

By: Representative Flaggs

To: Medicaid; Ways and Means

HOUSE BILL NO. 1013
(As Passed the House)

1 AN ACT TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972,
2 TO INCREASE THE MAXIMUM FAMILY INCOME FOR CERTAIN CHILDREN TO BE
3 ELIGIBLE FOR MEDICAID TO 200% OF THE POVERTY LEVEL; TO AMEND
4 SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT
5 MEDICAID RECIPIENTS REQUIRING TRANSPLANTS SHALL NOT HAVE THOSE
6 DAYS INCLUDED IN THE TRANSPLANT CASE RATE COUNT AGAINST THE
7 THIRTY-DAY LIMIT FOR INPATIENT HOSPITAL CARE; TO PROVIDE THAT THE
8 DIVISION, IN OBTAINING MEDICAL AND MENTAL HEALTH ASSESSMENTS FOR
9 CHILDREN WHO ARE IN, OR AT RISK FOR BEING PUT IN, THE CUSTODY OF
10 THE DEPARTMENT OF HUMAN SERVICES MAY ENTER A COOPERATIVE AGREEMENT
11 WITH THE DEPARTMENT FOR THE PROVISION OF THOSE SERVICES; TO
12 AUTHORIZE THE DIVISION TO PROVIDE FOR PRESCRIPTION DRUGS TO
13 MEDICAID BENEFICIARIES IN A COMBINATION OF PREFERRED AND
14 NON-PREFERRED DRUGS INSTEAD OF A COMBINATION OF SINGLE SOURCE AND
15 INNOVATOR MULTIPLE SOURCE DRUGS AND GENERIC DRUGS; TO PROVIDE
16 MEDICAID REIMBURSEMENT FOR FAMILY PLANNING SERVICES THAT ARE
17 PROVIDED UNDER THE SUPERVISION OF A PHYSICIAN ASSISTANT; TO
18 PROVIDE THAT THE ASSESSMENT ON HOSPITALS UNDER THE AUTHORITY FOR
19 THE MEDICARE UPPER PAYMENT LIMITS PROGRAM SHALL BE USED FOR THE
20 SOLE PURPOSE OF FINANCING THE STATE PORTION OF THAT PROGRAM; TO
21 PROVIDE MEDICAID REIMBURSEMENT FOR PRETERM LABOR MANAGEMENT
22 SERVICES TO PREGNANT WOMEN WHO ARE EXPERIENCING PRETERM LABOR,
23 WITH THE PRIOR AUTHORIZATION OF THE DIVISION AND SUBJECT TO
24 UTILIZATION CONTROLS; TO PROHIBIT THE DIVISION FROM CHANGING THE
25 PAYMENT METHODOLOGY TO MEDICAID PROVIDERS WITHOUT SPECIFIC
26 AUTHORIZATION BY THE LEGISLATURE; TO AMEND SECTION 43-13-117.1,
27 MISSISSIPPI CODE OF 1972, TO PROVIDE THAT THE DIVISION SHALL
28 IMPLEMENT A "MONEY FOLLOWS THE PERSON" PROCESS BY WHICH FUNDING
29 FOR NURSING FACILITY SERVICES FOR MEDICAID-ELIGIBLE BENEFICIARIES
30 MAY BE USED TO PAY FOR HOME- AND COMMUNITY-BASED WAIVER SERVICES
31 FOR THOSE NURSING FACILITY RESIDENTS WHO CHOOSE THOSE SERVICES; TO
32 AMEND SECTION 43-13-213, MISSISSIPPI CODE OF 1972, TO CLARIFY THE
33 DEFINITION AND PENALTIES FOR FALSE OR FRAUDULENT MEDICAID CLAIMS
34 IN CONFORMITY WITH FEDERAL LAW; TO CREATE NEW SECTION 43-13-221.1,
35 MISSISSIPPI CODE OF 1972, TO AUTHORIZE THE ATTORNEY GENERAL AND
36 PRIVATE CITIZENS TO RECOVER PAYMENTS INCORRECTLY MADE FOR FALSE OR
37 FRAUDULENT MEDICAID CLAIMS; TO AMEND SECTION 43-13-223,
38 MISSISSIPPI CODE OF 1972, TO ESTABLISH THE STATUTE OF LIMITATION
39 FOR ACTIONS BROUGHT UNDER THE PRECEDING SECTIONS; TO BRING FORWARD
40 SECTIONS 43-13-107, 43-13-113, 43-13-117.2, 43-13-121, 43-13-122,
41 43-13-125, 43-13-126, 43-13-129, 43-13-131, 43-13-143 AND
42 43-13-145, MISSISSIPPI CODE OF 1972, OF THE MISSISSIPPI MEDICAID
43 LAW, FOR THE PURPOSES OF AMENDMENT; TO AMEND SECTION 43-13-117.3,
44 MISSISSIPPI CODE OF 1972, TO REVISE CERTAIN NONSUBSTANTIVE
45 LANGUAGE IN THAT SECTION; TO AMEND SECTION 27-69-13, MISSISSIPPI
46 CODE OF 1972, TO INCREASE THE EXCISE TAX ON CIGARETTES; TO AMEND



47 SECTION 27-69-75, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT THE
48 REVENUE DERIVED FROM THE TAX INCREASE PROVIDED FOR BY THE
49 PRECEDING SECTION SHALL BE DEPOSITED INTO THE MISSISSIPPI TRAUMA
50 CARE SYSTEMS FUND AND INTO THE SPECIAL FUND IN THE STATE TREASURY
51 TO THE CREDIT OF THE GOVERNOR'S OFFICE - DIVISION OF MEDICAID; AND
52 FOR RELATED PURPOSES.

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

54 **SECTION 1.** Section 43-13-107, Mississippi Code of 1972, is
55 brought forward as follows:

56 43-13-107. (1) The Division of Medicaid is created in the
57 Office of the Governor and established to administer this article
58 and perform such other duties as are prescribed by law.

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

75 (b) The executive director shall serve at the will and
76 pleasure of the Governor.

77 (c) The executive director shall, before entering upon
78 the discharge of the duties of the office, take and subscribe to
79 the oath of office prescribed by the Mississippi Constitution and
80 shall file the same in the Office of the Secretary of State, and
81 shall execute a bond in some surety company authorized to do



82 business in the state in the penal sum of One Hundred Thousand
83 Dollars (\$100,000.00), conditioned for the faithful and impartial
84 discharge of the duties of the office. The premium on the bond
85 shall be paid as provided by law out of funds appropriated to the
86 Division of Medicaid for contractual services.

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

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

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

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

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

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



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

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

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

131 (e) The chairmanship of the advisory committee shall be
132 elected by the voting members of the committee annually and shall
133 not serve more than two (2) consecutive years as chairman.

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

145 (g) The advisory committee shall meet not less than
146 quarterly, and advisory committee members shall be furnished



147 written notice of the meetings at least ten (10) days before the
148 date of the meeting.

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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



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

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

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



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

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

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

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

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

273 **SECTION 2.** Section 43-13-113, Mississippi Code of 1972, is
274 brought forward as follows:



275 43-13-113. (1) The State Treasurer shall receive on behalf
276 of the state, and execute all instruments incidental thereto,
277 federal and other funds to be used for financing the medical
278 assistance plan or program adopted pursuant to this article, and
279 place all such funds in a special account to the credit of the
280 Governor's Office-Division of Medicaid, which funds shall be
281 expended by the division for the purposes and under the provisions
282 of this article, and shall be paid out by the State Treasurer as
283 funds appropriated to carry out the provisions of this article are
284 paid out by him.

285 The division shall issue all checks or electronic transfers
286 for administrative expenses, and for medical assistance under the
287 provisions of this article. All such checks or electronic
288 transfers shall be drawn upon funds made available to the division
289 by the State Auditor, upon requisition of the director. It is the
290 purpose of this section to provide that the State Auditor shall
291 transfer, in lump sums, amounts to the division for disbursement
292 under the regulations which shall be made by the director with the
293 approval of the Governor; however, the division, or its fiscal
294 agent in behalf of the division, shall be authorized in
295 maintaining separate accounts with a Mississippi bank to handle
296 claim payments, refund recoveries and related Medicaid program
297 financial transactions, to aggressively manage the float in these
298 accounts while awaiting clearance of checks or electronic
299 transfers and/or other disposition so as to accrue maximum
300 interest advantage of the funds in the account, and to retain all
301 earned interest on these funds to be applied to match federal
302 funds for Medicaid program operations.

303 (2) The division is authorized to obtain a line of credit
304 through the State Treasurer from the Working Cash-Stabilization
305 Fund or any other special source funds maintained in the State
306 Treasury in an amount not exceeding One Hundred Fifty Million
307 Dollars (\$150,000,000.00) to fund shortfalls which, from time to



308 time, may occur due to decreases in state matching fund cash flow.
309 The length of indebtedness under this provision shall not carry
310 past the end of the quarter following the loan origination. Loan
311 proceeds shall be received by the State Treasurer and shall be
312 placed in a Medicaid designated special fund account. Loan
313 proceeds shall be expended only for health care services provided
314 under the Medicaid program. The division may pledge as security
315 for such interim financing future funds that will be received by
316 the division. Any such loans shall be repaid from the first
317 available funds received by the division in the manner of and
318 subject to the same terms provided in this section.

319 In the event the State Treasurer makes a determination that
320 special source funds are not sufficient to cover a line of credit
321 for the Division of Medicaid, the division is authorized to obtain
322 a line of credit, in an amount not exceeding One Hundred Fifty
323 Million Dollars (\$150,000,000.00), from a commercial lender or a
324 consortium of lenders. The length of indebtedness under this
325 provision shall not carry past the end of the quarter following
326 the loan origination. The division shall obtain a minimum of two
327 (2) written quotes that shall be presented to the State Fiscal
328 Officer and State Treasurer, who shall jointly select a lender.
329 Loan proceeds shall be received by the State Treasurer and shall
330 be placed in a Medicaid designated special fund account. Loan
331 proceeds shall be expended only for health care services provided
332 under the Medicaid program. The division may pledge as security
333 for such interim financing future funds that will be received by
334 the division. Any such loans shall be repaid from the first
335 available funds received by the division in the manner of and
336 subject to the same terms provided in this section.

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



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

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

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

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

350 (e) If a claim is neither paid nor denied for valid and
351 proper reasons by the end of the time periods as specified above,
352 the Division of Medicaid's fiscal agent must pay the provider
353 interest on the claim at the rate of one and one-half percent
354 (1-1/2%) per month on the amount of such claim until it is finally
355 settled or adjudicated.

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

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

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

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

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



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

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

380 (7) Repealed.

381 (8) If sufficient funds are appropriated therefor by the
382 Legislature, the Division of Medicaid may contract with the
383 Mississippi Dental Association, or an approved designee, to
384 develop and operate a Donated Dental Services (DDS) program
385 through which volunteer dentists will treat needy disabled, aged
386 and medically compromised individuals who are non-Medicaid
387 eligible recipients.

388 **SECTION 3.** Section 43-13-115, Mississippi Code of 1972, is
389 amended as follows:

390 43-13-115. Recipients of Medicaid shall be the following
391 persons only:

392 (1) Those who are qualified for public assistance
393 grants under provisions of Title IV-A and E of the federal Social
394 Security Act, as amended, including those statutorily deemed to be
395 IV-A and low-income families and children under Section 1931 of
396 the federal Social Security Act. For the purposes of this
397 paragraph (1) and paragraphs (8), (17) and (18) of this section,
398 any reference to Title IV-A or to Part A of Title IV of the
399 federal Social Security Act, as amended, or the state plan under
400 Title IV-A or Part A of Title IV, shall be considered as a
401 reference to Title IV-A of the federal Social Security Act, as
402 amended, and the state plan under Title IV-A, including the income
403 and resource standards and methodologies under Title IV-A and the
404 state plan, as they existed on July 16, 1996. The Department of



405 Human Services shall determine Medicaid eligibility for children
406 receiving public assistance grants under Title IV-E. The division
407 shall determine eligibility for low-income families under Section
408 1931 of the federal Social Security Act and shall redetermine
409 eligibility for those continuing under Title IV-A grants.

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

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

421 (4) [Deleted]

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

432 (6) Children certified by the State Department of Human
433 Services to the Division of Medicaid of whom the state and county
434 departments of human services have custody and financial
435 responsibility, and children who are in adoptions subsidized in
436 full or part by the Department of Human Services, including
437 special needs children in non-Title IV-E adoption assistance, who



438 are approvable under Title XIX of the Medicaid program. The
439 eligibility of the children covered under this paragraph shall be
440 determined by the State Department of Human Services.

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

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

459 (9) Individuals who are:

460 (a) Children born after September 30, 1983, who
461 have not attained the age of nineteen (19), with family income
462 that does not exceed two hundred percent (200%) of the nonfarm
463 official poverty level;

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

468 (c) Pregnant women and infants who have not
469 attained the age of one (1), with family income that does not



470 exceed one hundred eighty-five percent (185%) of the federal
471 poverty level.

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

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

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

495 Any individual who applied for Medicaid during the period
496 from July 1, 2004, through March 31, 2005, who otherwise would
497 have been eligible for coverage under this paragraph (11) if it
498 had been in effect at the time the individual submitted his or her
499 application and is still eligible for coverage under this
500 paragraph (11) on March 31, 2005, shall be eligible for Medicaid
501 coverage under this paragraph (11) from March 31, 2005, through
502 December 31, 2005. The division shall give priority in processing



503 the applications for those individuals to determine their
504 eligibility under this paragraph (11).

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

512 The eligibility of individuals covered under this paragraph
513 shall be determined by the Division of Medicaid, and those
514 individuals determined eligible shall receive Medicare
515 cost-sharing expenses only as more fully defined by the Medicare
516 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
517 1997.

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

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

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



536 (14) [Deleted]

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

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

552 (17) In accordance with the terms of the federal
553 Personal Responsibility and Work Opportunity Reconciliation Act of
554 1996 (Public Law 104-193), persons who become ineligible for
555 assistance under Title IV-A of the federal Social Security Act, as
556 amended, because of increased income from or hours of employment
557 of the caretaker relative or because of the expiration of the
558 applicable earned income disregards, who were eligible for
559 Medicaid for at least three (3) of the six (6) months preceding
560 the month in which the ineligibility begins, shall be eligible for
561 Medicaid for up to twelve (12) months. The eligibility of the
562 individuals covered under this paragraph shall be determined by
563 the division.

564 (18) Persons who become ineligible for assistance under
565 Title IV-A of the federal Social Security Act, as amended, as a
566 result, in whole or in part, of the collection or increased
567 collection of child or spousal support under Title IV-D of the
568 federal Social Security Act, as amended, who were eligible for



569 Medicaid for at least three (3) of the six (6) months immediately
570 preceding the month in which the ineligibility begins, shall be
571 eligible for Medicaid for an additional four (4) months beginning
572 with the month in which the ineligibility begins. The eligibility
573 of the individuals covered under this paragraph shall be
574 determined by the division.

575 (19) Disabled workers, whose incomes are above the
576 Medicaid eligibility limits, but below two hundred fifty percent
577 (250%) of the federal poverty level, shall be allowed to purchase
578 Medicaid coverage on a sliding fee scale developed by the Division
579 of Medicaid.

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

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

597 The Division of Medicaid shall apply to the United States
598 Secretary of Health and Human Services for a federal waiver of the
599 applicable provisions of Title XIX of the federal Social Security
600 Act, as amended, and any other applicable provisions of federal
601 law as necessary to allow for the implementation of this paragraph



602 (21). The provisions of this paragraph (21) shall be implemented
603 from and after the date that the Division of Medicaid receives the
604 federal waiver.

605 (22) Persons who are workers with a potentially severe
606 disability, as determined by the division, shall be allowed to
607 purchase Medicaid coverage. The term "worker with a potentially
608 severe disability" means a person who is at least sixteen (16)
609 years of age but under sixty-five (65) years of age, who has a
610 physical or mental impairment that is reasonably expected to cause
611 the person to become blind or disabled as defined under Section
612 1614(a) of the federal Social Security Act, as amended, if the
613 person does not receive items and services provided under
614 Medicaid.

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

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

629 (24) Individuals who have not attained age sixty-five
630 (65), are not otherwise covered by creditable coverage as defined
631 in the Public Health Services Act, and have been screened for
632 breast and cervical cancer under the Centers for Disease Control
633 and Prevention Breast and Cervical Cancer Early Detection Program
634 established under Title XV of the Public Health Service Act in



635 accordance with the requirements of that act and who need
636 treatment for breast or cervical cancer. Eligibility of
637 individuals under this paragraph (24) shall be determined by the
638 Division of Medicaid.

639 (25) The division shall apply to the Centers for
640 Medicare and Medicaid Services (CMS) for any necessary waivers to
641 provide services to individuals who are sixty-five (65) years of
642 age or older or are disabled as determined under Section
643 1614(a)(3) of the federal Social Security Act, as amended, and
644 whose income does not exceed one hundred thirty-five percent
645 (135%) of the nonfarm official poverty level as defined by the
646 Office of Management and Budget and revised annually, and whose
647 resources do not exceed those established by the Division of
648 Medicaid, and who are not otherwise covered by Medicare. Nothing
649 contained in this paragraph (25) shall entitle an individual to
650 benefits. The eligibility of individuals covered under this
651 paragraph shall be determined by the Division of Medicaid.

652 (26) The division shall apply to the Centers for
653 Medicare and Medicaid Services (CMS) for any necessary waivers to
654 provide services to individuals who are sixty-five (65) years of
655 age or older or are disabled as determined under Section
656 1614(a)(3) of the federal Social Security Act, as amended, who are
657 end stage renal disease patients on dialysis, cancer patients on
658 chemotherapy or organ transplant recipients on anti-rejection
659 drugs, whose income does not exceed one hundred thirty-five
660 percent (135%) of the nonfarm official poverty level as defined by
661 the Office of Management and Budget and revised annually, and
662 whose resources do not exceed those established by the division.
663 Nothing contained in this paragraph (26) shall entitle an
664 individual to benefits. The eligibility of individuals covered
665 under this paragraph shall be determined by the Division of
666 Medicaid.



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

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

676 **SECTION 4.** Section 43-13-117, Mississippi Code of 1972, is
677 amended as follows:

678 43-13-117. Medicaid as authorized by this article shall
679 include payment of part or all of the costs, at the discretion of
680 the division, with approval of the Governor, of the following
681 types of care and services rendered to eligible applicants who
682 have been determined to be eligible for that care and services,
683 within the limits of state appropriations and federal matching
684 funds:

685 (1) Inpatient hospital services.

686 (a) The division shall allow thirty (30) days of
687 inpatient hospital care annually for all Medicaid recipients.
688 Medicaid recipients requiring transplants shall not have those
689 days included in the transplant case rate count against the
690 thirty-day limit for inpatient hospital care. Precertification of
691 inpatient days must be obtained as required by the division. The
692 division may allow unlimited days in disproportionate hospitals as
693 defined by the division for eligible infants and children under
694 the age of six (6) years if certified as medically necessary as
695 required by the division.

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



700 Capital Cost Component utilized to determine total hospital costs
701 allocated to the Medicaid program.

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

709 (2) Outpatient hospital services.

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

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

720 (3) Laboratory and x-ray services.

721 (4) Nursing facility services.

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

729 (b) From and after July 1, 1997, the division
730 shall implement the integrated case-mix payment and quality
731 monitoring system, which includes the fair rental system for
732 property costs and in which recapture of depreciation is



733 eliminated. The division may reduce the payment for hospital
734 leave and therapeutic home leave days to the lower of the case-mix
735 category as computed for the resident on leave using the
736 assessment being utilized for payment at that point in time, or a
737 case-mix score of 1.000 for nursing facilities, and shall compute
738 case-mix scores of residents so that only services provided at the
739 nursing facility are considered in calculating a facility's per
740 diem.

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

744 (d) When a facility of a category that does not
745 require a certificate of need for construction and that could not
746 be eligible for Medicaid reimbursement is constructed to nursing
747 facility specifications for licensure and certification, and the
748 facility is subsequently converted to a nursing facility under a
749 certificate of need that authorizes conversion only and the
750 applicant for the certificate of need was assessed an application
751 review fee based on capital expenditures incurred in constructing
752 the facility, the division shall allow reimbursement for capital
753 expenditures necessary for construction of the facility that were
754 incurred within the twenty-four (24) consecutive calendar months
755 immediately preceding the date that the certificate of need
756 authorizing the conversion was issued, to the same extent that
757 reimbursement would be allowed for construction of a new nursing
758 facility under a certificate of need that authorizes that
759 construction. The reimbursement authorized in this subparagraph
760 (d) may be made only to facilities the construction of which was
761 completed after June 30, 1989. Before the division shall be
762 authorized to make the reimbursement authorized in this
763 subparagraph (d), the division first must have received approval
764 from the Centers for Medicare and Medicaid Services (CMS) of the
765 change in the state Medicaid plan providing for the reimbursement.



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

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

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

787 (5) Periodic screening and diagnostic services for
788 individuals under age twenty-one (21) years as are needed to
789 identify physical and mental defects and to provide health care
790 treatment and other measures designed to correct or ameliorate
791 defects and physical and mental illness and conditions discovered
792 by the screening services, regardless of whether these services
793 are included in the state plan. The division may include in its
794 periodic screening and diagnostic program those discretionary
795 services authorized under the federal regulations adopted to
796 implement Title XIX of the federal Social Security Act, as
797 amended. The division, in obtaining physical therapy services,
798 occupational therapy services, and services for individuals with



799 speech, hearing and language disorders, may enter into a
800 cooperative agreement with the State Department of Education for
801 the provision of those services to handicapped students by public
802 school districts using state funds that are provided from the
803 appropriation to the Department of Education to obtain federal
804 matching funds through the division. The division, in obtaining
805 medical and mental health assessments for children who are in, or
806 at risk for being put in, the custody of the Mississippi
807 Department of Human Services may enter into a cooperative
808 agreement with the Mississippi Department of Human Services for
809 the provision of those services using state funds that are
810 provided from the appropriation to the Department of Human
811 Services to obtain federal matching funds through the division.

812 (6) Physician's services. The division shall allow
813 twelve (12) physician visits annually. All fees for physicians'
814 services that are covered only by Medicaid shall be reimbursed at
815 ninety percent (90%) of the rate established on January 1, 1999,
816 and as may be adjusted each July thereafter, under Medicare (Title
817 XVIII of the federal Social Security Act, as amended). The
818 division may develop and implement a different reimbursement model
819 or schedule for physician's services provided by physicians based
820 at an academic health care center and by physicians at rural
821 health centers that are associated with an academic health care
822 center.

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

828 (b) [Repealed]

829 (8) Emergency medical transportation services. On
830 January 1, 1994, emergency medical transportation services shall
831 be reimbursed at seventy percent (70%) of the rate established



832 under Medicare (Title XVIII of the federal Social Security Act, as
833 amended). "Emergency medical transportation services" shall mean,
834 but shall not be limited to, the following services by a properly
835 permitted ambulance operated by a properly licensed provider in
836 accordance with the Emergency Medical Services Act of 1974
837 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
838 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
839 (vi) disposable supplies, (vii) similar services.

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

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

846 The division may seek to establish relationships with other
847 states in order to lower acquisition costs of prescription drugs
848 to include single source and innovator multiple source drugs or
849 generic drugs. In addition, if allowed by federal law or
850 regulation, the division may seek to establish relationships with
851 and negotiate with other countries to facilitate the acquisition
852 of prescription drugs to include single source and innovator
853 multiple source drugs or generic drugs, if that will lower the
854 acquisition costs of those prescription drugs.

855 Unless the division implements the alternative method
856 authorized in the next paragraph, the division shall allow for a
857 combination of prescriptions for single source and innovator
858 multiple source drugs and generic drugs to meet the needs of the
859 beneficiaries, not to exceed five (5) prescriptions per month for
860 each noninstitutionalized Medicaid beneficiary, with not more than
861 two (2) of those prescriptions being for single source or
862 innovator multiple source drugs.

863 As an alternative to allowing for a combination of
864 prescriptions for single source and innovator multiple source



865 drugs and generic drugs as provider in the previous paragraph, the
866 division, in its discretion, may allow for a combination of
867 preferred and non-preferred drugs to meet the needs of the
868 beneficiaries, not to exceed five (5) prescriptions per month for
869 each noninstitutionalized Medicaid beneficiary, with not more than
870 two (2) of those prescriptions being for non-preferred drugs as
871 determined by the division.

872 The executive director may approve specific maintenance drugs
873 for beneficiaries with certain medical conditions, which may be
874 prescribed and dispensed in three-month supply increments.

875 Drugs prescribed for a resident of a psychiatric residential
876 treatment facility must be provided in true unit doses when
877 available. The division may require that drugs not covered by
878 Medicare Part D for a resident of a long-term care facility be
879 provided in true unit doses when available. Those drugs that were
880 originally billed to the division but are not used by a resident
881 in any of those facilities shall be returned to the billing
882 pharmacy for credit to the division, in accordance with the
883 guidelines of the State Board of Pharmacy and any requirements of
884 federal law and regulation. Drugs shall be dispensed to a
885 recipient and only one (1) dispensing fee per month may be
886 charged. The division shall develop a methodology for reimbursing
887 for restocked drugs, which shall include a restock fee as
888 determined by the division not exceeding Seven Dollars and
889 Eighty-two Cents (\$7.82).

890 If the division does not allow for a combination of preferred
891 and non-preferred drugs to meet the needs of the beneficiaries,
892 the voluntary preferred drug list shall be expanded to function in
893 the interim in order to have a manageable prior authorization
894 system, thereby minimizing disruption of service to beneficiaries.

895 Except for those specific maintenance drugs approved by the
896 executive director, the division shall not reimburse for any



897 portion of a prescription that exceeds a thirty-one-day supply of
898 the drug based on the daily dosage.

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

903 All claims for drugs for dually eligible Medicare/Medicaid
904 beneficiaries that are paid for by Medicare must be submitted to
905 Medicare for payment * * *.

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

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

919 Notwithstanding any law or regulation, information obtained
920 or maintained by the division regarding the prescription drug
921 program, including trade secrets and manufacturer or labeler
922 pricing, is confidential and not subject to disclosure except to
923 other state agencies.

924 (b) Payment by the division for covered
925 multisource drugs shall be limited to the lower of the upper
926 limits established and published by the Centers for Medicare and
927 Medicaid Services (CMS) plus a dispensing fee, or the estimated
928 acquisition cost (EAC) as determined by the division, plus a



929 dispensing fee, or the providers' usual and customary charge to
930 the general public.

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

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

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

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

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

951 (10) (a) Dental care that is an adjunct to treatment
952 of an acute medical or surgical condition; services of oral
953 surgeons and dentists in connection with surgery related to the
954 jaw or any structure contiguous to the jaw or the reduction of any
955 fracture of the jaw or any facial bone; and emergency dental
956 extractions and treatment related thereto. On July 1, 2007, fees
957 for dental care and surgery under authority of this paragraph (10)
958 shall be reimbursed as provided in paragraph (b). It is the
959 intent of the Legislature that this rate revision for dental
960 services will be an incentive designed to increase the number of
961 dentists who actively provide Medicaid services. This dental



962 services rate revision shall be known as the "James Russell Dumas
963 Medicaid Dental Incentive Program."

964 The division shall annually determine the effect of this
965 incentive by evaluating the number of dentists who are Medicaid
966 providers, the number who and the degree to which they are
967 actively billing Medicaid, the geographic trends of where dentists
968 are offering what types of Medicaid services and other statistics
969 pertinent to the goals of this legislative intent. This data
970 shall be presented to the Chair of the Senate Public Health and
971 Welfare Committee and the Chair of the House Medicaid Committee.

972 (b) The Division of Medicaid shall establish a fee
973 schedule, to be effective from and after July 1, 2007, for dental
974 services. The schedule shall provide for a fee for each dental
975 service that is equal to a percentile of normal and customary
976 private provider fees, as defined by the Ingenix Customized Fee
977 Analyzer Report, which percentile shall be determined by the
978 division. The schedule shall be reviewed annually by the division
979 and dental fees shall be adjusted to reflect the percentile
980 determined by the division.

981 (c) For fiscal year 2008, the amount of state
982 funds appropriated for reimbursement for dental care and surgery
983 shall be increased by ten percent (10%) of the amount of state
984 fund expenditures for that purpose for fiscal year 2007. For each
985 of fiscal years 2009 and 2010, the amount of state funds
986 appropriated for reimbursement for dental care and surgery shall
987 be increased by ten percent (10%) of the amount of state fund
988 expenditures for that purpose for the preceding fiscal year.

989 (d) The division shall establish an annual benefit
990 limit of Two Thousand Five Hundred Dollars (\$2,500.00) in dental
991 expenditures per Medicaid-eligible recipient; however, a recipient
992 may exceed the annual limit on dental expenditures provided in
993 this paragraph with prior approval of the division.



994 (e) The division shall include dental services as
995 a necessary component of overall health services provided to
996 children who are eligible for services.

997 (f) This paragraph (10) shall stand repealed on
998 July 1, 2010.

999 (11) Eyeglasses for all Medicaid beneficiaries who have
1000 (a) had surgery on the eyeball or ocular muscle that results in a
1001 vision change for which eyeglasses or a change in eyeglasses is
1002 medically indicated within six (6) months of the surgery and is in
1003 accordance with policies established by the division, or (b) one
1004 (1) pair every five (5) years and in accordance with policies
1005 established by the division. In either instance, the eyeglasses
1006 must be prescribed by a physician skilled in diseases of the eye
1007 or an optometrist, whichever the beneficiary may select.

1008 (12) Intermediate care facility services.

1009 (a) The division shall make full payment to all
1010 intermediate care facilities for the mentally retarded for each
1011 day, not exceeding eighty-four (84) days per year, that a patient
1012 is absent from the facility on home leave. Payment may be made
1013 for the following home leave days in addition to the
1014 eighty-four-day limitation: Christmas, the day before Christmas,
1015 the day after Christmas, Thanksgiving, the day before Thanksgiving
1016 and the day after Thanksgiving.

1017 (b) All state-owned intermediate care facilities
1018 for the mentally retarded shall be reimbursed on a full reasonable
1019 cost basis.

1020 (13) Family planning services, including drugs,
1021 supplies and devices, when those services are under the
1022 supervision of a physician, physician assistant or nurse
1023 practitioner.

1024 (14) Clinic services. Such diagnostic, preventive,
1025 therapeutic, rehabilitative or palliative services furnished to an
1026 outpatient by or under the supervision of a physician or dentist



1027 in a facility that is not a part of a hospital but that is
1028 organized and operated to provide medical care to outpatients.
1029 Clinic services shall include any services reimbursed as
1030 outpatient hospital services that may be rendered in such a
1031 facility, including those that become so after July 1, 1991. On
1032 July 1, 1999, all fees for physicians' services reimbursed under
1033 authority of this paragraph (14) shall be reimbursed at ninety
1034 percent (90%) of the rate established on January 1, 1999, and as
1035 may be adjusted each July thereafter, under Medicare (Title XVIII
1036 of the federal Social Security Act, as amended). The division may
1037 develop and implement a different reimbursement model or schedule
1038 for physician's services provided by physicians based at an
1039 academic health care center and by physicians at rural health
1040 centers that are associated with an academic health care center.

1041 (15) Home- and community-based services for the elderly
1042 and disabled, as provided under Title XIX of the federal Social
1043 Security Act, as amended, under waivers, subject to the
1044 availability of funds specifically appropriated for that purpose
1045 by the Legislature.

1046 (16) Mental health services. Approved therapeutic and
1047 case management services (a) provided by an approved regional
1048 mental health/retardation center established under Sections
1049 41-19-31 through 41-19-39, or by another community mental health
1050 service provider meeting the requirements of the Department of
1051 Mental Health to be an approved mental health/retardation center
1052 if determined necessary by the Department of Mental Health, using
1053 state funds that are provided from the appropriation to the State
1054 Department of Mental Health and/or funds transferred to the
1055 department by a political subdivision or instrumentality of the
1056 state and used to match federal funds under a cooperative
1057 agreement between the division and the department, or (b) provided
1058 by a facility that is certified by the State Department of Mental
1059 Health to provide therapeutic and case management services, to be



1060 reimbursed on a fee for service basis, or (c) provided in the
1061 community by a facility or program operated by the Department of
1062 Mental Health. Any such services provided by a facility described
1063 in subparagraph (b) must have the prior approval of the division
1064 to be reimbursable under this section. After June 30, 1997,
1065 mental health services provided by regional mental
1066 health/retardation centers established under Sections 41-19-31
1067 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
1068 and/or their subsidiaries and divisions, or by psychiatric
1069 residential treatment facilities as defined in Section 43-11-1, or
1070 by another community mental health service provider meeting the
1071 requirements of the Department of Mental Health to be an approved
1072 mental health/retardation center if determined necessary by the
1073 Department of Mental Health, shall not be included in or provided
1074 under any capitated managed care pilot program provided for under
1075 paragraph (24) of this section.

1076 (17) Durable medical equipment services and medical
1077 supplies. Precertification of durable medical equipment and
1078 medical supplies must be obtained as required by the division.
1079 The Division of Medicaid may require durable medical equipment
1080 providers to obtain a surety bond in the amount and to the
1081 specifications as established by the Balanced Budget Act of 1997.

1082 (18) (a) Notwithstanding any other provision of this
1083 section to the contrary, the division shall make additional
1084 reimbursement to hospitals that serve a disproportionate share of
1085 low-income patients and that meet the federal requirements for
1086 those payments as provided in Section 1923 of the federal Social
1087 Security Act and any applicable regulations. It is the intent of
1088 the Legislature that the division shall draw down all available
1089 federal funds allotted to the state for disproportionate share
1090 hospitals. However, from and after January 1, 1999, no public
1091 hospital shall participate in the Medicaid disproportionate share
1092 program unless the public hospital participates in an



1093 intergovernmental transfer program as provided in Section 1903 of
1094 the federal Social Security Act and any applicable regulations.

1095 (b) The division shall establish a Medicare Upper
1096 Payment Limits Program, as defined in Section 1902(a)(30) of the
1097 federal Social Security Act and any applicable federal
1098 regulations, for hospitals, and may establish a Medicare Upper
1099 Payment Limits Program for nursing facilities. The division shall
1100 assess each hospital and, if the program is established for
1101 nursing facilities, shall assess each nursing facility, for the
1102 sole purpose of financing the state portion of the Medicare Upper
1103 Payment Limits Program. The assessment shall be based on Medicaid
1104 utilization or other appropriate method consistent with federal
1105 regulations. The assessment will remain in effect as long as the
1106 state participates in the Medicare Upper Payment Limits Program.
1107 The division shall make additional reimbursement to hospitals and,
1108 if the program is established for nursing facilities, shall make
1109 additional reimbursement to nursing facilities, for the Medicare
1110 Upper Payment Limits, as defined in Section 1902(a)(30) of the
1111 federal Social Security Act and any applicable federal
1112 regulations.

1113 (19) (a) Perinatal risk management services. The
1114 division shall promulgate regulations to be effective from and
1115 after October 1, 1988, to establish a comprehensive perinatal
1116 system for risk assessment of all pregnant and infant Medicaid
1117 recipients and for management, education and follow-up for those
1118 who are determined to be at risk. Services to be performed
1119 include case management, nutrition assessment/counseling,
1120 psychosocial assessment/counseling and health education.

1121 (b) Early intervention system services. The
1122 division shall cooperate with the State Department of Health,
1123 acting as lead agency, in the development and implementation of a
1124 statewide system of delivery of early intervention services, under
1125 Part C of the Individuals with Disabilities Education Act (IDEA).



1126 The State Department of Health shall certify annually in writing
1127 to the executive director of the division the dollar amount of
1128 state early intervention funds available that will be utilized as
1129 a certified match for Medicaid matching funds. Those funds then
1130 shall be used to provide expanded targeted case management
1131 services for Medicaid eligible children with special needs who are
1132 eligible for the state's early intervention system.

1133 Qualifications for persons providing service coordination shall be
1134 determined by the State Department of Health and the Division of
1135 Medicaid.

1136 (20) Home- and community-based services for physically
1137 disabled approved services as allowed by a waiver from the United
1138 States Department of Health and Human Services for home- and
1139 community-based services for physically disabled people using
1140 state funds that are provided from the appropriation to the State
1141 Department of Rehabilitation Services and used to match federal
1142 funds under a cooperative agreement between the division and the
1143 department, provided that funds for these services are
1144 specifically appropriated to the Department of Rehabilitation
1145 Services.

1146 (21) Nurse practitioner services. Services furnished
1147 by a registered nurse who is licensed and certified by the
1148 Mississippi Board of Nursing as a nurse practitioner, including,
1149 but not limited to, nurse anesthetists, nurse midwives, family
1150 nurse practitioners, family planning nurse practitioners,
1151 pediatric nurse practitioners, obstetrics-gynecology nurse
1152 practitioners and neonatal nurse practitioners, under regulations
1153 adopted by the division. Reimbursement for those services shall
1154 not exceed ninety percent (90%) of the reimbursement rate for
1155 comparable services rendered by a physician.

1156 (22) Ambulatory services delivered in federally
1157 qualified health centers, rural health centers and clinics of the
1158 local health departments of the State Department of Health for



1159 individuals eligible for Medicaid under this article based on
1160 reasonable costs as determined by the division.

1161 (23) Inpatient psychiatric services. Inpatient
1162 psychiatric services to be determined by the division for
1163 recipients under age twenty-one (21) that are provided under the
1164 direction of a physician in an inpatient program in a licensed
1165 acute care psychiatric facility or in a licensed psychiatric
1166 residential treatment facility, before the recipient reaches age
1167 twenty-one (21) or, if the recipient was receiving the services
1168 immediately before he or she reached age twenty-one (21), before
1169 the earlier of the date he or she no longer requires the services
1170 or the date he or she reaches age twenty-two (22), as provided by
1171 federal regulations. Precertification of inpatient days and
1172 residential treatment days must be obtained as required by the
1173 division.

1174 (24) [Deleted]

1175 (25) [Deleted]

1176 (26) Hospice care. As used in this paragraph, the term
1177 "hospice care" means a coordinated program of active professional
1178 medical attention within the home and outpatient and inpatient
1179 care that treats the terminally ill patient and family as a unit,
1180 employing a medically directed interdisciplinary team. The
1181 program provides relief of severe pain or other physical symptoms
1182 and supportive care to meet the special needs arising out of
1183 physical, psychological, spiritual, social and economic stresses
1184 that are experienced during the final stages of illness and during
1185 dying and bereavement and meets the Medicare requirements for
1186 participation as a hospice as provided in federal regulations.

1187 (27) Group health plan premiums and cost sharing if it
1188 is cost effective as defined by the United States Secretary of
1189 Health and Human Services.

1190 (28) Other health insurance premiums that are cost
1191 effective as defined by the United States Secretary of Health and



1192 Human Services. Medicare eligible must have Medicare Part B
1193 before other insurance premiums can be paid.

1194 (29) The Division of Medicaid may apply for a waiver
1195 from the United States Department of Health and Human Services for
1196 home- and community-based services for developmentally disabled
1197 people using state funds that are provided from the appropriation
1198 to the State Department of Mental Health and/or funds transferred
1199 to the department by a political subdivision or instrumentality of
1200 the state and used to match federal funds under a cooperative
1201 agreement between the division and the department, provided that
1202 funds for these services are specifically appropriated to the
1203 Department of Mental Health and/or transferred to the department
1204 by a political subdivision or instrumentality of the state.

1205 (30) Pediatric skilled nursing services for eligible
1206 persons under twenty-one (21) years of age.

1207 (31) Targeted case management services for children
1208 with special needs, under waivers from the United States
1209 Department of Health and Human Services, using state funds that
1210 are provided from the appropriation to the Mississippi Department
1211 of Human Services and used to match federal funds under a
1212 cooperative agreement between the division and the department.

1213 (32) Care and services provided in Christian Science
1214 Sanatoria listed and certified by the Commission for Accreditation
1215 of Christian Science Nursing Organizations/Facilities, Inc.,
1216 rendered in connection with treatment by prayer or spiritual means
1217 to the extent that those services are subject to reimbursement
1218 under Section 1903 of the federal Social Security Act.

1219 (33) Podiatrist services.

1220 (34) Assisted living services as provided through home-
1221 and community-based services under Title XIX of the federal Social
1222 Security Act, as amended, subject to the availability of funds
1223 specifically appropriated for that purpose by the Legislature.



1224 (35) Services and activities authorized in Sections
1225 43-27-101 and 43-27-103, using state funds that are provided from
1226 the appropriation to the Mississippi Department of Human Services
1227 and used to match federal funds under a cooperative agreement
1228 between the division and the department.

1229 (36) Nonemergency transportation services for
1230 Medicaid-eligible persons, to be provided by the Division of
1231 Medicaid. The division may contract with additional entities to
1232 administer nonemergency transportation services as it deems
1233 necessary. All providers shall have a valid driver's license,
1234 vehicle inspection sticker, valid vehicle license tags and a
1235 standard liability insurance policy covering the vehicle. The
1236 division may pay providers a flat fee based on mileage tiers, or
1237 in the alternative, may reimburse on actual miles traveled. The
1238 division may apply to the Center for Medicare and Medicaid
1239 Services (CMS) for a waiver to draw federal matching funds for
1240 nonemergency transportation services as a covered service instead
1241 of an administrative cost. The PEER Committee shall conduct a
1242 performance evaluation of the nonemergency transportation program
1243 to evaluate the administration of the program and the providers of
1244 transportation services to determine the most cost effective ways
1245 of providing nonemergency transportation services to the patients
1246 served under the program. The performance evaluation shall be
1247 completed and provided to the members of the Senate Public Health
1248 and Welfare Committee and the House Medicaid Committee not later
1249 than January 15, 2008.

1250 (37) [Deleted]

1251 (38) Chiropractic services. A chiropractor's manual
1252 manipulation of the spine to correct a subluxation, if x-ray
1253 demonstrates that a subluxation exists and if the subluxation has
1254 resulted in a neuromusculoskeletal condition for which
1255 manipulation is appropriate treatment, and related spinal x-rays
1256 performed to document these conditions. Reimbursement for



1257 chiropractic services shall not exceed Seven Hundred Dollars
1258 (\$700.00) per year per beneficiary.

1259 (39) Dually eligible Medicare/Medicaid beneficiaries.
1260 The division shall pay the Medicare deductible and coinsurance
1261 amounts for services available under Medicare, as determined by
1262 the division.

1263 (40) [Deleted]

1264 (41) Services provided by the State Department of
1265 Rehabilitation Services for the care and rehabilitation of persons
1266 with spinal cord injuries or traumatic brain injuries, as allowed
1267 under waivers from the United States Department of Health and
1268 Human Services, using up to seventy-five percent (75%) of the
1269 funds that are appropriated to the Department of Rehabilitation
1270 Services from the Spinal Cord and Head Injury Trust Fund
1271 established under Section 37-33-261 and used to match federal
1272 funds under a cooperative agreement between the division and the
1273 department.

1274 (42) (a) Notwithstanding any other provision in this
1275 article to the contrary, the division may develop a population
1276 health management program for women and children health services
1277 through the age of one (1) year. This program is primarily for
1278 obstetrical care associated with low birth weight and pre-term
1279 babies. The division may apply to the federal Centers for
1280 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
1281 any other waivers that may enhance the program. In order to
1282 effect cost savings, the division may develop a revised payment
1283 methodology that may include at-risk capitated payments, and may
1284 require member participation in accordance with the terms and
1285 conditions of an approved federal waiver.

1286 (b) Preterm labor management services. The
1287 division shall provide reimbursement for preterm labor management
1288 services to pregnant women who are experiencing preterm labor and
1289 who meet the at-risk criteria specified by the division, with the



1290 prior authorization of the division and subject to utilization
1291 controls. Preterm labor management services include home infusion
1292 therapy, tocolytic infusion therapy, administrative services,
1293 pharmacy services, nursing visits, care coordination, supplies,
1294 equipment and telephonic care coordination. Authorized providers
1295 of these preterm labor management services shall be only the
1296 following types of providers who meet the criteria specified by
1297 the division: durable medical equipment providers, home health
1298 providers and home infusion therapy providers. The division shall
1299 prepare an annual report evaluating the medical effectiveness and
1300 cost effectiveness of the preterm labor management services
1301 reimbursed under this subparagraph (b). Nothing in this
1302 subparagraph shall be construed to establish a medical standard of
1303 care. This subparagraph shall stand repealed on July 1, 2011.

1304 (43) The division shall provide reimbursement,
1305 according to a payment schedule developed by the division, for
1306 smoking cessation medications for pregnant women during their
1307 pregnancy and other Medicaid-eligible women who are of
1308 child-bearing age.

1309 (44) Nursing facility services for the severely
1310 disabled.

1311 (a) Severe disabilities include, but are not
1312 limited to, spinal cord injuries, closed head injuries and
1313 ventilator dependent patients.

1314 (b) Those services must be provided in a long-term
1315 care nursing facility dedicated to the care and treatment of
1316 persons with severe disabilities, and shall be reimbursed as a
1317 separate category of nursing facilities.

1318 (45) Physician assistant services. Services furnished
1319 by a physician assistant who is licensed by the State Board of
1320 Medical Licensure and is practicing with physician supervision
1321 under regulations adopted by the board, under regulations adopted
1322 by the division. Reimbursement for those services shall not



1323 exceed ninety percent (90%) of the reimbursement rate for
1324 comparable services rendered by a physician.

1325 (46) The division shall make application to the federal
1326 Centers for Medicare and Medicaid Services (CMS) for a waiver to
1327 develop and provide services for children with serious emotional
1328 disturbances as defined in Section 43-14-1(1), which may include
1329 home- and community-based services, case management services or
1330 managed care services through mental health providers certified by
1331 the Department of Mental Health. The division may implement and
1332 provide services under this waived program only if funds for
1333 these services are specifically appropriated for this purpose by
1334 the Legislature, or if funds are voluntarily provided by affected
1335 agencies.

1336 (47) (a) Notwithstanding any other provision in this
1337 article to the contrary, the division may develop and implement
1338 disease management programs for individuals with high-cost chronic
1339 diseases and conditions, including the use of grants, waivers,
1340 demonstrations or other projects as necessary.

1341 (b) Participation in any disease management
1342 program implemented under this paragraph (47) is optional with the
1343 individual. An individual must affirmatively elect to participate
1344 in the disease management program in order to participate, and
1345 may elect to discontinue participation in the program at any time.

1346 (48) Pediatric long-term acute care hospital services.

1347 (a) Pediatric long-term acute care hospital
1348 services means services provided to eligible persons under
1349 twenty-one (21) years of age by a freestanding Medicare-certified
1350 hospital that has an average length of inpatient stay greater than
1351 twenty-five (25) days and that is primarily engaged in providing
1352 chronic or long-term medical care to persons under twenty-one (21)
1353 years of age.

1354 (b) The services under this paragraph (48) shall
1355 be reimbursed as a separate category of hospital services.



1356 (49) The division shall establish copayments and/or
1357 coinsurance for all Medicaid services for which copayments and/or
1358 coinsurance are allowable under federal law or regulation, and
1359 shall set the amount of the copayment and/or coinsurance for each
1360 of those services at the maximum amount allowable under federal
1361 law or regulation.

1362 (50) Services provided by the State Department of
1363 Rehabilitation Services for the care and rehabilitation of persons
1364 who are deaf and blind, as allowed under waivers from the United
1365 States Department of Health and Human Services to provide home-
1366 and community-based services using state funds that are provided
1367 from the appropriation to the State Department of Rehabilitation
1368 Services or if funds are voluntarily provided by another agency.

1369 (51) Upon determination of Medicaid eligibility and in
1370 association with annual redetermination of Medicaid eligibility,
1371 beneficiaries shall be encouraged to undertake a physical
1372 examination that will establish a base-line level of health and
1373 identification of a usual and customary source of care (a medical
1374 home) to aid utilization of disease management tools. This
1375 physical examination and utilization of these disease management
1376 tools shall be consistent with current United States Preventive
1377 Services Task Force or other recognized authority recommendations.

1378 For persons who are determined ineligible for Medicaid, the
1379 division will provide information and direction for accessing
1380 medical care and services in the area of their residence.

1381 (52) Notwithstanding any provisions of this article,
1382 the division may pay enhanced reimbursement fees related to trauma
1383 care, as determined by the division in conjunction with the State
1384 Department of Health, using funds appropriated to the State
1385 Department of Health for trauma care and services and used to
1386 match federal funds under a cooperative agreement between the
1387 division and the State Department of Health. The division, in
1388 conjunction with the State Department of Health, may use grants,



1389 waivers, demonstrations, or other projects as necessary in the
1390 development and implementation of this reimbursement program.

1391 (53) Targeted case management services for high-cost
1392 beneficiaries shall be developed by the division for all services
1393 under this section.

1394 (54) Adult foster care services pilot program. Social
1395 and protective services on a pilot program basis in an approved
1396 foster care facility for vulnerable adults who would otherwise
1397 need care in a long-term care facility, to be implemented in an
1398 area of the state with the greatest need for such program, under
1399 the Medicaid Waivers for the Elderly and Disabled program or an
1400 assisted living waiver. The division may use grants, waivers,
1401 demonstrations or other projects as necessary in the development
1402 and implementation of this adult foster care services pilot
1403 program.

1404 (55) Therapy services. The plan of care for therapy
1405 services may be developed to cover a period of treatment for up to
1406 six (6) months, but in no event shall the plan of care exceed a
1407 six-month period of treatment. The projected period of treatment
1408 must be indicated on the initial plan of care and must be updated
1409 with each subsequent revised plan of care. Based on medical
1410 necessity, the division shall approve certification periods for
1411 less than or up to six (6) months, but in no event shall the
1412 certification period exceed the period of treatment indicated on
1413 the plan of care. The appeal process for any reduction in therapy
1414 services shall be consistent with the appeal process in federal
1415 regulations.

1416 Notwithstanding any other provision of this article to the
1417 contrary, the division shall reduce the rate of reimbursement to
1418 providers for any service provided under this section by five
1419 percent (5%) of the allowed amount for that service. However, the
1420 reduction in the reimbursement rates required by this paragraph
1421 shall not apply to inpatient hospital services, nursing facility



1422 services, intermediate care facility services, psychiatric
1423 residential treatment facility services, pharmacy services
1424 provided under paragraph (9) of this section, or any service
1425 provided by the University of Mississippi Medical Center or a
1426 state agency, a state facility or a public agency that either
1427 provides its own state match through intergovernmental transfer or
1428 certification of funds to the division, or a service for which the
1429 federal government sets the reimbursement methodology and rate.
1430 In addition, the reduction in the reimbursement rates required by
1431 this paragraph shall not apply to case management services and
1432 home-delivered meals provided under the home- and community-based
1433 services program for the elderly and disabled by a planning and
1434 development district (PDD). Planning and development districts
1435 participating in the home- and community-based services program
1436 for the elderly and disabled as case management providers shall be
1437 reimbursed for case management services at the maximum rate
1438 approved by the Centers for Medicare and Medicaid Services (CMS).

1439 The division may pay to those providers who participate in
1440 and accept patient referrals from the division's emergency room
1441 redirection program a percentage, as determined by the division,
1442 of savings achieved according to the performance measures and
1443 reduction of costs required of that program. Federally qualified
1444 health centers may participate in the emergency room redirection
1445 program, and the division may pay those centers a percentage of
1446 any savings to the Medicaid program achieved by the centers'
1447 accepting patient referrals through the program, as provided in
1448 this paragraph.

1449 Notwithstanding any provision of this article, except as
1450 authorized in the following paragraph and in Section 43-13-139,
1451 neither (a) the limitations on quantity or frequency of use of or
1452 the fees or charges for any of the care or services available to
1453 recipients under this section, nor (b) the payments, payment
1454 methodology, or rates of reimbursement to providers rendering care



1455 or services authorized under this section to recipients, may be
1456 increased, decreased or otherwise changed from the levels in
1457 effect on July 1, 1999, unless they are authorized by an amendment
1458 to this section by the Legislature. However, the restriction in
1459 this paragraph shall not prevent the division from changing the
1460 payments, payment methodology, or rates of reimbursement to
1461 providers without an amendment to this section whenever those
1462 changes are required by federal law or regulation, or whenever
1463 those changes are necessary to correct administrative errors or
1464 omissions in calculating those payments or rates of reimbursement.

1465 Notwithstanding any provision of this article, no new groups
1466 or categories of recipients and new types of care and services may
1467 be added without enabling legislation from the Mississippi
1468 Legislature, except that the division may authorize those changes
1469 without enabling legislation when the addition of recipients or
1470 services is ordered by a court of proper authority.

1471 The executive director shall keep the Governor advised on a
1472 timely basis of the funds available for expenditure and the
1473 projected expenditures. If current or projected expenditures of
1474 the division are reasonably anticipated to exceed the amount of
1475 funds appropriated to the division for any fiscal year, the
1476 Governor, after consultation with the executive director, shall
1477 discontinue any or all of the payment of the types of care and
1478 services as provided in this section that are deemed to be
1479 optional services under Title XIX of the federal Social Security
1480 Act, as amended, and when necessary, shall institute any other
1481 cost containment measures on any program or programs authorized
1482 under the article to the extent allowed under the federal law
1483 governing that program or programs. However, the Governor shall
1484 not be authorized to discontinue or eliminate any service under
1485 this section that is mandatory under federal law, or to
1486 discontinue or eliminate, or adjust income limits or resource
1487 limits for, any eligibility category or group under Section



1488 43-13-115. It is the intent of the Legislature that the
1489 expenditures of the division during any fiscal year shall not
1490 exceed the amounts appropriated to the division for that fiscal
1491 year.

1492 Notwithstanding any other provision of this article, it shall
1493 be the duty of each nursing facility, intermediate care facility
1494 for the mentally retarded, psychiatric residential treatment
1495 facility, and nursing facility for the severely disabled that is
1496 participating in the Medicaid program to keep and maintain books,
1497 documents and other records as prescribed by the Division of
1498 Medicaid in substantiation of its cost reports for a period of
1499 three (3) years after the date of submission to the Division of
1500 Medicaid of an original cost report, or three (3) years after the
1501 date of submission to the Division of Medicaid of an amended cost
1502 report.

1503 **SECTION 5.** Section 43-13-117.1, Mississippi Code of 1972, is
1504 amended as follows:

1505 43-13-117.1. (1) It is the intent of the Legislature to
1506 implement a "money follows the person" process by which a portion
1507 of the money used to cover the cost of nursing facility services
1508 for Medicaid-eligible beneficiaries may be transferred to fund
1509 home- and community-based waiver services through the Elderly and
1510 Disabled Waiver, and the Assisted Living Waiver, administered by
1511 the Division of Medicaid, and the Independent Living Waiver and
1512 the Traumatic Brain Injury/Spinal Cord Injury Waiver, administered
1513 by the Department of Rehabilitation Services.

1514 (2) Notwithstanding any other state law, the Executive
1515 Director of the Division of Medicaid is authorized to transfer
1516 funds allocated for nursing facility services for
1517 Medicaid-eligible nursing facility residents to cover the cost of
1518 home- and community-based waiver services if the nursing facility
1519 resident meets the eligibility criteria for either the Independent
1520 Living Waiver, the Traumatic Brain Injury/Spinal Cord Injury



1521 Waiver, the Elderly and Disabled Waiver or the Assisted Living
1522 Waiver and the resident chooses to receive those * * *
1523 services. * * *

1524 (3) The authority of the executive director of the division
1525 to transfer funds from nursing facility services shall apply to
1526 home- and community-based waiver programs administered by the
1527 division, the Department of Rehabilitation Services and the
1528 Department of Mental Health.

1529 (4) Under the "money follows the person" process, the
1530 executive director of the division shall transfer funds to the
1531 appropriate home- and community-based waiver program administering
1532 agency to cover the cost of services provided through the Elderly
1533 and Disabled Waiver, the Independent Living Waiver, the Assisted
1534 Living Waiver, and the Traumatic Brain Injury/Spinal Cord Injury
1535 Waiver programs for Medicaid-eligible nursing facility residents
1536 who choose to leave the nursing facility and receive home- and
1537 community-based waiver services. The executive director of the
1538 division shall ensure that the amount transferred under this
1539 section is redirected to the appropriate home- and community-based
1540 waiver program in an amount sufficient to provide waiver services
1541 to each nursing facility resident upon his or her discharge from
1542 the nursing facility. The executive director shall prepare a
1543 monthly report on the pre-admission screening (PAS) process that
1544 shall include, but not be limited to, the following information:

1545 (a) The number of individuals for whom an initial PAS
1546 is completed and submitted to the division, broken down by the
1547 type of screener, including nursing facility (NF) personnel,
1548 hospital personnel, planning and development (PDD) staff or
1549 contracted entities, Department of Rehabilitation Services (DRS)
1550 staff, division staff or other contracted entities, and the place
1551 the screening occurred including home, hospital and NF;



1552 (b) The number of Medicaid-eligible individuals or
1553 those who are seeking Medicaid eligibility who are admitted to
1554 NFs;

1555 (c) The number of Medicaid-eligible individuals or
1556 those who are seeking Medicaid eligibility whose PAS assessment is
1557 completed by NF staff following admission to the NF;

1558 (d) The number of Medicaid-eligible individuals or
1559 those who are seeking Medicaid eligibility whose PAS assessment is
1560 completed by hospital staff;

1561 (e) Of the total number of individuals in paragraph
1562 (a), the number who were found eligible for NF care;

1563 (f) Of the total number of individuals in paragraph
1564 (a), the number who were found eligible for Home and Community
1565 Based Waiver (HCBW) services; and

1566 (g) The number of HCBW participants who were found
1567 ineligible for HCBW services following completion of a
1568 reevaluation using the PAS process.

1569 (5) The number of nursing facility residents who receive
1570 home- and community-based waiver services through the "money
1571 follows the person" process shall not count against the total
1572 number of individuals previously approved by the Centers for
1573 Medicare and Medicaid Services (CMS) to receive home- and
1574 community-based services through the Elderly and Disabled Waiver,
1575 the Independent Living Waiver, the Assisted Living Waiver, or the
1576 Traumatic Brain Injury/Spinal Cord Injury Waiver programs. In
1577 addition, the number of nursing facility residents who receive
1578 services as a result of the "money follows the person" process
1579 shall not count against any additional slots approved by CMS and
1580 authorized by the state as a result of prior litigation
1581 settlements reached by the state. Instead, the division shall
1582 request CMS to amend the Elderly and Disabled Waiver, the
1583 Independent Living Waiver, the Assisted Living Waiver, and the
1584 Traumatic Brain Injury/Spinal Cord Injury Waiver, as necessary, to



1585 obtain authorization from CMS to specifically serve this group of
1586 former nursing facility residents through the "money follows the
1587 person" process.

1588 (6) Rules and regulations pertaining to the implementation
1589 of the process shall be written and promulgated by the division no
1590 later than February 1, 2009. Two (2) months before implementation
1591 of the "money follows the person" process, the executive director
1592 of the division shall send a letter to all Medicaid-eligible
1593 nursing facility residents informing them of the option to obtain
1594 home- and community-based waiver services through this process and
1595 providing them with contact information for applying for home- and
1596 community-based waiver services.

1597 (7) Consistent with federal requirements, the division shall
1598 assure that necessary safeguards are taken to protect the health
1599 and safety of nursing facility residents who choose to receive
1600 home- and community-based waiver services through the "money
1601 follows the person" process. This assurance must include a formal
1602 system by which:

1603 (a) The division or its designee monitors that all
1604 provider standards and health and welfare protections are
1605 continuously met; and

1606 (b) Plans of care for waiver participants are
1607 periodically reviewed to ensure that the services furnished are
1608 consistent with the identified needs of waiver participants; and

1609 (c) All deficiencies identified through this quality
1610 monitoring system are addressed in an appropriate and timely
1611 manner, consistent with the severity and nature of the
1612 deficiencies.

1613 (8) There shall be a Money Follows the Person (MFP) Advisory
1614 Committee to make recommendations and advise the division with
1615 regard to the process mandated in this section, by which funding
1616 for nursing facility services for Medicaid-eligible beneficiaries
1617 may be used to pay for home- and community-based waiver services



1618 for those nursing facility residents who choose to receive those
1619 services. The committee shall be composed of the following
1620 individuals:

1621 (a) The respective chairmen of the House Medicaid
1622 Committee and the Senate Public Health and Welfare Committee;

1623 (b) One (1) member of the House of Representatives
1624 appointed by the Speaker of the House, and one (1) member of the
1625 Senate appointed by the Lieutenant Governor;

1626 (c) The Executive Director of the Division of Medicaid,
1627 or his designee;

1628 (d) The Executive Directors of the State Department of
1629 Mental Health and of the State Department of Rehabilitation
1630 Services, or their designees;

1631 (e) A designee of the Office of Aging of the Department
1632 of Human Services;

1633 (f) One (1) member each appointed by the Speaker of the
1634 House and the Lieutenant Governor, from among the membership of
1635 any recognized statewide association representing the concerns of
1636 the nursing facility owners and managers; and

1637 (g) One (1) member each appointed by the Chairman of
1638 the House Medicaid Committee and the Chairman of the Senate Public
1639 Health and Welfare Committee, from among members of the community
1640 representing the concerns of individuals with disabilities.

1641 (9) The executive director of the division shall report to
1642 the Attorney General the name and location of individuals who have
1643 transitioned from nursing facilities to the Elderly and Disabled
1644 Waiver, the Independent Living Waiver, the Assisted Living Waiver,
1645 and the Traumatic Brain Injury/Spinal Cord Injury Waiver programs.
1646 The director shall furnish, to each individual making such a
1647 transition and to the person who will be responsible for providing
1648 home- and community-based waiver services to the individual, the
1649 telephone number of the Attorney General's office and a copy of
1650 the Mississippi Vulnerable Adults Act contained in Sections



1651 43-47-1 through 43-47-37, with particular emphasis on the
1652 penalties imposed under that act. The Attorney General is
1653 authorized to designate members of his office to initiate
1654 follow-up visits with those individuals who have made such a
1655 transition.

1656 (10) The executive director of the division shall submit an
1657 annual report by January 1 of each year to the Legislature and to
1658 the MFP Advisory Committee concerning:

1659 (a) The number of individuals who have transitioned
1660 from nursing facilities to the Elderly and Disabled Waiver, the
1661 Independent Living Waiver, the Assisted Living Waiver, and the
1662 Traumatic Brain Injury/Spinal Cord Injury Waiver programs;

1663 (b) The number of individuals in nursing facilities who
1664 have indicated that they want to return to the community; and

1665 (c) The number of individuals on referral lists for the
1666 Elderly and Disabled Waiver, the Independent Living Waiver, the
1667 Assisted Living Waiver, and the Traumatic Brain Injury/Spinal Cord
1668 Injury Waiver programs.

1669 **SECTION 6.** Section 43-13-117.2, Mississippi Code of 1972, is
1670 brought forward as follows:

1671 43-13-117.2. The Division of Medicaid is authorized and
1672 directed to study the feasibility of implementing a pilot program
1673 to provide chronic disease management of chronic obstructive
1674 pulmonary disease (COPD) using private sources of funding in an
1675 effort to reduce the financial and clinical burden of COPD illness
1676 upon the Medicaid program and the citizens of Mississippi. If a
1677 pilot program is deemed feasible, such a program shall be
1678 implemented and a report of findings and recommendations be
1679 prepared and provided to the Office of the Governor and the
1680 Chairmen of the House and Senate Public Health and Welfare
1681 Committees and the Chairman of the House Medicaid Committee in
1682 order to evaluate the effectiveness of the pilot program in



1683 reducing costs within the Medicaid program and in providing
1684 improved health and well-being of the affected patients.

1685 **SECTION 7.** Section 43-13-117.3, Mississippi Code of 1972, is
1686 amended as follows:

1687 43-13-117.3. The Division of Medicaid, in consultation with
1688 the State Department of Health and the State Department of
1689 Rehabilitation Services, is authorized and directed to study the
1690 feasibility of implementing a pilot program to provide bariatric
1691 surgery in the morbidly obese as a treatment option in an effort
1692 to reduce the financial and clinical burden of morbid obesity upon
1693 the Medicaid program and the citizens of Mississippi. If a pilot
1694 program is deemed feasible, * * * such a program shall be
1695 implemented and a report of findings and recommendations be
1696 prepared and provided to the Office of the Governor and the
1697 Chairmen of the House and Senate Public Health and Welfare
1698 Committees and the Chairman of the House Medicaid Committee in
1699 order to evaluate the effectiveness of the pilot program.

1700 **SECTION 8.** Section 43-13-121, Mississippi Code of 1972, is
1701 brought forward as follows:

1702 43-13-121. (1) The division shall administer the Medicaid
1703 program under the provisions of this article, and may do the
1704 following:

1705 (a) Adopt and promulgate reasonable rules, regulations
1706 and standards, with approval of the Governor, and in accordance
1707 with the Administrative Procedures Law, Section 25-43-1 et seq.:

1708 (i) Establishing methods and procedures as may be
1709 necessary for the proper and efficient administration of this
1710 article;

1711 (ii) Providing Medicaid to all qualified
1712 recipients under the provisions of this article as the division
1713 may determine and within the limits of appropriated funds;

1714 (iii) Establishing reasonable fees, charges and
1715 rates for medical services and drugs; in doing so, the division



1716 shall fix all of those fees, charges and rates at the minimum
1717 levels absolutely necessary to provide the medical assistance
1718 authorized by this article, and shall not change any of those
1719 fees, charges or rates except as may be authorized in Section
1720 43-13-117;

1721 (iv) Providing for fair and impartial hearings;

1722 (v) Providing safeguards for preserving the
1723 confidentiality of records; and

1724 (vi) For detecting and processing fraudulent
1725 practices and abuses of the program;

1726 (b) Receive and expend state, federal and other funds
1727 in accordance with court judgments or settlements and agreements
1728 between the State of Mississippi and the federal government, the
1729 rules and regulations promulgated by the division, with the
1730 approval of the Governor, and within the limitations and
1731 restrictions of this article and within the limits of funds
1732 available for that purpose;

1733 (c) Subject to the limits imposed by this article, to
1734 submit a Medicaid plan to the United States Department of Health
1735 and Human Services for approval under the provisions of the
1736 federal Social Security Act, to act for the state in making
1737 negotiations relative to the submission and approval of that plan,
1738 to make such arrangements, not inconsistent with the law, as may
1739 be required by or under federal law to obtain and retain that
1740 approval and to secure for the state the benefits of the
1741 provisions of that law.

1742 No agreements, specifically including the general plan for
1743 the operation of the Medicaid program in this state, shall be made
1744 by and between the division and the United States Department of
1745 Health and Human Services unless the Attorney General of the State
1746 of Mississippi has reviewed the agreements, specifically including
1747 the operational plan, and has certified in writing to the Governor
1748 and to the executive director of the division that the agreements,



1749 including the plan of operation, have been drawn strictly in
1750 accordance with the terms and requirements of this article;

1751 (d) In accordance with the purposes and intent of this
1752 article and in compliance with its provisions, provide for aged
1753 persons otherwise eligible for the benefits provided under Title
1754 XVIII of the federal Social Security Act by expenditure of funds
1755 available for those purposes;

1756 (e) To make reports to the United States Department of
1757 Health and Human Services as from time to time may be required by
1758 that federal department and to the Mississippi Legislature as
1759 provided in this section;

1760 (f) Define and determine the scope, duration and amount
1761 of Medicaid that may be provided in accordance with this article
1762 and establish priorities therefor in conformity with this article;

1763 (g) Cooperate and contract with other state agencies
1764 for the purpose of coordinating Medicaid provided under this
1765 article and eliminating duplication and inefficiency in the
1766 Medicaid program;

1767 (h) Adopt and use an official seal of the division;

1768 (i) Sue in its own name on behalf of the State of
1769 Mississippi and employ legal counsel on a contingency basis with
1770 the approval of the Attorney General;

1771 (j) To recover any and all payments incorrectly made by
1772 the division to a recipient or provider from the recipient or
1773 provider receiving the payments. To recover those payments, the
1774 division may use the following methods, in addition to any other
1775 methods available to the division:

1776 (i) The division shall report to the State Tax
1777 Commission the name of any current or former Medicaid recipient
1778 who has received medical services rendered during a period of
1779 established Medicaid ineligibility and who has not reimbursed the
1780 division for the related medical service payment(s). The State
1781 Tax Commission shall withhold from the state tax refund of the



1782 individual, and pay to the division, the amount of the payment(s)
1783 for medical services rendered to the ineligible individual that
1784 have not been reimbursed to the division for the related medical
1785 service payment(s).

1786 (ii) The division shall report to the State Tax
1787 Commission the name of any Medicaid provider to whom payments were
1788 incorrectly made that the division has not been able to recover by
1789 other methods available to the division. The State Tax Commission
1790 shall withhold from the state tax refund of the provider, and pay
1791 to the division, the amount of the payments that were incorrectly
1792 made to the provider that have not been recovered by other
1793 available methods;

1794 (k) To recover any and all payments by the division
1795 fraudulently obtained by a recipient or provider. Additionally,
1796 if recovery of any payments fraudulently obtained by a recipient
1797 or provider is made in any court, then, upon motion of the
1798 Governor, the judge of the court may award twice the payments
1799 recovered as damages;

1800 (l) Have full, complete and plenary power and authority
1801 to conduct such investigations as it may deem necessary and
1802 requisite of alleged or suspected violations or abuses of the
1803 provisions of this article or of the regulations adopted under
1804 this article, including, but not limited to, fraudulent or
1805 unlawful act or deed by applicants for Medicaid or other benefits,
1806 or payments made to any person, firm or corporation under the
1807 terms, conditions and authority of this article, to suspend or
1808 disqualify any provider of services, applicant or recipient for
1809 gross abuse, fraudulent or unlawful acts for such periods,
1810 including permanently, and under such conditions as the division
1811 deems proper and just, including the imposition of a legal rate of
1812 interest on the amount improperly or incorrectly paid. Recipients
1813 who are found to have misused or abused Medicaid benefits may be
1814 locked into one (1) physician and/or one (1) pharmacy of the



1815 recipient's choice for a reasonable amount of time in order to
1816 educate and promote appropriate use of medical services, in
1817 accordance with federal regulations. If an administrative hearing
1818 becomes necessary, the division may, if the provider does not
1819 succeed in his or her defense, tax the costs of the administrative
1820 hearing, including the costs of the court reporter or stenographer
1821 and transcript, to the provider. The convictions of a recipient
1822 or a provider in a state or federal court for abuse, fraudulent or
1823 unlawful acts under this chapter shall constitute an automatic
1824 disqualification of the recipient or automatic disqualification of
1825 the provider from participation under the Medicaid program.

1826 A conviction, for the purposes of this chapter, shall include
1827 a judgment entered on a plea of nolo contendere or a
1828 nonadjudicated guilty plea and shall have the same force as a
1829 judgment entered pursuant to a guilty plea or a conviction
1830 following trial. A certified copy of the judgment of the court of
1831 competent jurisdiction of the conviction shall constitute prima
1832 facie evidence of the conviction for disqualification purposes;

1833 (m) Establish and provide such methods of
1834 administration as may be necessary for the proper and efficient
1835 operation of the Medicaid program, fully utilizing computer
1836 equipment as may be necessary to oversee and control all current
1837 expenditures for purposes of this article, and to closely monitor
1838 and supervise all recipient payments and vendors rendering
1839 services under this article;

1840 (n) To cooperate and contract with the federal
1841 government for the purpose of providing Medicaid to Vietnamese and
1842 Cambodian refugees, under the provisions of Public Law 94-23 and
1843 Public Law 94-24, including any amendments to those laws, only to
1844 the extent that the Medicaid assistance and the administrative
1845 cost related thereto are one hundred percent (100%) reimbursable
1846 by the federal government. For the purposes of Section 43-13-117,
1847 persons receiving Medicaid under Public Law 94-23 and Public Law



1848 94-24, including any amendments to those laws, shall not be
1849 considered a new group or category of recipient; and

1850 (o) The division shall impose penalties upon Medicaid
1851 only, Title XIX participating long-term care facilities found to
1852 be in noncompliance with division and certification standards in
1853 accordance with federal and state regulations, including interest
1854 at the same rate calculated by the United States Department of
1855 Health and Human Services and/or the Centers for Medicare and
1856 Medicaid Services (CMS) under federal regulations.

1857 (2) The division also shall exercise such additional powers
1858 and perform such other duties as may be conferred upon the
1859 division by act of the Legislature.

1860 (3) The division, and the State Department of Health as the
1861 agency for licensure of health care facilities and certification
1862 and inspection for the Medicaid and/or Medicare programs, shall
1863 contract for or otherwise provide for the consolidation of on-site
1864 inspections of health care facilities that are necessitated by the
1865 respective programs and functions of the division and the
1866 department.

1867 (4) The division and its hearing officers shall have power
1868 to preserve and enforce order during hearings; to issue subpoenas
1869 for, to administer oaths to and to compel the attendance and
1870 testimony of witnesses, or the production of books, papers,
1871 documents and other evidence, or the taking of depositions before
1872 any designated individual competent to administer oaths; to
1873 examine witnesses; and to do all things conformable to law that
1874 may be necessary to enable them effectively to discharge the
1875 duties of their office. In compelling the attendance and
1876 testimony of witnesses, or the production of books, papers,
1877 documents and other evidence, or the taking of depositions, as
1878 authorized by this section, the division or its hearing officers
1879 may designate an individual employed by the division or some other
1880 suitable person to execute and return that process, whose action



1881 in executing and returning that process shall be as lawful as if
1882 done by the sheriff or some other proper officer authorized to
1883 execute and return process in the county where the witness may
1884 reside. In carrying out the investigatory powers under the
1885 provisions of this article, the executive director or other
1886 designated person or persons may examine, obtain, copy or
1887 reproduce the books, papers, documents, medical charts,
1888 prescriptions and other records relating to medical care and
1889 services furnished by the provider to a recipient or designated
1890 recipients of Medicaid services under investigation. In the
1891 absence of the voluntary submission of the books, papers,
1892 documents, medical charts, prescriptions and other records, the
1893 Governor, the executive director, or other designated person may
1894 issue and serve subpoenas instantly upon the provider, his or her
1895 agent, servant or employee for the production of the books,
1896 papers, documents, medical charts, prescriptions or other records
1897 during an audit or investigation of the provider. If any provider
1898 or his or her agent, servant or employee refuses to produce the
1899 records after being duly subpoenaed, the executive director may
1900 certify those facts and institute contempt proceedings in the
1901 manner, time and place as authorized by law for administrative
1902 proceedings. As an additional remedy, the division may recover
1903 all amounts paid to the provider covering the period of the audit
1904 or investigation, inclusive of a legal rate of interest and a
1905 reasonable attorney's fee and costs of court if suit becomes
1906 necessary. Division staff shall have immediate access to the
1907 provider's physical location, facilities, records, documents,
1908 books, and any other records relating to medical care and services
1909 rendered to recipients during regular business hours.

1910 (5) If any person in proceedings before the division
1911 disobeys or resists any lawful order or process, or misbehaves
1912 during a hearing or so near the place thereof as to obstruct the
1913 hearing, or neglects to produce, after having been ordered to do



1914 so, any pertinent book, paper or document, or refuses to appear
1915 after having been subpoenaed, or upon appearing refuses to take
1916 the oath as a witness, or after having taken the oath refuses to
1917 be examined according to law, the executive director shall certify
1918 the facts to any court having jurisdiction in the place in which
1919 it is sitting, and the court shall thereupon, in a summary manner,
1920 hear the evidence as to the acts complained of, and if the
1921 evidence so warrants, punish that person in the same manner and to
1922 the same extent as for a contempt committed before the court, or
1923 commit that person upon the same condition as if the doing of the
1924 forbidden act had occurred with reference to the process of, or in
1925 the presence of, the court.

1926 (6) In suspending or terminating any provider from
1927 participation in the Medicaid program, the division shall preclude
1928 the provider from submitting claims for payment, either personally
1929 or through any clinic, group, corporation or other association to
1930 the division or its fiscal agents for any services or supplies
1931 provided under the Medicaid program except for those services or
1932 supplies provided before the suspension or termination. No
1933 clinic, group, corporation or other association that is a provider
1934 of services shall submit claims for payment to the division or its
1935 fiscal agents for any services or supplies provided by a person
1936 within that organization who has been suspended or terminated from
1937 participation in the Medicaid program except for those services or
1938 supplies provided before the suspension or termination. When this
1939 provision is violated by a provider of services that is a clinic,
1940 group, corporation or other association, the division may suspend
1941 or terminate that organization from participation. Suspension may
1942 be applied by the division to all known affiliates of a provider,
1943 provided that each decision to include an affiliate is made on a
1944 case-by-case basis after giving due regard to all relevant facts
1945 and circumstances. The violation, failure or inadequacy of
1946 performance may be imputed to a person with whom the provider is



1947 affiliated where that conduct was accomplished within the course
1948 of his or her official duty or was effectuated by him or her with
1949 the knowledge or approval of that person.

1950 (7) The division may deny or revoke enrollment in the
1951 Medicaid program to a provider if any of the following are found
1952 to be applicable to the provider, his or her agent, a managing
1953 employee or any person having an ownership interest equal to five
1954 percent (5%) or greater in the provider:

1955 (a) Failure to truthfully or fully disclose any and all
1956 information required, or the concealment of any and all
1957 information required, on a claim, a provider application or a
1958 provider agreement, or the making of a false or misleading
1959 statement to the division relative to the Medicaid program.

1960 (b) Previous or current exclusion, suspension,
1961 termination from or the involuntary withdrawing from participation
1962 in the Medicaid program, any other state's Medicaid program,
1963 Medicare or any other public or private health or health insurance
1964 program. If the division ascertains that a provider has been
1965 convicted of a felony under federal or state law for an offense
1966 that the division determines is detrimental to the best interest
1967 of the program or of Medicaid beneficiaries, the division may
1968 refuse to enter into an agreement with that provider, or may
1969 terminate or refuse to renew an existing agreement.

1970 (c) Conviction under federal or state law of a criminal
1971 offense relating to the delivery of any goods, services or
1972 supplies, including the performance of management or
1973 administrative services relating to the delivery of the goods,
1974 services or supplies, under the Medicaid program, any other
1975 state's Medicaid program, Medicare or any other public or private
1976 health or health insurance program.

1977 (d) Conviction under federal or state law of a criminal
1978 offense relating to the neglect or abuse of a patient in
1979 connection with the delivery of any goods, services or supplies.



1980 (e) Conviction under federal or state law of a criminal
1981 offense relating to the unlawful manufacture, distribution,
1982 prescription or dispensing of a controlled substance.

1983 (f) Conviction under federal or state law of a criminal
1984 offense relating to fraud, theft, embezzlement, breach of
1985 fiduciary responsibility or other financial misconduct.

1986 (g) Conviction under federal or state law of a criminal
1987 offense punishable by imprisonment of a year or more that involves
1988 moral turpitude, or acts against the elderly, children or infirm.

1989 (h) Conviction under federal or state law of a criminal
1990 offense in connection with the interference or obstruction of any
1991 investigation into any criminal offense listed in paragraphs (c)
1992 through (i) of this subsection.

1993 (i) Sanction for a violation of federal or state laws
1994 or rules relative to the Medicaid program, any other state's
1995 Medicaid program, Medicare or any other public health care or
1996 health insurance program.

1997 (j) Revocation of license or certification.

1998 (k) Failure to pay recovery properly assessed or
1999 pursuant to an approved repayment schedule under the Medicaid
2000 program.

2001 (l) Failure to meet any condition of enrollment.

2002 **SECTION 9.** Section 43-13-122, Mississippi Code of 1972, is
2003 brought forward as follows:

2004 43-13-122. (1) The division is authorize to apply to the
2005 Center for Medicare and Medicaid Services of the United States
2006 Department of Health and Human Services for waivers and research
2007 and demonstration grants.

2008 (2) The division is further authorized to accept and expend
2009 any grants, donations or contributions from any public or private
2010 organization together with any additional federal matching funds
2011 that may accrue and including, but not limited to, one hundred
2012 percent (100%) federal grant funds or funds from any governmental



2013 entity or instrumentality thereof in furthering the purposes and
2014 objectives of the Mississippi Medicaid program, provided that such
2015 receipts and expenditures are reported and otherwise handled in
2016 accordance with the General Fund Stabilization Act. The
2017 Department of Finance and Administration is authorized to transfer
2018 monies to the division from special funds in the State Treasury in
2019 amounts not exceeding the amounts authorized in the appropriation
2020 to the division.

2021 **SECTION 10.** Section 43-13-125, Mississippi Code of 1972, is
2022 brought forward as follows:

2023 43-13-125. (1) If Medicaid is provided to a recipient under
2024 this article for injuries, disease or sickness caused under
2025 circumstances creating a cause of action in favor of the recipient
2026 against any person, firm or corporation, then the division shall
2027 be entitled to recover the proceeds that may result from the
2028 exercise of any rights of recovery that the recipient may have
2029 against any such person, firm or corporation to the extent of the
2030 Division of Medicaid's interest on behalf of the recipient. The
2031 recipient shall execute and deliver instruments and papers to do
2032 whatever is necessary to secure those rights and shall do nothing
2033 after Medicaid is provided to prejudice the subrogation rights of
2034 the division. Court orders or agreements for reimbursement of
2035 Medicaid's interest shall direct those payments to the Division of
2036 Medicaid, which shall be authorized to endorse any and all,
2037 including, but not limited to, multi-payee checks, drafts, money
2038 orders, or other negotiable instruments representing Medicaid
2039 payment recoveries that are received. In accordance with Section
2040 43-13-305, endorsement of multi-payee checks, drafts, money orders
2041 or other negotiable instruments by the Division of Medicaid shall
2042 be deemed endorsed by the recipient.

2043 The division, with the approval of the Governor, may
2044 compromise or settle any such claim and execute a release of any
2045 claim it has by virtue of this section.



2046 (2) The acceptance of Medicaid under this article or the
2047 making of a claim under this article shall not affect the right of
2048 a recipient or his or her legal representative to recover
2049 Medicaid's interest as an element of damages in any action at law;
2050 however, a copy of the pleadings shall be certified to the
2051 division at the time of the institution of suit, and proof of
2052 that notice shall be filed of record in that action. The division
2053 may, at any time before the trial on the facts, join in that
2054 action or may intervene in that action. Any amount recovered by a
2055 recipient or his or her legal representative shall be applied as
2056 follows:

2057 (a) The reasonable costs of the collection, including
2058 attorney's fees, as approved and allowed by the court in which
2059 that action is pending, or in case of settlement without suit, by
2060 the legal representative of the division;

2061 (b) The amount of Medicaid's interest on behalf of the
2062 recipient; or such pro rata amount as may be arrived at by the
2063 legal representative of the division and the recipient's attorney,
2064 or as set by the court having jurisdiction; and

2065 (c) Any excess shall be awarded to the recipient.

2066 (3) No compromise of any claim by the recipient or his or
2067 her legal representative shall be binding upon or affect the
2068 rights of the division against the third party unless the
2069 division, with the approval of the Governor, has entered into the
2070 compromise. Any compromise effected by the recipient or his or
2071 her legal representative with the third party in the absence of
2072 advance notification to and approved by the division shall
2073 constitute conclusive evidence of the liability of the third
2074 party, and the division, in litigating its claim against the third
2075 party, shall be required only to prove the amount and correctness
2076 of its claim relating to the injury, disease or sickness. If the
2077 recipient or his or her legal representative fails to notify the
2078 division of the institution of legal proceedings against a third



2079 party for which the division has a cause of action, the facts
2080 relating to negligence and the liability of the third party, if
2081 judgment is rendered for the recipient, shall constitute
2082 conclusive evidence of liability in a subsequent action maintained
2083 by the division and only the amount and correctness of the
2084 division's claim relating to injuries, disease or sickness shall
2085 be tried before the court. The division shall be authorized in
2086 bringing that action against the third party and his or her
2087 insurer jointly or against the insurer alone.

2088 (4) Nothing in this section shall be construed to diminish
2089 or otherwise restrict the subrogation rights of the Division of
2090 Medicaid against a third party for Medicaid provided by the
2091 Division of Medicaid to the recipient as a result of injuries,
2092 disease or sickness caused under circumstances creating a cause of
2093 action in favor of the recipient against such a third party.

2094 (5) Any amounts recovered by the division under this section
2095 shall, by the division, be placed to the credit of the funds
2096 appropriated for benefits under this article proportionate to the
2097 amounts provided by the state and federal governments
2098 respectively.

2099 **SECTION 11.** Section 43-13-126, Mississippi Code of 1972, is
2100 brought forward as follows:

2101 43-13-126. As a condition of doing business in the state,
2102 health insurers, including self-insured plans, group health plans
2103 (as defined in Section 607(1) of the Employee Retirement Income
2104 Security Act of 1974), service benefit plans, managed care
2105 organizations, pharmacy benefit managers, or other parties that
2106 are by statute, contract, or agreement, legally responsible for
2107 payment of a claim for a health care item or service, are required
2108 to:

2109 (a) Provide, with respect to individuals who are
2110 eligible for, or are provided, medical assistance under the state
2111 plan, upon the request of the Division of Medicaid, information to



2112 determine during what period the individual or their spouses or
2113 their dependents may be (or may have been) covered by a health
2114 insurer and the nature of the coverage that is or was provided by
2115 the health insurer (including the name, address and identifying
2116 number of the plan) in a manner prescribed by the Secretary of the
2117 Department of Health and Human Services;

2118 (b) Accept the Division of Medicaid's right of recovery
2119 and the assignment to the division of any right of an individual
2120 or other entity to payment from the party for an item or service
2121 for which payment has been made under the state plan;

2122 (c) Respond to any inquiry by the Division of Medicaid
2123 regarding a claim for payment for any health care item or service
2124 that is submitted not later than three (3) years after the date of
2125 the provision of that health care item or service; and

2126 (d) Agree not to deny a claim submitted by the Division
2127 of Medicaid solely on the basis of the date of submission of the
2128 claim, the type or format of the claim form, or a failure to
2129 present proper documentation at the point of sale that is the
2130 basis of the claim, if:

2131 (i) The claim is submitted by the division within
2132 the three-year period beginning on the date on which the item or
2133 service was furnished; and

2134 (ii) Any action by the division to enforce its
2135 rights with respect to the claim is begun within six (6) years of
2136 the division's submission of the claim.

2137 **SECTION 12.** Section 43-13-129, Mississippi Code of 1972, is
2138 brought forward as follows:

2139 43-13-129. Any person making application for benefits under
2140 this article for himself or for another person, and any provider
2141 of services, who knowingly makes a false statement or false
2142 representation or fails to disclose a material fact to obtain or
2143 increase any benefit or payment under this article shall be guilty
2144 of a misdemeanor and, upon conviction thereof, shall be punished



2145 by a fine not to exceed Five Hundred Dollars (\$500.00) or
2146 imprisoned not to exceed one (1) year, or by both such fine and
2147 imprisonment. Each false statement or false representation or
2148 failure to disclose a material fact shall constitute a separate
2149 offense. This section shall not prohibit prosecution under any
2150 other criminal statutes of this state or the United States.

2151 **SECTION 13.** Section 43-13-131, Mississippi Code of 1972, is
2152 brought forward as follows:

2153 43-13-131. Any person who shall, through intentional
2154 misrepresentation, fraud, deceit or unlawful design, either acting
2155 individually or in concert with others, influence any recipient to
2156 elect any particular provider of services, or any particular type
2157 of services, for the purposes and with the intent to obtain or
2158 increase any benefit or payment under this article shall be guilty
2159 of a misdemeanor and, upon conviction thereof, shall be punished
2160 by a fine not exceeding Five Hundred Dollars (\$500.00) or
2161 imprisonment not exceeding one (1) year, or by both such fine and
2162 imprisonment. This section shall not prohibit prosecution under
2163 any other criminal statutes of this state or the United States.

2164 **SECTION 14.** Section 43-13-143, Mississippi Code of 1972, is
2165 brought forward as follows:

2166 43-13-143. There is created in the State Treasury a special
2167 fund to be known as the "Medical Care Fund," which shall be
2168 comprised of monies transferred by public or private health care
2169 providers, governing bodies of counties, municipalities, public or
2170 community hospitals and other political subdivisions of the state,
2171 individuals, corporations, associations and any other entities for
2172 the purpose of providing health care services. Any transfer made
2173 to the fund shall be paid to the State Treasurer for deposit into
2174 the fund, and all such transfers shall be considered as
2175 unconditional transfers to the fund. The monies in the Medical
2176 Care Fund shall be expended only for health care services, and may
2177 be expended only upon appropriation of the Legislature. All



2178 transfers of monies to the Division of Medicaid by health care
2179 providers and by governing bodies of counties, municipalities,
2180 public or community hospitals and other political subdivisions of
2181 the state shall be deposited into the fund. Unexpended monies
2182 remaining in the fund at the end of a fiscal year shall not lapse
2183 into the State General Fund, and any interest earned on monies in
2184 the fund shall be deposited to the credit of the fund.

2185 **SECTION 15.** Section 43-13-145, Mississippi Code of 1972, is
2186 brought forward as follows:

2187 43-13-145. (1) (a) Upon each nursing facility licensed by
2188 the State of Mississippi, there is levied an assessment in an
2189 amount set by the division, not exceeding the maximum rate allowed
2190 by federal law or regulation, for each licensed and occupied bed
2191 of the facility.

2192 (b) A nursing facility is exempt from the assessment
2193 levied under this subsection if the facility is operated under the
2194 direction and control of:

2195 (i) The United States Veterans Administration or
2196 other agency or department of the United States government;

2197 (ii) The State Veterans Affairs Board;

2198 (iii) The University of Mississippi Medical
2199 Center; or

2200 (iv) A state agency or a state facility that
2201 either provides its own state match through intergovernmental
2202 transfer or certification of funds to the division.

2203 (2) (a) Upon each intermediate care facility for the
2204 mentally retarded licensed by the State of Mississippi, there is
2205 levied an assessment in an amount set by the division, not
2206 exceeding the maximum rate allowed by federal law or regulation,
2207 for each licensed and occupied bed of the facility.

2208 (b) An intermediate care facility for the mentally
2209 retarded is exempt from the assessment levied under this



2210 subsection if the facility is operated under the direction and
2211 control of:

2212 (i) The United States Veterans Administration or
2213 other agency or department of the United States government;

2214 (ii) The State Veterans Affairs Board; or

2215 (iii) The University of Mississippi Medical
2216 Center.

2217 (3) (a) Upon each psychiatric residential treatment
2218 facility licensed by the State of Mississippi, there is levied an
2219 assessment in an amount set by the division, not exceeding the
2220 maximum rate allowed by federal law or regulation, for each
2221 licensed and occupied bed of the facility.

2222 (b) A psychiatric residential treatment facility is
2223 exempt from the assessment levied under this subsection if the
2224 facility is operated under the direction and control of:

2225 (i) The United States Veterans Administration or
2226 other agency or department of the United States government;

2227 (ii) The University of Mississippi Medical Center;

2228 (iii) A state agency or a state facility that
2229 either provides its own state match through intergovernmental
2230 transfer or certification of funds to the division.

2231 (4) (a) Upon each hospital licensed by the State of
2232 Mississippi, there is levied an assessment in the amount of Three
2233 Dollars and Twenty-five Cents (\$3.25) per bed for each licensed
2234 inpatient acute care bed of the hospital.

2235 (b) A hospital is exempt from the assessment levied
2236 under this subsection if the hospital is operated under the
2237 direction and control of:

2238 (i) The United States Veterans Administration or
2239 other agency or department of the United States government;

2240 (ii) The University of Mississippi Medical Center;

2241 or



2242 (iii) A state agency or a state facility that
2243 either provides its own state match through intergovernmental
2244 transfer or certification of funds to the division.

2245 (5) Each health care facility that is subject to the
2246 provisions of this section shall keep and preserve such suitable
2247 books and records as may be necessary to determine the amount of
2248 assessment for which it is liable under this section. The books
2249 and records shall be kept and preserved for a period of not less
2250 than five (5) years, and those books and records shall be open for
2251 examination during business hours by the division, the State Tax
2252 Commission, the Office of the Attorney General and the State
2253 Department of Health.

2254 (6) The assessment levied under this section shall be
2255 collected by the division each month beginning on March 31, 2005.

2256 (7) All assessments collected under this section shall be
2257 deposited in the Medical Care Fund created by Section 43-13-143.

2258 (8) The assessment levied under this section shall be in
2259 addition to any other assessments, taxes or fees levied by law,
2260 and the assessment shall constitute a debt due the State of
2261 Mississippi from the time the assessment is due until it is paid.

2262 (9) (a) If a health care facility that is liable for
2263 payment of an assessment levied by the division does not pay the
2264 assessment when it is due, the division shall give written notice
2265 to the health care facility by certified or registered mail
2266 demanding payment of the assessment within ten (10) days from the
2267 date of delivery of the notice. If the health care facility
2268 fails or refuses to pay the assessment after receiving the notice
2269 and demand from the division, the division shall withhold from any
2270 Medicaid reimbursement payments that are due to the health care
2271 facility the amount of the unpaid assessment and a penalty of ten
2272 percent (10%) of the amount of the assessment, plus the legal rate
2273 of interest until the assessment is paid in full. If the health
2274 care facility does not participate in the Medicaid program, the



2275 division shall turn over to the Office of the Attorney General the
2276 collection of the unpaid assessment by civil action. In any such
2277 civil action, the Office of the Attorney General shall collect the
2278 amount of the unpaid assessment and a penalty of ten percent (10%)
2279 of the amount of the assessment, plus the legal rate of interest
2280 until the assessment is paid in full.

2281 (b) As an additional or alternative method for
2282 collecting unpaid assessments levied by the division, if a health
2283 care facility fails or refuses to pay the assessment after
2284 receiving notice and demand from the division, the division may
2285 file a notice of a tax lien with the circuit clerk of the county
2286 in which the health care facility is located, for the amount of
2287 the unpaid assessment and a penalty of ten percent (10%) of the
2288 amount of the assessment, plus the legal rate of interest until
2289 the assessment is paid in full. Immediately upon receipt of
2290 notice of the tax lien for the assessment, the circuit clerk shall
2291 enter the notice of the tax lien as a judgment upon the judgment
2292 roll and show in the appropriate columns the name of the health
2293 care facility as judgment debtor, the name of the division as
2294 judgment creditor, the amount of the unpaid assessment, and the
2295 date and time of enrollment. The judgment shall be valid as
2296 against mortgagees, pledgees, entrusters, purchasers, judgment
2297 creditors and other persons from the time of filing with the
2298 clerk. The amount of the judgment shall be a debt due the State
2299 of Mississippi and remain a lien upon the tangible property of the
2300 health care facility until the judgment is satisfied. The
2301 judgment shall be the equivalent of any enrolled judgment of a
2302 court of record and shall serve as authority for the issuance of
2303 writs of execution, writs of attachment or other remedial writs.

2304 **SECTION 16.** Section 43-13-213, Mississippi Code of 1972, is
2305 amended as follows:



2306 43-13-213. (1) A person shall not make, present or cause to
2307 be made or presented a claim for Medicaid benefits, knowing the
2308 claim to be false, fictitious or fraudulent.

2309 (2) Any person who:

2310 (a) Knowingly presents, or causes to be presented, to
2311 an officer, employee or agent of the State of Mississippi, a false
2312 or fraudulent claim for payment or approval;

2313 (b) Knowingly makes, uses, or causes to be made or
2314 used, a false record or statement to get a false or fraudulent
2315 claim paid or approved by the State of Mississippi;

2316 (c) Conspires to defraud the State of Mississippi by
2317 getting a false or fraudulent claim allowed or paid;

2318 (d) Has possession, custody, or control of property or
2319 money used, or to be used, by the State of Mississippi and,
2320 intending to defraud the State of Mississippi or willfully to
2321 conceal the property, delivers, or causes to be delivered, less
2322 property than the amount for which the person receives a
2323 certificate or receipt;

2324 (e) Authorizes to make or deliver a document certifying
2325 receipt of property used, or to be used, by the State of
2326 Mississippi and, intending to defraud the State of Mississippi,
2327 makes or delivers the receipt without completely knowing that the
2328 information on the receipt is true;

2329 (f) Knowingly buys, or receives as a pledge of an
2330 obligation or debt, public property from an officer, employee or
2331 agent of the State of Mississippi, who lawfully may not sell or
2332 pledge the property; or

2333 (g) Knowingly makes, uses, or causes to be made or
2334 used, a false record or statement to conceal, avoid, or decrease
2335 an obligation to pay or transmit money or property to the State of
2336 Mississippi;

2337 is liable to the State of Mississippi for a civil penalty of not
2338 less than Five Thousand Dollars (\$5,000.00) and not more than Ten



2339 Thousand Dollars (\$10,000.00), plus three (3) times the amount of
2340 damages that the state sustains because of the act of that person,
2341 except that if the court finds that:

2342 (i) The person committing the violation of this
2343 subsection furnished officials of the State of Mississippi
2344 responsible for investigating false claims violations with all
2345 information known to the person about the violation within thirty
2346 (30) days after the date on which the defendant first obtained the
2347 information;

2348 (ii) The person fully cooperated with any
2349 investigation of such violation; and

2350 (iii) At the time the person furnished the State
2351 of Mississippi with the information about the violation, no
2352 criminal prosecution, civil action or administrative action had
2353 begun under this chapter with respect to the violation, and the
2354 person did not have actual knowledge of the existence of an
2355 investigation into the violation;

2356 the court may assess not less than two (2) times the amount of
2357 damages that the state sustains because of the act of the person.
2358 A person violating this subsection shall also be liable to the
2359 United States government for the costs of a civil action brought
2360 to recover any such penalty or damages.

2361 (3) For purposes of this section, the terms "knowing" and
2362 "knowingly" mean that a person, with respect to information:

2363 (a) Has actual knowledge of the information;

2364 (b) Acts in deliberate ignorance of the truth or
2365 falsity of the information; or

2366 (c) Acts in reckless disregard of the truth or falsity
2367 of the information, and no proof of specific intent to defraud is
2368 required.

2369 (4) For purposes of this section, "claim" includes any
2370 request or demand, whether under a contract or otherwise, for
2371 money or property that is made to a contractor, grantee or other



2372 recipient if the State of Mississippi provides any portion of the
2373 money or property that is requested or demanded, or if the state
2374 will reimburse the contractor, grantee or other recipient for any
2375 portion of the money or property that is requested or demanded.

2376 (5) Any information furnished under paragraphs (a) through
2377 (c) of subsection (3) shall be exempt from disclosure under the
2378 Mississippi Public Records Act.

2379 **SECTION 17.** The following shall be codified as Section
2380 43-13-221.1, Mississippi Code of 1972:

2381 43-13-221.1. (1) (a) A person may bring a civil action for
2382 a violation of the provisions of this article for the person and
2383 for the State of Mississippi. The action shall be brought in the
2384 name of the State of Mississippi. The action may be dismissed
2385 only if the court and the Attorney General give written consent to
2386 the dismissal and their reasons for consenting.

2387 (b) A copy of the complaint and written disclosure of
2388 substantially all material evidence and information the person
2389 possesses shall be served on the Attorney General, on behalf of
2390 the state, under the Mississippi Rules of Civil Procedure. The
2391 complaint shall be filed in camera, shall remain under seal for at
2392 least sixty (60) days, and shall not be served on the defendant
2393 until the court so orders. The state may elect to intervene and
2394 proceed with the action within sixty (60) days after it receives
2395 both the complaint and the material evidence and information.

2396 (c) The state may, for good cause shown, move the court
2397 for extensions of the time during which the complaint remains
2398 under seal under subsection (2). Any such motions may be
2399 supported by affidavits or other submissions in camera. The
2400 defendant shall not be required to respond to any complaint filed
2401 under this section until thirty (30) days after the complaint is
2402 unsealed and served upon the defendant under the Mississippi Rules
2403 of Civil Procedure.



2404 (d) Before the expiration of the sixty-day period or
2405 any extensions obtained under paragraph (c), the Attorney General,
2406 on behalf of the state, shall:

2407 (i) Proceed with the action, in which case the
2408 action shall be conducted by the state; or

2409 (ii) Notify the court that it declines to take
2410 over the action, in which case the person bringing the action
2411 shall have the right to conduct the action.

2412 (e) When a person brings an action under this
2413 subsection, no person other than the Attorney General, on behalf
2414 of the state, may intervene or bring a related action based on the
2415 facts underlying the pending action.

2416 (2) (a) If the Attorney General, on behalf of the state,
2417 proceeds with the action, the Attorney General shall have the
2418 primary responsibility for prosecuting the action, and shall not
2419 be bound by an act of the person bringing the action. The person
2420 shall have the right to continue as a party to the action, subject
2421 to the limitations set forth in paragraph (b).

2422 (b) (i) The state may dismiss the action
2423 notwithstanding the objections of the person initiating the action
2424 if the person has been notified by the state of the filing of the
2425 motion and the court has provided the person with an opportunity
2426 for a hearing on the motion.

2427 (ii) The state may settle the action with the
2428 defendant notwithstanding the objections of the person initiating
2429 the action if the court determines, after a hearing, that the
2430 proposed settlement is fair, adequate and reasonable under all the
2431 circumstances. Upon a showing of good cause, the hearing may be
2432 held in camera.

2433 (iii) Upon a showing by the state that
2434 unrestricted participation during the course of the litigation by
2435 the person initiating the action would interfere with or unduly
2436 delay the state's prosecution of the case, or would be



2437 repetitious, irrelevant, or for purposes of harassment, the court
2438 may, in its discretion, impose limitations on the person's
2439 participation, such as:

- 2440 1. Limiting the number of witnesses the
2441 person may call;
- 2442 2. Limiting the length of the testimony of
2443 the witnesses;
- 2444 3. Limiting the person's cross-examination of
2445 witnesses; or
- 2446 4. Otherwise limiting the participation by
2447 the person in the litigation.

2448 (iv) Upon a showing by the defendant that
2449 unrestricted participation during the course of the litigation by
2450 the person initiating the action would be for purposes of
2451 harassment or would cause the defendant undue burden or
2452 unnecessary expense, the court may limit the participation by the
2453 person in the litigation.

2454 (c) If the state elects not to proceed with the action,
2455 the person who initiated the action shall have the right to
2456 conduct the action. If the state so requests, it shall be served
2457 with copies of all pleadings filed in the action and shall be
2458 supplied with copies of all deposition transcripts (at the state's
2459 expense). When a person proceeds with the action, the court,
2460 without limiting the status and rights of the person initiating
2461 the action, may nevertheless permit the state to intervene at a
2462 later date upon a showing of good cause.

2463 (d) Whether or not the state proceeds with the action,
2464 upon a showing by the state that certain actions of discovery by
2465 the person initiating the action would interfere with the state's
2466 investigation or prosecution of a criminal or civil matter arising
2467 out of the same facts, the court may stay the discovery for a
2468 period of not more than sixty (60) days. The showing shall be
2469 conducted in camera. The court may extend the sixty-day period



2470 upon a further showing in camera that the state has pursued the
2471 criminal or civil investigation or proceedings with reasonable
2472 diligence and any proposed discovery in the civil action will
2473 interfere with the ongoing criminal or civil investigation or
2474 proceedings.

2475 (e) Notwithstanding subsection (2), the state may elect
2476 to pursue its claim through any alternate remedy available to the
2477 state, including any administrative proceeding to determine a
2478 civil money penalty. If any such alternate remedy is pursued in
2479 another proceeding, the person initiating the action shall have
2480 the same rights in the proceeding as the person would have had if
2481 the action had continued under this section. Any finding of fact
2482 or conclusion of law made in any other proceeding that has become
2483 final shall be conclusive on all parties to an action under this
2484 section. For purposes of the preceding sentence, a finding or
2485 conclusion is final if it has been finally determined on appeal to
2486 the appropriate court of competent jurisdiction, if all time for
2487 filing such an appeal with respect to the finding or conclusion
2488 has expired, or if the finding or conclusion is not subject to
2489 judicial review.

2490 (3) (a) If the state proceeds with an action brought by a
2491 person under subsection (2), the person shall, subject to the
2492 second sentence of this paragraph, receive at least fifteen
2493 percent (15%) but not more than twenty-five percent (25%) of the
2494 proceeds of the action or settlement of the claim, depending upon
2495 the extent to which the person substantially contributed to the
2496 prosecution of the action. Where the action is one which the
2497 court finds to be based primarily on disclosures of specific
2498 information (other than information provided by the person
2499 bringing the action) relating to allegations or transactions in a
2500 criminal, civil or administrative hearing, in a congressional,
2501 administrative, Division of Medicaid, Joint Legislative PEER
2502 Committee, State Auditor or Government Accounting Office report,



2503 hearing, audit, or investigation, or from the news media, the
2504 court may award such sums as it considers appropriate, but in no
2505 case more than ten percent (10%) of the proceeds, taking into
2506 account the significance of the information and the role of the
2507 person bringing the action in advancing the case to litigation.
2508 Any payment to a person under the first or second sentence of this
2509 paragraph shall be made from the proceeds. Any such person shall
2510 also receive an amount for reasonable expenses which the court
2511 finds to have been necessarily incurred, plus reasonable
2512 attorneys' fees and costs. All of those expenses, fees and costs
2513 shall be awarded against the defendant.

2514 (b) If the state does not proceed with an action under
2515 this section, the person bringing the action or settling the claim
2516 shall receive an amount that the court decides is reasonable for
2517 collecting the civil penalty and damages. The amount shall be not
2518 less than twenty-five percent (25%) and not more than thirty
2519 percent (30%) of the proceeds of the action or settlement and
2520 shall be paid out of the proceeds. The person shall also receive
2521 an amount for reasonable expenses that the court finds to have
2522 been necessarily incurred, plus reasonable attorneys' fees and
2523 costs. All of those expenses, fees and costs shall be awarded
2524 against the defendant.

2525 (c) Whether or not the state proceeds with the action,
2526 if the court finds that the action was brought by a person who
2527 planned and initiated the violation of this article upon which the
2528 action was brought, then the court may, to the extent the court
2529 considers appropriate, reduce the share of the proceeds of the
2530 action that the person would otherwise receive under paragraph (a)
2531 or (b) of this subsection, taking into account the role of that
2532 person in advancing the case to litigation and any relevant
2533 circumstances pertaining to the violation. If the person bringing
2534 the action is convicted of criminal conduct arising from his or
2535 her role in the violation of this article, that person shall be



2536 dismissed from the civil action and shall not receive any share of
2537 the proceeds of the action. The dismissal shall not prejudice the
2538 right of the state or the United States to continue the action,
2539 represented by the Attorney General or the Department of Justice
2540 respectively.

2541 (d) If the state does not proceed with the action and
2542 the person bringing the action conducts the action, the court may
2543 award to the defendant its reasonable attorneys' fees and expenses
2544 if the defendant prevails in the action and the court finds that
2545 the claim of the person bringing the action was clearly frivolous,
2546 clearly vexatious, or brought primarily for purposes of
2547 harassment.

2548 (4) (a) (i) No court shall have jurisdiction over an
2549 action brought under paragraph (b) against a member of the
2550 Legislature, a member of the judiciary, or a senior executive
2551 branch official if the action is based on evidence or information
2552 known to the state when the action was brought.

2553 (ii) In no event may a person bring an action
2554 under subsection (2) that is based upon allegations or
2555 transactions that are the subject of a civil suit or an
2556 administrative civil money penalty proceeding in which the state
2557 is already a party.

2558 (b) (i) No court shall have jurisdiction over an
2559 action under this section based upon the public disclosure of
2560 allegations or transactions in a criminal, civil or administrative
2561 hearing, in a congressional, administrative, Joint Legislative
2562 PEER Commission, State Auditor or Government Accounting Office
2563 report, hearing, audit, or investigation, or from the news media,
2564 unless the action is brought by the Attorney General or the person
2565 bringing the action is an original source of the information.

2566 (ii) For purposes of this paragraph (b), "original
2567 source" means an individual who has direct and independent
2568 knowledge of the information on which the allegations are based



2569 and has voluntarily provided the information to the government
2570 before filing an action under this section that is based on the
2571 information.

2572 (5) The state is not liable for expenses that a person
2573 incurs in bringing an action under this section.

2574 (6) Any employee who is discharged, demoted, suspended,
2575 threatened, harassed, or in any other manner discriminated against
2576 in the terms and conditions of employment by his or her employer
2577 because of lawful acts done by the employee on behalf of the
2578 employee or others in furtherance of an action under this section,
2579 including investigation for, initiation of, testimony for, or
2580 assistance in an action filed or to be filed under this section,
2581 shall be entitled to all relief necessary to make the employee
2582 whole. The relief shall include reinstatement with the same
2583 seniority status the employee would have had but for the
2584 discrimination, two (2) times the amount of back pay, interest on
2585 the back pay, and compensation for any special damages sustained
2586 as a result of the discrimination, including litigation costs and
2587 reasonable attorneys' fees. An employee may bring an action in
2588 the appropriate state court for the relief provided in this
2589 subsection.

2590 **SECTION 18.** Section 43-13-223, Mississippi Code of 1972, is
2591 amended as follows:

2592 43-13-223. (1) An action brought in connection with any
2593 matter under this article may be filed in the circuit court of the
2594 First Judicial District of Hinds County or in the circuit court of
2595 the county in which the defendant resides, and may be prosecuted
2596 to final judgment in satisfaction there.

2597 (2) Process issued by a court in which an action is filed
2598 may be served anywhere in the state.

2599 (3) A civil action brought under this article may not be
2600 brought:



2601 (a) More than six (6) years after the date on which the
2602 violation of this article is committed, or

2603 (b) More than three (3) years after the date when facts
2604 material to the right of action are known, or reasonably should
2605 have been known, by the official of the state charged with
2606 responsibility to act in the circumstances, but in no event are
2607 more than ten (10) years after the date on which the violation is
2608 committed, whichever occurs last.

2609 **SECTION 19.** Section 27-69-13, Mississippi Code of 1972, is
2610 amended as follows:

2611 27-69-13. (1) There is * * * imposed, levied and assessed,
2612 to be collected and paid as * * * provided in this chapter, an
2613 excise tax on each person or dealer in cigarettes, cigars,
2614 stogies, snuff, chewing tobacco, and smoking tobacco, or
2615 substitutes therefor, upon the sale, use, consumption, handling or
2616 distribution in the State of Mississippi, as follows:

2617 (a) On cigarettes, the rate of tax shall be
2618 Eighteen-twentieths of One Cent (18/20 of 1¢) on each cigarette
2619 sold with a maximum length of one hundred twenty (120)
2620 millimeters; any cigarette in excess of this length shall be taxed
2621 as if it were two (2) or more cigarettes. * * * However, if the
2622 federal tax rate on cigarettes in effect on June 1, 1985, is
2623 reduced, then the rate as provided in this subsection shall be
2624 increased by the amount of the federal tax reduction. That tax
2625 increase shall take effect on the first day of the month following
2626 the effective date of the reduction in the federal tax rate.

2627 (b) In addition to the excise tax levied by paragraph
2628 (a), there is levied an excise tax of Five Cents (5¢) on each
2629 cigarette sold with a maximum length of one hundred twenty (120)
2630 millimeters; any cigarette in excess of this length shall be taxed
2631 as if it were two (2) or more cigarettes.

2632 (c) On cigars, cheroots, stogies, snuff, chewing and
2633 smoking tobacco and all other tobacco products except cigarettes,



2634 the rate of tax shall be fifteen percent (15%) of the
2635 manufacturer's list price.

2636 (2) No stamp evidencing the tax * * * levied in this section
2637 on cigarettes shall be of a denomination of less than One Cent
2638 (1¢), and whenever the tax computed at the rates * * * prescribed
2639 in this section on cigarettes is a specified amount, plus a
2640 fractional part of One Cent (1¢), the package shall be stamped for
2641 the next full cent; however, the additional face value of stamps
2642 purchased to comply with taxes imposed by this section after June
2643 1, 1985, shall be subject to a four percent (4%) discount or
2644 compensation to dealers for their services rather than the eight
2645 percent (8%) discount or compensation allowed by Section 27-69-31.

2646 (3) Every wholesaler shall purchase stamps as provided in
2647 this chapter, and affix the same to all packages of cigarettes
2648 handled by him as * * * provided in this chapter.

2649 (4) The above tax is levied upon the sale, use, gift,
2650 possession or consumption of tobacco within the State of
2651 Mississippi, and the impact of the tax levied by this chapter
2652 is * * * declared to be on the vendee, user, consumer or possessor
2653 of tobacco in this state; and when the tax is paid by any other
2654 person, the payment shall be considered as an advance payment and
2655 shall thereafter be added to the price of the tobacco and
2656 recovered from the ultimate consumer or user.

2657 **SECTION 20.** Section 27-69-75, Mississippi Code of 1972, is
2658 amended as follows:

2659 27-69-75. (1) All taxes levied by this chapter shall be
2660 payable to the commissioner in cash, or by personal check,
2661 cashier's check, bank exchange, post office money order or express
2662 money order, and shall be deposited by the commissioner in the
2663 State Treasury on the same day collected. No remittance other
2664 than cash shall be a final discharge of liability for the
2665 tax * * * assessed and levied in this chapter, unless and until it
2666 has been paid in cash to the commissioner.



2667 (2) The revenue derived from the tax levied in Section
2668 27-69-13(1)(b) shall be deposited into the State Treasury, as
2669 follows:

2670 (a) Ten percent (10%) of the revenue collected shall be
2671 deposited into the Mississippi Trauma Care Systems Fund created in
2672 Section 41-59-75.

2673 (b) Ninety percent (90%) of the revenue collected shall
2674 be deposited into the special fund to the credit of the Governor's
2675 Office - Division of Medicaid created in Section 43-13-113.

2676 (3) Except as otherwise provided in subsection (2) of this
2677 section, all tobacco taxes collected, including tobacco license
2678 taxes, shall be deposited into the State Treasury to the credit of
2679 the General Fund.

2680 Wholesalers who are entitled to purchase stamps at a
2681 discount, as provided by Section 27-69-31, may have consigned to
2682 them, without advance payment, those stamps, if and when the
2683 wholesaler * * * gives to the commissioner a good and sufficient
2684 bond executed by some surety company authorized to do business in
2685 this state, conditioned to secure the payment for the stamps so
2686 consigned. The commissioner shall require payment for the stamps
2687 not later than thirty (30) days from the date the stamps were
2688 consigned.

2689 **SECTION 21.** This act shall take effect and be in force from
2690 and after July 1, 2008, except for Sections 19 and 20 which shall
2691 take effect and be in force from and after June 1, 2008.

