twenty percent (120%), but less than one hundred thirty-five percent (135%) of the federal poverty level, and not otherwise eligible for Medicaid Eligibility for Medicaid benefits is limited to full payment of Medicare Part B premiums. The number of eligible individuals is limited by the availability of the federal capped allocation at one hundred percent (100%) of federal matching funds, as more fully defined in the Balanced Budget Act of 1997.

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

(14) [Deleted]

(15) Disabled workers who are eligible to enroll in Part A Medicare as required by Public Law 101-239, known as the Omnibus Budget Reconciliation Act of 1989, and whose income does not exceed two hundred percent (200%) of the federal poverty level as determined in accordance with the Supplemental Security Income (SSI) program. The eligibility of individuals covered under this

paragraph shall be determined by the Division of Medicaid and those individuals shall be entitled to buy-in coverage of Medicare Part A premiums only under the provisions of this paragraph (15).

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

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

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

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

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

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

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

(22) Persons who are workers with a potentially severe disability, as determined by the division, shall be allowed to purchase Medicaid coverage. The term "worker with a potentially

severe disability" means a person who is at least sixteen (16) years of age but under sixty-five (65) years of age, who has a physical or mental impairment that is reasonably expected to cause the person to become blind or disabled as defined under Section 1614(a) of the federal Social Security Act, as amended, if the person does not receive items and services provided under Medicaid.

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

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

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

(25) The division shall apply to the Centers for Medicare and Medicaid Services (CMS) for any necessary waivers to

provide services to individuals who are sixty-five (65) years of age or older or are disabled as determined under Section 1614(a)(3) of the federal Social Security Act, as amended, and whose income does not exceed one hundred thirty-five percent (135%) of the nonfarm official poverty level as defined by the Office of Management and Budget and revised annually, and whose resources do not exceed those established by the Division of Medicaid, and who are not otherwise covered by Medicare. Nothing contained in this paragraph (25) shall entitle an individual to benefits. The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid.

(26) The division shall apply to the Centers for Medicare and Medicaid Services (CMS) for any necessary waivers to provide services to individuals who are sixty-five (65) years of age or older or are disabled as determined under Section 1614(a)(3) of the federal Social Security Act, as amended, who are end stage renal disease patients on dialysis, cancer patients on chemotherapy or organ transplant recipients on anti-rejection drugs, whose income does not exceed one hundred thirty-five percent (135%) of the nonfarm official poverty level as defined by the Office of Management and Budget and revised annually, and whose resources do not exceed those established by the division. Nothing contained in this paragraph (26) shall entitle an individual to benefits. The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid.

(27) Individuals who are entitled to Medicare Part D and whose income does not exceed one hundred fifty percent (150%) of the nonfarm official poverty level as defined by the Office of Management and Budget and revised annually. Eligibility for payment of the Medicare Part D subsidy under this paragraph shall be determined by the division.

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

SECTION 3. Section 43-13-117, Mississippi Code of 1972, is amended as follows:

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

(1) Inpatient hospital services.

(a) The division shall allow fifteen (15) days of inpatient hospital care annually for all Medicaid recipients. The division shall establish a Twenty-five Dollar ($25.00) co-payment requirement for each inpatient day used by a recipient, or a co-payment in an amount equal to the maximum allowable under federal regulation. Precertification of inpatient days must be obtained as required by the division. The division may allow unlimited days in disproportionate hospitals as defined by the division for eligible infants and children under the age of six (6) years if certified as medically necessary as required by the division.

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

(c) Hospitals will receive an additional payment for the implantable programmable baclofen drug pump used to treat spasticity that is implanted on an inpatient basis. The payment

pursuant to written invoice will be in addition to the facility's per diem reimbursement and will represent a reduction of costs on the facility's annual cost report, and shall not exceed Ten Thousand Dollars ($10,000.00) per year per recipient. This subparagraph (c) shall stand repealed on July 1, 2005.

(2) Outpatient hospital services.

(a) Emergency. The division shall allow three (3) medically necessary emergency room visits per beneficiary per fiscal year. The division shall establish a Twenty-five Dollar ($25.00) per visit co-payment requirement for each nonemergency visit to an emergency room, or an amount equal to the maximum allowable under federal regulation.

(b) Other outpatient hospital services. The division shall allow benefits for other medically necessary outpatient hospital services (such as chemotherapy, radiation, surgery and therapy). Where the same services are reimbursed as clinic services, the division may revise the rate or methodology of outpatient reimbursement to maintain consistency, efficiency, economy and quality of life.

(c) Where the same services are reimbursed as clinic services, the division may revise the rate or methodology of outpatient reimbursement to maintain consistency, efficiency, economy and quality of care.

(3) Laboratory and x-ray services.

(4) Nursing facility services.

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

(b) From and after July 1, 1997, the division shall implement the integrated case-mix payment and quality monitoring system, which includes the fair rental system for property costs and in which recapture of depreciation is eliminated. The division may reduce the payment for hospital leave and therapeutic home leave days to the lower of the case-mix category as computed for the resident on leave using the assessment being utilized for payment at that point in time, or a case-mix score of 1.000 for nursing facilities, and shall compute case-mix scores of residents so that only services provided at the nursing facility are considered in calculating a facility's per diem.

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

(d) When a facility of a category that does not require a certificate of need for construction and that could not be eligible for Medicaid reimbursement is constructed to nursing facility specifications for licensure and certification, and the facility is subsequently converted to a nursing facility under a certificate of need that authorizes conversion only and the applicant for the certificate of need was assessed an application review fee based on capital expenditures incurred in constructing the facility, the division shall allow reimbursement for capital expenditures necessary for construction of the facility that were incurred within the twenty-four (24) consecutive calendar months immediately preceding the date that the certificate of need authorizing the conversion was issued, to the same extent that reimbursement would be allowed for construction of a new nursing facility under a certificate of need that authorizes that construction. The reimbursement authorized in this subparagraph (d) may be made only to facilities the construction of which was completed after June 30, 1989. Before the division shall be

authorized to make the reimbursement authorized in this subparagraph (d), the division first must have received approval from the Centers for Medicare and Medicaid Services (CMS) of the change in the state Medicaid plan providing for the reimbursement.

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

(f) The division shall develop and implement an assessment process for long-term care services. The division may provide the assessment and related functions directly or through contract with the area agencies on aging.

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

(5) Periodic screening and diagnostic services for individuals under age twenty-one (21) years as are needed to identify physical and mental defects and to provide health care treatment and other measures designed to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services, regardless of whether these services are included in the state plan. The division may include in its periodic screening and diagnostic program those discretionary

services authorized under the federal regulations adopted to implement Title XIX of the federal Social Security Act, as amended. The division, in obtaining physical therapy services, occupational therapy services, and services for individuals with speech, hearing and language disorders, may enter into a cooperative agreement with the State Department of Education for the provision of those services to handicapped students by public school districts using state funds that are provided from the appropriation to the Department of Education to obtain federal matching funds through the division. The division, in obtaining medical and psychological evaluations for children in the custody of the State Department of Human Services may enter into a cooperative agreement with the State Department of Human Services for the provision of those services using state funds that are provided from the appropriation to the Department of Human Services to obtain federal matching funds through the division.

(6) Physician's services. The division shall allow twelve (12) physician visits annually. The division shall establish a Ten Dollar ($10.00) co-payment requirement for each visit to a primary care physician (except for an annual physical required by the division), and a Fifteen Dollar ($15.00) co-payment requirement for each visit to a specialist for each beneficiary, or an amount equal to the maximum allowable under federal regulation. All fees for physicians' services that are covered only by Medicaid shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as may be adjusted each July thereafter, under Medicare (Title XVIII of the federal Social Security Act, as amended) * * *.

(7) (a) Home health services for eligible persons, not to exceed in cost the prevailing cost of nursing facility services, not to exceed twenty-five (25) visits per year. The division shall establish a Ten Dollar ($10.00) co-payment requirement for each visit to an eligible beneficiary, or an

amount equal to the maximum allowable under federal regulation. All home health visits must be precertified as required by the division.

(b) Repealed.

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

(9) (a) Legend and other drugs as may be determined by the division.

(b) The division shall establish a mandatory preferred drug list. Drugs not on the mandatory preferred drug list shall be made available by utilizing prior authorization procedures established by the division. The division may seek to establish relationships with other states in order to lower acquisition costs of prescription drugs to include single source and innovator multiple source drugs or generic drugs. In addition, if allowed by federal law or regulation, the division may seek to establish relationships with and negotiate with other countries to facilitate the acquisition of prescription drugs to include single source and innovator multiple source drugs or generic drugs, if that will lower the acquisition costs of those prescription drugs.

(c) The division shall establish a Five Dollar ($5.00) per prescription co-payment requirement for each eligible

beneficiary, or an amount equal to the maximum allowable under federal regulation.

(d) The division shall allow up to one (1) brand name prescription drug per month for noninstitutionalized Medicaid recipients without prior authorization from the division and/or its designee, one (1) brand name prescription drug per month for noninstitutionalized Medicaid recipients with prior authorization from the division and/or its designee, and two (2) generic prescription drugs per month; up to two (2) additional prescriptions per month may be allowed for exceptional medical conditions as determined by the division with the prior approval of the executive director.

(e) * * * The voluntary preferred drug list shall be expanded to function in the interim in order to have a manageable prior authorization system, thereby minimizing disruption of service to beneficiaries. The division shall not reimburse for any portion of a prescription that exceeds a thirty-one-day supply of the drug based on the daily dosage.

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

(g) All claims for drugs for dually eligible Medicare/Medicaid beneficiaries that are paid for by Medicare Part B must be submitted to Medicare for payment before they may be processed by the division's on-line payment system.

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

* * *

(i) All drugs prescribed for a resident of a long-term care facility must be provided in true unit doses. Those that were originally billed to the Division of Medicaid but are not used by the resident, shall be returned to the billing pharmacy for credit to the Division of Medicaid, in accordance with the guidelines of the State Board of Pharmacy. Drugs shall be dispensed to a recipient and only one (1) dispensing fee per month may be charged. The division shall develop a methodology for reimbursing for restocked drugs.

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

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

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

(m) The dispensing fee for each new or refill prescription, including nonlegend or over-the-counter drugs covered by the division, shall be not less than Three Dollars and Ninety-one Cents ($3.91), as determined by the division.

(n) The division shall not reimburse for single source or innovator multiple source drugs if there are equally effective generic equivalents available and if the generic equivalents are the least expensive.

(o) It is the intent of the Legislature that the pharmacists providers be reimbursed for the reasonable costs of filling and dispensing prescriptions for Medicaid beneficiaries.

(p) Notwithstanding any other state law, information obtained or maintained by the division regarding the prescription drug program, including trade secrets and manufacturer or labeler pricing, is confidential and not subject to disclosure.

(10) Dental care that is an adjunct to treatment of an acute medical or surgical condition; services of oral surgeons and dentists in connection with surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone; and emergency dental extractions and treatment related thereto. On July 1, 1999, all fees for dental care and surgery under authority of this paragraph (10) shall be increased to one hundred sixty percent (160%) of the amount of the reimbursement rate that was in effect on June 30, 1999. It is the intent of the Legislature to encourage more dentists to participate in the Medicaid program. Reimbursement for dental services under this paragraph (10) shall not exceed Five Hundred Dollars ($500.00) per year per recipient.

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

(12) Intermediate care facility services.

(a) The division shall make full payment to all intermediate care facilities for the mentally retarded for each

day, not exceeding eighty-four (84) days per year, that a patient is absent from the facility on home leave. Payment may be made for the following home leave days in addition to the eighty-four-day limitation: Christmas, the day before Christmas, the day after Christmas, Thanksgiving, the day before Thanksgiving and the day after Thanksgiving.

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

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

(14) Clinic services. Such diagnostic, preventive, therapeutic, rehabilitative or palliative services furnished to an outpatient by or under the supervision of a physician or dentist in a facility that is not a part of a hospital but that is organized and operated to provide medical care to outpatients. Clinic services shall include any services reimbursed as outpatient hospital services that may be rendered in such a facility, including those that become so after July 1, 1991. The division shall establish a co-payment requirement for clinic services at the same rate applicable to physician services. On July 1, 1999, all fees for physicians' services reimbursed under authority of this paragraph (14) shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as may be adjusted each July thereafter, under Medicare (Title XVIII of the federal Social Security Act, as amended) * * *. On July 1, 1999, all fees for dentists' services reimbursed under authority of this paragraph (14) shall be increased to one hundred sixty percent (160%) of the amount of the reimbursement rate that was in effect on June 30, 1999.

(15) Home- and community-based services for the elderly and disabled, as provided under Title XIX of the federal Social

Security Act, as amended, under waivers, subject to the availability of funds specifically appropriated for that purpose by the Legislature.

(16) Mental health services. Approved therapeutic and case management services (a) provided by an approved regional mental health/retardation center established under Sections 41-19-31 through 41-19-39, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/retardation center if determined necessary by the Department of Mental Health, using state funds that are provided from the appropriation to the State Department of Mental Health and/or funds transferred to the department by a political subdivision or instrumentality of the state and used to match federal funds under a cooperative agreement between the division and the department, or (b) provided by a facility that is certified by the State Department of Mental Health to provide therapeutic and case management services, to be reimbursed on a fee for service basis, or (c) provided in the community by a facility or program operated by the Department of Mental Health. Any such services provided by a facility described in subparagraph (b) must have the prior approval of the division to be reimbursable under this section. After June 30, 1997, mental health services provided by regional mental health/retardation centers established under Sections 41-19-31 through 41-19-39, or by hospitals as defined in Section 41-9-3(a) and/or their subsidiaries and divisions, or by psychiatric residential treatment facilities as defined in Section 43-11-1, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/retardation center if determined necessary by the Department of Mental Health, shall not be included in or provided under any capitated managed care pilot program provided for under paragraph (24) of this section.

(17) Durable medical equipment services and medical supplies. The division shall establish a Five Dollar ($5.00) co-payment requirement for each item of durable medical equipment and a One Dollar ($1.00) co-payment requirement for each medical supply item, or an amount equal to the maximum allowable under federal regulation. Precertification of durable medical equipment and medical supplies must be obtained as required by the division. The Division of Medicaid may require durable medical equipment providers to obtain a surety bond in the amount and to the specifications as established by the Balanced Budget Act of 1997.

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

(b) The division shall establish a Medicare Upper Payment Limits Program, as defined in Section 1902(a)(30) of the federal Social Security Act and any applicable federal regulations, for hospitals, and may establish a Medicare Upper Payments Limits Program for nursing facilities. The division shall assess each hospital and, if the program is established for nursing facilities, shall assess each nursing facility, based on Medicaid utilization or other appropriate method consistent with federal regulations. The assessment will remain in effect as long as the state participates in the Medicare Upper Payment Limits Program. The division shall make additional reimbursement to hospitals and, if the program is established for nursing

facilities, shall make additional reimbursement to nursing facilities, for the Medicare Upper Payment Limits, as defined in Section 1902(a)(30) of the federal Social Security Act and any applicable federal regulations. * * *

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

(b) Early intervention system services. The division shall cooperate with the State Department of Health, acting as lead agency, in the development and implementation of a statewide system of delivery of early intervention services, under Part C of the Individuals with Disabilities Education Act (IDEA). The State Department of Health shall certify annually in writing to the executive director of the division the dollar amount of state early intervention funds available that will be utilized as a certified match for Medicaid matching funds. Those funds then shall be used to provide expanded targeted case management services for Medicaid eligible children with special needs who are eligible for the state's early intervention system. Qualifications for persons providing service coordination shall be determined by the State Department of Health and the Division of Medicaid.

(20) Home- and community-based services for physically disabled approved services as allowed by a waiver from the United States Department of Health and Human Services for home- and community-based services for physically disabled people using state funds that are provided from the appropriation to the State Department of Rehabilitation Services and used to match federal

funds under a cooperative agreement between the division and the department, provided that funds for these services are specifically appropriated to the Department of Rehabilitation Services.

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

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

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

(24) Managed care services may be developed by the division utilizing a public or private provider. Notwithstanding any other provision in this article to the contrary, the division shall establish rates of reimbursement to providers rendering care and services under this section through a managed care program, and may revise such rates of reimbursement for the purpose of achieving effective and accessible health services and for responsible containment of costs. If allowed by federal law or regulation, the division may seek to establish managed care agreements with other jurisdictions to provide similar care and services to beneficiaries with a responsible containment of costs.

(25) [Deleted]

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

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

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

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

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

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

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

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

(33) Podiatrist services.

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

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

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

(37) [Deleted]

(38) Chiropractic services. A chiropractor's manual manipulation of the spine to correct a subluxation, if x-ray demonstrates that a subluxation exists and if the subluxation has resulted in a neuromusculoskeletal condition for which manipulation is appropriate treatment, and related spinal x-rays performed to document these conditions. The division shall establish a Fifteen Dollar ($15.00) per visit co-payment requirement for chiropractic services to beneficiaries, or an amount equal to the maximum allowable under federal regulation. Reimbursement for chiropractic services shall not exceed Seven Hundred Dollars ($700.00) per year per beneficiary.

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

(40) [Deleted]

(41) Services provided by the State Department of Rehabilitation Services for the care and rehabilitation of persons

with spinal cord injuries or traumatic brain injuries, as allowed under waivers from the United States Department of Health and Human Services, using up to seventy-five percent (75%) of the funds that are appropriated to the Department of Rehabilitation Services from the Spinal Cord and Head Injury Trust Fund established under Section 37-33-261 and used to match federal funds under a cooperative agreement between the division and the department.

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

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

(44) Nursing facility services for the severely disabled.

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

(b) Those services must be provided in a long-term care nursing facility dedicated to the care and treatment of

persons with severe disabilities, and shall be reimbursed as a separate category of nursing facilities.

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

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

(47) (a) Notwithstanding any other provision in this article to the contrary, the division, in conjunction with the State Department of Health, shall develop and implement disease management programs for individuals with chronic diseases and conditions, including the use of grants, waivers, demonstrations or other projects as necessary.

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

(c) An individual who participates in the disease management program has the option of participating in the prescription drug home delivery component of the program at any

time while participating in the program. An individual must affirmatively elect to participate in the prescription drug home delivery component in order to participate.

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

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

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

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

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

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

(49) The division shall establish co-payments and/or coinsurance for all Medicaid services for which co-payments and/or coinsurance are allowable under federal law or regulation, and shall set the amount of the co-payment and/or coinsurance for each

of those services at the maximum amount allowable under federal law or regulation.

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

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

For persons who are determined ineligible for Medicaid, the division will provide information and direction for accessing medical care and services in the area of their residence.

(52) Notwithstanding any provisions of this article, the division may pay enhanced reimbursement fees related to trauma care, as determined by the division in conjunction with the State Department of Health, using funds appropriated to the State Department of Health for trauma care and services and used to match federal funds under a cooperative agreement between the division and the State Department of Health. The division, in conjunction with the State Department of Health, may use grants, waivers, demonstrations, or other projects as necessary in the development and implementation of this reimbursement program.

(53) Targeted case management services for high-cost beneficiaries shall be developed by the division for all services under this section.

Notwithstanding any other provision of this article to the contrary, the division shall reduce the rate of reimbursement to providers for any service provided under this section by five percent (5%) of the allowed amount for that service. However, the reduction in the reimbursement rates required by this paragraph shall not apply to inpatient hospital services, nursing facility services, intermediate care facility services, psychiatric residential treatment facility services, pharmacy services provided under paragraph (9) of this section, or any service provided by the University of Mississippi Medical Center or a state agency, a state facility or a public agency that either provides its own state match through intergovernmental transfer or certification of funds to the division, or a service for which the federal government sets the reimbursement methodology and rate. In addition, the reduction in the reimbursement rates required by this paragraph shall not apply to case management services and home-delivered meals provided under the home- and community-based services program for the elderly and disabled by a planning and development district (PDD). Planning and development districts participating in the home- and community-based services program for the elderly and disabled as case management providers shall be reimbursed for case management services at the maximum rate approved by the Centers for Medicare and Medicaid Services (CMS).

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

Notwithstanding any provision of this article, except as authorized in the following paragraph and in Section 43-13-139,

neither (a) the limitations on quantity or frequency of use of or the fees or charges for any of the care or services available to recipients under this section, nor (b) the payments or rates of reimbursement to providers rendering care or services authorized under this section to recipients, may be increased, decreased or otherwise changed from the levels in effect on July 1, 1999, unless they are authorized by an amendment to this section by the Legislature. However, the restriction in this paragraph shall not prevent the division from changing the payments or rates of reimbursement to providers without an amendment to this section whenever those changes are required by federal law or regulation, or whenever those changes are necessary to correct administrative errors or omissions in calculating those payments or rates of reimbursement.

Notwithstanding any provision of this article, no new groups or categories of recipients and new types of care and services may be added without enabling legislation from the Mississippi Legislature, except that the division may authorize those changes without enabling legislation when the addition of recipients or services is ordered by a court of proper authority. The executive director shall keep the Governor advised on a timely basis of the funds available for expenditure and the projected expenditures. If current or projected expenditures of the division during the * * * fiscal year are reasonably anticipated to be * * * above the amount of the appropriated funds that is authorized to be expended during the * * * fiscal year, the Governor, after consultation with the executive director, may discontinue any or all of the payment of the types of care and services as provided in this section that are deemed to be optional services under Title XIX of the federal Social Security Act, as amended, and when necessary may institute any other cost containment measures on any program or programs authorized under the article to the extent allowed under the federal law governing that program or programs.

If current or projected expenditures of the division during the * * * fiscal year are reasonably anticipated to exceed the amount of the appropriated funds that is authorized to be expended during the first allotment period of the fiscal year * * *, the Governor, after consultation with the executive director, shall discontinue any or all of the payment of the types of care and services as provided in this section that are deemed to be optional services under Title XIX of the federal Social Security Act, as amended, for any period necessary to ensure that the actual expenditures of the division will not exceed the amount of the appropriated funds that is authorized to be expended during the first allotment period of the fiscal year * * *, and when necessary shall institute any other cost containment measures on any program or programs authorized under the article to the extent allowed under the federal law governing that program or programs. * * * It is the intent of the Legislature that the expenditures of the division during any fiscal year shall not exceed the amounts appropriated to the division for that fiscal year.

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

This section shall stand repealed on July 1, 2007.

SECTION 4. Section 43-13-145, Mississippi Code of 1972, is amended as follows:

43-13-145. (1) (a) Upon each nursing facility and each intermediate care facility for the mentally retarded licensed by the State of Mississippi, there is levied an assessment up to the maximum amount allowable under federal regulations per day for each licensed and * * * occupied bed of the facility.

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

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

(ii) The State Veterans Affairs Board;

(iii) The University of Mississippi Medical Center; or

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

(2) (a) Upon each psychiatric residential treatment facility licensed by the State of Mississippi, there is levied an assessment up to the maximum amount allowable under federal regulations per day for each licensed and * * * occupied bed of the facility.

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

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

(ii) The University of Mississippi Medical Center.

* * *

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

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

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

(ii) The University of Mississippi Medical Center; or

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

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

(5) The assessment levied under this section shall be collected by the division each month beginning on the effective date of Senate Bill No. 2745, 2005 Regular Session.

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

(7) The assessment levied under this section shall be in addition to any other assessments, taxes or fees levied by law, and the assessment shall constitute a debt due the State of Mississippi from the time the assessment is due until it is paid.

(8) (a) If a health care facility that is liable for payment of the assessment levied under this section does not pay the assessment when it is due, the division shall give written notice to the health care facility by certified or registered mail demanding payment of the assessment within ten (10) days from the

date of delivery of the notice. If the health care facility fails or refuses to pay the assessment after receiving the notice and demand from the division, the division shall withhold from any Medicaid reimbursement payments that are due to the health care facility the amount of the unpaid assessment and a penalty of ten percent (10%) of the amount of the assessment, plus the legal rate of interest until the assessment is paid in full. If the health care facility does not participate in the Medicaid program, the division shall turn over to the Office of the Attorney General the collection of the unpaid assessment by civil action. In any such civil action, the Office of the Attorney General shall collect the amount of the unpaid assessment and a penalty of ten percent (10%) of the amount of the assessment, plus the legal rate of interest until the assessment is paid in full.

(b) As an additional or alternative method for collecting unpaid assessments under this section, if a health care facility fails or refuses to pay the assessment after receiving notice and demand from the division, the division may file a notice of a tax lien with the circuit clerk of the county in which the health care facility is located, for the amount of the unpaid assessment and a penalty of ten percent (10%) of the amount of the assessment, plus the legal rate of interest until the assessment is paid in full. Immediately upon receipt of notice of the tax lien for the assessment, the circuit clerk shall enter the notice of the tax lien as a judgment upon the judgment roll and show in the appropriate columns the name of the health care facility as judgment debtor, the name of the division as judgment creditor, the amount of the unpaid assessment, and the date and time of enrollment. The judgment shall be valid as against mortgagees, pledgees, entrusters, purchasers, judgment creditors and other persons from the time of filing with the clerk. The amount of the judgment shall be a debt due the State of Mississippi and remain a lien upon the tangible property of the health care facility until

the judgment is satisfied. The judgment shall be the equivalent of any enrolled judgment of a court of record and shall serve as authority for the issuance of writs of execution, writs of attachment or other remedial writs.

SECTION 5. Section 25-9-107, Mississippi Code of 1972, is amended as follows:

25-9-107. The following terms, when used in this chapter, unless a different meaning is plainly required by the context, shall have the following meanings:

(a) "Board" means the State Personnel Board created under the provisions of this chapter.

(b) "State service" means all employees of state departments, agencies and institutions as defined herein, except those officers and employees excluded by this chapter.

(c) "Nonstate service" means the following officers and employees excluded from the state service by this chapter. The following are excluded from the state service:

(i) Members of the State Legislature, their staffs and other employees of the legislative branch;

(ii) The Governor and staff members of the immediate Office of the Governor;

(iii) Justices and judges of the judicial branch or members of appeals boards on a per diem basis;

(iv) The Lieutenant Governor, staff members of the immediate Office of the Lieutenant Governor and officers and employees directly appointed by the Lieutenant Governor;

(v) Officers and officials elected by popular vote and persons appointed to fill vacancies in elective offices;

(vi) Members of boards and commissioners appointed by the Governor, Lieutenant Governor or the State Legislature;

(vii) All academic officials, members of the teaching staffs and employees of the state institutions of higher

learning, the State Board for Community and Junior Colleges, and community and junior colleges;

(viii) Officers and enlisted members of the National Guard of the state;

(ix) Prisoners, inmates, student or patient help working in or about institutions;

(x) Contract personnel; provided, that any agency which employs state service employees may enter into contracts for personal and professional services only if such contracts are approved in compliance with the rules and regulations promulgated by the State Personal Service Contract Review Board under Section 25-9-120(3). Before paying any warrant for such contractual services in excess of One Hundred Thousand Dollars ($100,000.00), the Auditor of Public Accounts, or the successor to those duties, shall determine whether the contract involved was for personal or professional services, and, if so, was approved by the State Personal Service Contract Review Board;

(xi) Part-time employees; provided, however, part-time employees shall only be hired into authorized employment positions classified by the board, shall meet minimum qualifications as set by the board, and shall be paid in accordance with the Variable Compensation Plan as certified by the board;

(xii) Persons appointed on an emergency basis for the duration of the emergency; the effective date of the emergency appointments shall not be earlier than the date approved by the State Personnel Director, and shall be limited to thirty (30) working days. Emergency appointments may be extended to sixty (60) working days by the State Personnel Board;

(xiii) Physicians, dentists, veterinarians, nurse practitioners and attorneys, while serving in their professional capacities in authorized employment positions who are required by statute to be licensed, registered or otherwise certified as such,

provided that the State Personnel Director shall verify that the statutory qualifications are met prior to issuance of a payroll warrant by the auditor;

(xiv) Personnel who are employed and paid from funds received from a federal grant program which has been approved by the Legislature or the Department of Finance and Administration whose length of employment has been determined to be time-limited in nature. This subparagraph shall apply to personnel employed under the provisions of the Comprehensive Employment and Training Act of 1973, as amended, and other special federal grant programs which are not a part of regular federally funded programs wherein appropriations and employment positions are appropriated by the Legislature. Such employees shall be paid in accordance with the Variable Compensation Plan and shall meet all qualifications required by federal statutes or by the Mississippi Classification Plan;

(xv) The administrative head who is in charge of any state department, agency, institution, board or commission, wherein the statute specifically authorizes the Governor, board, commission or other authority to appoint said administrative head; provided, however, that the salary of such administrative head shall be determined by the State Personnel Board in accordance with the Variable Compensation Plan unless otherwise fixed by statute;

(xvi) The State Personnel Board shall exclude top level positions if the incumbents determine and publicly advocate substantive program policy and report directly to the agency head, or the incumbents are required to maintain a direct confidential working relationship with a key excluded official. Provided further, a written job classification shall be approved by the board for each such position, and positions so excluded shall be paid in conformity with the Variable Compensation Plan;

(xvii) Employees whose employment is solely in connection with an agency's contract to produce, store or transport goods, and whose compensation is derived therefrom;

(xviii) Repealed;

(xix) The associate director, deputy directors and bureau directors within the Department of Agriculture and Commerce;

(xx) Personnel employed by the Mississippi Industries for the Blind; provided, that any agency may enter into contracts for the personal services of MIB employees without the prior approval of the State Personnel Board or the State Personal Service Contract Review Board; however, any agency contracting for the personal services of an MIB employee shall provide the MIB employee with not less than the entry level compensation and benefits that the agency would provide to a full-time employee of the agency who performs the same services;

(xxi) Personnel employed by the Mississippi Department of Wildlife, Fisheries and Parks as law enforcement trainees (cadets); such personnel shall be paid in accordance with the Colonel Guy Groff State Variable Compensation Plan;

(xxii) For a period beginning with the effective date of Senate Bill No. 2745, 2005 Regular Session, through June 30, 2006, all employees in the executive branch of government who are under the purview of the State Personnel Board. Such employees shall be paid in accordance with the Variable Compensation Plan and shall be otherwise subject to the policies and procedures of the State Personnel Board.

(d) "Agency" means any state board, commission, committee, council, department or unit thereof created by the Constitution or statutes if such board, commission, committee, council, department, unit or the head thereof, is authorized to appoint subordinate staff by the Constitution or statute, except a

legislative or judicial board, commission, committee, council, department or unit thereof.

SECTION 6. Section 25-9-127, Mississippi Code of 1972, is amended as follows:

25-9-127. (1) No employee of any department, agency or institution who is included under this chapter or hereafter included under its authority, and who is subject to the rules and regulations prescribed by the state personnel system may be dismissed or otherwise adversely affected as to compensation or employment status except for inefficiency or other good cause, and after written notice and hearing within the department, agency or institution as shall be specified in the rules and regulations of the State Personnel Board complying with due process of law; and any employee who has by written notice of dismissal or action adversely affecting his compensation or employment status shall, on hearing and on any appeal of any decision made in such action, be required to furnish evidence that the reasons stated in the notice of dismissal or action adversely affecting his compensation or employment status are not true or are not sufficient grounds for the action taken; provided, however, that this provision shall not apply (a) to persons separated from any department, agency or institution due to curtailment of funds or reduction in staff when such separation is in accordance with rules and regulations of the state personnel system; (b) during the probationary period of state service of twelve (12) months; * * * (c) to an executive officer of any state agency who serves at the will and pleasure of the Governor, board, commission or other appointing authority; and (d) all employees employed in the executive branch of government who are under the purview of the State Personnel Board, whose accumulated property interests in state service employment shall be suspended for a period beginning upon the effective date of Senate Bill No. 2745, 2005 Regular Session, and through June 30, 2006, notwithstanding any existing statutory provision which

conveys state service status. The executive agencies shall consult with the Office of the Attorney General before taking personnel actions permitted by this subsection (1)(d) to review those actions for compliance with applicable state and federal law.

(2) The operation of a state-owned motor vehicle without a valid Mississippi driver's license by an employee of any department, agency or institution that is included under this chapter and that is subject to the rules and regulations of the state personnel system shall constitute good cause for dismissal of such person from employment.

(3) Beginning July 1, 1999, every male between the ages of eighteen (18) and twenty-six (26) who is required to register under the federal Military Selective Service Act, 50 USCS App. 453, and who is an employee of the state shall not be promoted to any higher position of employment with the state until he submits to the person, commission, board or agency by which he is employed satisfactory documentation of his compliance with the draft registration requirements of the Military Selective Service Act. The documentation shall include a signed affirmation under penalty of perjury that the male employee has complied with the requirements of the federal selective service act.

SECTION 7. This act shall take effect and be in force from and after its passage.