REPORT OF CONFERENCE COMMITTEE

MR. SPEAKER AND MADAM PRESIDENT:

We, the undersigned conferees, have had under consideration the amendments to the following entitled BILL:

H. B. No. 528: Medicaid program; make certain technical amendments regarding administration of.

We, therefore, respectfully submit the following report and recommendation:

1. That the Senate recede from its Amendment No. 1.

2. That the House and Senate adopt the following amendment:

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

56 **SECTION 1.** Section 43-13-107, Mississippi Code of 1972, is
57 amended as follows:
58 43-13-107. (1) The Division of Medicaid is created in the
59 Office of the Governor and established to administer this article
60 and perform such other duties as are prescribed by law.
61 (2) (a) The Governor shall appoint a full-time executive
62 director, with the advice and consent of the Senate, who shall be
63 either (i) a physician with administrative experience in a medical
64 care or health program, or (ii) a person holding a graduate degree
65 in medical care administration, public health, hospital
66 administration, or the equivalent, or (iii) a person holding a
67 bachelor's degree in business administration or hospital
68 administration, with at least ten (10) years' experience in
69 management-level administration of Medicaid programs. The
70 executive director shall be the official secretary and legal
71 custodian of the records of the division; shall be the agent of
72 the division for the purpose of receiving all service of process,
73 summons and notices directed to the division; *** * *** shall perform
74 such other duties as the Governor may prescribe from time to time;
75 and shall perform all other duties that are now or may be imposed
76 upon him or her by law.

77 (b) The * * * executive director * * * shall serve at
78 the will and pleasure of the Governor * * *. * * *
79 (c) The executive director * * * shall, before entering
80 upon the discharge of the duties of the office, take and subscribe
81 to the oath of office prescribed by the Mississippi Constitution
82 and shall file the same in the Office of the Secretary of State,
83 and * * * shall execute a bond in some surety company authorized
84 to do business in the state in the penal sum of One Hundred
85 Thousand Dollars ($100,000.00), conditioned for the faithful and
86 impartial discharge of the duties of the office. The premium on
87 the bond shall be paid as provided by law out of funds
88 appropriated to the Division of Medicaid for contractual services.
89 (d) The executive director, with the approval of the
90 Governor and subject to the rules and regulations of the State
91 Personnel Board, shall employ such professional, administrative,
92 stenographic, secretarial, clerical and technical assistance as
93 may be necessary to perform the duties required in administering
94 this article and fix the compensation for those persons, all in
95 accordance with a state merit system meeting federal requirements.
96 When the salary of the executive director is not set by law, that
97 salary shall be set by the State Personnel Board. No employees of
98 the Division of Medicaid shall be considered to be staff members
99 of the immediate Office of the Governor; however, the provisions
100 of Section 25-9-107(c)(xv) shall apply to the executive director
101 and other administrative heads of the division.
102 (3) (a) There is established a Medical Care Advisory
103 Committee, which shall be the committee that is required by
104 federal regulation to advise the Division of Medicaid about health
105 and medical care services.
106 (b) The advisory committee shall consist of not less
107 than eleven (11) members, as follows:

108 (i) The Governor shall appoint five (5) members,
109 one (1) from each congressional district and one (1) from the
110 state at large;
111 (ii) The Lieutenant Governor shall appoint three
112 (3) members, one (1) from each Supreme Court district;
113 (iii) The Speaker of the House of Representatives
114 shall appoint three (3) members, one (1) from each Supreme Court
115 district.
116 All members appointed under this paragraph shall either be
117 health care providers or consumers of health care services. One
118 (1) member appointed by each of the appointing authorities shall
119 be a board certified physician.
120 (c) The respective Chairmen of the House Medicaid
121 Committee, the House Public Health and Human Services Committee,
122 the House Appropriations Committee, the Senate Public Health and
123 Welfare Committee and the Senate Appropriations Committee, or
124 their designees, two (2) members of the State Senate appointed by
125 the Lieutenant Governor and one (1) member of the House of
126 Representatives appointed by the Speaker of the House, shall serve
127 as ex officio nonvoting members of the advisory committee.
128 (d) In addition to the committee members required by
129 paragraph (b), the advisory committee shall consist of such other
130 members as are necessary to meet the requirements of the federal
131 regulation applicable to the advisory committee, who shall be
132 appointed as provided in the federal regulation.
133 (e) The chairmanship of the advisory committee shall be
134 elected by the voting members of the committee annually and shall
135 not serve more than two (2) consecutive years as chairman.
136 (f) The members of the advisory committee specified in
137 paragraph (b) shall serve for terms that are concurrent with the
138 terms of members of the Legislature, and any member appointed
139 under paragraph (b) may be reappointed to the advisory committee.

140 The members of the advisory committee specified in paragraph (b)
141 shall serve without compensation, but shall receive reimbursement
142 to defray actual expenses incurred in the performance of committee
143 business as authorized by law. Legislators shall receive per diem
144 and expenses, which may be paid from the contingent expense funds
145 of their respective houses in the same amounts as provided for
146 committee meetings when the Legislature is not in session.
147 (g) The advisory committee shall meet not less than
148 quarterly, and advisory committee members shall be furnished
149 written notice of the meetings at least ten (10) days before the
150 date of the meeting.
151 (h) The executive director shall submit to the advisory
152 committee all amendments, modifications and changes to the state
153 plan for the operation of the Medicaid program, for review by the
154 advisory committee before the amendments, modifications or changes
155 may be implemented by the division.
156 (i) The advisory committee, among its duties and
157 responsibilities, shall:
158 (i) Advise the division with respect to
159 amendments, modifications and changes to the state plan for the
160 operation of the Medicaid program;
161 (ii) Advise the division with respect to issues
162 concerning receipt and disbursement of funds and eligibility for
163 Medicaid;
164 (iii) Advise the division with respect to
165 determining the quantity, quality and extent of medical care
166 provided under this article;
167 (iv) Communicate the views of the medical care
168 professions to the division and communicate the views of the
169 division to the medical care professions;
170 (v) Gather information on reasons that medical
171 care providers do not participate in the Medicaid program and

172 changes that could be made in the program to encourage more
173 providers to participate in the Medicaid program, and advise the
174 division with respect to encouraging physicians and other medical
175 care providers to participate in the Medicaid program;

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

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

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

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

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

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

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

199 (d) The board meetings shall be open to the public,
200 members of the press, legislators and consumers. Additionally,
201 all documents provided to board members shall be available to
202 members of the Legislature in the same manner, and shall be made
203 available to others for a reasonable fee for copying. However,

204 patient confidentiality and provider confidentiality shall be
205 protected by blinding patient names and provider names with
206 numerical or other anonymous identifiers. The board meetings
207 shall be subject to the Open Meetings Act (Section 25-41-1 et
208 seq.). Board meetings conducted in violation of this section
209 shall be deemed unlawful.

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

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

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

227 (d) After a thirty-day public notice, the executive
228 director, or his or her designee, shall present the division's
229 recommendation regarding prior approval for a therapeutic class of
230 drugs to the committee. However, in circumstances where the
231 division deems it necessary for the health and safety of Medicaid
232 beneficiaries, the division may present to the committee its
233 recommendations regarding a particular drug without a thirty-day
234 public notice. In making that presentation, the division shall
235 state to the committee the circumstances that precipitate the need

236 for the committee to review the status of a particular drug
237 without a thirty-day public notice. The committee may determine
238 whether or not to review the particular drug under the
239 circumstances stated by the division without a thirty-day public
240 notice. If the committee determines to review the status of the
241 particular drug, it shall make its recommendations to the
242 division, after which the division shall file those
243 recommendations for a thirty-day public comment under the
244 provisions of Section 25-43-7(1).

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

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

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

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

274 (6) This section shall stand repealed on July 1, 2009.

275 **SECTION 2.** Section 43-13-117, Mississippi Code of 1972, as
276 amended by Senate Bill No. 2416, 2007 Regular Session, is amended
277 as follows:

278 **[Through June 30, 2007, this section shall read as follows:]**

279 43-13-117. Medicaid as authorized by this article shall
280 include payment of part or all of the costs, at the discretion of
281 the division, with approval of the Governor, of the following
282 types of care and services rendered to eligible applicants who
283 have been determined to be eligible for that care and services,
284 within the limits of state appropriations and federal matching
285 funds:

286 (1) Inpatient hospital services.

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

294 (b) From and after July 1, 1994, the Executive
295 Director of the Division of Medicaid shall amend the Mississippi
296 Title XIX Inpatient Hospital Reimbursement Plan to remove the
297 occupancy rate penalty from the calculation of the Medicaid

298 Capital Cost Component utilized to determine total hospital costs
299 allocated to the Medicaid program.
300 (c) Hospitals will receive an additional payment
301 for the implantable programmable baclofen drug pump used to treat
302 spasticity that is implanted on an inpatient basis. The payment
303 pursuant to written invoice will be in addition to the facility's
304 per diem reimbursement and will represent a reduction of costs on
305 the facility's annual cost report, and shall not exceed Ten
306 Thousand Dollars ($10,000.00) per year per recipient.
307 (2) Outpatient hospital services.
308 (a) Emergency services. The division shall allow
309 six (6) medically necessary emergency room visits per beneficiary
310 per fiscal year.
311 (b) Other outpatient hospital services. The
312 division shall allow benefits for other medically necessary
313 outpatient hospital services (such as chemotherapy, radiation,
314 surgery and therapy). Where the same services are reimbursed as
315 clinic services, the division may revise the rate or methodology
316 of outpatient reimbursement to maintain consistency, efficiency,
317 economy and quality of care.
318 (3) Laboratory and x-ray services.
319 (4) Nursing facility services.
320 (a) The division shall make full payment to
321 nursing facilities for each day, not exceeding fifty-two (52) days
322 per year, that a patient is absent from the facility on home
323 leave. Payment may be made for the following home leave days in
324 addition to the fifty-two-day limitation: Christmas, the day
325 before Christmas, the day after Christmas, Thanksgiving, the day
326 before Thanksgiving and the day after Thanksgiving.
327 (b) From and after July 1, 1997, the division
328 shall implement the integrated case-mix payment and quality
329 monitoring system, which includes the fair rental system for

330 property costs and in which recapture of depreciation is
331 eliminated. The division may reduce the payment for hospital
332 leave and therapeutic home leave days to the lower of the case-mix
333 category as computed for the resident on leave using the
334 assessment being utilized for payment at that point in time, or a
335 case-mix score of 1.000 for nursing facilities, and shall compute
336 case-mix scores of residents so that only services provided at the
337 nursing facility are considered in calculating a facility's per
338 diem.

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

342 (d) When a facility of a category that does not
343 require a certificate of need for construction and that could not
344 be eligible for Medicaid reimbursement is constructed to nursing
345 facility specifications for licensure and certification, and the
346 facility is subsequently converted to a nursing facility under a
347 certificate of need that authorizes conversion only and the
348 applicant for the certificate of need was assessed an application
349 review fee based on capital expenditures incurred in constructing
350 the facility, the division shall allow reimbursement for capital
351 expenditures necessary for construction of the facility that were
352 incurred within the twenty-four (24) consecutive calendar months
353 immediately preceding the date that the certificate of need
354 authorizing the conversion was issued, to the same extent that
355 reimbursement would be allowed for construction of a new nursing
356 facility under a certificate of need that authorizes that
357 construction. The reimbursement authorized in this subparagraph
358 (d) may be made only to facilities the construction of which was
359 completed after June 30, 1989. Before the division shall be
360 authorized to make the reimbursement authorized in this
361 subparagraph (d), the division first must have received approval

362 from the Centers for Medicare and Medicaid Services (CMS) of the
363 change in the state Medicaid plan providing for the reimbursement.
364 (e) The division shall develop and implement, not
365 later than January 1, 2001, a case-mix payment add-on determined
366 by time studies and other valid statistical data that will
367 reimburse a nursing facility for the additional cost of caring for
368 a resident who has a diagnosis of Alzheimer's or other related
369 dementia and exhibits symptoms that require special care. Any
370 such case-mix add-on payment shall be supported by a determination
371 of additional cost. The division shall also develop and implement
372 as part of the fair rental reimbursement system for nursing
373 facility beds, an Alzheimer's resident bed depreciation enhanced
374 reimbursement system that will provide an incentive to encourage
375 nursing facilities to convert or construct beds for residents with
376 Alzheimer's or other related dementia.
377 (f) The division shall develop and implement an
378 assessment process for long-term care services. The division may
379 provide the assessment and related functions directly or through
380 contract with the area agencies on aging.
381 The division shall apply for necessary federal waivers to
382 assure that additional services providing alternatives to nursing
383 facility care are made available to applicants for nursing
384 facility care.
385 (5) Periodic screening and diagnostic services for
386 individuals under age twenty-one (21) years as are needed to
387 identify physical and mental defects and to provide health care
388 treatment and other measures designed to correct or ameliorate
389 defects and physical and mental illness and conditions discovered
390 by the screening services, regardless of whether these services
391 are included in the state plan. The division may include in its
392 periodic screening and diagnostic program those discretionary
393 services authorized under the federal regulations adopted to

394 implement Title XIX of the federal Social Security Act, as
395 amended. The division, in obtaining physical therapy services,
396 occupational therapy services, and services for individuals with
397 speech, hearing and language disorders, may enter into a
398 cooperative agreement with the State Department of Education for
399 the provision of those services to handicapped students by public
400 school districts using state funds that are provided from the
401 appropriation to the Department of Education to obtain federal
402 matching funds through the division. The division, in obtaining
403 medical and psychological evaluations for children in the custody
404 of the State Department of Human Services may enter into a
405 cooperative agreement with the State Department of Human Services
406 for the provision of those services using state funds that are
407 provided from the appropriation to the Department of Human
408 Services to obtain federal matching funds through the division.
409 (6) Physician's services. The division shall allow
410 twelve (12) physician visits annually. All fees for physicians'
411 services that are covered only by Medicaid shall be reimbursed at
412 ninety percent (90%) of the rate established on January 1, 1999,
413 and as may be adjusted each July thereafter, under Medicare (Title
414 XVIII of the federal Social Security Act, as amended). The
415 division may develop and implement a different reimbursement model
416 or schedule for physician's services provided by physicians based
417 at an academic health care center and by physicians at rural
418 health centers that are associated with an academic health care
419 center.
420 (7) (a) Home health services for eligible persons, not
421 to exceed in cost the prevailing cost of nursing facility
422 services, not to exceed twenty-five (25) visits per year. All
423 home health visits must be precertified as required by the
424 division.
425 (b) Repealed.

426 (8) Emergency medical transportation services. On
427 January 1, 1994, emergency medical transportation services shall
428 be reimbursed at seventy percent (70%) of the rate established
429 under Medicare (Title XVIII of the federal Social Security Act, as
430 amended). "Emergency medical transportation services" shall mean,
431 but shall not be limited to, the following services by a properly
432 permitted ambulance operated by a properly licensed provider in
433 accordance with the Emergency Medical Services Act of 1974
434 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
435 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
436 (vi) disposable supplies, (vii) similar services.
437 (9) (a) Legend and other drugs as may be determined by
438 the division.
439 The division shall establish a mandatory preferred drug list.
440 Drugs not on the mandatory preferred drug list shall be made
441 available by utilizing prior authorization procedures established
442 by the division.
443 The division may seek to establish relationships with other
444 states in order to lower acquisition costs of prescription drugs
445 to include single source and innovator multiple source drugs or
446 generic drugs. In addition, if allowed by federal law or
447 regulation, the division may seek to establish relationships with
448 and negotiate with other countries to facilitate the acquisition
449 of prescription drugs to include single source and innovator
450 multiple source drugs or generic drugs, if that will lower the
451 acquisition costs of those prescription drugs.
452 The division shall allow for a combination of prescriptions
453 for single source and innovator multiple source drugs and generic
454 drugs to meet the needs of the beneficiaries, not to exceed five
455 (5) prescriptions per month for each noninstitutionalized Medicaid
456 beneficiary, with not more than two (2) of those prescriptions
457 being for single source or innovator multiple source drugs.

458 The executive director may approve specific maintenance drugs
459 for beneficiaries with certain medical conditions, which may be
460 prescribed and dispensed in three-month supply increments. ***
461 Drugs prescribed for a resident of a psychiatric residential
462 treatment facility must be provided in true unit doses when
463 available. The division may require that drugs not covered by
464 Medicare Part D for a resident of a long-term care facility be
465 provided in true unit doses when available. Those drugs that were
466 originally billed to the division but are not used by a resident
467 in any of those facilities shall be returned to the billing
468 pharmacy for credit to the division, in accordance with the
469 guidelines of the State Board of Pharmacy and any requirements of
470 federal law and regulation. Drugs shall be dispensed to a
471 recipient and only one (1) dispensing fee per month may be
472 charged. The division shall develop a methodology for reimbursing
473 for restocked drugs, which shall include a restock fee as
474 determined by the division not exceeding Seven Dollars and
475 Eighty-two Cents ($7.82).
476 The voluntary preferred drug list shall be expanded to
477 function in the interim in order to have a manageable prior
478 authorization system, thereby minimizing disruption of service to
479 beneficiaries.
480 Except for those specific maintenance drugs approved by the
481 executive director, the division shall not reimburse for any
482 portion of a prescription that exceeds a thirty-one-day supply of
483 the drug based on the daily dosage.
484 The division shall develop and implement a program of payment
485 for additional pharmacist services, with payment to be based on
486 demonstrated savings, but in no case shall the total payment
487 exceed twice the amount of the dispensing fee.
488 All claims for drugs for dually eligible Medicare/Medicaid
489 beneficiaries that are paid for by Medicare must be submitted to

490 Medicare for payment before they may be processed by the
491 division's on-line payment system.
492 The division shall develop a pharmacy policy in which drugs
493 in tamper-resistant packaging that are prescribed for a resident
494 of a nursing facility but are not dispensed to the resident shall
495 be returned to the pharmacy and not billed to Medicaid, in
496 accordance with guidelines of the State Board of Pharmacy.
497 The division shall develop and implement a method or methods
498 by which the division will provide on a regular basis to Medicaid
499 providers who are authorized to prescribe drugs, information about
500 the costs to the Medicaid program of single source drugs and
501 innovator multiple source drugs, and information about other drugs
502 that may be prescribed as alternatives to those single source
503 drugs and innovator multiple source drugs and the costs to the
504 Medicaid program of those alternative drugs.
505 Notwithstanding any law or regulation, information obtained
506 or maintained by the division regarding the prescription drug
507 program, including trade secrets and manufacturer or labeler
508 pricing, is confidential and not subject to disclosure except to
509 other state agencies.
510 (b) Payment by the division for covered
511 multisource drugs shall be limited to the lower of the upper
512 limits established and published by the Centers for Medicare and
513 Medicaid Services (CMS) plus a dispensing fee, or the estimated
514 acquisition cost (EAC) as determined by the division, plus a
515 dispensing fee, or the providers' usual and customary charge to
516 the general public.
517 Payment for other covered drugs, other than multisource drugs
518 with CMS upper limits, shall not exceed the lower of the estimated
519 acquisition cost as determined by the division, plus a dispensing
520 fee or the providers' usual and customary charge to the general
521 public.

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

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

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

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

537 (10) <u>(a)</u> Dental care that is an adjunct to treatment
538 of an acute medical or surgical condition; services of oral
539 surgeons and dentists in connection with surgery related to the
540 jaw or any structure contiguous to the jaw or the reduction of any
541 fracture of the jaw or any facial bone; and emergency dental
542 extractions and treatment related thereto. On July 1, <u>2007</u>, *** * * ***
543 fees for dental care and surgery under authority of this paragraph
544 (10) shall be <u>reimbursed as provided in paragraph (b)</u>. It is the
545 intent of the Legislature <u>that this rate revision for dental</u>
546 <u>services will be an incentive designed to increase the number of</u>
547 <u>dentists who actively provide Medicaid services. This dental</u>
548 <u>services rate revision shall be known as the "James Russell Dumas</u>
549 <u>Medicaid Dental Incentive Program."</u>

550 <u>The division shall annually determine the effect of this</u>
551 <u>incentive by evaluating the number of dentists who are Medicaid</u>
552 <u>providers, the number who and the degree to which they are</u>
553 <u>actively billing Medicaid, the geographic trends of where dentists</u>

554 are offering what types of Medicaid services and other statistics
555 pertinent to the goals of this legislative intent. This data
556 shall be presented to the Chair of the Senate Public Health and
557 Welfare Committee and the Chair of the House Medicaid Committee.
558 (b) The Division of Medicaid shall establish a fee
559 schedule, to be effective from and after July 1, 2007, for dental
560 services. The schedule shall provide for a fee for each dental
561 service that is equal to a percentile of normal and customary
562 private provider fees, as defined by the Ingenix Customized Fee
563 Analyzer Report, which percentile shall be determined by the
564 division. The schedule shall be reviewed annually by the division
565 and dental fees shall be adjusted to reflect the percentile
566 determined by the division.
567 (c) For fiscal year 2008, the amount of state
568 funds appropriated for reimbursement for dental care and surgery
569 shall be increased by ten percent (10%) of the amount of state
570 fund expenditures for that purpose for fiscal year 2007. For each
571 of fiscal years 2009 and 2010, the amount of state funds
572 appropriated for reimbursement for dental care and surgery shall
573 be increased by ten percent (10%) of the amount of state fund
574 expenditures for that purpose for the preceding fiscal year.
575 (d) The division shall establish an annual benefit
576 limit of Two Thousand Five Hundred Dollars ($2,500.00) in dental
577 expenditures per Medicaid-eligible recipient; however, a recipient
578 may exceed the annual limit on dental expenditures provided in
579 this paragraph with prior approval of the division.
580 (e) The division shall include dental services as
581 a necessary component of overall health services provided to
582 children who are eligible for services.
583 (f) This paragraph (10) shall stand repealed on
584 July 1, 2010.

585 (11) Eyeglasses for all Medicaid beneficiaries who have
586 (a) had surgery on the eyeball or ocular muscle that results in a
587 vision change for which eyeglasses or a change in eyeglasses is
588 medically indicated within six (6) months of the surgery and is in
589 accordance with policies established by the division, or (b) one
590 (1) pair every five (5) years and in accordance with policies
591 established by the division. In either instance, the eyeglasses
592 must be prescribed by a physician skilled in diseases of the eye
593 or an optometrist, whichever the beneficiary may select.
594 (12) Intermediate care facility services.
595 (a) The division shall make full payment to all
596 intermediate care facilities for the mentally retarded for each
597 day, not exceeding eighty-four (84) days per year, that a patient
598 is absent from the facility on home leave. Payment may be made
599 for the following home leave days in addition to the
600 eighty-four-day limitation: Christmas, the day before Christmas,
601 the day after Christmas, Thanksgiving, the day before Thanksgiving
602 and the day after Thanksgiving.
603 (b) All state-owned intermediate care facilities
604 for the mentally retarded shall be reimbursed on a full reasonable
605 cost basis.
606 (13) Family planning services, including drugs,
607 supplies and devices, when those services are under the
608 supervision of a physician or nurse practitioner.
609 (14) Clinic services. Such diagnostic, preventive,
610 therapeutic, rehabilitative or palliative services furnished to an
611 outpatient by or under the supervision of a physician or dentist
612 in a facility that is not a part of a hospital but that is
613 organized and operated to provide medical care to outpatients.
614 Clinic services shall include any services reimbursed as
615 outpatient hospital services that may be rendered in such a
616 facility, including those that become so after July 1, 1991. On

617 July 1, 1999, all fees for physicians' services reimbursed under
618 authority of this paragraph (14) shall be reimbursed at ninety
619 percent (90%) of the rate established on January 1, 1999, and as
620 may be adjusted each July thereafter, under Medicare (Title XVIII
621 of the federal Social Security Act, as amended). The division may
622 develop and implement a different reimbursement model or schedule
623 for physician's services provided by physicians based at an
624 academic health care center and by physicians at rural health
625 centers that are associated with an academic health care
626 center. ***
627 (15) Home- and community-based services for the elderly
628 and disabled, as provided under Title XIX of the federal Social
629 Security Act, as amended, under waivers, subject to the
630 availability of funds specifically appropriated for that purpose
631 by the Legislature.
632 (16) Mental health services. Approved therapeutic and
633 case management services (a) provided by an approved regional
634 mental health/retardation center established under Sections
635 41-19-31 through 41-19-39, or by another community mental health
636 service provider meeting the requirements of the Department of
637 Mental Health to be an approved mental health/retardation center
638 if determined necessary by the Department of Mental Health, using
639 state funds that are provided from the appropriation to the State
640 Department of Mental Health and/or funds transferred to the
641 department by a political subdivision or instrumentality of the
642 state and used to match federal funds under a cooperative
643 agreement between the division and the department, or (b) provided
644 by a facility that is certified by the State Department of Mental
645 Health to provide therapeutic and case management services, to be
646 reimbursed on a fee for service basis, or (c) provided in the
647 community by a facility or program operated by the Department of
648 Mental Health. Any such services provided by a facility described

649 in subparagraph (b) must have the prior approval of the division
650 to be reimbursable under this section. After June 30, 1997,
651 mental health services provided by regional mental
652 health/retardation centers established under Sections 41-19-31
653 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
654 and/or their subsidiaries and divisions, or by psychiatric
655 residential treatment facilities as defined in Section 43-11-1, or
656 by another community mental health service provider meeting the
657 requirements of the Department of Mental Health to be an approved
658 mental health/retardation center if determined necessary by the
659 Department of Mental Health, shall not be included in or provided
660 under any capitated managed care pilot program provided for under
661 paragraph (24) of this section.

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

668 (18) (a) Notwithstanding any other provision of this
669 section to the contrary, the division shall make additional
670 reimbursement to hospitals that serve a disproportionate share of
671 low-income patients and that meet the federal requirements for
672 those payments as provided in Section 1923 of the federal Social
673 Security Act and any applicable regulations. <u>It is the intent of</u>
674 <u>the Legislature that the division shall draw down all available</u>
675 <u>federal funds allotted to the state for disproportionate share</u>
676 <u>hospitals.</u> However, from and after January 1, 1999, no public
677 hospital shall participate in the Medicaid disproportionate share
678 program unless the public hospital participates in an
679 intergovernmental transfer program as provided in Section 1903 of
680 the federal Social Security Act and any applicable regulations.

681 (b) The division shall establish a Medicare Upper
682 Payment Limits Program, as defined in Section 1902(a)(30) of the
683 federal Social Security Act and any applicable federal
684 regulations, for hospitals, and may establish a Medicare Upper
685 Payment Limits Program for nursing facilities. The division shall
686 assess each hospital and, if the program is established for
687 nursing facilities, shall assess each nursing facility, based on
688 Medicaid utilization or other appropriate method consistent with
689 federal regulations. The assessment will remain in effect as long
690 as the state participates in the Medicare Upper Payment Limits
691 Program. The division shall make additional reimbursement to
692 hospitals and, if the program is established for nursing
693 facilities, shall make additional reimbursement to nursing
694 facilities, for the Medicare Upper Payment Limits, as defined in
695 Section 1902(a)(30) of the federal Social Security Act and any
696 applicable federal regulations.
697 (19) (a) Perinatal risk management services. The
698 division shall promulgate regulations to be effective from and
699 after October 1, 1988, to establish a comprehensive perinatal
700 system for risk assessment of all pregnant and infant Medicaid
701 recipients and for management, education and follow-up for those
702 who are determined to be at risk. Services to be performed
703 include case management, nutrition assessment/counseling,
704 psychosocial assessment/counseling and health education.
705 (b) Early intervention system services. The
706 division shall cooperate with the State Department of Health,
707 acting as lead agency, in the development and implementation of a
708 statewide system of delivery of early intervention services, under
709 Part C of the Individuals with Disabilities Education Act (IDEA).
710 The State Department of Health shall certify annually in writing
711 to the executive director of the division the dollar amount of
712 state early intervention funds available that will be utilized as

713 a certified match for Medicaid matching funds. Those funds then
714 shall be used to provide expanded targeted case management
715 services for Medicaid eligible children with special needs who are
716 eligible for the state's early intervention system.
717 Qualifications for persons providing service coordination shall be
718 determined by the State Department of Health and the Division of
719 Medicaid.

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

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

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

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

758 (24) [Deleted]

759 (25) [Deleted]

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

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

774 (28) Other health insurance premiums that are cost
775 effective as defined by the United States Secretary of Health and

776 Human Services. Medicare eligible must have Medicare Part B
777 before other insurance premiums can be paid.
778 (29) The Division of Medicaid may apply for a waiver
779 from the United States Department of Health and Human Services for
780 home- and community-based services for developmentally disabled
781 people using state funds that are provided from the appropriation
782 to the State Department of Mental Health and/or funds transferred
783 to the department by a political subdivision or instrumentality of
784 the state and used to match federal funds under a cooperative
785 agreement between the division and the department, provided that
786 funds for these services are specifically appropriated to the
787 Department of Mental Health and/or transferred to the department
788 by a political subdivision or instrumentality of the state.
789 (30) Pediatric skilled nursing services for eligible
790 persons under twenty-one (21) years of age.
791 (31) Targeted case management services for children
792 with special needs, under waivers from the United States
793 Department of Health and Human Services, using state funds that
794 are provided from the appropriation to the Mississippi Department
795 of Human Services and used to match federal funds under a
796 cooperative agreement between the division and the department.
797 (32) Care and services provided in Christian Science
798 Sanatoria listed and certified by the Commission for Accreditation
799 of Christian Science Nursing Organizations/Facilities, Inc.,
800 rendered in connection with treatment by prayer or spiritual means
801 to the extent that those services are subject to reimbursement
802 under Section 1903 of the federal Social Security Act.
803 (33) Podiatrist services.
804 (34) Assisted living services as provided through home-
805 and community-based services under Title XIX of the federal Social
806 Security Act, as amended, subject to the availability of funds
807 specifically appropriated for that purpose by the Legislature.

808 (35) Services and activities authorized in Sections
809 43-27-101 and 43-27-103, using state funds that are provided from
810 the appropriation to the State Department of Human Services and
811 used to match federal funds under a cooperative agreement between
812 the division and the department.
813 (36) Nonemergency transportation services for
814 Medicaid-eligible persons, to be provided by the Division of
815 Medicaid. The division may contract with additional entities to
816 administer nonemergency transportation services as it deems
817 necessary. All providers shall have a valid driver's license,
818 vehicle inspection sticker, valid vehicle license tags and a
819 standard liability insurance policy covering the vehicle. The
820 division may pay providers a flat fee based on mileage tiers, or
821 in the alternative, may reimburse on actual miles traveled. The
822 division may apply to the Center for Medicare and Medicaid
823 Services (CMS) for a waiver to draw federal matching funds for
824 nonemergency transportation services as a covered service instead
825 of an administrative cost. The PEER Committee shall conduct a
826 performance evaluation of the nonemergency transportation program
827 to evaluate the administration of the program and the providers of
828 transportation services to determine the most cost effective ways
829 of providing nonemergency transportation services to the patients
830 served under the program. The performance evaluation shall be
831 completed and provided to the members of the Senate Public Health
832 and Welfare Committee and the House Medicaid Committee not later
833 than January 15, 2008.
834 (37) [Deleted]
835 (38) Chiropractic services. A chiropractor's manual
836 manipulation of the spine to correct a subluxation, if x-ray
837 demonstrates that a subluxation exists and if the subluxation has
838 resulted in a neuromusculoskeletal condition for which
839 manipulation is appropriate treatment, and related spinal x-rays

840 performed to document these conditions. Reimbursement for
841 chiropractic services shall not exceed Seven Hundred Dollars
842 ($700.00) per year per beneficiary.
843 (39) Dually eligible Medicare/Medicaid beneficiaries.
844 The division shall pay the Medicare deductible and coinsurance
845 amounts for services available under Medicare, as determined by
846 the division.
847 (40) [Deleted]
848 (41) Services provided by the State Department of
849 Rehabilitation Services for the care and rehabilitation of persons
850 with spinal cord injuries or traumatic brain injuries, as allowed
851 under waivers from the United States Department of Health and
852 Human Services, using up to seventy-five percent (75%) of the
853 funds that are appropriated to the Department of Rehabilitation
854 Services from the Spinal Cord and Head Injury Trust Fund
855 established under Section 37-33-261 and used to match federal
856 funds under a cooperative agreement between the division and the
857 department.
858 (42) Notwithstanding any other provision in this
859 article to the contrary, the division may develop a population
860 health management program for women and children health services
861 through the age of one (1) year. This program is primarily for
862 obstetrical care associated with low birth weight and pre-term
863 babies. The division may apply to the federal Centers for
864 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
865 any other waivers that may enhance the program. In order to
866 effect cost savings, the division may develop a revised payment
867 methodology that may include at-risk capitated payments, and may
868 require member participation in accordance with the terms and
869 conditions of an approved federal waiver.
870 (43) The division shall provide reimbursement,
871 according to a payment schedule developed by the division, for

872 smoking cessation medications for pregnant women during their
873 pregnancy and other Medicaid-eligible women who are of
874 child-bearing age.

875 (44) Nursing facility services for the severely
876 disabled.

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

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

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

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

902 (47) (a) Notwithstanding any other provision in this
903 article to the contrary, the division *** * *** may develop and

904 implement disease management programs for individuals with
905 high-cost chronic diseases and conditions, including the use of
906 grants, waivers, demonstrations or other projects as necessary.
907 (b) Participation in any disease management
908 program implemented under this paragraph (47) is optional with the
909 individual. An individual must affirmatively elect to participate
910 in the disease management program in order to participate, and
911 may elect to discontinue participation in the program at any
912 time. * * *
913 * * *
914 (48) Pediatric long-term acute care hospital services.
915 (a) Pediatric long-term acute care hospital
916 services means services provided to eligible persons under
917 twenty-one (21) years of age by a freestanding Medicare-certified
918 hospital that has an average length of inpatient stay greater than
919 twenty-five (25) days and that is primarily engaged in providing
920 chronic or long-term medical care to persons under twenty-one (21)
921 years of age.
922 (b) The services under this paragraph (48) shall
923 be reimbursed as a separate category of hospital services.
924 (49) The division shall establish co-payments and/or
925 coinsurance for all Medicaid services for which co-payments and/or
926 coinsurance are allowable under federal law or regulation, and
927 shall set the amount of the co-payment and/or coinsurance for each
928 of those services at the maximum amount allowable under federal
929 law or regulation.
930 (50) Services provided by the State Department of
931 Rehabilitation Services for the care and rehabilitation of persons
932 who are deaf and blind, as allowed under waivers from the United
933 States Department of Health and Human Services to provide home-
934 and community-based services using state funds that are provided

935 from the appropriation to the State Department of Rehabilitation
936 Services or if funds are voluntarily provided by another agency.
937 (51) Upon determination of Medicaid eligibility and in
938 association with annual redetermination of Medicaid eligibility,
939 beneficiaries shall be encouraged to undertake a physical
940 examination that will establish a base-line level of health and
941 identification of a usual and customary source of care (a medical
942 home) to aid utilization of disease management tools. This
943 physical examination and utilization of these disease management
944 tools shall be consistent with current United States Preventive
945 Services Task Force or other recognized authority recommendations.
946 For persons who are determined ineligible for Medicaid, the
947 division will provide information and direction for accessing
948 medical care and services in the area of their residence.
949 (52) Notwithstanding any provisions of this article,
950 the division may pay enhanced reimbursement fees related to trauma
951 care, as determined by the division in conjunction with the State
952 Department of Health, using funds appropriated to the State
953 Department of Health for trauma care and services and used to
954 match federal funds under a cooperative agreement between the
955 division and the State Department of Health. The division, in
956 conjunction with the State Department of Health, may use grants,
957 waivers, demonstrations, or other projects as necessary in the
958 development and implementation of this reimbursement program.
959 (53) Targeted case management services for high-cost
960 beneficiaries shall be developed by the division for all services
961 under this section.
962 <u>(54) Therapy services. The plan of care for therapy</u>
963 <u>services may be developed to cover a period of treatment for up to</u>
964 <u>six (6) months, but in no event shall the plan of care exceed a</u>
965 <u>six-month period of treatment. The projected period of treatment</u>
966 <u>must be indicated on the initial plan of care and must be updated</u>

967 <u>with each subsequent revised plan of care. Based on medical</u>
968 <u>necessity, the division shall approve certification periods for</u>
969 <u>less than or up to six (6) months, but in no event shall the</u>
970 <u>certification period exceed the period of treatment indicated on</u>
971 <u>the plan of care. The appeal process for any reduction in therapy</u>
972 <u>services shall be consistent with the appeal process in federal</u>
973 <u>regulations.</u>
974 Notwithstanding any other provision of this article to the
975 contrary, the division shall reduce the rate of reimbursement to
976 providers for any service provided under this section by five
977 percent (5%) of the allowed amount for that service. However, the
978 reduction in the reimbursement rates required by this paragraph
979 shall not apply to inpatient hospital services, nursing facility
980 services, intermediate care facility services, psychiatric
981 residential treatment facility services, pharmacy services
982 provided under paragraph (9) of this section, or any service
983 provided by the University of Mississippi Medical Center or a
984 state agency, a state facility or a public agency that either
985 provides its own state match through intergovernmental transfer or
986 certification of funds to the division, or a service for which the
987 federal government sets the reimbursement methodology and rate.
988 In addition, the reduction in the reimbursement rates required by
989 this paragraph shall not apply to case management services and
990 home-delivered meals provided under the home- and community-based
991 services program for the elderly and disabled by a planning and
992 development district (PDD). Planning and development districts
993 participating in the home- and community-based services program
994 for the elderly and disabled as case management providers shall be
995 reimbursed for case management services at the maximum rate
996 approved by the Centers for Medicare and Medicaid Services (CMS).
997 The division may pay to those providers who participate in
998 and accept patient referrals from the division's emergency room

999 redirection program a percentage, as determined by the division,
1000 of savings achieved according to the performance measures and
1001 reduction of costs required of that program. Federally qualified
1002 health centers may participate in the emergency room redirection
1003 program, and the division may pay those centers a percentage of
1004 any savings to the Medicaid program achieved by the centers'
1005 accepting patient referrals through the program, as provided in
1006 this paragraph.

1007 Notwithstanding any provision of this article, except as
1008 authorized in the following paragraph and in Section 43-13-139,
1009 neither (a) the limitations on quantity or frequency of use of or
1010 the fees or charges for any of the care or services available to
1011 recipients under this section, nor (b) the payments or rates of
1012 reimbursement to providers rendering care or services authorized
1013 under this section to recipients, may be increased, decreased or
1014 otherwise changed from the levels in effect on July 1, 1999,
1015 unless they are authorized by an amendment to this section by the
1016 Legislature. However, the restriction in this paragraph shall not
1017 prevent the division from changing the payments or rates of
1018 reimbursement to providers without an amendment to this section
1019 whenever those changes are required by federal law or regulation,
1020 or whenever those changes are necessary to correct administrative
1021 errors or omissions in calculating those payments or rates of
1022 reimbursement.

1023 Notwithstanding any provision of this article, no new groups
1024 or categories of recipients and new types of care and services may
1025 be added without enabling legislation from the Mississippi
1026 Legislature, except that the division may authorize those changes
1027 without enabling legislation when the addition of recipients or
1028 services is ordered by a court of proper authority.

1029 The executive director shall keep the Governor advised on a
1030 timely basis of the funds available for expenditure and the

1031 projected expenditures. If current or projected expenditures of
1032 the division are reasonably anticipated to exceed the amount of
1033 funds appropriated to the division for any fiscal year, the
1034 Governor, after consultation with the executive director, shall
1035 discontinue any or all of the payment of the types of care and
1036 services as provided in this section that are deemed to be
1037 optional services under Title XIX of the federal Social Security
1038 Act, as amended, and when necessary, shall institute any other
1039 cost containment measures on any program or programs authorized
1040 under the article to the extent allowed under the federal law
1041 governing that program or programs. However, the Governor shall
1042 not be authorized to discontinue or eliminate any service under
1043 this section that is mandatory under federal law, or to
1044 discontinue or eliminate, or adjust income limits or resource
1045 limits for, any eligibility category or group under Section
1046 43-13-115. It is the intent of the Legislature that the
1047 expenditures of the division during any fiscal year shall not
1048 exceed the amounts appropriated to the division for that fiscal
1049 year.

1050 Notwithstanding any other provision of this article, it shall
1051 be the duty of each nursing facility, intermediate care facility
1052 for the mentally retarded, psychiatric residential treatment
1053 facility, and nursing facility for the severely disabled that is
1054 participating in the Medicaid program to keep and maintain books,
1055 documents and other records as prescribed by the Division of
1056 Medicaid in substantiation of its cost reports for a period of
1057 three (3) years after the date of submission to the Division of
1058 Medicaid of an original cost report, or three (3) years after the
1059 date of submission to the Division of Medicaid of an amended cost
1060 report.

1061 **[From and after June 30, 2007, this section shall read as**
1062 **follows:]**

1063 43-13-117. Medicaid as authorized by this article shall
1064 include payment of part or all of the costs, at the discretion of
1065 the division, with approval of the Governor, of the following
1066 types of care and services rendered to eligible applicants who
1067 have been determined to be eligible for that care and services,
1068 within the limits of state appropriations and federal matching
1069 funds:

1070 (1) Inpatient hospital services.

1071 (a) The division shall allow thirty (30) days of
1072 inpatient hospital care annually for all Medicaid recipients.
1073 Precertification of inpatient days must be obtained as required by
1074 the division. The division may allow unlimited days in
1075 disproportionate hospitals as defined by the division for eligible
1076 infants and children under the age of six (6) years if certified
1077 as medically necessary as required by the division.

1078 (b) From and after July 1, 1994, the Executive
1079 Director of the Division of Medicaid shall amend the Mississippi
1080 Title XIX Inpatient Hospital Reimbursement Plan to remove the
1081 occupancy rate penalty from the calculation of the Medicaid
1082 Capital Cost Component utilized to determine total hospital costs
1083 allocated to the Medicaid program.

1084 (c) Hospitals will receive an additional payment
1085 for the implantable programmable baclofen drug pump used to treat
1086 spasticity that is implanted on an inpatient basis. The payment
1087 pursuant to written invoice will be in addition to the facility's
1088 per diem reimbursement and will represent a reduction of costs on
1089 the facility's annual cost report, and shall not exceed Ten
1090 Thousand Dollars ($10,000.00) per year per recipient.

1091 (2) Outpatient hospital services.

1092 (a) Emergency services. The division shall allow
1093 six (6) medically necessary emergency room visits per beneficiary
1094 per fiscal year.

1095 (b) Other outpatient hospital services. The
1096 division shall allow benefits for other medically necessary
1097 outpatient hospital services (such as chemotherapy, radiation,
1098 surgery and therapy). Where the same services are reimbursed as
1099 clinic services, the division may revise the rate or methodology
1100 of outpatient reimbursement to maintain consistency, efficiency,
1101 economy and quality of care.
1102 (3) Laboratory and x-ray services.
1103 (4) Nursing facility services.
1104 (a) The division shall make full payment to
1105 nursing facilities for each day, not exceeding fifty-two (52) days
1106 per year, that a patient is absent from the facility on home
1107 leave. Payment may be made for the following home leave days in
1108 addition to the fifty-two-day limitation: Christmas, the day
1109 before Christmas, the day after Christmas, Thanksgiving, the day
1110 before Thanksgiving and the day after Thanksgiving.
1111 (b) From and after July 1, 1997, the division
1112 shall implement the integrated case-mix payment and quality
1113 monitoring system, which includes the fair rental system for
1114 property costs and in which recapture of depreciation is
1115 eliminated. The division may reduce the payment for hospital
1116 leave and therapeutic home leave days to the lower of the case-mix
1117 category as computed for the resident on leave using the
1118 assessment being utilized for payment at that point in time, or a
1119 case-mix score of 1.000 for nursing facilities, and shall compute
1120 case-mix scores of residents so that only services provided at the
1121 nursing facility are considered in calculating a facility's per
1122 diem.
1123 (c) From and after July 1, 1997, all state-owned
1124 nursing facilities shall be reimbursed on a full reasonable cost
1125 basis.

1126 (d) When a facility of a category that does not
1127 require a certificate of need for construction and that could not
1128 be eligible for Medicaid reimbursement is constructed to nursing
1129 facility specifications for licensure and certification, and the
1130 facility is subsequently converted to a nursing facility under a
1131 certificate of need that authorizes conversion only and the
1132 applicant for the certificate of need was assessed an application
1133 review fee based on capital expenditures incurred in constructing
1134 the facility, the division shall allow reimbursement for capital
1135 expenditures necessary for construction of the facility that were
1136 incurred within the twenty-four (24) consecutive calendar months
1137 immediately preceding the date that the certificate of need
1138 authorizing the conversion was issued, to the same extent that
1139 reimbursement would be allowed for construction of a new nursing
1140 facility under a certificate of need that authorizes that
1141 construction. The reimbursement authorized in this subparagraph
1142 (d) may be made only to facilities the construction of which was
1143 completed after June 30, 1989. Before the division shall be
1144 authorized to make the reimbursement authorized in this
1145 subparagraph (d), the division first must have received approval
1146 from the Centers for Medicare and Medicaid Services (CMS) of the
1147 change in the state Medicaid plan providing for the reimbursement.
1148 (e) The division shall develop and implement, not
1149 later than January 1, 2001, a case-mix payment add-on determined
1150 by time studies and other valid statistical data that will
1151 reimburse a nursing facility for the additional cost of caring for
1152 a resident who has a diagnosis of Alzheimer's or other related
1153 dementia and exhibits symptoms that require special care. Any
1154 such case-mix add-on payment shall be supported by a determination
1155 of additional cost. The division shall also develop and implement
1156 as part of the fair rental reimbursement system for nursing
1157 facility beds, an Alzheimer's resident bed depreciation enhanced

1158 reimbursement system that will provide an incentive to encourage
1159 nursing facilities to convert or construct beds for residents with
1160 Alzheimer's or other related dementia.

1161 (f) The division shall develop and implement an
1162 assessment process for long-term care services. The division may
1163 provide the assessment and related functions directly or through
1164 contract with the area agencies on aging.

1165 The division shall apply for necessary federal waivers to
1166 assure that additional services providing alternatives to nursing
1167 facility care are made available to applicants for nursing
1168 facility care.

1169 (5) Periodic screening and diagnostic services for
1170 individuals under age twenty-one (21) years as are needed to
1171 identify physical and mental defects and to provide health care
1172 treatment and other measures designed to correct or ameliorate
1173 defects and physical and mental illness and conditions discovered
1174 by the screening services, regardless of whether these services
1175 are included in the state plan. The division may include in its
1176 periodic screening and diagnostic program those discretionary
1177 services authorized under the federal regulations adopted to
1178 implement Title XIX of the federal Social Security Act, as
1179 amended. The division, in obtaining physical therapy services,
1180 occupational therapy services, and services for individuals with
1181 speech, hearing and language disorders, may enter into a
1182 cooperative agreement with the State Department of Education for
1183 the provision of those services to handicapped students by public
1184 school districts using state funds that are provided from the
1185 appropriation to the Department of Education to obtain federal
1186 matching funds through the division. The division, in obtaining
1187 medical and psychological evaluations for children in the custody
1188 of the State Department of Human Services may enter into a
1189 cooperative agreement with the State Department of Human Services

1190 for the provision of those services using state funds that are
1191 provided from the appropriation to the Department of Human
1192 Services to obtain federal matching funds through the division.
1193 (6) Physician's services. The division shall allow
1194 twelve (12) physician visits annually. All fees for physicians'
1195 services that are covered only by Medicaid shall be reimbursed at
1196 ninety percent (90%) of the rate established on January 1, 1999,
1197 and as may be adjusted each July thereafter, under Medicare (Title
1198 XVIII of the federal Social Security Act, as amended). The
1199 division may develop and implement a different reimbursement model
1200 or schedule for physician's services provided by physicians based
1201 at an academic health care center and by physicians at rural
1202 health centers that are associated with an academic health care
1203 center.
1204 (7) (a) Home health services for eligible persons, not
1205 to exceed in cost the prevailing cost of nursing facility
1206 services, not to exceed twenty-five (25) visits per year. All
1207 home health visits must be precertified as required by the
1208 division.
1209 (b) Repealed.
1210 (8) Emergency medical transportation services. On
1211 January 1, 1994, emergency medical transportation services shall
1212 be reimbursed at seventy percent (70%) of the rate established
1213 under Medicare (Title XVIII of the federal Social Security Act, as
1214 amended). "Emergency medical transportation services" shall mean,
1215 but shall not be limited to, the following services by a properly
1216 permitted ambulance operated by a properly licensed provider in
1217 accordance with the Emergency Medical Services Act of 1974
1218 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
1219 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
1220 (vi) disposable supplies, (vii) similar services.

1221 (9) (a) Legend and other drugs as may be determined by
1222 the division.
1223 The division shall establish a mandatory preferred drug list.
1224 Drugs not on the mandatory preferred drug list shall be made
1225 available by utilizing prior authorization procedures established
1226 by the division.
1227 The division may seek to establish relationships with other
1228 states in order to lower acquisition costs of prescription drugs
1229 to include single source and innovator multiple source drugs or
1230 generic drugs. In addition, if allowed by federal law or
1231 regulation, the division may seek to establish relationships with
1232 and negotiate with other countries to facilitate the acquisition
1233 of prescription drugs to include single source and innovator
1234 multiple source drugs or generic drugs, if that will lower the
1235 acquisition costs of those prescription drugs.
1236 The division shall allow for a combination of prescriptions
1237 for single source and innovator multiple source drugs and generic
1238 drugs to meet the needs of the beneficiaries, not to exceed five
1239 (5) prescriptions per month for each noninstitutionalized Medicaid
1240 beneficiary, with not more than two (2) of those prescriptions
1241 being for single source or innovator multiple source drugs.
1242 The executive director may approve specific maintenance drugs
1243 for beneficiaries with certain medical conditions, which may be
1244 prescribed and dispensed in three-month supply increments. * * *
1245 Drugs prescribed for a resident of a psychiatric residential
1246 treatment facility must be provided in true unit doses when
1247 available. The division may require that drugs not covered by
1248 Medicare Part D for a resident of a long-term care facility be
1249 provided in true unit doses when available. Those drugs that were
1250 originally billed to the division but are not used by a resident
1251 in any of those facilities shall be returned to the billing
1252 pharmacy for credit to the division, in accordance with the

1253 guidelines of the State Board of Pharmacy and any requirements of
1254 federal law and regulation. Drugs shall be dispensed to a
1255 recipient and only one (1) dispensing fee per month may be
1256 charged. The division shall develop a methodology for reimbursing
1257 for restocked drugs, which shall include a restock fee as
1258 determined by the division not exceeding Seven Dollars and
1259 Eighty-two Cents ($7.82).

1260 The voluntary preferred drug list shall be expanded to
1261 function in the interim in order to have a manageable prior
1262 authorization system, thereby minimizing disruption of service to
1263 beneficiaries.

1264 Except for those specific maintenance drugs approved by the
1265 executive director, the division shall not reimburse for any
1266 portion of a prescription that exceeds a thirty-one-day supply of
1267 the drug based on the daily dosage.

1268 The division shall develop and implement a program of payment
1269 for additional pharmacist services, with payment to be based on
1270 demonstrated savings, but in no case shall the total payment
1271 exceed twice the amount of the dispensing fee.

1272 All claims for drugs for dually eligible Medicare/Medicaid
1273 beneficiaries that are paid for by Medicare must be submitted to
1274 Medicare for payment before they may be processed by the
1275 division's on-line payment system.

1276 The division shall develop a pharmacy policy in which drugs
1277 in tamper-resistant packaging that are prescribed for a resident
1278 of a nursing facility but are not dispensed to the resident shall
1279 be returned to the pharmacy and not billed to Medicaid, in
1280 accordance with guidelines of the State Board of Pharmacy.

1281 The division shall develop and implement a method or methods
1282 by which the division will provide on a regular basis to Medicaid
1283 providers who are authorized to prescribe drugs, information about
1284 the costs to the Medicaid program of single source drugs and

1285 innovator multiple source drugs, and information about other drugs
1286 that may be prescribed as alternatives to those single source
1287 drugs and innovator multiple source drugs and the costs to the
1288 Medicaid program of those alternative drugs.

1289 Notwithstanding any law or regulation, information obtained
1290 or maintained by the division regarding the prescription drug
1291 program, including trade secrets and manufacturer or labeler
1292 pricing, is confidential and not subject to disclosure except to
1293 other state agencies.

1294 (b) Payment by the division for covered
1295 multisource drugs shall be limited to the lower of the upper
1296 limits established and published by the Centers for Medicare and
1297 Medicaid Services (CMS) plus a dispensing fee, or the estimated
1298 acquisition cost (EAC) as determined by the division, plus a
1299 dispensing fee, or the providers' usual and customary charge to
1300 the general public.

1301 Payment for other covered drugs, other than multisource drugs
1302 with CMS upper limits, shall not exceed the lower of the estimated
1303 acquisition cost as determined by the division, plus a dispensing
1304 fee or the providers' usual and customary charge to the general
1305 public.

1306 Payment for nonlegend or over-the-counter drugs covered by
1307 the division shall be reimbursed at the lower of the division's
1308 estimated shelf price or the providers' usual and customary charge
1309 to the general public.

1310 The dispensing fee for each new or refill prescription,
1311 including nonlegend or over-the-counter drugs covered by the
1312 division, shall be not less than Three Dollars and Ninety-one
1313 Cents ($3.91), as determined by the division.

1314 The division shall not reimburse for single source or
1315 innovator multiple source drugs if there are equally effective

1316 generic equivalents available and if the generic equivalents are
1317 the least expensive.

1318 It is the intent of the Legislature that the pharmacists
1319 providers be reimbursed for the reasonable costs of filling and
1320 dispensing prescriptions for Medicaid beneficiaries.

1321 (10) (a) Dental care that is an adjunct to treatment
1322 of an acute medical or surgical condition; services of oral
1323 surgeons and dentists in connection with surgery related to the
1324 jaw or any structure contiguous to the jaw or the reduction of any
1325 fracture of the jaw or any facial bone; and emergency dental
1326 extractions and treatment related thereto. On July 1, 2007, *** * ***
1327 fees for dental care and surgery under authority of this paragraph
1328 (10) shall be reimbursed as provided in paragraph (b). It is the
1329 intent of the Legislature that this rate revision for dental
1330 services will be an incentive designed to increase the number of
1331 dentists who actively provide Medicaid services. This dental
1332 services rate revision shall be known as the "James Russell Dumas
1333 Medicaid Dental Incentive Program."

1334 The division shall annually determine the effect of this
1335 incentive by evaluating the number of dentists who are Medicaid
1336 providers, the number who and the degree to which they are
1337 actively billing Medicaid, the geographic trends of where dentists
1338 are offering what types of Medicaid services and other statistics
1339 pertinent to the goals of this legislative intent. This data
1340 shall be presented to the Chair of the Senate Public Health and
1341 Welfare Committee and the Chair of the House Medicaid Committee.

1342 (b) The Division of Medicaid shall establish a fee
1343 schedule, to be effective from and after July 1, 2007, for dental
1344 services. The schedule shall provide for a fee for each dental
1345 service that is equal to a percentile of normal and customary
1346 private provider fees, as defined by the Ingenix Customized Fee
1347 Analyzer Report, which percentile shall be determined by the

1348 division. The schedule shall be reviewed annually by the division
1349 and dental fees shall be adjusted to reflect the percentile
1350 determined by the division.
1351 (c) For fiscal year 2008, the amount of state
1352 funds appropriated for reimbursement for dental care and surgery
1353 shall be increased by ten percent (10%) of the amount of state
1354 fund expenditures for that purpose for fiscal year 2007. For each
1355 of fiscal years 2009 and 2010, the amount of state funds
1356 appropriated for reimbursement for dental care and surgery shall
1357 be increased by ten percent (10%) of the amount of state fund
1358 expenditures for that purpose for the preceding fiscal year.
1359 (d) The division shall establish an annual benefit
1360 limit of Two Thousand Five Hundred Dollars ($2,500.00) in dental
1361 expenditures per Medicaid-eligible recipient; however, a recipient
1362 may exceed the annual limit on dental expenditures provided in
1363 this paragraph with prior approval of the division.
1364 (e) The division shall include dental services as
1365 a necessary component of overall health services provided to
1366 children who are eligible for services.
1367 (f) This paragraph (10) shall stand repealed on
1368 July 1, 2010.
1369 (11) Eyeglasses for all Medicaid beneficiaries who have
1370 (a) had surgery on the eyeball or ocular muscle that results in a
1371 vision change for which eyeglasses or a change in eyeglasses is
1372 medically indicated within six (6) months of the surgery and is in
1373 accordance with policies established by the division, or (b) one
1374 (1) pair every five (5) years and in accordance with policies
1375 established by the division. In either instance, the eyeglasses
1376 must be prescribed by a physician skilled in diseases of the eye
1377 or an optometrist, whichever the beneficiary may select.
1378 (12) Intermediate care facility services.

1379 (a) The division shall make full payment to all
1380 intermediate care facilities for the mentally retarded for each
1381 day, not exceeding eighty-four (84) days per year, that a patient
1382 is absent from the facility on home leave. Payment may be made
1383 for the following home leave days in addition to the
1384 eighty-four-day limitation: Christmas, the day before Christmas,
1385 the day after Christmas, Thanksgiving, the day before Thanksgiving
1386 and the day after Thanksgiving.
1387 (b) All state-owned intermediate care facilities
1388 for the mentally retarded shall be reimbursed on a full reasonable
1389 cost basis.
1390 (13) Family planning services, including drugs,
1391 supplies and devices, when those services are under the
1392 supervision of a physician or nurse practitioner.
1393 (14) Clinic services. Such diagnostic, preventive,
1394 therapeutic, rehabilitative or palliative services furnished to an
1395 outpatient by or under the supervision of a physician or dentist
1396 in a facility that is not a part of a hospital but that is
1397 organized and operated to provide medical care to outpatients.
1398 Clinic services shall include any services reimbursed as
1399 outpatient hospital services that may be rendered in such a
1400 facility, including those that become so after July 1, 1991. On
1401 July 1, 1999, all fees for physicians' services reimbursed under
1402 authority of this paragraph (14) shall be reimbursed at ninety
1403 percent (90%) of the rate established on January 1, 1999, and as
1404 may be adjusted each July thereafter, under Medicare (Title XVIII
1405 of the federal Social Security Act, as amended). The division may
1406 develop and implement a different reimbursement model or schedule
1407 for physician's services provided by physicians based at an
1408 academic health care center and by physicians at rural health
1409 centers that are associated with an academic health care
1410 center. *** * ***

1411 (15) Home- and community-based services for the elderly
1412 and disabled, as provided under Title XIX of the federal Social
1413 Security Act, as amended, under waivers, subject to the
1414 availability of funds specifically appropriated for that purpose
1415 by the Legislature.
1416 (16) Mental health services. Approved therapeutic and
1417 case management services (a) provided by an approved regional
1418 mental health/retardation center established under Sections
1419 41-19-31 through 41-19-39, or by another community mental health
1420 service provider meeting the requirements of the Department of
1421 Mental Health to be an approved mental health/retardation center
1422 if determined necessary by the Department of Mental Health, using
1423 state funds that are provided from the appropriation to the State
1424 Department of Mental Health and/or funds transferred to the
1425 department by a political subdivision or instrumentality of the
1426 state and used to match federal funds under a cooperative
1427 agreement between the division and the department, or (b) provided
1428 by a facility that is certified by the State Department of Mental
1429 Health to provide therapeutic and case management services, to be
1430 reimbursed on a fee for service basis, or (c) provided in the
1431 community by a facility or program operated by the Department of
1432 Mental Health. Any such services provided by a facility described
1433 in subparagraph (b) must have the prior approval of the division
1434 to be reimbursable under this section. After June 30, 1997,
1435 mental health services provided by regional mental
1436 health/retardation centers established under Sections 41-19-31
1437 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
1438 and/or their subsidiaries and divisions, or by psychiatric
1439 residential treatment facilities as defined in Section 43-11-1, or
1440 by another community mental health service provider meeting the
1441 requirements of the Department of Mental Health to be an approved
1442 mental health/retardation center if determined necessary by the

1443 Department of Mental Health, shall not be included in or provided
1444 under any capitated managed care pilot program provided for under
1445 paragraph (24) of this section.
1446 (17) Durable medical equipment services and medical
1447 supplies. Precertification of durable medical equipment and
1448 medical supplies must be obtained as required by the division.
1449 The Division of Medicaid may require durable medical equipment
1450 providers to obtain a surety bond in the amount and to the
1451 specifications as established by the Balanced Budget Act of 1997.
1452 (18) (a) Notwithstanding any other provision of this
1453 section to the contrary, the division shall make additional
1454 reimbursement to hospitals that serve a disproportionate share of
1455 low-income patients and that meet the federal requirements for
1456 those payments as provided in Section 1923 of the federal Social
1457 Security Act and any applicable regulations. It is the intent of
1458 the Legislature that the division shall draw down all available
1459 federal funds allotted to the state for disproportionate share
1460 hospitals. However, from and after January 1, 1999, no public
1461 hospital shall participate in the Medicaid disproportionate share
1462 program unless the public hospital participates in an
1463 intergovernmental transfer program as provided in Section 1903 of
1464 the federal Social Security Act and any applicable regulations.
1465 (b) The division shall establish a Medicare Upper
1466 Payment Limits Program, as defined in Section 1902(a)(30) of the
1467 federal Social Security Act and any applicable federal
1468 regulations, for hospitals, and may establish a Medicare Upper
1469 Payment Limits Program for nursing facilities. The division shall
1470 assess each hospital and, if the program is established for
1471 nursing facilities, shall assess each nursing facility, based on
1472 Medicaid utilization or other appropriate method consistent with
1473 federal regulations. The assessment will remain in effect as long
1474 as the state participates in the Medicare Upper Payment Limits

1475 Program. The division shall make additional reimbursement to
1476 hospitals and, if the program is established for nursing
1477 facilities, shall make additional reimbursement to nursing
1478 facilities, for the Medicare Upper Payment Limits, as defined in
1479 Section 1902(a)(30) of the federal Social Security Act and any
1480 applicable federal regulations.
1481 (19) (a) Perinatal risk management services. The
1482 division shall promulgate regulations to be effective from and
1483 after October 1, 1988, to establish a comprehensive perinatal
1484 system for risk assessment of all pregnant and infant Medicaid
1485 recipients and for management, education and follow-up for those
1486 who are determined to be at risk. Services to be performed
1487 include case management, nutrition assessment/counseling,
1488 psychosocial assessment/counseling and health education.
1489 (b) Early intervention system services. The
1490 division shall cooperate with the State Department of Health,
1491 acting as lead agency, in the development and implementation of a
1492 statewide system of delivery of early intervention services, under
1493 Part C of the Individuals with Disabilities Education Act (IDEA).
1494 The State Department of Health shall certify annually in writing
1495 to the executive director of the division the dollar amount of
1496 state early intervention funds available that will be utilized as
1497 a certified match for Medicaid matching funds. Those funds then
1498 shall be used to provide expanded targeted case management
1499 services for Medicaid eligible children with special needs who are
1500 eligible for the state's early intervention system.
1501 Qualifications for persons providing service coordination shall be
1502 determined by the State Department of Health and the Division of
1503 Medicaid.
1504 (20) Home- and community-based services for physically
1505 disabled approved services as allowed by a waiver from the United
1506 States Department of Health and Human Services for home- and

1507 community-based services for physically disabled people using
1508 state funds that are provided from the appropriation to the State
1509 Department of Rehabilitation Services and used to match federal
1510 funds under a cooperative agreement between the division and the
1511 department, provided that funds for these services are
1512 specifically appropriated to the Department of Rehabilitation
1513 Services.

1514 (21) Nurse practitioner services. Services furnished
1515 by a registered nurse who is licensed and certified by the
1516 Mississippi Board of Nursing as a nurse practitioner, including,
1517 but not limited to, nurse anesthetists, nurse midwives, family
1518 nurse practitioners, family planning nurse practitioners,
1519 pediatric nurse practitioners, obstetrics-gynecology nurse
1520 practitioners and neonatal nurse practitioners, under regulations
1521 adopted by the division. Reimbursement for those services shall
1522 not exceed ninety percent (90%) of the reimbursement rate for
1523 comparable services rendered by a physician.

1524 (22) Ambulatory services delivered in federally
1525 qualified health centers, rural health centers and clinics of the
1526 local health departments of the State Department of Health for
1527 individuals eligible for Medicaid under this article based on
1528 reasonable costs as determined by the division.

1529 (23) Inpatient psychiatric services. Inpatient
1530 psychiatric services to be determined by the division for
1531 recipients under age twenty-one (21) that are provided under the
1532 direction of a physician in an inpatient program in a licensed
1533 acute care psychiatric facility or in a licensed psychiatric
1534 residential treatment facility, before the recipient reaches age
1535 twenty-one (21) or, if the recipient was receiving the services
1536 immediately before he or she reached age twenty-one (21), before
1537 the earlier of the date he or she no longer requires the services
1538 or the date he or she reaches age twenty-two (22), as provided by

1539 federal regulations. Precertification of inpatient days and
1540 residential treatment days must be obtained as required by the
1541 division.

1542 (24) [Deleted]

1543 (25) [Deleted]

1544 (26) Hospice care. As used in this paragraph, the term
1545 "hospice care" means a coordinated program of active professional
1546 medical attention within the home and outpatient and inpatient
1547 care that treats the terminally ill patient and family as a unit,
1548 employing a medically directed interdisciplinary team. The
1549 program provides relief of severe pain or other physical symptoms
1550 and supportive care to meet the special needs arising out of
1551 physical, psychological, spiritual, social and economic stresses
1552 that are experienced during the final stages of illness and during
1553 dying and bereavement and meets the Medicare requirements for
1554 participation as a hospice as provided in federal regulations.

1555 (27) Group health plan premiums and cost sharing if it
1556 is cost effective as defined by the United States Secretary of
1557 Health and Human Services.

1558 (28) Other health insurance premiums that are cost
1559 effective as defined by the United States Secretary of Health and
1560 Human Services. Medicare eligible must have Medicare Part B
1561 before other insurance premiums can be paid.

1562 (29) The Division of Medicaid may apply for a waiver
1563 from the United States Department of Health and Human Services for
1564 home- and community-based services for developmentally disabled
1565 people using state funds that are provided from the appropriation
1566 to the State Department of Mental Health and/or funds transferred
1567 to the department by a political subdivision or instrumentality of
1568 the state and used to match federal funds under a cooperative
1569 agreement between the division and the department, provided that
1570 funds for these services are specifically appropriated to the

1571 Department of Mental Health and/or transferred to the department
1572 by a political subdivision or instrumentality of the state.
1573 (30) Pediatric skilled nursing services for eligible
1574 persons under twenty-one (21) years of age.
1575 (31) Targeted case management services for children
1576 with special needs, under waivers from the United States
1577 Department of Health and Human Services, using state funds that
1578 are provided from the appropriation to the Mississippi Department
1579 of Human Services and used to match federal funds under a
1580 cooperative agreement between the division and the department.
1581 (32) Care and services provided in Christian Science
1582 Sanatoria listed and certified by the Commission for Accreditation
1583 of Christian Science Nursing Organizations/Facilities, Inc.,
1584 rendered in connection with treatment by prayer or spiritual means
1585 to the extent that those services are subject to reimbursement
1586 under Section 1903 of the federal Social Security Act.
1587 (33) Podiatrist services.
1588 (34) Assisted living services as provided through home-
1589 and community-based services under Title XIX of the federal Social
1590 Security Act, as amended, subject to the availability of funds
1591 specifically appropriated for that purpose by the Legislature.
1592 (35) Services and activities authorized in Sections
1593 43-27-101 and 43-27-103, using state funds that are provided from
1594 the appropriation to the State Department of Human Services and
1595 used to match federal funds under a cooperative agreement between
1596 the division and the department.
1597 (36) Nonemergency transportation services for
1598 Medicaid-eligible persons, to be provided by the Division of
1599 Medicaid. The division may contract with additional entities to
1600 administer nonemergency transportation services as it deems
1601 necessary. All providers shall have a valid driver's license,
1602 vehicle inspection sticker, valid vehicle license tags and a

1603 standard liability insurance policy covering the vehicle. The
1604 division may pay providers a flat fee based on mileage tiers, or
1605 in the alternative, may reimburse on actual miles traveled. The
1606 division may apply to the Center for Medicare and Medicaid
1607 Services (CMS) for a waiver to draw federal matching funds for
1608 nonemergency transportation services as a covered service instead
1609 of an administrative cost. The PEER Committee shall conduct a
1610 performance evaluation of the nonemergency transportation program
1611 to evaluate the administration of the program and the providers of
1612 transportation services to determine the most cost effective ways
1613 of providing nonemergency transportation services to the patients
1614 served under the program. The performance evaluation shall be
1615 completed and provided to the members of the Senate Public Health
1616 and Welfare Committee and the House Medicaid Committee not later
1617 than January 15, 2008.
1618 (37) [Deleted]
1619 (38) Chiropractic services. A chiropractor's manual
1620 manipulation of the spine to correct a subluxation, if x-ray
1621 demonstrates that a subluxation exists and if the subluxation has
1622 resulted in a neuromusculoskeletal condition for which
1623 manipulation is appropriate treatment, and related spinal x-rays
1624 performed to document these conditions. Reimbursement for
1625 chiropractic services shall not exceed Seven Hundred Dollars
1626 ($700.00) per year per beneficiary.
1627 (39) Dually eligible Medicare/Medicaid beneficiaries.
1628 The division shall pay the Medicare deductible and coinsurance
1629 amounts for services available under Medicare, as determined by
1630 the division.
1631 (40) [Deleted]
1632 (41) Services provided by the State Department of
1633 Rehabilitation Services for the care and rehabilitation of persons
1634 with spinal cord injuries or traumatic brain injuries, as allowed

1635 under waivers from the United States Department of Health and
1636 Human Services, using up to seventy-five percent (75%) of the
1637 funds that are appropriated to the Department of Rehabilitation
1638 Services from the Spinal Cord and Head Injury Trust Fund
1639 established under Section 37-33-261 and used to match federal
1640 funds under a cooperative agreement between the division and the
1641 department.

1642 (42) Notwithstanding any other provision in this
1643 article to the contrary, the division may develop a population
1644 health management program for women and children health services
1645 through the age of one (1) year. This program is primarily for
1646 obstetrical care associated with low birth weight and pre-term
1647 babies. The division may apply to the federal Centers for
1648 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
1649 any other waivers that may enhance the program. In order to
1650 effect cost savings, the division may develop a revised payment
1651 methodology that may include at-risk capitated payments, and may
1652 require member participation in accordance with the terms and
1653 conditions of an approved federal waiver.

1654 (43) The division shall provide reimbursement,
1655 according to a payment schedule developed by the division, for
1656 smoking cessation medications for pregnant women during their
1657 pregnancy and other Medicaid-eligible women who are of
1658 child-bearing age.

1659 (44) Nursing facility services for the severely
1660 disabled.

1661 (a) Severe disabilities include, but are not
1662 limited to, spinal cord injuries, closed head injuries and
1663 ventilator dependent patients.

1664 (b) Those services must be provided in a long-term
1665 care nursing facility dedicated to the care and treatment of

1666 persons with severe disabilities, and shall be reimbursed as a
1667 separate category of nursing facilities.
1668 (45) Physician assistant services. Services furnished
1669 by a physician assistant who is licensed by the State Board of
1670 Medical Licensure and is practicing with physician supervision
1671 under regulations adopted by the board, under regulations adopted
1672 by the division. Reimbursement for those services shall not
1673 exceed ninety percent (90%) of the reimbursement rate for
1674 comparable services rendered by a physician.
1675 (46) The division shall make application to the federal
1676 Centers for Medicare and Medicaid Services (CMS) for a waiver to
1677 develop and provide services for children with serious emotional
1678 disturbances as defined in Section 43-14-1(1), which may include
1679 home- and community-based services, case management services or
1680 managed care services through mental health providers certified by
1681 the Department of Mental Health. The division may implement and
1682 provide services under this waivered program only if funds for
1683 these services are specifically appropriated for this purpose by
1684 the Legislature, or if funds are voluntarily provided by affected
1685 agencies.
1686 (47) (a) Notwithstanding any other provision in this
1687 article to the contrary, the division *** * *** may develop and
1688 implement disease management programs for individuals with
1689 high-cost chronic diseases and conditions, including the use of
1690 grants, waivers, demonstrations or other projects as necessary.
1691 (b) Participation in any disease management
1692 program implemented under this paragraph (47) is optional with the
1693 individual. An individual must affirmatively elect to participate
1694 in the disease management program in order to participate<u>, and</u>
1695 may elect to discontinue participation in the program at any
1696 time. *** * ***
1697 *** * ***

1698 (48) Pediatric long-term acute care hospital services.
1699 (a) Pediatric long-term acute care hospital
1700 services means services provided to eligible persons under
1701 twenty-one (21) years of age by a freestanding Medicare-certified
1702 hospital that has an average length of inpatient stay greater than
1703 twenty-five (25) days and that is primarily engaged in providing
1704 chronic or long-term medical care to persons under twenty-one (21)
1705 years of age.
1706 (b) The services under this paragraph (48) shall
1707 be reimbursed as a separate category of hospital services.
1708 (49) The division shall establish co-payments and/or
1709 coinsurance for all Medicaid services for which co-payments and/or
1710 coinsurance are allowable under federal law or regulation, and
1711 shall set the amount of the co-payment and/or coinsurance for each
1712 of those services at the maximum amount allowable under federal
1713 law or regulation.
1714 (50) Services provided by the State Department of
1715 Rehabilitation Services for the care and rehabilitation of persons
1716 who are deaf and blind, as allowed under waivers from the United
1717 States Department of Health and Human Services to provide home-
1718 and community-based services using state funds that are provided
1719 from the appropriation to the State Department of Rehabilitation
1720 Services or if funds are voluntarily provided by another agency.
1721 (51) Upon determination of Medicaid eligibility and in
1722 association with annual redetermination of Medicaid eligibility,
1723 beneficiaries shall be encouraged to undertake a physical
1724 examination that will establish a base-line level of health and
1725 identification of a usual and customary source of care (a medical
1726 home) to aid utilization of disease management tools. This
1727 physical examination and utilization of these disease management
1728 tools shall be consistent with current United States Preventive
1729 Services Task Force or other recognized authority recommendations.

1730 For persons who are determined ineligible for Medicaid, the
1731 division will provide information and direction for accessing
1732 medical care and services in the area of their residence.
1733 (52) Notwithstanding any provisions of this article,
1734 the division may pay enhanced reimbursement fees related to trauma
1735 care, as determined by the division in conjunction with the State
1736 Department of Health, using funds appropriated to the State
1737 Department of Health for trauma care and services and used to
1738 match federal funds under a cooperative agreement between the
1739 division and the State Department of Health. The division, in
1740 conjunction with the State Department of Health, may use grants,
1741 waivers, demonstrations, or other projects as necessary in the
1742 development and implementation of this reimbursement program.
1743 (53) Targeted case management services for high-cost
1744 beneficiaries shall be developed by the division for all services
1745 under this section.
1746 (54) Adult foster care services pilot program. Social
1747 and protective services on a pilot program basis in an approved
1748 foster care facility for vulnerable adults who would otherwise
1749 need care in a long-term care facility, to be implemented in an
1750 area of the state with the greatest need for such program, under
1751 the Medicaid Waivers for the Elderly and Disabled program or an
1752 assisted living waiver. The division may use grants, waivers,
1753 demonstrations or other projects as necessary in the development
1754 and implementation of this adult foster care services pilot
1755 program.
1756 (55) Therapy services. The plan of care for therapy
1757 services may be developed to cover a period of treatment for up to
1758 six (6) months, but in no event shall the plan of care exceed a
1759 six-month period of treatment. The projected period of treatment
1760 must be indicated on the initial plan of care and must be updated
1761 with each subsequent revised plan of care. Based on medical

1762 necessity, the division shall approve certification periods for
1763 less than or up to six (6) months, but in no event shall the
1764 certification period exceed the period of treatment indicated on
1765 the plan of care. The appeal process for any reduction in therapy
1766 services shall be consistent with the appeal process in federal
1767 regulations.
1768 Notwithstanding any other provision of this article to the
1769 contrary, the division shall reduce the rate of reimbursement to
1770 providers for any service provided under this section by five
1771 percent (5%) of the allowed amount for that service. However, the
1772 reduction in the reimbursement rates required by this paragraph
1773 shall not apply to inpatient hospital services, nursing facility
1774 services, intermediate care facility services, psychiatric
1775 residential treatment facility services, pharmacy services
1776 provided under paragraph (9) of this section, or any service
1777 provided by the University of Mississippi Medical Center or a
1778 state agency, a state facility or a public agency that either
1779 provides its own state match through intergovernmental transfer or
1780 certification of funds to the division, or a service for which the
1781 federal government sets the reimbursement methodology and rate.
1782 In addition, the reduction in the reimbursement rates required by
1783 this paragraph shall not apply to case management services and
1784 home-delivered meals provided under the home- and community-based
1785 services program for the elderly and disabled by a planning and
1786 development district (PDD). Planning and development districts
1787 participating in the home- and community-based services program
1788 for the elderly and disabled as case management providers shall be
1789 reimbursed for case management services at the maximum rate
1790 approved by the Centers for Medicare and Medicaid Services (CMS).
1791 The division may pay to those providers who participate in
1792 and accept patient referrals from the division's emergency room
1793 redirection program a percentage, as determined by the division,

1794 of savings achieved according to the performance measures and
1795 reduction of costs required of that program. Federally qualified
1796 health centers may participate in the emergency room redirection
1797 program, and the division may pay those centers a percentage of
1798 any savings to the Medicaid program achieved by the centers'
1799 accepting patient referrals through the program, as provided in
1800 this paragraph.

1801 Notwithstanding any provision of this article, except as
1802 authorized in the following paragraph and in Section 43-13-139,
1803 neither (a) the limitations on quantity or frequency of use of or
1804 the fees or charges for any of the care or services available to
1805 recipients under this section, nor (b) the payments or rates of
1806 reimbursement to providers rendering care or services authorized
1807 under this section to recipients, may be increased, decreased or
1808 otherwise changed from the levels in effect on July 1, 1999,
1809 unless they are authorized by an amendment to this section by the
1810 Legislature. However, the restriction in this paragraph shall not
1811 prevent the division from changing the payments or rates of
1812 reimbursement to providers without an amendment to this section
1813 whenever those changes are required by federal law or regulation,
1814 or whenever those changes are necessary to correct administrative
1815 errors or omissions in calculating those payments or rates of
1816 reimbursement.

1817 Notwithstanding any provision of this article, no new groups
1818 or categories of recipients and new types of care and services may
1819 be added without enabling legislation from the Mississippi
1820 Legislature, except that the division may authorize those changes
1821 without enabling legislation when the addition of recipients or
1822 services is ordered by a court of proper authority.

1823 The executive director shall keep the Governor advised on a
1824 timely basis of the funds available for expenditure and the
1825 projected expenditures. If current or projected expenditures of

1826 the division are reasonably anticipated to exceed the amount of
1827 funds appropriated to the division for any fiscal year, the
1828 Governor, after consultation with the executive director, shall
1829 discontinue any or all of the payment of the types of care and
1830 services as provided in this section that are deemed to be
1831 optional services under Title XIX of the federal Social Security
1832 Act, as amended, and when necessary, shall institute any other
1833 cost containment measures on any program or programs authorized
1834 under the article to the extent allowed under the federal law
1835 governing that program or programs. However, the Governor shall
1836 not be authorized to discontinue or eliminate any service under
1837 this section that is mandatory under federal law, or to
1838 discontinue or eliminate, or adjust income limits or resource
1839 limits for, any eligibility category or group under Section
1840 43-13-115. It is the intent of the Legislature that the
1841 expenditures of the division during any fiscal year shall not
1842 exceed the amounts appropriated to the division for that fiscal
1843 year.

1844 Notwithstanding any other provision of this article, it shall
1845 be the duty of each nursing facility, intermediate care facility
1846 for the mentally retarded, psychiatric residential treatment
1847 facility, and nursing facility for the severely disabled that is
1848 participating in the Medicaid program to keep and maintain books,
1849 documents and other records as prescribed by the Division of
1850 Medicaid in substantiation of its cost reports for a period of
1851 three (3) years after the date of submission to the Division of
1852 Medicaid of an original cost report, or three (3) years after the
1853 date of submission to the Division of Medicaid of an amended cost
1854 report.

1855 **SECTION 3.** The following shall be codified as Section
1856 43-13-126, Mississippi Code of 1972:

1857 43-13-126. As a condition of doing business in the state,
1858 health insurers, including self-insured plans, group health plans
1859 (as defined in Section 607(1) of the Employee Retirement Income
1860 Security Act of 1974), service benefit plans, managed care
1861 organizations, pharmacy benefit managers, or other parties that
1862 are by statute, contract, or agreement, legally responsible for
1863 payment of a claim for a health care item or service, are required
1864 to:
1865 (a) Provide, with respect to individuals who are
1866 eligible for, or are provided, medical assistance under the state
1867 plan, upon the request of the Division of Medicaid, information to
1868 determine during what period the individual or their spouses or
1869 their dependents may be (or may have been) covered by a health
1870 insurer and the nature of the coverage that is or was provided by
1871 the health insurer (including the name, address and identifying
1872 number of the plan) in a manner prescribed by the Secretary of the
1873 Department of Health and Human Services;
1874 (b) Accept the Division of Medicaid's right of recovery
1875 and the assignment to the division of any right of an individual
1876 or other entity to payment from the party for an item or service
1877 for which payment has been made under the state plan;
1878 (c) Respond to any inquiry by the Division of Medicaid
1879 regarding a claim for payment for any health care item or service
1880 that is submitted not later than three (3) years after the date of
1881 the provision of that health care item or service; and
1882 (d) Agree not to deny a claim submitted by the Division
1883 of Medicaid solely on the basis of the date of submission of the
1884 claim, the type or format of the claim form, or a failure to
1885 present proper documentation at the point-of-sale that is the
1886 basis of the claim, if:

1887 (i) The claim is submitted by the division within
1888 the three-year period beginning on the date on which the item or
1889 service was furnished; and
1890 (ii) Any action by the division to enforce its
1891 rights with respect to the claim is began within six (6) years of
1892 the division's submission of the claim.
1893 **SECTION 4.** It is the intent of the Legislature to expand
1894 access to Medicaid-funded home- and community-based services for
1895 eligible nursing facility residents who choose those services.
1896 The Executive Director of the Division of Medicaid is authorized
1897 to transfer funds allocated for nursing facility services for
1898 eligible residents to cover the cost of services available through
1899 the Independent Living Waiver, the Traumatic Brain Injury/Spinal
1900 Cord Injury Waiver, the Elderly and Disabled Waiver, and the
1901 Assisted Living Waiver programs when eligible residents choose
1902 those community services. The amount of funding transferred by
1903 the division shall be sufficient to cover the cost of home- and
1904 community-based waiver services for each eligible nursing facility
1905 residents who choose those services. The number of nursing
1906 facility residents who return to the community and home- and
1907 community-based waiver services shall not count against the total
1908 number of waiver slots for which the Legislature appropriates
1909 funding each year. Any funds remaining in the program when a
1910 former nursing facility resident ceases to participate in a home-
1911 and community-based waiver program under this provision shall be
1912 returned to nursing facility funding.
1913 **SECTION 5.** The Division of Medicaid is authorized and
1914 directed to study the feasibility of implementing a pilot program
1915 to provide chronic disease management of chronic obstructive
1916 pulmonary disease (COPD) using private sources of funding in an
1917 effort to reduce the financial and clinical burden of COPD illness
1918 upon the Medicaid program and the citizens of Mississippi. If a

1919 pilot program is deemed feasible, such a program shall be
1920 implemented and a report of findings and recommendations be
1921 prepared and provided to the Office of the Governor and the
1922 Chairmen of the House and Senate Public Health and Welfare
1923 Committees and the Chairman of the House Medicaid Committee in
1924 order to evaluate the effectiveness of the pilot program in
1925 reducing costs within the Medicaid program and in providing
1926 improved health and well-being of the affected patients.
1927 **SECTION 6.** The Division of Medicaid, in consultation with
1928 the State Department of Health and the State Department of
1929 Rehabilitation Services, is authorized and directed to study the
1930 feasibility of implementing a pilot program to provide bariatric
1931 surgery in the morbidly obese as a treatment option in an effort
1932 to reduce the financial and clinical burden of morbid obesity upon
1933 the Medicaid program and the citizens of Mississippi. If a pilot
1934 program is deemed feasible, that such a program be implemented and
1935 a report of findings and recommendations be prepared and provided
1936 to the Office of the Governor and the Chairmen of the House and
1937 Senate Public Health and Welfare Committees and the Chairman of
1938 the House Medicaid Committee in order to evaluate the
1939 effectiveness of the pilot program.
1940 **SECTION 7.** (1) "Health discount plan" means a card,
1941 program, device, arrangement, contract or mechanism that purports
1942 to offer discounts or access to discounts on health care services
1943 or supplies that is not insurance or that does not provide
1944 coverage for services or benefits regulated under Section 83-9-1
1945 et seq.
1946 (2) A person may not sell, market, promote, advertise or
1947 otherwise distribute a health discount plan unless:
1948 (a) Each advertisement, policy, document, information,
1949 statement or other communication regarding the health discount

1950 plan and the plan itself contain a statement, in bold and
1951 prominent type, that the health discount plan is not insurance;
1952 (b) The discounts offered under the health discount
1953 plan are specifically authorized by a contract with each provider
1954 of the services or supplies listed in conjunction with the plan;
1955 (c) The health discount plan states the name, address
1956 and telephone number of the administrator of the plan;
1957 (d) The person makes readily available to the consumer
1958 a complete, accurate and up-to-date list of providers
1959 participating in the plan that offer discounted health care
1960 services or supplies in the consumer's local area and the
1961 discounts offered by the providers;
1962 (e) The person provides the consumer the right to
1963 cancel the health discount plan within thirty (30) days after
1964 purchase of the plan; and
1965 (f) The person provides the consumer with a full refund
1966 of all payments made, except for a nominal processing fee, within
1967 thirty (30) days after notification of cancellation of the plan
1968 under paragraph (e) of this subsection.
1969 (3) The Commissioner of Insurance may adopt regulations to
1970 implement this section and to establish additional requirements
1971 intended to prohibit unfair or deceptive practices relating to
1972 health discount plans.
1973 (4) Rebates and discounts for health discount plans shall
1974 not apply to manufacturers of pharmaceuticals or supplies. This
1975 section shall not apply to the Division of Medicaid and shall not
1976 apply to pharmaceutical manufacturer discount cards.
1977 (5) This section shall stand repealed on July 1, 2010.
1978 **SECTION 8.** Section 14 of Senate Bill No. 2764, 2007 Regular
1979 Session, is amended as follows:

1980 Section 14. (1) There is hereby created the Office of
1981 Tobacco Control (office) which shall be an administrative division
1982 of the State Department of Health.
1983 (2) The Office of Tobacco Control, with the advice of the
1984 Mississippi Tobacco Control Advisory Board, shall develop and
1985 implement a comprehensive and statewide tobacco education,
1986 prevention and cessation program that is consistent with the
1987 recommendations for effective program components and funding
1988 recommendations in the 1999 Best Practices for Comprehensive
1989 Tobacco Control Programs of the federal Centers for Disease
1990 Control and Prevention, as those Best Practices may be
1991 periodically amended by the Centers for Disease Control and
1992 Prevention.
1993 (3) At a minimum, the program shall include the following
1994 components, and may include additional components that are
1995 contained within the Best Practices for Comprehensive Tobacco
1996 Control Programs of the federal Centers for Disease Control and
1997 Prevention, as periodically amended, and that based on scientific
1998 data and research have been shown to be effective at accomplishing
1999 the purposes of this section:
2000 (a) The use of mass media, including paid advertising
2001 and other communication tools to discourage the use of tobacco
2002 products and to educate people, especially youth, about the health
2003 hazards from the use of tobacco products, which shall be designed
2004 to be effective at achieving these goals and shall include, but
2005 need not be limited to, television, radio, and print advertising,
2006 as well as sponsorship, exhibits and other opportunities to raise
2007 awareness statewide;
2008 (b) Evidence-based curricula and programs implemented
2009 in schools to educate youth about tobacco and to discourage their
2010 use of tobacco products, including, but not limited to, programs
2011 that involve youth, educate youth about the health hazards from

2012 the use of tobacco products, help youth develop skills to refuse
2013 tobacco products, and demonstrate to youth how to stop using
2014 tobacco products;

2015 (c) Local community programs, including, but not
2016 limited to, youth-based partnerships that discourage the use of
2017 tobacco products and involve community-based organizations in
2018 tobacco education, prevention and cessation programs in their
2019 communities;

2020 (d) Enforcement of laws, regulations and policies
2021 against the sale or other provision of tobacco products to minors,
2022 and the possession of tobacco products by minors;

2023 (e) Programs to assist and help people to stop using
2024 tobacco products; and

2025 (f) A surveillance and evaluation system that monitors
2026 program accountability and results, produces publicly available
2027 reports that review how monies expended for the program are spent,
2028 and includes an evaluation of the program's effectiveness in
2029 reducing and preventing the use of tobacco products, and annual
2030 recommendations for improvements to enhance the program's
2031 effectiveness.

2032 (4) All programs or activities funded by the State
2033 Department of Health through the tobacco education, prevention and
2034 cessation program, whether part of a component described in
2035 subsection (2) or an additional component, must be consistent with
2036 the Best Practices for Comprehensive Tobacco Control Programs of
2037 the federal Centers for Disease Control and Prevention, as
2038 periodically amended, and all funds received by any person or
2039 entity under any such program or activity must be expended for
2040 purposes that are consistent with those Best Practices. <u>The</u>
2041 <u>State Department of Health shall exercise sole discretion in</u>
2042 <u>determining whether components are consistent with the Best</u>

2043 Practices for Comprehensive Tobacco Control Programs of the
2044 federal Centers for Disease Control and Prevention.
2045 (5) Funding for the different components of the program
2046 shall be apportioned between the components based on the
2047 recommendations in the Best Practices for Comprehensive Tobacco
2048 Control Programs of the federal Centers for Disease Control and
2049 Prevention, as periodically amended, or any additional programs as
2050 determined by the State Board of Health to provide adequate
2051 program development, implementation and evaluation for effective
2052 control of the use of tobacco products. While the office shall
2053 develop annual budgets based on strategic planning, components of
2054 the program shall be funded using the following areas as
2055 guidelines for priority:
2056 (a) School nurses and school programs;
2057 (b) Mass media (counter-marketing);
2058 (c) Cessation programs (including media promotions);
2059 (d) Community programs;
2060 (e) Surveillance and evaluation;
2061 (f) Law enforcement; and
2062 (g) Administration and management; however, not more
2063 than five percent (5%) of the total budget may be expended for
2064 administration and management purposes.
2065 (6) In funding the components of the program, the State
2066 Department of Health may provide funding for health care programs
2067 at the University of Mississippi Medical Center that are related
2068 to the prevention and cessation of the use of tobacco products and
2069 the treatment of illnesses that are related to the use of tobacco
2070 products.
2071 (7) No statewide, district, local, county or municipal
2072 elected official shall take part as a public official in mass
2073 media advertising under the provisions of Sections 13 through 17
2074 of this act.

2075 **SECTION 9.** This act shall take effect and be in force from

2076 and after July 1, 2007, except for Section 2, which shall take

2077 effect and be in force from and after the passage of this act.

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

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 PROVIDE THAT THE EXECUTIVE DIRECTOR OF THE DIVISION OF
4 MEDICAID SHALL SERVE AT THE WILL AND PLEASURE OF THE GOVERNOR; TO
5 DELETE PROVISIONS RELATING TO THE POSITION OF DEPUTY DIRECTOR OF
6 ADMINISTRATION OF THE DIVISION OF MEDICAID; TO PROVIDE THAT THE
7 CHAIRMANSHIP OF THE MEDICAL CARE ADVISORY COMMITTEE SHALL BE
8 ELECTED BY THE VOTING MEMBERS OF THE COMMITTEE ANNUALLY; TO EXTEND
9 THE AUTOMATIC REPEALER ON THE SECTION THAT CREATES THE DIVISION OF
10 MEDICAID; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, AS
11 AMENDED BY SENATE BILL NO. 2416, 2007 REGULAR SESSION, TO DELETE
12 THE AUTHORITY OF THE DIVISION TO ALLOW A STATE AGENCY TO BE THE
13 SOLE SOURCE PURCHASER AND DISTRIBUTOR OF CERTAIN MEDICATIONS; TO
14 PROVIDE THAT THE DIVISION SHALL ESTABLISH A FEE SCHEDULE FOR
15 DENTAL SERVICES PROVIDED TO CHILDREN THAT IS EQUAL TO A PERCENTILE
16 OF NORMAL AND CUSTOMARY PRIVATE PROVIDER FEES DETERMINED BY THE
17 DIVISION; TO PROVIDE THAT FOR EACH OF FISCAL YEARS 2008, 2009 AND
18 2010, THE AMOUNT OF STATE FUNDS APPROPRIATED FOR DENTAL SERVICES
19 SHALL BE INCREASED BY 10% OF THE AMOUNT OF STATE FUND EXPENDITURES
20 FOR THE PRECEDING FISCAL YEAR; TO PROVIDE THAT THE DIVISION SHALL
21 INCLUDE DENTAL SERVICES AS A NECESSARY COMPONENT OF OVERALL HEALTH
22 SERVICES PROVIDED TO CHILDREN WHO ARE ELIGIBLE FOR SERVICES; TO
23 DIRECT THE PEER COMMITTEE TO CONDUCT A PERFORMANCE EVALUATION OF
24 THE NONEMERGENCY TRANSPORTATION PROGRAM; TO DELETE THE PROVISIONS
25 RELATING TO THE PRESCRIPTION DRUG HOME DELIVERY COMPONENT OF THE
26 DISEASE MANAGEMENT PROGRAM; TO PROVIDE THAT THERAPY SERVICES WILL
27 BE REIMBURSABLE UNDER MEDICAID; TO PROVIDE THAT THE PLAN OF CARE
28 FOR THERAPY SERVICES MAY COVER A PERIOD OF TREATMENT FOR UP TO SIX
29 MONTHS; TO CODIFY NEW SECTION 43-13-126, MISSISSIPPI CODE OF 1972,
30 TO REQUIRE HEALTH INSURERS TO PROVIDE CERTAIN INFORMATION
31 REGARDING INDIVIDUAL COVERAGE TO THE DIVISION OF MEDICAID AS A
32 CONDITION OF DOING BUSINESS IN THE STATE, TO ACCEPT THE DIVISION'S
33 RIGHT OF RECOVERY IN THIRD-PARTY ACTIONS AND NOT TO DENY A CLAIM
34 SUBMITTED BY THE DIVISION ON THE BASIS OF CERTAIN ERRORS; TO
35 AUTHORIZE THE EXECUTIVE DIRECTOR OF THE DIVISION TO TRANSFER FUNDS
36 ALLOCATED FOR NURSING FACILITY SERVICES FOR ELIGIBLE RESIDENTS TO
37 COVER THE COST OF SERVICES AVAILABLE THROUGH THE INDEPENDENT
38 LIVING WAIVER, THE TRAUMATIC BRAIN INJURY/SPINAL CORD INJURY
39 WAIVER, THE ELDERLY AND DISABLED WAIVER, AND THE ASSISTED LIVING
40 WAIVER PROGRAMS WHEN ELIGIBLE RESIDENTS CHOOSE THOSE COMMUNITY
41 SERVICES; TO DIRECT THE DIVISION TO STUDY THE FEASIBILITY OF
42 IMPLEMENTING PILOT PROGRAMS TO PROVIDE CHRONIC DISEASE MANAGEMENT
43 OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE AND TO PROVIDE BARIATRIC
44 SURGERY IN THE MORBIDLY OBESE AS A TREATMENT OPTION; TO DEFINE
45 HEALTH DISCOUNT PLANS AND PROVIDE RESTRICTIONS ON THE MARKETING
46 AND DISTRIBUTION OF THOSE HEALTH DISCOUNT PLANS; TO AUTHORIZE THE
47 COMMISSIONER OF INSURANCE TO ADOPT REGULATIONS TO IMPLEMENT THE
48 PRECEDING PROVISIONS AND TO ESTABLISH ADDITIONAL REQUIREMENTS
49 INTENDED TO PROHIBIT UNFAIR OR DECEPTIVE PRACTICES RELATING TO
50 HEALTH DISCOUNT PLANS; TO AMEND SECTION 14 OF SENATE BILL NO.
51 2764, 2007 REGULAR SESSION, TO ALLOW FUNDING FOR THE TOBACCO
52 EDUCATION, PREVENTION AND CESSATION PROGRAM TO BE APPORTIONED TO

53 ADDITIONAL PROGRAMS AS DETERMINED BY THE STATE BOARD OF HEALTH;
54 AND FOR RELATED PURPOSES.

CONFEREES FOR THE HOUSE	CONFEREES FOR THE SENATE
X (SIGNED) Dedeaux	X (SIGNED) Nunnelee
X (SIGNED) Holland	X (SIGNED) Burton
X (SIGNED) Scott	X (SIGNED) Gordon