MISSISSIPPI LEGISLATURE REGULAR SESSION 2006

By: Representative Morris

To: Medicaid

HOUSE BILL NO. 1181

AN ACT TO BRING FORWARD SECTIONS 43-13-105, 43-13-107, 43-13-113, 43-13-115, 43-13-117, 43-13-121, 43-13-145, 43-13-203, 43-13-205 AND 43-13-211, MISSISSIPPI CODE OF 1972, FROM THE MISSISSIPPI MEDICAID LAW AND THE MEDICAID FRAUD CONTROL ACT, FOR THE PURPOSES OF AMENDMENT; AND FOR RELATED PURPOSES.

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

SECTION 1. Section 43-13-105, Mississippi Code of 1972, is brought forward as follows:

43-13-105. When used in this article, the following definitions shall apply, unless the context requires otherwise:

(a) "Administering agency" means the Division of Medicaid in the Office of the Governor as created by this article.

(b) "Division" or "Division of Medicaid" means the Division of Medicaid in the Office of the Governor.

(c) "Medical assistance" means payment of part or all of the costs of medical and remedial care provided under the terms of this article and in accordance with provisions of Titles XIX and XXI of the Social Security Act, as amended.

(d) "Applicant" means a person who applies for assistance under Titles IV, XVI, XIX or XXI of the Social Security Act, as amended, and under the terms of this article.

(e) "Recipient" means a person who is eligible for assistance under Title XIX or XXI of the Social Security Act, as amended and under the terms of this article.

(f) "State health agency" shall mean any agency, department, institution, board or commission of the State of Mississippi, except the University Medical School, which is supported in whole or in part by any public funds, including funds

directly appropriated from the State Treasury, funds derived by taxes, fees levied or collected by statutory authority, or any other funds used by "state health agencies" derived from federal sources, when any funds available to such agency are expended either directly or indirectly in connection with, or in support of, any public health, hospital, hospitalization or other public programs for the preventive treatment or actual medical treatment of persons who are physically or mentally ill or mentally retarded.

(g) "Mississippi Medicaid Commission" or "Medicaid Commission" wherever they appear in the laws of the State of Mississippi, shall mean the Division of Medicaid in the Office of the Governor.

SECTION 2. Section 43-13-107, Mississippi Code of 1972, is brought forward as follows:

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

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

(b) The Governor shall appoint a full-time Deputy Director of Administration, with the advice and consent of the Senate, who shall have at least a bachelor's degree from an accredited college or university, and/or shall possess a special knowledge of Medicaid as pertaining to the State of Mississippi. The Deputy Director of Administration may perform those duties of the executive director that the executive director has not expressly retained for himself.

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

(d) The terms of office of the executive director and the Deputy Director of Administration shall be concurrent with the terms of the Governor appointing them. In the event of a vacancy, the same shall be filled by the Governor for the unexpired portion of the term in which the vacancy occurs. However, the incumbent executive director and Deputy Director of Administration shall serve until the appointment and qualification of their successors.

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

(f) The executive director, with the approval of the Governor and subject to the rules and regulations of the State Personnel Board, shall employ such professional, administrative, stenographic, secretarial, clerical and technical assistance as

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

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

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

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

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

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

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

(c) The respective Chairmen of the House Medicaid Committee, the House Public Health and Human Services Committee, the House Appropriations Committee, the Senate Public Health and Welfare Committee and the Senate Appropriations Committee, or their designees, two (2) members of the State Senate appointed by the Lieutenant Governor and one (1) member of the House of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) The committee meetings shall be open to the public, members of the press, legislators and consumers. Additionally, all documents provided to committee members shall be available to members of the Legislature in the same manner, and shall be made available to others for a reasonable fee for copying. However, patient confidentiality and provider confidentiality shall be protected by blinding patient names and provider names with numerical or other anonymous identifiers. The committee meetings

shall be subject to the Open Meetings Act (Section 25-41-1 et seq.). Committee meetings conducted in violation of this section shall be deemed unlawful.

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

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

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

existing prior approval requirements for a therapeutic class of drugs.

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

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

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

SECTION 3. Section 43-13-113, Mississippi Code of 1972, is brought forward as follows:

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

The division shall issue all checks or electronic transfers for administrative expenses, and for medical assistance under the provisions of this article. All such checks or electronic

transfers shall be drawn upon funds made available to the division by the State Auditor, upon requisition of the director. It is the purpose of this section to provide that the State Auditor shall transfer, in lump sums, amounts to the division for disbursement under the regulations which shall be made by the director with the approval of the Governor; however, the division, or its fiscal agent in behalf of the division, shall be authorized in maintaining separate accounts with a Mississippi bank to handle claim payments, refund recoveries and related Medicaid program financial transactions, to aggressively manage the float in these accounts while awaiting clearance of checks or electronic transfers and/or other disposition so as to accrue maximum interest advantage of the funds in the account, and to retain all earned interest on these funds to be applied to match federal funds for Medicaid program operations.

(2) The division is authorized to obtain a line of credit through the State Treasurer from the Working Cash-Stabilization Fund or any other special source funds maintained in the State Treasury in an amount not exceeding One Hundred Fifty Million Dollars ($150,000,000.00) to fund shortfalls which, from time to time, may occur due to decreases in state matching fund cash flow. The length of indebtedness under this provision shall not carry past the end of the quarter following the loan origination. Loan proceeds shall be received by the State Treasurer and shall be placed in a Medicaid designated special fund account. Loan proceeds shall be expended only for health care services provided under the Medicaid program. The division may pledge as security for such interim financing future funds that will be received by the division. Any such loans shall be repaid from the first available funds received by the division in the manner of and subject to the same terms provided in this section.

In the event the State Treasurer makes a determination that special source funds are not sufficient to cover a line of credit

for the Division of Medicaid, the division is authorized to obtain a line of credit, in an amount not exceeding One Hundred Fifty Million Dollars ($150,000,000.00), from a commercial lender or a consortium of lenders. The length of indebtedness under this provision shall not carry past the end of the quarter following the loan origination. The division shall obtain a minimum of two (2) written quotes that shall be presented to the State Fiscal Officer and State Treasurer, who shall jointly select a lender. Loan proceeds shall be received by the State Treasurer and shall be placed in a Medicaid designated special fund account. Loan proceeds shall be expended only for health care services provided under the Medicaid program. The division may pledge as security for such interim financing future funds that will be received by the division. Any such loans shall be repaid from the first available funds received by the division in the manner of and subject to the same terms provided in this section.

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

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

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

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

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

(e) If a claim is neither paid nor denied for valid and proper reasons by the end of the time periods as specified above, the Division of Medicaid's fiscal agent must pay the provider interest on the claim at the rate of one and one-half percent

(1-1/2%) per month on the amount of such claim until it is finally settled or adjudicated.

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

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

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

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

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

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

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

(7) Repealed.

(8) If sufficient funds are appropriated therefor by the Legislature, the Division of Medicaid may contract with the Mississippi Dental Association, or an approved designee, to develop and operate a Donated Dental Services (DDS) program through which volunteer dentists will treat needy disabled, aged

and medically-compromised individuals who are non-Medicaid eligible recipients.

SECTION 4. Section 43-13-115, Mississippi Code of 1972, is brought forward as follows:

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

(1) Those who are qualified for public assistance grants under provisions of Title IV-A and E of the federal Social Security Act, as amended, including those statutorily deemed to be IV-A and low income families and children under Section 1931 of the federal Social Security Act. For the purposes of this paragraph (1) and paragraphs (8), (17) and (18) of this section, any reference to Title IV-A or to Part A of Title IV of the federal Social Security Act, as amended, or the state plan under Title IV-A or Part A of Title IV, shall be considered as a reference to Title IV-A of the federal Social Security Act, as amended, and the state plan under Title IV-A, including the income and resource standards and methodologies under Title IV-A and the state plan, as they existed on July 16, 1996. The Department of Human Services shall determine Medicaid eligibility for children receiving public assistance grants under Title IV-E. The division shall determine eligibility for low income families under Section 1931 of the federal Social Security Act and shall redetermine eligibility for those continuing under Title IV-A grants.

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

(3) Qualified pregnant women who would be eligible for Medicaid as a low income family member under Section 1931 of the federal Social Security Act if her child were born. The

eligibility of the individuals covered under this paragraph shall be determined by the division.

(4) [Deleted]

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

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

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

the maximum standard set by the Division of Medicaid, which standard shall not exceed that prescribed by federal regulation.

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

(9) Individuals who are:

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

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

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

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

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

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

Any individual who applied for Medicaid during the period from July 1, 2004, through March 31, 2005, who otherwise would have been eligible for coverage under this paragraph (11) if it had been in effect at the time the individual submitted his or her application and is still eligible for coverage under this paragraph (11) on March 31, 2005, shall be eligible for Medicaid coverage under this paragraph (11) from March 31, 2005, through December 31, 2005. The division shall give priority in processing the applications for those individuals to determine their eligibility under this paragraph (11).

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

The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid, and those individuals determined eligible shall receive Medicare cost-sharing expenses only as more fully defined by the Medicare

Catastrophic Coverage Act of 1988 and the Balanced Budget Act of 1997.

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

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

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

(14) [Deleted]

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

(16) In accordance with the terms and conditions of approved Title XIX waiver from the United States Department of Health and Human Services, persons provided home- and

community-based services who are physically disabled and certified by the Division of Medicaid as eligible due to applying the income and deeming requirements as if they were institutionalized.

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

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

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

(20) Medicaid eligible children under age eighteen (18) shall remain eligible for Medicaid benefits until the end of a

period of twelve (12) months following an eligibility determination, or until such time that the individual exceeds age eighteen (18).

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

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

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

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

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

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

(25) The division shall apply to the Centers for Medicare and Medicaid Services (CMS) for any necessary waivers to provide services to individuals who are sixty-five (65) years of age or older or are disabled as determined under Section 1614(a)(3) of the federal Social Security Act, as amended, and whose income does not exceed one hundred thirty-five percent (135%) of the nonfarm official poverty level as defined by the Office of Management and Budget and revised annually, and whose resources do not exceed those established by the Division of

Medicaid, and who are not otherwise covered by Medicare. Nothing contained in this paragraph (25) shall entitle an individual to benefits. The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid.

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

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

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

SECTION 5. Section 43-13-117, Mississippi Code of 1972, is brought forward as follows:

43-13-117. Medicaid as authorized by this article shall include payment of part or all of the costs, at the discretion of the division, with approval of the Governor, of the following

types of care and services rendered to eligible applicants who have been determined to be eligible for that care and services, within the limits of state appropriations and federal matching funds:

(1) Inpatient hospital services.

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

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

(c) Hospitals will receive an additional payment for the implantable programmable baclofen drug pump used to treat spasticity that is implanted on an inpatient basis. The payment pursuant to written invoice will be in addition to the facility's per diem reimbursement and will represent a reduction of costs on the facility's annual cost report, and shall not exceed Ten Thousand Dollars ($10,000.00) per year per recipient.

(2) Outpatient hospital services.

(a) Emergency services. The division shall allow six (6) medically necessary emergency room visits per beneficiary per fiscal year.

(b) Other outpatient hospital services. The division shall allow benefits for other medically necessary outpatient hospital services (such as chemotherapy, radiation, surgery and therapy). Where the same services are reimbursed as

clinic services, the division may revise the rate or methodology of outpatient reimbursement to maintain consistency, efficiency, economy and quality of care.

(3) Laboratory and x-ray services.

(4) Nursing facility services.

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

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

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

(d) When a facility of a category that does not require a certificate of need for construction and that could not be eligible for Medicaid reimbursement is constructed to nursing facility specifications for licensure and certification, and the facility is subsequently converted to a nursing facility under a certificate of need that authorizes conversion only and the

applicant for the certificate of need was assessed an application review fee based on capital expenditures incurred in constructing the facility, the division shall allow reimbursement for capital expenditures necessary for construction of the facility that were incurred within the twenty-four (24) consecutive calendar months immediately preceding the date that the certificate of need authorizing the conversion was issued, to the same extent that reimbursement would be allowed for construction of a new nursing facility under a certificate of need that authorizes that construction. The reimbursement authorized in this subparagraph (d) may be made only to facilities the construction of which was completed after June 30, 1989. Before the division shall be authorized to make the reimbursement authorized in this subparagraph (d), the division first must have received approval from the Centers for Medicare and Medicaid Services (CMS) of the change in the state Medicaid plan providing for the reimbursement.

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

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

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

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

(6) Physician's services. The division shall allow twelve (12) physician visits annually. All fees for physicians' services that are covered only by Medicaid shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as may be adjusted each July thereafter, under Medicare (Title

XVIII of the federal Social Security Act, as amended). The division may develop and implement a different reimbursement model or schedule for physician's services provided by physicians based at an academic health care center and by physicians at rural health centers that are associated with an academic health care center.

(7) (a) Home health services for eligible persons, not to exceed in cost the prevailing cost of nursing facility services, not to exceed twenty-five (25) visits per year. All home health visits must be precertified as required by the division.

(b) Repealed.

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

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

The division shall establish a mandatory preferred drug list. Drugs not on the mandatory preferred drug list shall be made available by utilizing prior authorization procedures established by the division.

The division may seek to establish relationships with other states in order to lower acquisition costs of prescription drugs to include single source and innovator multiple source drugs or generic drugs. In addition, if allowed by federal law or

regulation, the division may seek to establish relationships with and negotiate with other countries to facilitate the acquisition of prescription drugs to include single source and innovator multiple source drugs or generic drugs, if that will lower the acquisition costs of those prescription drugs.

The division shall allow for a combination of prescriptions for single source and innovator multiple source drugs and generic drugs to meet the needs of the beneficiaries, not to exceed five (5) prescriptions per month for each noninstitutionalized Medicaid beneficiary, with not more than two (2) of those prescriptions being for single source or innovator multiple source drugs.

The executive director may approve specific maintenance drugs for beneficiaries with certain medical conditions, which may be prescribed and dispensed in three-month supply increments. The executive director may allow a state agency or agencies to be the sole source purchaser and distributor of hemophilia factor medications, HIV/AIDS medications and other medications as determined by the executive director as allowed by federal regulations.

Drugs prescribed for a resident of a psychiatric residential treatment facility must be provided in true unit doses when available. The division may require that drugs not covered by Medicare Part D for a resident of a long-term care facility be provided in true unit doses when available. Those drugs that were originally billed to the division but are not used by a resident in any of those facilities shall be returned to the billing pharmacy for credit to the division, in accordance with the guidelines of the State Board of Pharmacy and any requirements of federal law and regulation. Drugs shall be dispensed to a recipient and only one (1) dispensing fee per month may be charged. The division shall develop a methodology for reimbursing for restocked drugs, which shall include a restock fee as

determined by the division not exceeding Seven Dollars and Eighty-two Cents ($7.82).

The voluntary preferred drug list shall be expanded to function in the interim in order to have a manageable prior authorization system, thereby minimizing disruption of service to beneficiaries.

Except for those specific maintenance drugs approved by the executive director, the division shall not reimburse for any portion of a prescription that exceeds a thirty-one-day supply of the drug based on the daily dosage.

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

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

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

The division shall develop and implement a method or methods by which the division will provide on a regular basis to Medicaid providers who are authorized to prescribe drugs, information about the costs to the Medicaid program of single source drugs and innovator multiple source drugs, and information about other drugs that may be prescribed as alternatives to those single source drugs and innovator multiple source drugs and the costs to the Medicaid program of those alternative drugs.

Notwithstanding any law or regulation, information obtained or maintained by the division regarding the prescription drug

program, including trade secrets and manufacturer or labeler pricing, is confidential and not subject to disclosure except to other state agencies.

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

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

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

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

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

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

(10) Dental care that is an adjunct to treatment of an acute medical or surgical condition; services of oral surgeons and dentists in connection with surgery related to the jaw or any

structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone; and emergency dental extractions and treatment related thereto. On July 1, 1999, all fees for dental care and surgery under authority of this paragraph (10) shall be increased to one hundred sixty percent (160%) of the amount of the reimbursement rate that was in effect on June 30, 1999. It is the intent of the Legislature to encourage more dentists to participate in the Medicaid program.

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

(12) Intermediate care facility services.

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

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

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

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

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

(16) Mental health services. Approved therapeutic and case management services (a) provided by an approved regional mental health/retardation center established under Sections 41-19-31 through 41-19-39, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/retardation center if determined necessary by the Department of Mental Health, using

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

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

(18) (a) Notwithstanding any other provision of this section to the contrary, the division shall make additional reimbursement to hospitals that serve a disproportionate share of low-income patients and that meet the federal requirements for

those payments as provided in Section 1923 of the federal Social Security Act and any applicable regulations. However, from and after January 1, 1999, no public hospital shall participate in the Medicaid disproportionate share program unless the public hospital participates in an intergovernmental transfer program as provided in Section 1903 of the federal Social Security Act and any applicable regulations.

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

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

(b) Early intervention system services. The division shall cooperate with the State Department of Health,

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

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

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

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

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

(24) [Deleted]

(25) [Deleted]

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

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

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

(29) The Division of Medicaid may apply for a waiver from the United States Department of Health and Human Services for home- and community-based services for developmentally disabled people using state funds that are provided from the appropriation to the State Department of Mental Health and/or funds transferred to the department by a political subdivision or instrumentality of the state and used to match federal funds under a cooperative agreement between the division and the department, provided that funds for these services are specifically appropriated to the Department of Mental Health and/or transferred to the department by a political subdivision or instrumentality of the state.

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

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

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

(33) Podiatrist services.

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

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

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

(37) [Deleted]

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

(39) Dually eligible Medicare/Medicaid beneficiaries. The division shall pay the Medicare deductible and coinsurance

amounts for services available under Medicare, as determined by the division.

(40) [Deleted]

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

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

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

(44) Nursing facility services for the severely disabled.

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

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

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

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

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

(b) Participation in any disease management program implemented under this paragraph (47) is optional with the

individual. An individual must affirmatively elect to participate in the disease management program in order to participate.

(c) An individual who participates in the disease management program has the option of participating in the prescription drug home delivery component of the program at any time while participating in the program. An individual must affirmatively elect to participate in the prescription drug home delivery component in order to participate.

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

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

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

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

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

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

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

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

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

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

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

waivers, demonstrations, or other projects as necessary in the development and implementation of this reimbursement program.

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

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

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

health centers may participate in the emergency room redirection program, and the division may pay those centers a percentage of any savings to the Medicaid program achieved by the centers' accepting patient referrals through the program, as provided in this paragraph.

Notwithstanding any provision of this article, except as authorized in the following paragraph and in Section 43-13-139, neither (a) the limitations on quantity or frequency of use of or the fees or charges for any of the care or services available to recipients under this section, nor (b) the payments or rates of reimbursement to providers rendering care or services authorized under this section to recipients, may be increased, decreased or otherwise changed from the levels in effect on July 1, 1999, unless they are authorized by an amendment to this section by the Legislature. However, the restriction in this paragraph shall not prevent the division from changing the payments or rates of reimbursement to providers without an amendment to this section whenever those changes are required by federal law or regulation, or whenever those changes are necessary to correct administrative errors or omissions in calculating those payments or rates of reimbursement.

Notwithstanding any provision of this article, no new groups or categories of recipients and new types of care and services may be added without enabling legislation from the Mississippi Legislature, except that the division may authorize those changes without enabling legislation when the addition of recipients or services is ordered by a court of proper authority.

The executive director shall keep the Governor advised on a timely basis of the funds available for expenditure and the projected expenditures. If current or projected expenditures of the division are reasonably anticipated to exceed the amount of funds appropriated to the division for any fiscal year, the Governor, after consultation with the executive director, shall

discontinue any or all of the payment of the types of care and services as provided in this section that are deemed to be optional services under Title XIX of the federal Social Security Act, as amended, and when necessary, shall institute any other cost containment measures on any program or programs authorized under the article to the extent allowed under the federal law governing that program or programs. However, the Governor shall not be authorized to discontinue or eliminate any service under this section that is mandatory under federal law, or to discontinue or eliminate, or adjust income limits or resource limits for, any eligibility category or group under Section 43-13-115. It is the intent of the Legislature that the expenditures of the division during any fiscal year shall not exceed the amounts appropriated to the division for that fiscal year.

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

SECTION 6. Section 43-13-121, Mississippi Code of 1972, is brought forward as follows:

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

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

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

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

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

(iv) Providing for fair and impartial hearings;

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

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

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

(c) Subject to the limits imposed by this article, to submit a Medicaid plan to the United States Department of Health and Human Services for approval under the provisions of the federal Social Security Act, to act for the state in making negotiations relative to the submission and approval of that plan,

to make such arrangements, not inconsistent with the law, as may be required by or under federal law to obtain and retain that approval and to secure for the state the benefits of the provisions of that law.

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

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

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

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

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

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

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

(j) To recover any and all payments incorrectly made by the division to a recipient or provider from the recipient or provider receiving the payments. To recover those payments, the division may use the following methods, in addition to any other methods available to the division:

(i) The division shall report to the State Tax Commission the name of any current or former Medicaid recipient who has received medical services rendered during a period of established Medicaid ineligibility and who has not reimbursed the division for the related medical service payment(s). The State Tax Commission shall withhold from the state tax refund of the individual, and pay to the division, the amount of the payment(s) for medical services rendered to the ineligible individual that have not been reimbursed to the division for the related medical service payment(s).

(ii) The division shall report to the State Tax Commission the name of any Medicaid provider to whom payments were incorrectly made that the division has not been able to recover by other methods available to the division. The State Tax Commission shall withhold from the state tax refund of the provider, and pay to the division, the amount of the payments that were incorrectly made to the provider that have not been recovered by other available methods;

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

(l) Have full, complete and plenary power and authority to conduct such investigations as it may deem necessary and requisite of alleged or suspected violations or abuses of the provisions of this article or of the regulations adopted under

this article, including, but not limited to, fraudulent or unlawful act or deed by applicants for Medicaid or other benefits, or payments made to any person, firm or corporation under the terms, conditions and authority of this article, to suspend or disqualify any provider of services, applicant or recipient for gross abuse, fraudulent or unlawful acts for such periods, including permanently, and under such conditions as the division deems proper and just, including the imposition of a legal rate of interest on the amount improperly or incorrectly paid. Recipients who are found to have misused or abused Medicaid benefits may be locked into one (1) physician and/or one (1) pharmacy of the recipient's choice for a reasonable amount of time in order to educate and promote appropriate use of medical services, in accordance with federal regulations. If an administrative hearing becomes necessary, the division may, if the provider does not succeed in his or her defense, tax the costs of the administrative hearing, including the costs of the court reporter or stenographer and transcript, to the provider. The convictions of a recipient or a provider in a state or federal court for abuse, fraudulent or unlawful acts under this chapter shall constitute an automatic disqualification of the recipient or automatic disqualification of the provider from participation under the Medicaid program.

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

(m) Establish and provide such methods of administration as may be necessary for the proper and efficient operation of the Medicaid program, fully utilizing computer equipment as may be necessary to oversee and control all current

expenditures for purposes of this article, and to closely monitor and supervise all recipient payments and vendors rendering services under this article;

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

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

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

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

(4) The division and its hearing officers shall have power to preserve and enforce order during hearings; to issue subpoenas for, to administer oaths to and to compel the attendance and

testimony of witnesses, or the production of books, papers, documents and other evidence, or the taking of depositions before any designated individual competent to administer oaths; to examine witnesses; and to do all things conformable to law that may be necessary to enable them effectively to discharge the duties of their office. In compelling the attendance and testimony of witnesses, or the production of books, papers, documents and other evidence, or the taking of depositions, as authorized by this section, the division or its hearing officers may designate an individual employed by the division or some other suitable person to execute and return that process, whose action in executing and returning that process shall be as lawful as if done by the sheriff or some other proper officer authorized to execute and return process in the county where the witness may reside. In carrying out the investigatory powers under the provisions of this article, the executive director or other designated person or persons may examine, obtain, copy or reproduce the books, papers, documents, medical charts, prescriptions and other records relating to medical care and services furnished by the provider to a recipient or designated recipients of Medicaid services under investigation. In the absence of the voluntary submission of the books, papers, documents, medical charts, prescriptions and other records, the Governor, the executive director, or other designated person may issue and serve subpoenas instantly upon the provider, his or her agent, servant or employee for the production of the books, papers, documents, medical charts, prescriptions or other records during an audit or investigation of the provider. If any provider or his or her agent, servant or employee refuses to produce the records after being duly subpoenaed, the executive director may certify those facts and institute contempt proceedings in the manner, time and place as authorized by law for administrative proceedings. As an additional remedy, the division may recover

all amounts paid to the provider covering the period of the audit or investigation, inclusive of a legal rate of interest and a reasonable attorney's fee and costs of court if suit becomes necessary. Division staff shall have immediate access to the provider's physical location, facilities, records, documents, books, and any other records relating to medical care and services rendered to recipients during regular business hours.

(5) If any person in proceedings before the division disobeys or resists any lawful order or process, or misbehaves during a hearing or so near the place thereof as to obstruct the hearing, or neglects to produce, after having been ordered to do so, any pertinent book, paper or document, or refuses to appear after having been subpoenaed, or upon appearing refuses to take the oath as a witness, or after having taken the oath refuses to be examined according to law, the executive director shall certify the facts to any court having jurisdiction in the place in which it is sitting, and the court shall thereupon, in a summary manner, hear the evidence as to the acts complained of, and if the evidence so warrants, punish that person in the same manner and to the same extent as for a contempt committed before the court, or commit that person upon the same condition as if the doing of the forbidden act had occurred with reference to the process of, or in the presence of, the court.

(6) In suspending or terminating any provider from participation in the Medicaid program, the division shall preclude the provider from submitting claims for payment, either personally or through any clinic, group, corporation or other association to the division or its fiscal agents for any services or supplies provided under the Medicaid program except for those services or supplies provided before the suspension or termination. No clinic, group, corporation or other association that is a provider of services shall submit claims for payment to the division or its fiscal agents for any services or supplies provided by a person

within that organization who has been suspended or terminated from participation in the Medicaid program except for those services or supplies provided before the suspension or termination. When this provision is violated by a provider of services that is a clinic, group, corporation or other association, the division may suspend or terminate that organization from participation. Suspension may be applied by the division to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure or inadequacy of performance may be imputed to a person with whom the provider is affiliated where that conduct was accomplished within the course of his or her official duty or was effectuated by him or her with the knowledge or approval of that person.

(7) The division may deny or revoke enrollment in the Medicaid program to a provider if any of the following are found to be applicable to the provider, his or her agent, a managing employee or any person having an ownership interest equal to five percent (5%) or greater in the provider:

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

(b) Previous or current exclusion, suspension, termination from or the involuntary withdrawing from participation in the Medicaid program, any other state's Medicaid program, Medicare or any other public or private health or health insurance program. If the division ascertains that a provider has been convicted of a felony under federal or state law for an offense that the division determines is detrimental to the best interest of the program or of Medicaid beneficiaries, the division may

refuse to enter into an agreement with that provider, or may terminate or refuse to renew an existing agreement.

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

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

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

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

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

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

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

(j) Revocation of license or certification.

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

(l) Failure to meet any condition of enrollment.

SECTION 7. Section 43-13-145, Mississippi Code of 1972, is brought forward as follows:

43-13-145. (1) (a) Upon each nursing facility licensed by the State of Mississippi, there is levied an assessment in an amount set by the division, not exceeding the maximum rate allowed by federal law or regulation, for each licensed and occupied bed of the facility.

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

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

(ii) The State Veterans Affairs Board;

(iii) The University of Mississippi Medical Center; or

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

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

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

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

(ii) The State Veterans Affairs Board; or

(iii) The University of Mississippi Medical Center.

(3) (a) Upon each psychiatric residential treatment facility licensed by the State of Mississippi, there is levied an assessment in an amount set by the division, not exceeding the maximum rate allowed by federal law or regulation, for each licensed and occupied bed of the facility.

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

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

(ii) The University of Mississippi Medical Center;

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

(4) (a) Upon each hospital licensed by the State of Mississippi, there is levied an assessment in the amount of Three Dollars and Twenty-five Cents ($3.25) per bed for each licensed inpatient acute care bed of the hospital.

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

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

(ii) The University of Mississippi Medical Center; or

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

(5) Each health care facility that is subject to the provisions of this section shall keep and preserve such suitable books and records as may be necessary to determine the amount of assessment for which it is liable under this section. The books and records shall be kept and preserved for a period of not less

than five (5) years, and those books and records shall be open for examination during business hours by the division, the State Tax Commission, the Office of the Attorney General and the State Department of Health.

(6) The assessment levied under this section shall be collected by the division each month beginning on March 31, 2005.

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

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

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

(b) As an additional or alternative method for collecting unpaid assessments levied by the division, if a health

care facility fails or refuses to pay the assessment after receiving notice and demand from the division, the division may file a notice of a tax lien with the circuit clerk of the county in which the health care facility is located, for the amount of the unpaid assessment and a penalty of ten percent (10%) of the amount of the assessment, plus the legal rate of interest until the assessment is paid in full. Immediately upon receipt of notice of the tax lien for the assessment, the circuit clerk shall enter the notice of the tax lien as a judgment upon the judgment roll and show in the appropriate columns the name of the health care facility as judgment debtor, the name of the division as judgment creditor, the amount of the unpaid assessment, and the date and time of enrollment. The judgment shall be valid as against mortgagees, pledgees, entrusters, purchasers, judgment creditors and other persons from the time of filing with the clerk. The amount of the judgment shall be a debt due the State of Mississippi and remain a lien upon the tangible property of the health care facility until the judgment is satisfied. The judgment shall be the equivalent of any enrolled judgment of a court of record and shall serve as authority for the issuance of writs of execution, writs of attachment or other remedial writs.

SECTION 8. Section 43-13-203, Mississippi Code of 1972, is brought forward as follows:

43-13-203. As used in this article:

(a) "Benefit" means the receipt of money, goods, services or anything of pecuniary value.

(b) "False statement" or "false representation" means a statement or representation knowingly and willfully made by a person knowing of the falsity of the statement or representation.

(c) "Knowing" and "knowingly" means that a person is aware of the nature of his conduct and that such conduct is substantially certain to cause the intended result.

(d) "Medicaid benefit" means a benefit paid or payable under the Medicaid program established under Section 43-13-101 et seq.

(e) "Person" means an individual, corporation, unincorporated association, partnership or other form of business association.

SECTION 9. Section 43-13-205, Mississippi Code of 1972, is brought forward as follows:

43-13-205. (1) A person shall not knowingly make or cause to be made a false representation of a material fact in an application for Medicaid benefits.

(2) A person shall not knowingly make or cause to be made a false statement of a material fact for use in determining rights to a Medicaid benefit.

(3) A person, who having knowledge of the occurrence of an event affecting his initial or continued right to receive a Medicaid benefit, shall not conceal or fail to disclose that event with intent to obtain a Medicaid benefit to which the person or any other person is not entitled or in an amount greater than that to which the person or any other person is entitled.

SECTION 10. Section 43-13-211, Mississippi Code of 1972, is brought forward as follows:

43-13-211. A person shall not enter into an agreement, combination or conspiracy to defraud the state by obtaining or aiding another to obtain the payment or allowance of a false, fictitious or fraudulent claim for Medicaid benefits.

SECTION 11. This act shall take effect and be in force from and after July 1, 2006.