

By: Senator(s) Nunnelee, Burton

To: Public Health and
Welfare; AppropriationsSENATE BILL NO. 2745
(As Passed the Senate)

1 AN ACT RELATING TO THE MISSISSIPPI MEDICAID PROGRAM; TO AMEND
2 SECTION 43-13-107, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT THE
3 EXECUTIVE DIRECTOR AND THE DEPUTY DIRECTOR OF THE DIVISION OF
4 MEDICAID SHALL SERVE AT THE WILL AND PLEASURE OF THE GOVERNOR; TO
5 CONFORM THE OPERATION OF THE MEDICAID PHARMACY AND THERAPEUTICS
6 COMMITTEE WITH FEDERAL CONFIDENTIALITY REGULATIONS AND TO CONFORM
7 COMMITTEE MEETING REQUIREMENTS WITH THE MISSISSIPPI ADMINISTRATIVE
8 PROCEDURES ACT; TO PROVIDE FOR PUBLIC INPUT AT SUCH COMMITTEE
9 MEETINGS; TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972, TO
10 REINSTATE MEDICAID ELIGIBILITY FOR THE POVERTY-LEVEL, AGED OR
11 DISABLED GROUP (PLADS) UNTIL JANUARY 1, 2006, AND TO PROVIDE THAT
12 ELIGIBILITY FOR THAT GROUP SHALL BE DETERMINED BY THE DIVISION OF
13 MEDICAID; TO DEFINE MEDICAID ELIGIBILITY FOR INDIVIDUALS PURSUANT
14 TO MEDICARE PART D; TO DELETE A CATEGORY OF ELIGIBILITY RELATING
15 TO HOSPICE CARE; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF
16 1972, TO PROVIDE A LIMIT ON INPATIENT HOSPITAL DAYS REIMBURSABLE
17 UNDER MEDICAID; TO ESTABLISH A CO-PAYMENT REQUIREMENT FOR
18 INPATIENT HOSPITAL SERVICES; TO DEFINE THE AGE LIMITATION FOR
19 UNLIMITED DAYS IN DISPROPORTIONATE SHARE HOSPITALS; TO ESTABLISH A
20 REIMBURSEMENT LIMIT FOR EMERGENCY ROOM VISITS; TO ESTABLISH A
21 CO-PAYMENT REQUIREMENT FOR NONEMERGENCY VISITS TO AN EMERGENCY
22 ROOM; TO PROVIDE FOR NONEMERGENCY OUTPATIENT HOSPITAL SERVICES
23 REIMBURSABLE UNDER MEDICAID; TO ESTABLISH A CO-PAYMENT REQUIREMENT
24 FOR PHYSICIAN AND SPECIALIST VISITS; TO DELETE CERTAIN
25 RESTRICTIONS ON THE REIMBURSEMENT RATE FOR PHYSICIAN SERVICES; TO
26 PROVIDE A LIMIT ON HOME HEALTH SERVICE VISITS REIMBURSABLE UNDER
27 MEDICAID; TO ESTABLISH A CO-PAYMENT REQUIREMENT FOR HOME HEALTH
28 SERVICE VISITS; TO ESTABLISH A CO-PAYMENT REQUIREMENT FOR
29 PRESCRIPTION DRUGS REIMBURSABLE UNDER MEDICAID; TO PROVIDE A
30 MONTHLY LIMIT ON PRESCRIPTION DRUGS REIMBURSABLE UNDER MEDICAID
31 AND TO DELETE THE AUTHORITY FOR UNLIMITED PRESCRIPTIONS FOR
32 GENERIC DRUGS; TO REVISE THE DRUG SUPPLY REIMBURSABLE UNDER
33 MEDICAID; TO PROVIDE FOR TRUE UNIT DOSES OF DRUGS PRESCRIBED FOR
34 LONG-TERM CARE FACILITY RESIDENTS; TO PROVIDE FOR THE
35 CONFIDENTIALITY OF INFORMATION REGARDING THE DRUG PROGRAM; TO
36 PROVIDE AN ANNUAL LIMIT ON REIMBURSEMENT FOR DENTAL SERVICES; TO
37 ESTABLISH A CO-PAYMENT REQUIREMENT FOR CLINIC SERVICES
38 REIMBURSABLE UNDER MEDICAID; TO DELETE THE LIMITATION ON THE
39 REIMBURSEMENT RATE FOR CLINIC SERVICES UNDER MEDICAID; TO
40 ESTABLISH A CO-PAYMENT REQUIREMENT FOR DURABLE MEDICAL EQUIPMENT
41 AND MEDICAL SUPPLIES; TO DELETE THE AUTOMATIC REPEALER ON THE
42 MEDICARE UPPER PAYMENT LIMITS PROGRAM; TO AUTHORIZE THE DIVISION
43 TO ESTABLISH A MANAGED CARE SERVICES PROGRAM UTILIZING A PUBLIC OR
44 PRIVATE PROVIDER FOR THE RESPONSIBLE CONTAINMENT OF COSTS; TO
45 PROVIDE A LIMIT ON NONEMERGENCY TRANSPORTATION SERVICES
46 REIMBURSABLE UNDER MEDICAID; TO ESTABLISH A CO-PAYMENT REQUIREMENT
47 FOR CHIROPRACTIC SERVICES UNDER MEDICAID; TO CLARIFY THE DISEASES
48 AND CONDITIONS ELIGIBLE FOR THE DISEASE MANAGEMENT PROGRAM UNDER
49 MEDICAID; TO AUTHORIZE THE DIVISION TO PROVIDE TARGETED CASE
50 MANAGEMENT SERVICES FOR CERTAIN HIGH-COST CASES; TO REVISE THE
51 AUTHORITY OF THE GOVERNOR TO DISCONTINUE PAYMENT FOR SERVICES AND
52 TAKE COST CONTAINMENT MEASURES WHEN DIVISION EXPENDITURES ARE

53 ABOVE THE AMOUNT OF FUNDS APPROPRIATED; TO AMEND SECTION
54 43-13-145, MISSISSIPPI CODE OF 1972, TO INCREASE THE PER BED PER
55 DAY ASSESSMENT LEVIED UPON CERTAIN HEALTH CARE FACILITIES TO THE
56 MAXIMUM AMOUNT ALLOWABLE UNDER FEDERAL REGULATION AND TO REMOVE
57 CERTAIN EXCEPTIONS; TO AMEND SECTIONS 25-9-107 AND 25-9-127,
58 MISSISSIPPI CODE OF 1972, TO PROVIDE THAT FOR A PERIOD OF ONE
59 YEAR, THE PERSONNEL ACTIONS OF ALL EXECUTIVE AGENCIES SHALL BE
60 EXEMPT FROM CERTAIN STATE PERSONNEL BOARD PROCEDURES AND TO
61 SUSPEND EMPLOYMENT RIGHTS FOR SUCH EMPLOYEES DURING THAT PERIOD;
62 AND FOR RELATED PURPOSES.

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

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

66 43-13-107. (1) The Division of Medicaid is created in the
67 Office of the Governor and established to administer this article
68 and perform such other duties as are prescribed by law.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

286 existing prior approval requirements for a therapeutic class of
287 drugs.

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

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

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

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

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

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

319 and resource standards and methodologies under Title IV-A and the
320 state plan, as they existed on July 16, 1996. The Department of
321 Human Services shall determine Medicaid eligibility for children
322 receiving public assistance grants under Title IV-E. The division
323 shall determine eligibility for low-income families under Section
324 1931 of the federal Social Security Act and shall redetermine
325 eligibility for those continuing under Title IV-A grants.

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

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

337 (4) [Deleted]

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

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

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

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

369 * * *

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

376 (9) Individuals who are:

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

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

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

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

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

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

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

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

419 The eligibility of individuals covered under this paragraph
420 shall be determined by the Division of Medicaid, and those
421 individuals determined eligible shall receive Medicare
422 cost-sharing expenses only as more fully defined by the Medicare
423 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
424 1997.

425 (13) (a) Individuals who are entitled to Medicare Part
426 A as defined in Section 4501 of the Omnibus Budget Reconciliation
427 Act of 1990, and whose income does not exceed one hundred twenty
428 percent (120%) of the nonfarm official poverty level as defined by
429 the Office of Management and Budget and revised annually.

430 Eligibility for Medicaid benefits is limited to full payment of
431 Medicare Part B premiums.

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

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

443 (14) [Deleted]

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

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

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

459 (17) In accordance with the terms of the federal
460 Personal Responsibility and Work Opportunity Reconciliation Act of
461 1996 (Public Law 104-193), persons who become ineligible for
462 assistance under Title IV-A of the federal Social Security Act, as
463 amended, because of increased income from or hours of employment
464 of the caretaker relative or because of the expiration of the
465 applicable earned income disregards, who were eligible for
466 Medicaid for at least three (3) of the six (6) months preceding
467 the month in which the ineligibility begins, shall be eligible for
468 Medicaid for up to twelve (12) months. The eligibility of the
469 individuals covered under this paragraph shall be determined by
470 the division.

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

482 (19) Disabled workers, whose incomes are above the
483 Medicaid eligibility limits, but below two hundred fifty percent
484 (250%) of the federal poverty level, shall be allowed to purchase
485 Medicaid coverage on a sliding fee scale developed by the Division
486 of Medicaid.

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

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

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

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

515 severe disability" means a person who is at least sixteen (16)
516 years of age but under sixty-five (65) years of age, who has a
517 physical or mental impairment that is reasonably expected to cause
518 the person to become blind or disabled as defined under Section
519 1614(a) of the federal Social Security Act, as amended, if the
520 person does not receive items and services provided under
521 Medicaid.

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

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

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

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

548 provide services to individuals who are sixty-five (65) years of
549 age or older or are disabled as determined under Section
550 1614(a)(3) of the federal Social Security Act, as amended, and
551 whose income does not exceed one hundred thirty-five percent
552 (135%) of the nonfarm official poverty level as defined by the
553 Office of Management and Budget and revised annually, and whose
554 resources do not exceed those established by the Division of
555 Medicaid, and who are not otherwise covered by Medicare. Nothing
556 contained in this paragraph (25) shall entitle an individual to
557 benefits. The eligibility of individuals covered under this
558 paragraph shall be determined by the Division of Medicaid.

559 (26) The division shall apply to the Centers for
560 Medicare and Medicaid Services (CMS) for any necessary waivers to
561 provide services to individuals who are sixty-five (65) years of
562 age or older or are disabled as determined under Section
563 1614(a)(3) of the federal Social Security Act, as amended, who are
564 end stage renal disease patients on dialysis, cancer patients on
565 chemotherapy or organ transplant recipients on anti-rejection
566 drugs, whose income does not exceed one hundred thirty-five
567 percent (135%) of the nonfarm official poverty level as defined by
568 the Office of Management and Budget and revised annually, and
569 whose resources do not exceed those established by the division.
570 Nothing contained in this paragraph (26) shall entitle an
571 individual to benefits. The eligibility of individuals covered
572 under this paragraph shall be determined by the Division of
573 Medicaid.

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

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

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

585 43-13-117. Medicaid as authorized by this article shall
586 include payment of part or all of the costs, at the discretion of
587 the division, with approval of the Governor, of the following
588 types of care and services rendered to eligible applicants who
589 have been determined to be eligible for that care and services,
590 within the limits of state appropriations and federal matching
591 funds:

592 (1) Inpatient hospital services.

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

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

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

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

618 (2) Outpatient hospital services.

619 (a) Emergency. The division shall allow three (3)
620 medically necessary emergency room visits per beneficiary per
621 fiscal year. The division shall establish a Twenty-five Dollar
622 (\$25.00) per visit co-payment requirement for each nonemergency
623 visit to an emergency room, or an amount equal to the maximum
624 allowable under federal regulation.

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

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

636 (3) Laboratory and x-ray services.

637 (4) Nursing facility services.

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

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

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

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

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

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

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

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

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

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

727 (6) Physician's services. The division shall allow
728 twelve (12) physician visits annually. The division shall
729 establish a Ten Dollar (\$10.00) co-payment requirement for each
730 visit to a primary care physician (except for an annual physical
731 required by the division), and a Fifteen Dollar (\$15.00)
732 co-payment requirement for each visit to a specialist for each
733 beneficiary, or an amount equal to the maximum allowable under
734 federal regulation. All fees for physicians' services that are
735 covered only by Medicaid shall be reimbursed at ninety percent
736 (90%) of the rate established on January 1, 1999, and as may be
737 adjusted each July thereafter, under Medicare (Title XVIII of the
738 federal Social Security Act, as amended) * * *.

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

744 amount equal to the maximum allowable under federal regulation.

745 All home health visits must be precertified as required by the
746 division.

747 (b) Repealed.

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

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

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

774 (c) The division shall establish a Five Dollar
775 (\$5.00) per prescription co-payment requirement for each eligible

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

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

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

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

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

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

808 * * *

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

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

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

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

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

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

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

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

850 (10) Dental care that is an adjunct to treatment of an
851 acute medical or surgical condition; services of oral surgeons and
852 dentists in connection with surgery related to the jaw or any
853 structure contiguous to the jaw or the reduction of any fracture
854 of the jaw or any facial bone; and emergency dental extractions
855 and treatment related thereto. On July 1, 1999, all fees for
856 dental care and surgery under authority of this paragraph (10)
857 shall be increased to one hundred sixty percent (160%) of the
858 amount of the reimbursement rate that was in effect on June 30,
859 1999. It is the intent of the Legislature to encourage more
860 dentists to participate in the Medicaid program. Reimbursement
861 for dental services under this paragraph (10) shall not exceed
862 Five Hundred Dollars (\$500.00) per year per recipient.

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

872 (12) Intermediate care facility services.

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

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

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

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

887 (14) Clinic services. Such diagnostic, preventive,
888 therapeutic, rehabilitative or palliative services furnished to an
889 outpatient by or under the supervision of a physician or dentist
890 in a facility that is not a part of a hospital but that is
891 organized and operated to provide medical care to outpatients.
892 Clinic services shall include any services reimbursed as
893 outpatient hospital services that may be rendered in such a
894 facility, including those that become so after July 1, 1991. The
895 division shall establish a co-payment requirement for clinic
896 services at the same rate applicable to physician services. On
897 July 1, 1999, all fees for physicians' services reimbursed under
898 authority of this paragraph (14) shall be reimbursed at ninety
899 percent (90%) of the rate established on January 1, 1999, and as
900 may be adjusted each July thereafter, under Medicare (Title XVIII
901 of the federal Social Security Act, as amended) * * *. On July 1,
902 1999, all fees for dentists' services reimbursed under authority
903 of this paragraph (14) shall be increased to one hundred sixty
904 percent (160%) of the amount of the reimbursement rate that was in
905 effect on June 30, 1999.

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

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

911 (16) Mental health services. Approved therapeutic and
912 case management services (a) provided by an approved regional
913 mental health/retardation center established under Sections
914 41-19-31 through 41-19-39, or by another community mental health
915 service provider meeting the requirements of the Department of
916 Mental Health to be an approved mental health/retardation center
917 if determined necessary by the Department of Mental Health, using
918 state funds that are provided from the appropriation to the State
919 Department of Mental Health and/or funds transferred to the
920 department by a political subdivision or instrumentality of the
921 state and used to match federal funds under a cooperative
922 agreement between the division and the department, or (b) provided
923 by a facility that is certified by the State Department of Mental
924 Health to provide therapeutic and case management services, to be
925 reimbursed on a fee for service basis, or (c) provided in the
926 community by a facility or program operated by the Department of
927 Mental Health. Any such services provided by a facility described
928 in subparagraph (b) must have the prior approval of the division
929 to be reimbursable under this section. After June 30, 1997,
930 mental health services provided by regional mental
931 health/retardation centers established under Sections 41-19-31
932 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
933 and/or their subsidiaries and divisions, or by psychiatric
934 residential treatment facilities as defined in Section 43-11-1, or
935 by another community mental health service provider meeting the
936 requirements of the Department of Mental Health to be an approved
937 mental health/retardation center if determined necessary by the
938 Department of Mental Health, shall not be included in or provided
939 under any capitated managed care pilot program provided for under
940 paragraph (24) of this section.

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

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

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

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

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

986 (b) Early intervention system services. The
987 division shall cooperate with the State Department of Health,
988 acting as lead agency, in the development and implementation of a
989 statewide system of delivery of early intervention services, under
990 Part C of the Individuals with Disabilities Education Act (IDEA).
991 The State Department of Health shall certify annually in writing
992 to the executive director of the division the dollar amount of
993 state early intervention funds available that will be utilized as
994 a certified match for Medicaid matching funds. Those funds then
995 shall be used to provide expanded targeted case management
996 services for Medicaid eligible children with special needs who are
997 eligible for the state's early intervention system.
998 Qualifications for persons providing service coordination shall be
999 determined by the State Department of Health and the Division of
1000 Medicaid.

1001 (20) Home- and community-based services for physically
1002 disabled approved services as allowed by a waiver from the United
1003 States Department of Health and Human Services for home- and
1004 community-based services for physically disabled people using
1005 state funds that are provided from the appropriation to the State
1006 Department of Rehabilitation Services and used to match federal

1007 funds under a cooperative agreement between the division and the
1008 department, provided that funds for these services are
1009 specifically appropriated to the Department of Rehabilitation
1010 Services.

1011 (21) Nurse practitioner services. Services furnished
1012 by a registered nurse who is licensed and certified by the
1013 Mississippi Board of Nursing as a nurse practitioner, including,
1014 but not limited to, nurse anesthetists, nurse midwives, family
1015 nurse practitioners, family planning nurse practitioners,
1016 pediatric nurse practitioners, obstetrics-gynecology nurse
1017 practitioners and neonatal nurse practitioners, under regulations
1018 adopted by the division. Reimbursement for those services shall
1019 not exceed ninety percent (90%) of the reimbursement rate for
1020 comparable services rendered by a physician.

1021 (22) Ambulatory services delivered in federally
1022 qualified health centers, rural health centers and clinics of the
1023 local health departments of the State Department of Health for
1024 individuals eligible for Medicaid under this article based on
1025 reasonable costs as determined by the division.

1026 (23) Inpatient psychiatric services. Inpatient
1027 psychiatric services to be determined by the division for
1028 recipients under age twenty-one (21) that are provided under the
1029 direction of a physician in an inpatient program in a licensed
1030 acute care psychiatric facility or in a licensed psychiatric
1031 residential treatment facility, before the recipient reaches age
1032 twenty-one (21) or, if the recipient was receiving the services
1033 immediately before he or she reached age twenty-one (21), before
1034 the earlier of the date he or she no longer requires the services
1035 or the date he or she reaches age twenty-two (22), as provided by
1036 federal regulations. Precertification of inpatient days and
1037 residential treatment days must be obtained as required by the
1038 division.

1039 (24) Managed care services may be developed by the
1040 division utilizing a public or private provider. Notwithstanding
1041 any other provision in this article to the contrary, the division
1042 shall establish rates of reimbursement to providers rendering care
1043 and services under this section through a managed care program,
1044 and may revise such rates of reimbursement for the purpose of
1045 achieving effective and accessible health services and for
1046 responsible containment of costs. If allowed by federal law or
1047 regulation, the division may seek to establish managed care
1048 agreements with other jurisdictions to provide similar care and
1049 services to beneficiaries with a responsible containment of costs.

1050 (25) [Deleted]

1051 (26) Hospice care. As used in this paragraph, the term
1052 "hospice care" means a coordinated program of active professional
1053 medical attention within the home and outpatient and inpatient
1054 care that treats the terminally ill patient and family as a unit,
1055 employing a medically directed interdisciplinary team. The
1056 program provides relief of severe pain or other physical symptoms
1057 and supportive care to meet the special needs arising out of
1058 physical, psychological, spiritual, social and economic stresses
1059 that are experienced during the final stages of illness and during
1060 dying and bereavement and meets the Medicare requirements for
1061 participation as a hospice as provided in federal regulations.

1062 (27) Group health plan premiums and cost sharing if it
1063 is cost effective as defined by the United States Secretary of
1064 Health and Human Services.

1065 (28) Other health insurance premiums that are cost
1066 effective as defined by the United States Secretary of Health and
1067 Human Services. Medicare eligible must have Medicare Part B
1068 before other insurance premiums can be paid.

1069 (29) The Division of Medicaid may apply for a waiver
1070 from the United States Department of Health and Human Services for
1071 home- and community-based services for developmentally disabled

1072 people using state funds that are provided from the appropriation
1073 to the State Department of Mental Health and/or funds transferred
1074 to the department by a political subdivision or instrumentality of
1075 the state and used to match federal funds under a cooperative
1076 agreement between the division and the department, provided that
1077 funds for these services are specifically appropriated to the
1078 Department of Mental Health and/or transferred to the department
1079 by a political subdivision or instrumentality of the state.

1080 (30) Pediatric skilled nursing services for eligible
1081 persons under twenty-one (21) years of age.

1082 (31) Targeted case management services for children
1083 with special needs, under waivers from the United States
1084 Department of Health and Human Services, using state funds that
1085 are provided from the appropriation to the Mississippi Department
1086 of Human Services and used to match federal funds under a
1087 cooperative agreement between the division and the department.

1088 (32) Care and services provided in Christian Science
1089 Sanatoria listed and certified by the Commission for Accreditation
1090 of Christian Science Nursing Organizations/Facilities, Inc.,
1091 rendered in connection with treatment by prayer or spiritual means
1092 to the extent that those services are subject to reimbursement
1093 under Section 1903 of the federal Social Security Act.

1094 (33) Podiatrist services.

1095 (34) Assisted living services as provided through home-
1096 and community-based services under Title XIX of the federal Social
1097 Security Act, as amended, subject to the availability of funds
1098 specifically appropriated for that purpose by the Legislature.

1099 (35) Services and activities authorized in Sections
1100 43-27-101 and 43-27-103, using state funds that are provided from
1101 the appropriation to the State Department of Human Services and
1102 used to match federal funds under a cooperative agreement between
1103 the division and the department.

1104 (36) Nonemergency transportation services for
1105 Medicaid-eligible persons, to be provided by the Division of
1106 Medicaid, at the minimum reimbursement level required by federal
1107 regulation. The division may contract with additional entities to
1108 administer nonemergency transportation services as it deems
1109 necessary. All providers shall have a valid driver's license,
1110 vehicle inspection sticker, valid vehicle license tags and a
1111 standard liability insurance policy covering the vehicle. The
1112 division may pay providers a flat fee based on mileage tiers, or
1113 in the alternative, may reimburse on actual miles traveled. The
1114 division may apply to the Center for Medicare and Medicaid
1115 Services (CMS) for a waiver to draw federal matching funds for
1116 nonemergency transportation services as a covered service instead
1117 of an administrative cost.

1118 (37) [Deleted]

1119 (38) Chiropractic services. A chiropractor's manual
1120 manipulation of the spine to correct a subluxation, if x-ray
1121 demonstrates that a subluxation exists and if the subluxation has
1122 resulted in a neuromusculoskeletal condition for which
1123 manipulation is appropriate treatment, and related spinal x-rays
1124 performed to document these conditions. The division shall
1125 establish a Fifteen Dollar (\$15.00) per visit co-payment
1126 requirement for chiropractic services to beneficiaries, or an
1127 amount equal to the maximum allowable under federal regulation.
1128 Reimbursement for chiropractic services shall not exceed Seven
1129 Hundred Dollars (\$700.00) per year per beneficiary.

1130 (39) Dually eligible Medicare/Medicaid beneficiaries.
1131 The division shall pay the Medicare deductible and coinsurance
1132 amounts for services available under Medicare, as determined by
1133 the division.

1134 (40) [Deleted]

1135 (41) Services provided by the State Department of
1136 Rehabilitation Services for the care and rehabilitation of persons

1137 with spinal cord injuries or traumatic brain injuries, as allowed
1138 under waivers from the United States Department of Health and
1139 Human Services, using up to seventy-five percent (75%) of the
1140 funds that are appropriated to the Department of Rehabilitation
1141 Services from the Spinal Cord and Head Injury Trust Fund
1142 established under Section 37-33-261 and used to match federal
1143 funds under a cooperative agreement between the division and the
1144 department.

1145 (42) Notwithstanding any other provision in this
1146 article to the contrary, the division may develop a population
1147 health management program for women and children health services
1148 through the age of one (1) year. This program is primarily for
1149 obstetrical care associated with low birth weight and pre-term
1150 babies. The division may apply to the federal Centers for
1151 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
1152 any other waivers that may enhance the program. In order to
1153 effect cost savings, the division may develop a revised payment
1154 methodology that may include at-risk capitated payments, and may
1155 require member participation in accordance with the terms and
1156 conditions of an approved federal waiver.

1157 (43) The division shall provide reimbursement,
1158 according to a payment schedule developed by the division, for
1159 smoking cessation medications for pregnant women during their
1160 pregnancy and other Medicaid-eligible women who are of
1161 child-bearing age.

1162 (44) Nursing facility services for the severely
1163 disabled.

1164 (a) Severe disabilities include, but are not
1165 limited to, spinal cord injuries, closed head injuries and
1166 ventilator dependent patients.

1167 (b) Those services must be provided in a long-term
1168 care nursing facility dedicated to the care and treatment of

1169 persons with severe disabilities, and shall be reimbursed as a
1170 separate category of nursing facilities.

1171 (45) Physician assistant services. Services furnished
1172 by a physician assistant who is licensed by the State Board of
1173 Medical Licensure and is practicing with physician supervision
1174 under regulations adopted by the board, under regulations adopted
1175 by the division. Reimbursement for those services shall not
1176 exceed ninety percent (90%) of the reimbursement rate for
1177 comparable services rendered by a physician.

1178 (46) The division shall make application to the federal
1179 Centers for Medicare and Medicaid Services (CMS) for a waiver to
1180 develop and provide services for children with serious emotional
1181 disturbances as defined in Section 43-14-1(1), which may include
1182 home- and community-based services, case management services or
1183 managed care services through mental health providers certified by
1184 the Department of Mental Health. The division may implement and
1185 provide services under this waived program only if funds for
1186 these services are specifically appropriated for this purpose by
1187 the Legislature, or if funds are voluntarily provided by affected
1188 agencies.

1189 (47) (a) Notwithstanding any other provision in this
1190 article to the contrary, the division, in conjunction with the
1191 State Department of Health, shall develop and implement disease
1192 management programs for individuals with chronic diseases and
1193 conditions, including the use of grants, waivers, demonstrations
1194 or other projects as necessary.

1195 (b) Participation in any disease management
1196 program implemented under this paragraph (47) is optional with the
1197 individual. An individual must affirmatively elect to participate
1198 in the disease management program in order to participate.

1199 (c) An individual who participates in the disease
1200 management program has the option of participating in the
1201 prescription drug home delivery component of the program at any

1202 time while participating in the program. An individual must
1203 affirmatively elect to participate in the prescription drug home
1204 delivery component in order to participate.

1205 (d) An individual who participates in the disease
1206 management program may elect to discontinue participation in the
1207 program at any time. An individual who participates in the
1208 prescription drug home delivery component may elect to discontinue
1209 participation in the prescription drug home delivery component at
1210 any time.

1211 (e) The division shall send written notice to all
1212 individuals who participate in the disease management program
1213 informing them that they may continue using their local pharmacy
1214 or any other pharmacy of their choice to obtain their prescription
1215 drugs while participating in the program.

1216 (f) Prescription drugs that are provided to
1217 individuals under the prescription drug home delivery component
1218 shall be limited only to those drugs that are used for the
1219 treatment, management or care of asthma, diabetes or hypertension.

1220 (48) Pediatric long-term acute care hospital services.

1221 (a) Pediatric long-term acute care hospital
1222 services means services provided to eligible persons under
1223 twenty-one (21) years of age by a freestanding Medicare-certified
1224 hospital that has an average length of inpatient stay greater than
1225 twenty-five (25) days and that is primarily engaged in providing
1226 chronic or long-term medical care to persons under twenty-one (21)
1227 years of age.

1228 (b) The services under this paragraph (48) shall
1229 be reimbursed as a separate category of hospital services.

1230 (49) The division shall establish co-payments and/or
1231 coinsurance for all Medicaid services for which co-payments and/or
1232 coinsurance are allowable under federal law or regulation, and
1233 shall set the amount of the co-payment and/or coinsurance for each

1234 of those services at the maximum amount allowable under federal
1235 law or regulation.

1236 (50) Services provided by the State Department of
1237 Rehabilitation Services for the care and rehabilitation of persons
1238 who are deaf and blind, as allowed under waivers from the United
1239 States Department of Health and Human Services to provide home-
1240 and community-based services using state funds that are provided
1241 from the appropriation to the State Department of Rehabilitation
1242 Services or if funds are voluntarily provided by another agency.

1243 (51) Upon determination of Medicaid eligibility and in
1244 association with annual redetermination of Medicaid eligibility,
1245 beneficiaries shall be encouraged to undertake a physical
1246 examination that will establish a base-line level of health and
1247 identification of a usual and customary source of care (a medical
1248 home) to aid utilization of disease management tools. This
1249 physical examination and utilization of these disease management
1250 tools shall be consistent with current United States Preventive
1251 Services Task Force or other recognized authority recommendations.

1252 For persons who are determined ineligible for Medicaid, the
1253 division will provide information and direction for accessing
1254 medical care and services in the area of their residence.

1255 (52) Notwithstanding any provisions of this article,
1256 the division may pay enhanced reimbursement fees related to trauma
1257 care, as determined by the division in conjunction with the State
1258 Department of Health, using funds appropriated to the State
1259 Department of Health for trauma care and services and used to
1260 match federal funds under a cooperative agreement between the
1261 division and the State Department of Health. The division, in
1262 conjunction with the State Department of Health, may use grants,
1263 waivers, demonstrations, or other projects as necessary in the
1264 development and implementation of this reimbursement program.

1265 (53) Targeted case management services for high-cost
1266 beneficiaries shall be developed by the division for all services
1267 under this section.

1268 Notwithstanding any other provision of this article to the
1269 contrary, the division shall reduce the rate of reimbursement to
1270 providers for any service provided under this section by five
1271 percent (5%) of the allowed amount for that service. However, the
1272 reduction in the reimbursement rates required by this paragraph
1273 shall not apply to inpatient hospital services, nursing facility
1274 services, intermediate care facility services, psychiatric
1275 residential treatment facility services, pharmacy services
1276 provided under paragraph (9) of this section, or any service
1277 provided by the University of Mississippi Medical Center or a
1278 state agency, a state facility or a public agency that either
1279 provides its own state match through intergovernmental transfer or
1280 certification of funds to the division, or a service for which the
1281 federal government sets the reimbursement methodology and rate.

1282 In addition, the reduction in the reimbursement rates required by
1283 this paragraph shall not apply to case management services and
1284 home-delivered meals provided under the home- and community-based
1285 services program for the elderly and disabled by a planning and
1286 development district (PDD). Planning and development districts
1287 participating in the home- and community-based services program
1288 for the elderly and disabled as case management providers shall be
1289 reimbursed for case management services at the maximum rate
1290 approved by the Centers for Medicare and Medicaid Services (CMS).

1291 The division may pay to those providers who participate in
1292 and accept patient referrals from the division's emergency room
1293 redirection program a percentage, as determined by the division,
1294 of savings achieved according to the performance measures and
1295 reduction of costs required of that program.

1296 Notwithstanding any provision of this article, except as
1297 authorized in the following paragraph and in Section 43-13-139,

1298 neither (a) the limitations on quantity or frequency of use of or
1299 the fees or charges for any of the care or services available to
1300 recipients under this section, nor (b) the payments or rates of
1301 reimbursement to providers rendering care or services authorized
1302 under this section to recipients, may be increased, decreased or
1303 otherwise changed from the levels in effect on July 1, 1999,
1304 unless they are authorized by an amendment to this section by the
1305 Legislature. However, the restriction in this paragraph shall not
1306 prevent the division from changing the payments or rates of
1307 reimbursement to providers without an amendment to this section
1308 whenever those changes are required by federal law or regulation,
1309 or whenever those changes are necessary to correct administrative
1310 errors or omissions in calculating those payments or rates of
1311 reimbursement.

1312 Notwithstanding any provision of this article, no new groups
1313 or categories of recipients and new types of care and services may
1314 be added without enabling legislation from the Mississippi
1315 Legislature, except that the division may authorize those changes
1316 without enabling legislation when the addition of recipients or
1317 services is ordered by a court of proper authority. The executive
1318 director shall keep the Governor advised on a timely basis of the
1319 funds available for expenditure and the projected expenditures.
1320 If current or projected expenditures of the division during
1321 the * * * fiscal year are reasonably anticipated to be * * * above
1322 the amount of the appropriated funds that is authorized to be
1323 expended during the * * * fiscal year, the Governor, after
1324 consultation with the executive director, may discontinue any or
1325 all of the payment of the types of care and services as provided
1326 in this section that are deemed to be optional services under
1327 Title XIX of the federal Social Security Act, as amended, and when
1328 necessary may institute any other cost containment measures on any
1329 program or programs authorized under the article to the extent
1330 allowed under the federal law governing that program or programs.

1331 If current or projected expenditures of the division during
1332 the * * * fiscal year are reasonably anticipated to exceed the
1333 amount of the appropriated funds that is authorized to be expended
1334 during the first allotment period of the fiscal year * * *, the
1335 Governor, after consultation with the executive director, shall
1336 discontinue any or all of the payment of the types of care and
1337 services as provided in this section that are deemed to be
1338 optional services under Title XIX of the federal Social Security
1339 Act, as amended, for any period necessary to ensure that the
1340 actual expenditures of the division will not exceed the amount of
1341 the appropriated funds that is authorized to be expended during
1342 the first allotment period of the fiscal year * * *, and when
1343 necessary shall institute any other cost containment measures on
1344 any program or programs authorized under the article to the extent
1345 allowed under the federal law governing that program or
1346 programs. * * * It is the intent of the Legislature that the
1347 expenditures of the division during any fiscal year shall not
1348 exceed the amounts appropriated to the division for that fiscal
1349 year.

1350 Notwithstanding any other provision of this article, it shall
1351 be the duty of each nursing facility, intermediate care facility
1352 for the mentally retarded, psychiatric residential treatment
1353 facility, and nursing facility for the severely disabled that is
1354 participating in the Medicaid program to keep and maintain books,
1355 documents and other records as prescribed by the Division of
1356 Medicaid in substantiation of its cost reports for a period of
1357 three (3) years after the date of submission to the Division of
1358 Medicaid of an original cost report, or three (3) years after the
1359 date of submission to the Division of Medicaid of an amended cost
1360 report.

1361 This section shall stand repealed on July 1, 2007.

1362 **SECTION 4.** Section 43-13-145, Mississippi Code of 1972, is
1363 amended as follows:

1364 43-13-145. (1) (a) Upon each nursing facility and each
1365 intermediate care facility for the mentally retarded licensed by
1366 the State of Mississippi, there is levied an assessment up to the
1367 maximum amount allowable under federal regulations per day for
1368 each licensed and * * * occupied bed of the facility.

1369 (b) A nursing facility or intermediate care facility
1370 for the mentally retarded is exempt from the assessment levied
1371 under this subsection if the facility is operated under the
1372 direction and control of:

1373 (i) The United States Veterans Administration or
1374 other agency or department of the United States government;

1375 (ii) The State Veterans Affairs Board;

1376 (iii) The University of Mississippi Medical
1377 Center; or

1378 (iv) A state agency or a state facility that
1379 either provides its own state match through intergovernmental
1380 transfer or certification of funds to the division.

1381 (2) (a) Upon each intermediate care facility for the
1382 mentally retarded licensed by the State of Mississippi, there is
1383 levied an assessment in an amount set by the division, not
1384 exceeding the maximum rate allowed by federal law or regulation,
1385 for each licensed and/or certified bed of the facility that is
1386 occupied by a patient.

1387 (b) An intermediate care facility for the mentally
1388 retarded is exempt from the assessment levied under this
1389 subsection if the facility is operated under the direction and
1390 control of:

1391 (i) The United States Veterans Administration or
1392 other agency or department of the United States government;

1393 (ii) The State Veterans Affairs Board; or

1394 (iii) The University of Mississippi Medical
1395 Center.

1396 (3) (a) Upon each psychiatric residential treatment
1397 facility licensed by the State of Mississippi, there is levied an
1398 assessment up to the maximum amount allowable under federal
1399 regulations per day for each licensed and * * * occupied bed of
1400 the facility.

1401 (b) A psychiatric residential treatment facility is
1402 exempt from the assessment levied under this subsection if the
1403 facility is operated under the direction and control of:

1404 (i) The United States Veterans Administration or
1405 other agency or department of the United States government;

1406 (ii) The University of Mississippi Medical Center.

1407 * * *

1408 (4) (a) Upon each hospital licensed by the State of
1409 Mississippi, there is levied an assessment in the amount of One
1410 Dollar and Fifty Cents (\$1.50) per day for each licensed inpatient
1411 acute care bed of the hospital.

1412 (b) A hospital is exempt from the assessment levied
1413 under this subsection if the hospital is operated under the
1414 direction and control of:

1415 (i) The United States Veterans Administration or
1416 other agency or department of the United States government;

1417 (ii) The University of Mississippi Medical Center;

1418 or

1419 (iii) A state agency or a state facility that
1420 either provides its own state match through intergovernmental
1421 transfer or certification of funds to the division.

1422 (5) Each health care facility that is subject to the
1423 provisions of this section shall keep and preserve such suitable
1424 books and records as may be necessary to determine the amount of
1425 assessment for which it is liable under this section. The books
1426 and records shall be kept and preserved for a period of not less
1427 than five (5) years, and those books and records shall be open for
1428 examination during business hours by the division, the State Tax

1429 Commission, the Office of the Attorney General and the State
1430 Department of Health.

1431 (6) The assessment levied under this section shall be
1432 collected by the division each month beginning on the effective
1433 date of Senate Bill No. 2745, 2005 Regular Session.

1434 (7) All assessments collected under this section shall be
1435 deposited in the Medical Care Fund created by Section 43-13-143.

1436 (8) The assessment levied under this section shall be in
1437 addition to any other assessments, taxes or fees levied by law,
1438 and the assessment shall constitute a debt due the State of
1439 Mississippi from the time the assessment is due until it is paid.

1440 (9) (a) If a health care facility that is liable for
1441 payment of the assessment levied under this section does not pay
1442 the assessment when it is due, the division shall give written
1443 notice to the health care facility by certified or registered mail
1444 demanding payment of the assessment within ten (10) days from the
1445 date of delivery of the notice. If the health care facility
1446 fails or refuses to pay the assessment after receiving the notice
1447 and demand from the division, the division shall withhold from any
1448 Medicaid reimbursement payments that are due to the health care
1449 facility the amount of the unpaid assessment and a penalty of ten
1450 percent (10%) of the amount of the assessment, plus the legal rate
1451 of interest until the assessment is paid in full. If the health
1452 care facility does not participate in the Medicaid program, the
1453 division shall turn over to the Office of the Attorney General the
1454 collection of the unpaid assessment by civil action. In any such
1455 civil action, the Office of the Attorney General shall collect the
1456 amount of the unpaid assessment and a penalty of ten percent (10%)
1457 of the amount of the assessment, plus the legal rate of interest
1458 until the assessment is paid in full.

1459 (b) As an additional or alternative method for
1460 collecting unpaid assessments under this section, if a health care
1461 facility fails or refuses to pay the assessment after receiving

1462 notice and demand from the division, the division may file a
1463 notice of a tax lien with the circuit clerk of the county in which
1464 the health care facility is located, for the amount of the unpaid
1465 assessment and a penalty of ten percent (10%) of the amount of the
1466 assessment, plus the legal rate of interest until the assessment
1467 is paid in full. Immediately upon receipt of notice of the tax
1468 lien for the assessment, the circuit clerk shall enter the notice
1469 of the tax lien as a judgment upon the judgment roll and show in
1470 the appropriate columns the name of the health care facility as
1471 judgment debtor, the name of the division as judgment creditor,
1472 the amount of the unpaid assessment, and the date and time of
1473 enrollment. The judgment shall be valid as against mortgagees,
1474 pledgees, entrusters, purchasers, judgment creditors and other
1475 persons from the time of filing with the clerk. The amount of the
1476 judgment shall be a debt due the State of Mississippi and remain a
1477 lien upon the tangible property of the health care facility until
1478 the judgment is satisfied. The judgment shall be the equivalent
1479 of any enrolled judgment of a court of record and shall serve as
1480 authority for the issuance of writs of execution, writs of
1481 attachment or other remedial writs.

1482 **SECTION 5.** Section 25-9-107, Mississippi Code of 1972, is
1483 amended as follows:

1484 25-9-107. The following terms, when used in this chapter,
1485 unless a different meaning is plainly required by the context,
1486 shall have the following meanings:

1487 (a) "Board" means the State Personnel Board created
1488 under the provisions of this chapter.

1489 (b) "State service" means all employees of state
1490 departments, agencies and institutions as defined herein, except
1491 those officers and employees excluded by this chapter.

1492 (c) "Nonstate service" means the following officers and
1493 employees excluded from the state service by this chapter. The
1494 following are excluded from the state service:

1495 (i) Members of the State Legislature, their staffs
1496 and other employees of the legislative branch;
1497 (ii) The Governor and staff members of the
1498 immediate Office of the Governor;
1499 (iii) Justices and judges of the judicial branch
1500 or members of appeals boards on a per diem basis;
1501 (iv) The Lieutenant Governor, staff members of the
1502 immediate Office of the Lieutenant Governor and officers and
1503 employees directly appointed by the Lieutenant Governor;
1504 (v) Officers and officials elected by popular vote
1505 and persons appointed to fill vacancies in elective offices;
1506 (vi) Members of boards and commissioners appointed
1507 by the Governor, Lieutenant Governor or the State Legislature;
1508 (vii) All academic officials, members of the
1509 teaching staffs and employees of the state institutions of higher
1510 learning, the State Board for Community and Junior Colleges, and
1511 community and junior colleges;
1512 (viii) Officers and enlisted members of the
1513 National Guard of the state;
1514 (ix) Prisoners, inmates, student or patient help
1515 working in or about institutions;
1516 (x) Contract personnel; provided, that any agency
1517 which employs state service employees may enter into contracts for
1518 personal and professional services only if such contracts are
1519 approved in compliance with the rules and regulations promulgated
1520 by the State Personal Service Contract Review Board under Section
1521 25-9-120(3). Before paying any warrant for such contractual
1522 services in excess of One Hundred Thousand Dollars (\$100,000.00),
1523 the Auditor of Public Accounts, or the successor to those duties,
1524 shall determine whether the contract involved was for personal or
1525 professional services, and, if so, was approved by the State
1526 Personal Service Contract Review Board;

1527 (xi) Part-time employees; provided, however,
1528 part-time employees shall only be hired into authorized employment
1529 positions classified by the board, shall meet minimum
1530 qualifications as set by the board, and shall be paid in
1531 accordance with the Variable Compensation Plan as certified by the
1532 board;

1533 (xii) Persons appointed on an emergency basis for
1534 the duration of the emergency; the effective date of the emergency
1535 appointments shall not be earlier than the date approved by the
1536 State Personnel Director, and shall be limited to thirty (30)
1537 working days. Emergency appointments may be extended to sixty
1538 (60) working days by the State Personnel Board;

1539 (xiii) Physicians, dentists, veterinarians, nurse
1540 practitioners and attorneys, while serving in their professional
1541 capacities in authorized employment positions who are required by
1542 statute to be licensed, registered or otherwise certified as such,
1543 provided that the State Personnel Director shall verify that the
1544 statutory qualifications are met prior to issuance of a payroll
1545 warrant by the auditor;

1546 (xiv) Personnel who are employed and paid from
1547 funds received from a federal grant program which has been
1548 approved by the Legislature or the Department of Finance and
1549 Administration whose length of employment has been determined to
1550 be time-limited in nature. This subparagraph shall apply to
1551 personnel employed under the provisions of the Comprehensive
1552 Employment and Training Act of 1973, as amended, and other special
1553 federal grant programs which are not a part of regular federally
1554 funded programs wherein appropriations and employment positions
1555 are appropriated by the Legislature. Such employees shall be paid
1556 in accordance with the Variable Compensation Plan and shall meet
1557 all qualifications required by federal statutes or by the
1558 Mississippi Classification Plan;

1559 (xv) The administrative head who is in charge of
1560 any state department, agency, institution, board or commission,
1561 wherein the statute specifically authorizes the Governor, board,
1562 commission or other authority to appoint said administrative head;
1563 provided, however, that the salary of such administrative head
1564 shall be determined by the State Personnel Board in accordance
1565 with the Variable Compensation Plan unless otherwise fixed by
1566 statute;

1567 (xvi) The State Personnel Board shall exclude top
1568 level positions if the incumbents determine and publicly advocate
1569 substantive program policy and report directly to the agency head,
1570 or the incumbents are required to maintain a direct confidential
1571 working relationship with a key excluded official. Provided
1572 further, a written job classification shall be approved by the
1573 board for each such position, and positions so excluded shall be
1574 paid in conformity with the Variable Compensation Plan;

1575 (xvii) Employees whose employment is solely in
1576 connection with an agency's contract to produce, store or
1577 transport goods, and whose compensation is derived therefrom;

1578 (xviii) Repealed;

1579 (xix) The associate director, deputy directors and
1580 bureau directors within the Department of Agriculture and
1581 Commerce;

1582 (xx) Personnel employed by the Mississippi
1583 Industries for the Blind; provided, that any agency may enter into
1584 contracts for the personal services of MIB employees without the
1585 prior approval of the State Personnel Board or the State Personal
1586 Service Contract Review Board; however, any agency contracting for
1587 the personal services of an MIB employee shall provide the MIB
1588 employee with not less than the entry level compensation and
1589 benefits that the agency would provide to a full-time employee of
1590 the agency who performs the same services;

1591 (xxi) Personnel employed by the Mississippi
1592 Department of Wildlife, Fisheries and Parks as law enforcement
1593 trainees (cadets); such personnel shall be paid in accordance with
1594 the Colonel Guy Groff State Variable Compensation Plan;

1595 (xxii) For a period beginning with the effective
1596 date of Senate Bill No. 2745, 2005 Regular Session, through June
1597 30, 2006, all employees in the executive branch of government who
1598 are under the purview of the State Personnel Board with the
1599 exception of employees with the Mississippi Department of
1600 Corrections. Such employees shall be paid in accordance with the
1601 Variable Compensation Plan and shall be otherwise subject to the
1602 policies and procedures of the State Personnel Board.

1603 (d) "Agency" means any state board, commission,
1604 committee, council, department or unit thereof created by the
1605 Constitution or statutes if such board, commission, committee,
1606 council, department, unit or the head thereof, is authorized to
1607 appoint subordinate staff by the Constitution or statute, except a
1608 legislative or judicial board, commission, committee, council,
1609 department or unit thereof.

1610 **SECTION 6.** Section 25-9-127, Mississippi Code of 1972, is
1611 amended as follows:

1612 25-9-127. (1) No employee of any department, agency or
1613 institution who is included under this chapter or hereafter
1614 included under its authority, and who is subject to the rules and
1615 regulations prescribed by the state personnel system may be
1616 dismissed or otherwise adversely affected as to compensation or
1617 employment status except for inefficiency or other good cause, and
1618 after written notice and hearing within the department, agency or
1619 institution as shall be specified in the rules and regulations of
1620 the State Personnel Board complying with due process of law; and
1621 any employee who has by written notice of dismissal or action
1622 adversely affecting his compensation or employment status shall,
1623 on hearing and on any appeal of any decision made in such action,

1624 be required to furnish evidence that the reasons stated in the
1625 notice of dismissal or action adversely affecting his compensation
1626 or employment status are not true or are not sufficient grounds
1627 for the action taken; provided, however, that this provision shall
1628 not apply (a) to persons separated from any department, agency or
1629 institution due to curtailment of funds or reduction in staff when
1630 such separation is in accordance with rules and regulations of the
1631 state personnel system; (b) during the probationary period of
1632 state service of twelve (12) months; * * * (c) to an executive
1633 officer of any state agency who serves at the will and pleasure of
1634 the Governor, board, commission or other appointing authority; and
1635 (d) all employees employed in the executive branch of government
1636 who are under the purview of the State Personnel Board with the
1637 exception of employees with the Mississippi Department of
1638 Corrections, whose accumulated property interests in state service
1639 employment shall be suspended for a period beginning upon the
1640 effective date of Senate Bill No. 2745, 2005 Regular Session, and
1641 through June 30, 2006, notwithstanding any existing statutory
1642 provision which conveys state service status. The executive
1643 agencies shall consult with the Office of the Attorney General
1644 before taking personnel actions permitted by this subsection
1645 (1)(d) to review those actions for compliance with applicable
1646 state and federal law.

1647 (2) The operation of a state-owned motor vehicle without a
1648 valid Mississippi driver's license by an employee of any
1649 department, agency or institution that is included under this
1650 chapter and that is subject to the rules and regulations of the
1651 state personnel system shall constitute good cause for dismissal
1652 of such person from employment.

1653 (3) Beginning July 1, 1999, every male between the ages of
1654 eighteen (18) and twenty-six (26) who is required to register
1655 under the federal Military Selective Service Act, 50 USCS App.
1656 453, and who is an employee of the state shall not be promoted to

1657 any higher position of employment with the state until he submits
1658 to the person, commission, board or agency by which he is employed
1659 satisfactory documentation of his compliance with the draft
1660 registration requirements of the Military Selective Service Act.
1661 The documentation shall include a signed affirmation under penalty
1662 of perjury that the male employee has complied with the
1663 requirements of the federal selective service act.

1664 **SECTION 7.** This act shall take effect and be in force from
1665 and after its passage.