MISSISSIPPI LEGISLATURE REGULAR SESSION 2007

By: Representatives Dedeaux, Holland, Morris, Scott, Clark

To: Medicaid

COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 528

1 AN ACT RELATING TO THE ADMINISTRATION OF THE MISSISSIPPI
2 MEDICAID LAW; TO AMEND SECTION 43-13-107, MISSISSIPPI CODE OF
3 1972, TO DELETE PROVISIONS RELATING TO THE POSITION OF DEPUTY
4 DIRECTOR OF ADMINISTRATION OF THE DIVISION OF MEDICAID; TO EXTEND
5 THE AUTOMATIC REPEALER ON THE SECTION THAT CREATES THE DIVISION OF
6 MEDICAID; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO
7 PROVIDE THAT UNTIL JULY 1, 2008, THE DIVISION SHALL NOT INCREASE
8 ANY ASSESSMENT ON HOSPITALS AND SHALL NOT CHANGE THE METHODOLOGY
9 OF REIMBURSEMENT FOR PROVIDERS; TO CODIFY NEW SECTION 43-13-126,
10 MISSISSIPPI CODE OF 1972, TO REQUIRE HEALTH INSURERS TO PROVIDE
11 CERTAIN INFORMATION REGARDING INDIVIDUAL COVERAGE TO THE DIVISION
12 OF MEDICAID AS A CONDITION OF DOING BUSINESS IN THE STATE, TO
13 ACCEPT THE DIVISION OF MEDICAID'S RIGHT OF RECOVERY IN THIRD-PARTY
14 ACTIONS AND NOT TO DENY A CLAIM SUBMITTED BY THE DIVISION ON THE
15 BASIS OF CERTAIN ERRORS; AND FOR RELATED PURPOSES.

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

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

19 43-13-107. (1) The Division of Medicaid is created in the
20 Office of the Governor and established to administer this article
21 and perform such other duties as are prescribed by law.

22 (2) (a) The Governor shall appoint a full-time executive
23 director, with the advice and consent of the Senate, who shall be
24 either (i) a physician with administrative experience in a medical
25 care or health program, or (ii) a person holding a graduate degree
26 in medical care administration, public health, hospital
27 administration, or the equivalent, or (iii) a person holding a
28 bachelor's degree in business administration or hospital
29 administration, with at least ten (10) years' experience in
30 management-level administration of Medicaid programs. The
31 executive director shall be the official secretary and legal
32 custodian of the records of the division; shall be the agent of
33 the division for the purpose of receiving all service of process,

34 summons and notices directed to the division; * * * shall perform
35 such other duties as the Governor may prescribe from time to time;
36 and shall perform all other duties that are now or may be imposed
37 upon him or her by law.

38 (b) The term of office of the executive director * * *
39 shall be concurrent with the term of the appointing
40 Governor * * *. If there is a vacancy in office, it shall be
41 filled by the Governor for the unexpired portion of the term in
42 which the vacancy occurs. However, the incumbent executive
43 director * * * shall serve until the appointment and qualification
44 of his or her successor.

45 (c) The executive director * * * shall, before entering
46 upon the discharge of the duties of the office, take and subscribe
47 to the oath of office prescribed by the Mississippi Constitution
48 and shall file the same in the Office of the Secretary of State,
49 and * * * shall execute a bond in some surety company authorized
50 to do business in the state in the penal sum of One Hundred
51 Thousand Dollars ($100,000.00), conditioned for the faithful and
52 impartial discharge of the duties of the office. The premium on
53 the bond shall be paid as provided by law out of funds
54 appropriated to the Division of Medicaid for contractual services.

55 (d) The executive director, with the approval of the
56 Governor and subject to the rules and regulations of the State
57 Personnel Board, shall employ such professional, administrative,
58 stenographic, secretarial, clerical and technical assistance as
59 may be necessary to perform the duties required in administering
60 this article and fix the compensation for those persons, all in
61 accordance with a state merit system meeting federal requirements.
62 When the salary of the executive director is not set by law, that
63 salary shall be set by the State Personnel Board. No employees of
64 the Division of Medicaid shall be considered to be staff members
65 of the immediate Office of the Governor; however, the provisions

66 of Section 25-9-107(c)(xv) shall apply to the executive director
67 and other administrative heads of the division.
68 (3) (a) There is established a Medical Care Advisory
69 Committee, which shall be the committee that is required by
70 federal regulation to advise the Division of Medicaid about health
71 and medical care services.
72 (b) The advisory committee shall consist of not less
73 than eleven (11) members, as follows:
74 (i) The Governor shall appoint five (5) members,
75 one (1) from each congressional district and one (1) from the
76 state at large;
77 (ii) The Lieutenant Governor shall appoint three
78 (3) members, one (1) from each Supreme Court district;
79 (iii) The Speaker of the House of Representatives
80 shall appoint three (3) members, one (1) from each Supreme Court
81 district.
82 All members appointed under this paragraph shall either be
83 health care providers or consumers of health care services. One
84 (1) member appointed by each of the appointing authorities shall
85 be a board certified physician.
86 (c) The respective Chairmen of the House Medicaid
87 Committee, the House Public Health and Human Services Committee,
88 the House Appropriations Committee, the Senate Public Health and
89 Welfare Committee and the Senate Appropriations Committee, or
90 their designees, two (2) members of the State Senate appointed by
91 the Lieutenant Governor and one (1) member of the House of
92 Representatives appointed by the Speaker of the House, shall serve
93 as ex officio nonvoting members of the advisory committee.
94 (d) In addition to the committee members required by
95 paragraph (b), the advisory committee shall consist of such other
96 members as are necessary to meet the requirements of the federal
97 regulation applicable to the advisory committee, who shall be
98 appointed as provided in the federal regulation.

99 (e) The chairmanship of the advisory committee shall
100 alternate for twelve-month periods between the Chairmen of the
101 House Medicaid Committee and the Senate Public Health and Welfare
102 Committee.
103 (f) The members of the advisory committee specified in
104 paragraph (b) shall serve for terms that are concurrent with the
105 terms of members of the Legislature, and any member appointed
106 under paragraph (b) may be reappointed to the advisory committee.
107 The members of the advisory committee specified in paragraph (b)
108 shall serve without compensation, but shall receive reimbursement
109 to defray actual expenses incurred in the performance of committee
110 business as authorized by law. Legislators shall receive per diem
111 and expenses, which may be paid from the contingent expense funds
112 of their respective houses in the same amounts as provided for
113 committee meetings when the Legislature is not in session.
114 (g) The advisory committee shall meet not less than
115 quarterly, and advisory committee members shall be furnished
116 written notice of the meetings at least ten (10) days before the
117 date of the meeting.
118 (h) The executive director shall submit to the advisory
119 committee all amendments, modifications and changes to the state
120 plan for the operation of the Medicaid program, for review by the
121 advisory committee before the amendments, modifications or changes
122 may be implemented by the division.
123 (i) The advisory committee, among its duties and
124 responsibilities, shall:
125 (i) Advise the division with respect to
126 amendments, modifications and changes to the state plan for the
127 operation of the Medicaid program;
128 (ii) Advise the division with respect to issues
129 concerning receipt and disbursement of funds and eligibility for
130 Medicaid;

131 (iii) Advise the division with respect to
132 determining the quantity, quality and extent of medical care
133 provided under this article;
134 (iv) Communicate the views of the medical care
135 professions to the division and communicate the views of the
136 division to the medical care professions;
137 (v) Gather information on reasons that medical
138 care providers do not participate in the Medicaid program and
139 changes that could be made in the program to encourage more
140 providers to participate in the Medicaid program, and advise the
141 division with respect to encouraging physicians and other medical
142 care providers to participate in the Medicaid program;
143 (vi) Provide a written report on or before
144 November 30 of each year to the Governor, Lieutenant Governor and
145 Speaker of the House of Representatives.
146 (4) (a) There is established a Drug Use Review Board, which
147 shall be the board that is required by federal law to:
148 (i) Review and initiate retrospective drug use,
149 review including ongoing periodic examination of claims data and
150 other records in order to identify patterns of fraud, abuse, gross
151 overuse, or inappropriate or medically unnecessary care, among
152 physicians, pharmacists and individuals receiving Medicaid
153 benefits or associated with specific drugs or groups of drugs.
154 (ii) Review and initiate ongoing interventions for
155 physicians and pharmacists, targeted toward therapy problems or
156 individuals identified in the course of retrospective drug use
157 reviews.
158 (iii) On an ongoing basis, assess data on drug use
159 against explicit predetermined standards using the compendia and
160 literature set forth in federal law and regulations.
161 (b) The board shall consist of not less than twelve
162 (12) members appointed by the Governor, or his designee.

163 (c) The board shall meet at least quarterly, and board
164 members shall be furnished written notice of the meetings at least
165 ten (10) days before the date of the meeting.
166 (d) The board meetings shall be open to the public,
167 members of the press, legislators and consumers. Additionally,
168 all documents provided to board members shall be available to
169 members of the Legislature in the same manner, and shall be made
170 available to others for a reasonable fee for copying. However,
171 patient confidentiality and provider confidentiality shall be
172 protected by blinding patient names and provider names with
173 numerical or other anonymous identifiers. The board meetings
174 shall be subject to the Open Meetings Act (Section 25-41-1 et
175 seq.). Board meetings conducted in violation of this section
176 shall be deemed unlawful.
177 (5) (a) There is established a Pharmacy and Therapeutics
178 Committee, which shall be appointed by the Governor, or his
179 designee.
180 (b) The committee shall meet at least quarterly, and
181 committee members shall be furnished written notice of the
182 meetings at least ten (10) days before the date of the meeting.
183 (c) The committee meetings shall be open to the public,
184 members of the press, legislators and consumers. Additionally,
185 all documents provided to committee members shall be available to
186 members of the Legislature in the same manner, and shall be made
187 available to others for a reasonable fee for copying. However,
188 patient confidentiality and provider confidentiality shall be
189 protected by blinding patient names and provider names with
190 numerical or other anonymous identifiers. The committee meetings
191 shall be subject to the Open Meetings Act (Section 25-41-1 et
192 seq.). Committee meetings conducted in violation of this section
193 shall be deemed unlawful.
194 (d) After a thirty-day public notice, the executive
195 director, or his or her designee, shall present the division's

196 recommendation regarding prior approval for a therapeutic class of
197 drugs to the committee. However, in circumstances where the
198 division deems it necessary for the health and safety of Medicaid
199 beneficiaries, the division may present to the committee its
200 recommendations regarding a particular drug without a thirty-day
201 public notice. In making that presentation, the division shall
202 state to the committee the circumstances that precipitate the need
203 for the committee to review the status of a particular drug
204 without a thirty-day public notice. The committee may determine
205 whether or not to review the particular drug under the
206 circumstances stated by the division without a thirty-day public
207 notice. If the committee determines to review the status of the
208 particular drug, it shall make its recommendations to the
209 division, after which the division shall file those
210 recommendations for a thirty-day public comment under the
211 provisions of Section 25-43-7(1).

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

220 (f) Upon reviewing and considering all recommendations
221 including recommendation of the committee, comments, and data, the
222 executive director shall make a final determination whether to
223 require prior approval of a therapeutic class of drugs, or modify
224 existing prior approval requirements for a therapeutic class of
225 drugs.

226 (g) At least thirty (30) days before the executive
227 director implements new or amended prior authorization decisions,
228 written notice of the executive director's decision shall be

229 provided to all prescribing Medicaid providers, all Medicaid
230 enrolled pharmacies, and any other party who has requested the
231 notification. However, notice given under Section 25-43-7(1) will
232 substitute for and meet the requirement for notice under this
233 subsection.

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

241 (6) This section shall stand repealed on July 1, 2008.

242 **SECTION 2.** Section 43-13-117, Mississippi Code of 1972, is
243 amended as follows:

244 43-13-117. Medicaid as authorized by this article shall
245 include payment of part or all of the costs, at the discretion of
246 the division, with approval of the Governor, of the following
247 types of care and services rendered to eligible applicants who
248 have been determined to be eligible for that care and services,
249 within the limits of state appropriations and federal matching
250 funds:

251 (1) Inpatient hospital services.

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

259 (b) From and after July 1, 1994, the Executive
260 Director of the Division of Medicaid shall amend the Mississippi
261 Title XIX Inpatient Hospital Reimbursement Plan to remove the

262 occupancy rate penalty from the calculation of the Medicaid
263 Capital Cost Component utilized to determine total hospital costs
264 allocated to the Medicaid program.
265 (c) Hospitals will receive an additional payment
266 for the implantable programmable baclofen drug pump used to treat
267 spasticity that is implanted on an inpatient basis. The payment
268 pursuant to written invoice will be in addition to the facility's
269 per diem reimbursement and will represent a reduction of costs on
270 the facility's annual cost report, and shall not exceed Ten
271 Thousand Dollars ($10,000.00) per year per recipient.
272 (2) Outpatient hospital services.
273 (a) Emergency services. The division shall allow
274 six (6) medically necessary emergency room visits per beneficiary
275 per fiscal year.
276 (b) Other outpatient hospital services. The
277 division shall allow benefits for other medically necessary
278 outpatient hospital services (such as chemotherapy, radiation,
279 surgery and therapy). Where the same services are reimbursed as
280 clinic services, the division may revise the rate or methodology
281 of outpatient reimbursement to maintain consistency, efficiency,
282 economy and quality of care.
283 (3) Laboratory and x-ray services.
284 (4) Nursing facility services.
285 (a) The division shall make full payment to
286 nursing facilities for each day, not exceeding fifty-two (52) days
287 per year, that a patient is absent from the facility on home
288 leave. Payment may be made for the following home leave days in
289 addition to the fifty-two-day limitation: Christmas, the day
290 before Christmas, the day after Christmas, Thanksgiving, the day
291 before Thanksgiving and the day after Thanksgiving.
292 (b) From and after July 1, 1997, the division
293 shall implement the integrated case-mix payment and quality
294 monitoring system, which includes the fair rental system for

295 property costs and in which recapture of depreciation is
296 eliminated. The division may reduce the payment for hospital
297 leave and therapeutic home leave days to the lower of the case-mix
298 category as computed for the resident on leave using the
299 assessment being utilized for payment at that point in time, or a
300 case-mix score of 1.000 for nursing facilities, and shall compute
301 case-mix scores of residents so that only services provided at the
302 nursing facility are considered in calculating a facility's per
303 diem.

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

307 (d) When a facility of a category that does not
308 require a certificate of need for construction and that could not
309 be eligible for Medicaid reimbursement is constructed to nursing
310 facility specifications for licensure and certification, and the
311 facility is subsequently converted to a nursing facility under a
312 certificate of need that authorizes conversion only and the
313 applicant for the certificate of need was assessed an application
314 review fee based on capital expenditures incurred in constructing
315 the facility, the division shall allow reimbursement for capital
316 expenditures necessary for construction of the facility that were
317 incurred within the twenty-four (24) consecutive calendar months
318 immediately preceding the date that the certificate of need
319 authorizing the conversion was issued, to the same extent that
320 reimbursement would be allowed for construction of a new nursing
321 facility under a certificate of need that authorizes that
322 construction. The reimbursement authorized in this subparagraph
323 (d) may be made only to facilities the construction of which was
324 completed after June 30, 1989. Before the division shall be
325 authorized to make the reimbursement authorized in this
326 subparagraph (d), the division first must have received approval

327 from the Centers for Medicare and Medicaid Services (CMS) of the
328 change in the state Medicaid plan providing for the reimbursement.
329 (e) The division shall develop and implement, not
330 later than January 1, 2001, a case-mix payment add-on determined
331 by time studies and other valid statistical data that will
332 reimburse a nursing facility for the additional cost of caring for
333 a resident who has a diagnosis of Alzheimer's or other related
334 dementia and exhibits symptoms that require special care. Any
335 such case-mix add-on payment shall be supported by a determination
336 of additional cost. The division shall also develop and implement
337 as part of the fair rental reimbursement system for nursing
338 facility beds, an Alzheimer's resident bed depreciation enhanced
339 reimbursement system that will provide an incentive to encourage
340 nursing facilities to convert or construct beds for residents with
341 Alzheimer's or other related dementia.
342 (f) The division shall develop and implement an
343 assessment process for long-term care services. The division may
344 provide the assessment and related functions directly or through
345 contract with the area agencies on aging.
346 The division shall apply for necessary federal waivers to
347 assure that additional services providing alternatives to nursing
348 facility care are made available to applicants for nursing
349 facility care.
350 (5) Periodic screening and diagnostic services for
351 individuals under age twenty-one (21) years as are needed to
352 identify physical and mental defects and to provide health care
353 treatment and other measures designed to correct or ameliorate
354 defects and physical and mental illness and conditions discovered
355 by the screening services, regardless of whether these services
356 are included in the state plan. The division may include in its
357 periodic screening and diagnostic program those discretionary
358 services authorized under the federal regulations adopted to
359 implement Title XIX of the federal Social Security Act, as

360 amended. The division, in obtaining physical therapy services,
361 occupational therapy services, and services for individuals with
362 speech, hearing and language disorders, may enter into a
363 cooperative agreement with the State Department of Education for
364 the provision of those services to handicapped students by public
365 school districts using state funds that are provided from the
366 appropriation to the Department of Education to obtain federal
367 matching funds through the division. The division, in obtaining
368 medical and psychological evaluations for children in the custody
369 of the State Department of Human Services may enter into a
370 cooperative agreement with the State Department of Human Services
371 for the provision of those services using state funds that are
372 provided from the appropriation to the Department of Human
373 Services to obtain federal matching funds through the division.
374 (6) Physician's services. The division shall allow
375 twelve (12) physician visits annually. All fees for physicians'
376 services that are covered only by Medicaid shall be reimbursed at
377 ninety percent (90%) of the rate established on January 1, 1999,
378 and as may be adjusted each July thereafter, under Medicare (Title
379 XVIII of the federal Social Security Act, as amended). The
380 division may develop and implement a different reimbursement model
381 or schedule for physician's services provided by physicians based
382 at an academic health care center and by physicians at rural
383 health centers that are associated with an academic health care
384 center.
385 (7) (a) Home health services for eligible persons, not
386 to exceed in cost the prevailing cost of nursing facility
387 services, not to exceed twenty-five (25) visits per year. All
388 home health visits must be precertified as required by the
389 division.
390 (b) Repealed.
391 (8) Emergency medical transportation services. On
392 January 1, 1994, emergency medical transportation services shall

393 be reimbursed at seventy percent (70%) of the rate established
394 under Medicare (Title XVIII of the federal Social Security Act, as
395 amended). "Emergency medical transportation services" shall mean,
396 but shall not be limited to, the following services by a properly
397 permitted ambulance operated by a properly licensed provider in
398 accordance with the Emergency Medical Services Act of 1974
399 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
400 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
401 (vi) disposable supplies, (vii) similar services.
402 (9) (a) Legend and other drugs as may be determined by
403 the division.
404 The division shall establish a mandatory preferred drug list.
405 Drugs not on the mandatory preferred drug list shall be made
406 available by utilizing prior authorization procedures established
407 by the division.
408 The division may seek to establish relationships with other
409 states in order to lower acquisition costs of prescription drugs
410 to include single source and innovator multiple source drugs or
411 generic drugs. In addition, if allowed by federal law or
412 regulation, the division may seek to establish relationships with
413 and negotiate with other countries to facilitate the acquisition
414 of prescription drugs to include single source and innovator
415 multiple source drugs or generic drugs, if that will lower the
416 acquisition costs of those prescription drugs.
417 The division shall allow for a combination of prescriptions
418 for single source and innovator multiple source drugs and generic
419 drugs to meet the needs of the beneficiaries, not to exceed five
420 (5) prescriptions per month for each noninstitutionalized Medicaid
421 beneficiary, with not more than two (2) of those prescriptions
422 being for single source or innovator multiple source drugs.
423 The executive director may approve specific maintenance drugs
424 for beneficiaries with certain medical conditions, which may be
425 prescribed and dispensed in three-month supply increments. The

426 executive director may allow a state agency or agencies to be the
427 sole source purchaser and distributor of hemophilia factor
428 medications, HIV/AIDS medications and other medications as
429 determined by the executive director as allowed by federal
430 regulations.

431 Drugs prescribed for a resident of a psychiatric residential
432 treatment facility must be provided in true unit doses when
433 available. The division may require that drugs not covered by
434 Medicare Part D for a resident of a long-term care facility be
435 provided in true unit doses when available. Those drugs that were
436 originally billed to the division but are not used by a resident
437 in any of those facilities shall be returned to the billing
438 pharmacy for credit to the division, in accordance with the
439 guidelines of the State Board of Pharmacy and any requirements of
440 federal law and regulation. Drugs shall be dispensed to a
441 recipient and only one (1) dispensing fee per month may be
442 charged. The division shall develop a methodology for reimbursing
443 for restocked drugs, which shall include a restock fee as
444 determined by the division not exceeding Seven Dollars and
445 Eighty-two Cents ($7.82).

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

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

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

458 All claims for drugs for dually eligible Medicare/Medicaid
459 beneficiaries that are paid for by Medicare must be submitted to
460 Medicare for payment before they may be processed by the
461 division's on-line payment system.
462 The division shall develop a pharmacy policy in which drugs
463 in tamper-resistant packaging that are prescribed for a resident
464 of a nursing facility but are not dispensed to the resident shall
465 be returned to the pharmacy and not billed to Medicaid, in
466 accordance with guidelines of the State Board of Pharmacy.
467 The division shall develop and implement a method or methods
468 by which the division will provide on a regular basis to Medicaid
469 providers who are authorized to prescribe drugs, information about
470 the costs to the Medicaid program of single source drugs and
471 innovator multiple source drugs, and information about other drugs
472 that may be prescribed as alternatives to those single source
473 drugs and innovator multiple source drugs and the costs to the
474 Medicaid program of those alternative drugs.
475 Notwithstanding any law or regulation, information obtained
476 or maintained by the division regarding the prescription drug
477 program, including trade secrets and manufacturer or labeler
478 pricing, is confidential and not subject to disclosure except to
479 other state agencies.
480 (b) Payment by the division for covered
481 multisource drugs shall be limited to the lower of the upper
482 limits established and published by the Centers for Medicare and
483 Medicaid Services (CMS) plus a dispensing fee, or the estimated
484 acquisition cost (EAC) as determined by the division, plus a
485 dispensing fee, or the providers' usual and customary charge to
486 the general public.
487 Payment for other covered drugs, other than multisource drugs
488 with CMS upper limits, shall not exceed the lower of the estimated
489 acquisition cost as determined by the division, plus a dispensing

490 fee or the providers' usual and customary charge to the general
491 public.

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

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

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

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

507 (10) Dental care that is an adjunct to treatment of an
508 acute medical or surgical condition; services of oral surgeons and
509 dentists in connection with surgery related to the jaw or any
510 structure contiguous to the jaw or the reduction of any fracture
511 of the jaw or any facial bone; and emergency dental extractions
512 and treatment related thereto. On July 1, 1999, all fees for
513 dental care and surgery under authority of this paragraph (10)
514 shall be increased to one hundred sixty percent (160%) of the
515 amount of the reimbursement rate that was in effect on June 30,
516 1999. It is the intent of the Legislature to encourage more
517 dentists to participate in the Medicaid program.

518 (11) Eyeglasses for all Medicaid beneficiaries who have
519 (a) had surgery on the eyeball or ocular muscle that results in a
520 vision change for which eyeglasses or a change in eyeglasses is
521 medically indicated within six (6) months of the surgery and is in
522 accordance with policies established by the division, or (b) one

523 (1) pair every five (5) years and in accordance with policies
524 established by the division. In either instance, the eyeglasses
525 must be prescribed by a physician skilled in diseases of the eye
526 or an optometrist, whichever the beneficiary may select.
527 (12) Intermediate care facility services.
528 (a) The division shall make full payment to all
529 intermediate care facilities for the mentally retarded for each
530 day, not exceeding eighty-four (84) days per year, that a patient
531 is absent from the facility on home leave. Payment may be made
532 for the following home leave days in addition to the
533 eighty-four-day limitation: Christmas, the day before Christmas,
534 the day after Christmas, Thanksgiving, the day before Thanksgiving
535 and the day after Thanksgiving.
536 (b) All state-owned intermediate care facilities
537 for the mentally retarded shall be reimbursed on a full reasonable
538 cost basis.
539 (13) Family planning services, including drugs,
540 supplies and devices, when those services are under the
541 supervision of a physician or nurse practitioner.
542 (14) Clinic services. Such diagnostic, preventive,
543 therapeutic, rehabilitative or palliative services furnished to an
544 outpatient by or under the supervision of a physician or dentist
545 in a facility that is not a part of a hospital but that is
546 organized and operated to provide medical care to outpatients.
547 Clinic services shall include any services reimbursed as
548 outpatient hospital services that may be rendered in such a
549 facility, including those that become so after July 1, 1991. On
550 July 1, 1999, all fees for physicians' services reimbursed under
551 authority of this paragraph (14) shall be reimbursed at ninety
552 percent (90%) of the rate established on January 1, 1999, and as
553 may be adjusted each July thereafter, under Medicare (Title XVIII
554 of the federal Social Security Act, as amended). The division may
555 develop and implement a different reimbursement model or schedule

556 for physician's services provided by physicians based at an
557 academic health care center and by physicians at rural health
558 centers that are associated with an academic health care center.
559 On July 1, 1999, all fees for dentists' services reimbursed under
560 authority of this paragraph (14) shall be increased to one hundred
561 sixty percent (160%) of the amount of the reimbursement rate that
562 was in effect on June 30, 1999.

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

568 (16) Mental health services. Approved therapeutic and
569 case management services (a) provided by an approved regional
570 mental health/retardation center established under Sections
571 41-19-31 through 41-19-39, or by another community mental health
572 service provider meeting the requirements of the Department of
573 Mental Health to be an approved mental health/retardation center
574 if determined necessary by the Department of Mental Health, using
575 state funds that are provided from the appropriation to the State
576 Department of Mental Health and/or funds transferred to the
577 department by a political subdivision or instrumentality of the
578 state and used to match federal funds under a cooperative
579 agreement between the division and the department, or (b) provided
580 by a facility that is certified by the State Department of Mental
581 Health to provide therapeutic and case management services, to be
582 reimbursed on a fee for service basis, or (c) provided in the
583 community by a facility or program operated by the Department of
584 Mental Health. Any such services provided by a facility described
585 in subparagraph (b) must have the prior approval of the division
586 to be reimbursable under this section. After June 30, 1997,
587 mental health services provided by regional mental
588 health/retardation centers established under Sections 41-19-31

589 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
590 and/or their subsidiaries and divisions, or by psychiatric
591 residential treatment facilities as defined in Section 43-11-1, or
592 by another community mental health service provider meeting the
593 requirements of the Department of Mental Health to be an approved
594 mental health/retardation center if determined necessary by the
595 Department of Mental Health, shall not be included in or provided
596 under any capitated managed care pilot program provided for under
597 paragraph (24) of this section.
598 (17) Durable medical equipment services and medical
599 supplies. Precertification of durable medical equipment and
600 medical supplies must be obtained as required by the division.
601 The Division of Medicaid may require durable medical equipment
602 providers to obtain a surety bond in the amount and to the
603 specifications as established by the Balanced Budget Act of 1997.
604 (18) (a) Notwithstanding any other provision of this
605 section to the contrary, the division shall make additional
606 reimbursement to hospitals that serve a disproportionate share of
607 low-income patients and that meet the federal requirements for
608 those payments as provided in Section 1923 of the federal Social
609 Security Act and any applicable regulations. However, from and
610 after January 1, 1999, no public hospital shall participate in the
611 Medicaid disproportionate share program unless the public hospital
612 participates in an intergovernmental transfer program as provided
613 in Section 1903 of the federal Social Security Act and any
614 applicable regulations.
615 (b) The division shall establish a Medicare Upper
616 Payment Limits Program, as defined in Section 1902(a)(30) of the
617 federal Social Security Act and any applicable federal
618 regulations, for hospitals, and may establish a Medicare Upper
619 <u>Payment</u> Limits Program for nursing facilities. The division shall
620 assess each hospital and, if the program is established for
621 nursing facilities, shall assess each nursing facility, based on

622 Medicaid utilization or other appropriate method consistent with
623 federal regulations. The assessment will remain in effect as long
624 as the state participates in the Medicare Upper Payment Limits
625 Program. Until July 1, 2008, the division shall not increase the
626 rate, amount or method of calculating or imposing any assessment
627 authorized under this subparagraph (b). The division shall make
628 additional reimbursement to hospitals and, if the program is
629 established for nursing facilities, shall make additional
630 reimbursement to nursing facilities, for the Medicare Upper
631 Payment Limits, as defined in Section 1902(a)(30) of the federal
632 Social Security Act and any applicable federal regulations.
633 (19) (a) Perinatal risk management services. The
634 division shall promulgate regulations to be effective from and
635 after October 1, 1988, to establish a comprehensive perinatal
636 system for risk assessment of all pregnant and infant Medicaid
637 recipients and for management, education and follow-up for those
638 who are determined to be at risk. Services to be performed
639 include case management, nutrition assessment/counseling,
640 psychosocial assessment/counseling and health education.
641 (b) Early intervention system services. The
642 division shall cooperate with the State Department of Health,
643 acting as lead agency, in the development and implementation of a
644 statewide system of delivery of early intervention services, under
645 Part C of the Individuals with Disabilities Education Act (IDEA).
646 The State Department of Health shall certify annually in writing
647 to the executive director of the division the dollar amount of
648 state early intervention funds available that will be utilized as
649 a certified match for Medicaid matching funds. Those funds then
650 shall be used to provide expanded targeted case management
651 services for Medicaid eligible children with special needs who are
652 eligible for the state's early intervention system.
653 Qualifications for persons providing service coordination shall be

654 determined by the State Department of Health and the Division of
655 Medicaid.
656 (20) Home- and community-based services for physically
657 disabled approved services as allowed by a waiver from the United
658 States Department of Health and Human Services for home- and
659 community-based services for physically disabled people using
660 state funds that are provided from the appropriation to the State
661 Department of Rehabilitation Services and used to match federal
662 funds under a cooperative agreement between the division and the
663 department, provided that funds for these services are
664 specifically appropriated to the Department of Rehabilitation
665 Services.
666 (21) Nurse practitioner services. Services furnished
667 by a registered nurse who is licensed and certified by the
668 Mississippi Board of Nursing as a nurse practitioner, including,
669 but not limited to, nurse anesthetists, nurse midwives, family
670 nurse practitioners, family planning nurse practitioners,
671 pediatric nurse practitioners, obstetrics-gynecology nurse
672 practitioners and neonatal nurse practitioners, under regulations
673 adopted by the division. Reimbursement for those services shall
674 not exceed ninety percent (90%) of the reimbursement rate for
675 comparable services rendered by a physician.
676 (22) Ambulatory services delivered in federally
677 qualified health centers, rural health centers and clinics of the
678 local health departments of the State Department of Health for
679 individuals eligible for Medicaid under this article based on
680 reasonable costs as determined by the division.
681 (23) Inpatient psychiatric services. Inpatient
682 psychiatric services to be determined by the division for
683 recipients under age twenty-one (21) that are provided under the
684 direction of a physician in an inpatient program in a licensed
685 acute care psychiatric facility or in a licensed psychiatric
686 residential treatment facility, before the recipient reaches age

687 twenty-one (21) or, if the recipient was receiving the services
688 immediately before he or she reached age twenty-one (21), before
689 the earlier of the date he or she no longer requires the services
690 or the date he or she reaches age twenty-two (22), as provided by
691 federal regulations. Precertification of inpatient days and
692 residential treatment days must be obtained as required by the
693 division.

694 (24) [Deleted]

695 (25) [Deleted]

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

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

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

714 (29) The Division of Medicaid may apply for a waiver
715 from the United States Department of Health and Human Services for
716 home- and community-based services for developmentally disabled
717 people using state funds that are provided from the appropriation
718 to the State Department of Mental Health and/or funds transferred
719 to the department by a political subdivision or instrumentality of

720 the state and used to match federal funds under a cooperative
721 agreement between the division and the department, provided that
722 funds for these services are specifically appropriated to the
723 Department of Mental Health and/or transferred to the department
724 by a political subdivision or instrumentality of the state.
725 (30) Pediatric skilled nursing services for eligible
726 persons under twenty-one (21) years of age.
727 (31) Targeted case management services for children
728 with special needs, under waivers from the United States
729 Department of Health and Human Services, using state funds that
730 are provided from the appropriation to the Mississippi Department
731 of Human Services and used to match federal funds under a
732 cooperative agreement between the division and the department.
733 (32) Care and services provided in Christian Science
734 Sanatoria listed and certified by the Commission for Accreditation
735 of Christian Science Nursing Organizations/Facilities, Inc.,
736 rendered in connection with treatment by prayer or spiritual means
737 to the extent that those services are subject to reimbursement
738 under Section 1903 of the federal Social Security Act.
739 (33) Podiatrist services.
740 (34) Assisted living services as provided through home-
741 and community-based services under Title XIX of the federal Social
742 Security Act, as amended, subject to the availability of funds
743 specifically appropriated for that purpose by the Legislature.
744 (35) Services and activities authorized in Sections
745 43-27-101 and 43-27-103, using state funds that are provided from
746 the appropriation to the State Department of Human Services and
747 used to match federal funds under a cooperative agreement between
748 the division and the department.
749 (36) Nonemergency transportation services for
750 Medicaid-eligible persons, to be provided by the Division of
751 Medicaid. The division may contract with additional entities to
752 administer nonemergency transportation services as it deems

753 necessary. All providers shall have a valid driver's license,
754 vehicle inspection sticker, valid vehicle license tags and a
755 standard liability insurance policy covering the vehicle. The
756 division may pay providers a flat fee based on mileage tiers, or
757 in the alternative, may reimburse on actual miles traveled. The
758 division may apply to the Center for Medicare and Medicaid
759 Services (CMS) for a waiver to draw federal matching funds for
760 nonemergency transportation services as a covered service instead
761 of an administrative cost.

762 (37) [Deleted]

763 (38) Chiropractic services. A chiropractor's manual
764 manipulation of the spine to correct a subluxation, if x-ray
765 demonstrates that a subluxation exists and if the subluxation has
766 resulted in a neuromusculoskeletal condition for which
767 manipulation is appropriate treatment, and related spinal x-rays
768 performed to document these conditions. Reimbursement for
769 chiropractic services shall not exceed Seven Hundred Dollars
770 ($700.00) per year per beneficiary.

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

775 (40) [Deleted]

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

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

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

803 (44) Nursing facility services for the severely
804 disabled.

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

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

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

819 (46) The division shall make application to the federal
820 Centers for Medicare and Medicaid Services (CMS) for a waiver to
821 develop and provide services for children with serious emotional
822 disturbances as defined in Section 43-14-1(1), which may include
823 home- and community-based services, case management services or
824 managed care services through mental health providers certified by
825 the Department of Mental Health. The division may implement and
826 provide services under this waivered program only if funds for
827 these services are specifically appropriated for this purpose by
828 the Legislature, or if funds are voluntarily provided by affected
829 agencies.
830 (47) (a) Notwithstanding any other provision in this
831 article to the contrary, the division, in conjunction with the
832 State Department of Health, may develop and implement disease
833 management programs for individuals with high-cost chronic
834 diseases and conditions, including the use of grants, waivers,
835 demonstrations or other projects as necessary.
836 (b) Participation in any disease management
837 program implemented under this paragraph (47) is optional with the
838 individual. An individual must affirmatively elect to participate
839 in the disease management program in order to participate.
840 (c) An individual who participates in the disease
841 management program has the option of participating in the
842 prescription drug home delivery component of the program at any
843 time while participating in the program. An individual must
844 affirmatively elect to participate in the prescription drug home
845 delivery component in order to participate.
846 (d) An individual who participates in the disease
847 management program may elect to discontinue participation in the
848 program at any time. An individual who participates in the
849 prescription drug home delivery component may elect to discontinue
850 participation in the prescription drug home delivery component at
851 any time.

852 (e) The division shall send written notice to all
853 individuals who participate in the disease management program
854 informing them that they may continue using their local pharmacy
855 or any other pharmacy of their choice to obtain their prescription
856 drugs while participating in the program.
857 (f) Prescription drugs that are provided to
858 individuals under the prescription drug home delivery component
859 shall be limited only to those drugs that are used for the
860 treatment, management or care of asthma, diabetes or hypertension.
861 (48) Pediatric long-term acute care hospital services.
862 (a) Pediatric long-term acute care hospital
863 services means services provided to eligible persons under
864 twenty-one (21) years of age by a freestanding Medicare-certified
865 hospital that has an average length of inpatient stay greater than
866 twenty-five (25) days and that is primarily engaged in providing
867 chronic or long-term medical care to persons under twenty-one (21)
868 years of age.
869 (b) The services under this paragraph (48) shall
870 be reimbursed as a separate category of hospital services.
871 (49) The division shall establish co-payments and/or
872 coinsurance for all Medicaid services for which co-payments and/or
873 coinsurance are allowable under federal law or regulation, and
874 shall set the amount of the co-payment and/or coinsurance for each
875 of those services at the maximum amount allowable under federal
876 law or regulation.
877 (50) Services provided by the State Department of
878 Rehabilitation Services for the care and rehabilitation of persons
879 who are deaf and blind, as allowed under waivers from the United
880 States Department of Health and Human Services to provide home-
881 and community-based services using state funds that are provided
882 from the appropriation to the State Department of Rehabilitation
883 Services or if funds are voluntarily provided by another agency.

884 (51) Upon determination of Medicaid eligibility and in
885 association with annual redetermination of Medicaid eligibility,
886 beneficiaries shall be encouraged to undertake a physical
887 examination that will establish a base-line level of health and
888 identification of a usual and customary source of care (a medical
889 home) to aid utilization of disease management tools. This
890 physical examination and utilization of these disease management
891 tools shall be consistent with current United States Preventive
892 Services Task Force or other recognized authority recommendations.
893 For persons who are determined ineligible for Medicaid, the
894 division will provide information and direction for accessing
895 medical care and services in the area of their residence.
896 (52) Notwithstanding any provisions of this article,
897 the division may pay enhanced reimbursement fees related to trauma
898 care, as determined by the division in conjunction with the State
899 Department of Health, using funds appropriated to the State
900 Department of Health for trauma care and services and used to
901 match federal funds under a cooperative agreement between the
902 division and the State Department of Health. The division, in
903 conjunction with the State Department of Health, may use grants,
904 waivers, demonstrations, or other projects as necessary in the
905 development and implementation of this reimbursement program.
906 (53) Targeted case management services for high-cost
907 beneficiaries shall be developed by the division for all services
908 under this section.
909 Notwithstanding any other provision of this article to the
910 contrary, the division shall reduce the rate of reimbursement to
911 providers for any service provided under this section by five
912 percent (5%) of the allowed amount for that service. However, the
913 reduction in the reimbursement rates required by this paragraph
914 shall not apply to inpatient hospital services, nursing facility
915 services, intermediate care facility services, psychiatric
916 residential treatment facility services, pharmacy services

917 provided under paragraph (9) of this section, or any service
918 provided by the University of Mississippi Medical Center or a
919 state agency, a state facility or a public agency that either
920 provides its own state match through intergovernmental transfer or
921 certification of funds to the division, or a service for which the
922 federal government sets the reimbursement methodology and rate.
923 In addition, the reduction in the reimbursement rates required by
924 this paragraph shall not apply to case management services and
925 home-delivered meals provided under the home- and community-based
926 services program for the elderly and disabled by a planning and
927 development district (PDD). Planning and development districts
928 participating in the home- and community-based services program
929 for the elderly and disabled as case management providers shall be
930 reimbursed for case management services at the maximum rate
931 approved by the Centers for Medicare and Medicaid Services (CMS).
932 The division may pay to those providers who participate in
933 and accept patient referrals from the division's emergency room
934 redirection program a percentage, as determined by the division,
935 of savings achieved according to the performance measures and
936 reduction of costs required of that program. Federally qualified
937 health centers may participate in the emergency room redirection
938 program, and the division may pay those centers a percentage of
939 any savings to the Medicaid program achieved by the centers'
940 accepting patient referrals through the program, as provided in
941 this paragraph.
942 Notwithstanding any provision of this article, except as
943 authorized in the following paragraph and in Section 43-13-139,
944 neither (a) the limitations on quantity or frequency of use of or
945 the fees or charges for any of the care or services available to
946 recipients under this section, nor (b) the payments or rates of
947 reimbursement to providers rendering care or services authorized
948 under this section to recipients, may be increased, decreased or
949 otherwise changed from the levels in effect on July 1, 1999,

950 unless they are authorized by an amendment to this section by the
951 Legislature. In addition, until July 1, 2008, the division shall
952 not change the methodology of reimbursement for providers of
953 services authorized under this section, and shall not increase the
954 rate, amount or method of calculating or imposing any assessment
955 authorized under paragraph (18)(b) of this section. However, the
956 restriction in this paragraph shall not prevent the division from
957 changing the payments or rates of reimbursement to providers
958 without an amendment to this section whenever those changes are
959 required by federal law or regulation, or whenever those changes
960 are necessary to correct administrative errors or omissions in
961 calculating those payments or rates of reimbursement.

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

968 The executive director shall keep the Governor advised on a
969 timely basis of the funds available for expenditure and the
970 projected expenditures. If current or projected expenditures of
971 the division are reasonably anticipated to exceed the amount of
972 funds appropriated to the division for any fiscal year, the
973 Governor, after consultation with the executive director, shall
974 discontinue any or all of the payment of the types of care and
975 services as provided in this section that are deemed to be
976 optional services under Title XIX of the federal Social Security
977 Act, as amended, and when necessary, shall institute any other
978 cost containment measures on any program or programs authorized
979 under the article to the extent allowed under the federal law
980 governing that program or programs. However, the Governor shall
981 not be authorized to discontinue or eliminate any service under
982 this section that is mandatory under federal law, or to

983 discontinue or eliminate, or adjust income limits or resource
984 limits for, any eligibility category or group under Section
985 43-13-115. It is the intent of the Legislature that the
986 expenditures of the division during any fiscal year shall not
987 exceed the amounts appropriated to the division for that fiscal
988 year.
989 Notwithstanding any other provision of this article, it shall
990 be the duty of each nursing facility, intermediate care facility
991 for the mentally retarded, psychiatric residential treatment
992 facility, and nursing facility for the severely disabled that is
993 participating in the Medicaid program to keep and maintain books,
994 documents and other records as prescribed by the Division of
995 Medicaid in substantiation of its cost reports for a period of
996 three (3) years after the date of submission to the Division of
997 Medicaid of an original cost report, or three (3) years after the
998 date of submission to the Division of Medicaid of an amended cost
999 report.
1000 **SECTION 3.** The following shall be codified as Section
1001 43-13-126, Mississippi Code of 1972:
1002 43-13-126. As a condition of doing business in the state,
1003 health insurers, including self-insured plans, group health plans
1004 (as defined in Section 607(1) of the Employee Retirement Income
1005 Security Act of 1974), service benefit plans, managed care
1006 organizations, pharmacy benefit managers, or other parties that
1007 are by statute, contract, or agreement, legally responsible for
1008 payment of a claim for a health care item or service, are required
1009 to:
1010 (a) Provide, with respect to individuals who are
1011 eligible for, or are provided, medical assistance under the state
1012 plan, upon the request of the Division of Medicaid, information to
1013 determine during what period the individual or their spouses or
1014 their dependents may be (or may have been) covered by a health
1015 insurer and the nature of the coverage that is or was provided by

1016 the health insurer (including the name, address and identifying
1017 number of the plan) in a manner prescribed by the Secretary of the
1018 Department of Health and Human Services;
1019 (b) Accept the Division of Medicaid's right of recovery
1020 and the assignment to the division of any right of an individual
1021 or other entity to payment from the party for an item or service
1022 for which payment has been made under the state plan;
1023 (c) Respond to any inquiry by the Division of Medicaid
1024 regarding a claim for payment for any health care item or service
1025 that is submitted not later than three (3) years after the date of
1026 the provision of that health care item or service; and
1027 (d) Agree not to deny a claim submitted by the Division
1028 of Medicaid solely on the basis of the date of submission of the
1029 claim, the type or format of the claim form, or a failure to
1030 present proper documentation at the point-of-sale that is the
1031 basis of the claim, if:
1032 (i) The claim is submitted by the division within
1033 the three-year period beginning on the date on which the item or
1034 service was furnished; and
1035 (ii) Any action by the division to enforce its
1036 rights with respect to the claim is began within six (6) years of
1037 the division's submission of the claim.
1038 **SECTION 4.** This act shall take effect and be in force from
1039 and after its passage.

ST: Medicaid program; make certain technical amendments regarding administration of.