

By: Senator(s) Bryan

To: Public Health and  
Welfare; Appropriations

COMMITTEE SUBSTITUTE  
FOR  
SENATE BILL NO. 2904

1 AN ACT RELATING TO THE MEDICAID ASSISTANCE PROGRAM; TO BRING  
2 FORWARD SECTION 43-13-107, MISSISSIPPI CODE OF 1972; TO AMEND  
3 SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT  
4 TRANSPLANT PATIENTS SHALL NOT HAVE THOSE TRANSPLANT PROCEDURE DAYS  
5 COUNT AGAINST THE THIRTY-DAY INPATIENT HOSPITAL SERVICES ANNUAL  
6 LIMITATION; TO BRING FORWARD SECTION 43-13-145, MISSISSIPPI CODE  
7 OF 1972; AND FOR RELATED PURPOSES.

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

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

11 43-13-107. (1) The Division of Medicaid is created in the  
12 Office of the Governor and established to administer this article  
13 and perform such other duties as are prescribed by law.

14 (2) (a) The Governor shall appoint a full-time executive  
15 director, with the advice and consent of the Senate, who shall be  
16 either (i) a physician with administrative experience in a medical  
17 care or health program, or (ii) a person holding a graduate degree  
18 in medical care administration, public health, hospital  
19 administration, or the equivalent, or (iii) a person holding a  
20 bachelor's degree in business administration or hospital  
21 administration, with at least ten (10) years' experience in  
22 management-level administration of Medicaid programs. The  
23 executive director shall be the official secretary and legal  
24 custodian of the records of the division; shall be the agent of  
25 the division for the purpose of receiving all service of process,  
26 summons and notices directed to the division; shall perform such  
27 other duties as the Governor may prescribe from time to time; and  
28 shall perform all other duties that are now or may be imposed upon  
29 him or her by law.



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

32           (c) The executive director shall, before entering upon  
33 the discharge of the duties of the office, take and subscribe to  
34 the oath of office prescribed by the Mississippi Constitution and  
35 shall file the same in the Office of the Secretary of State, and  
36 shall execute a bond in some surety company authorized to do  
37 business in the state in the penal sum of One Hundred Thousand  
38 Dollars (\$100,000.00), conditioned for the faithful and impartial  
39 discharge of the duties of the office. The premium on the bond  
40 shall be paid as provided by law out of funds appropriated to the  
41 Division of Medicaid for contractual services.

42           (d) The executive director, with the approval of the  
43 Governor and subject to the rules and regulations of the State  
44 Personnel Board, shall employ such professional, administrative,  
45 stenographic, secretarial, clerical and technical assistance as  
46 may be necessary to perform the duties required in administering  
47 this article and fix the compensation for those persons, all in  
48 accordance with a state merit system meeting federal requirements.  
49 When the salary of the executive director is not set by law, that  
50 salary shall be set by the State Personnel Board. No employees of  
51 the Division of Medicaid shall be considered to be staff members  
52 of the immediate Office of the Governor; however, the provisions  
53 of Section 25-9-107(c)(xv) shall apply to the executive director  
54 and other administrative heads of the division.

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

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



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

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

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

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

73 (c) The respective Chairmen of the House Medicaid  
74 Committee, the House Public Health and Human Services Committee,  
75 the House Appropriations Committee, the Senate Public Health and  
76 Welfare Committee and the Senate Appropriations Committee, or  
77 their designees, two (2) members of the State Senate appointed by  
78 the Lieutenant Governor and one (1) member of the House of  
79 Representatives appointed by the Speaker of the House, shall serve  
80 as ex officio nonvoting members of the advisory committee.

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

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

89 (f) The members of the advisory committee specified in  
90 paragraph (b) shall serve for terms that are concurrent with the  
91 terms of members of the Legislature, and any member appointed  
92 under paragraph (b) may be reappointed to the advisory committee.  
93 The members of the advisory committee specified in paragraph (b)



94 shall serve without compensation, but shall receive reimbursement  
95 to defray actual expenses incurred in the performance of committee  
96 business as authorized by law. Legislators shall receive per diem  
97 and expenses, which may be paid from the contingent expense funds  
98 of their respective houses in the same amounts as provided for  
99 committee meetings when the Legislature is not in session.

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

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

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

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

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

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

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

123 (v) Gather information on reasons that medical  
124 care providers do not participate in the Medicaid program and  
125 changes that could be made in the program to encourage more  
126 providers to participate in the Medicaid program, and advise the



127 division with respect to encouraging physicians and other medical  
128 care providers to participate in the Medicaid program;

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

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

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

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

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

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

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

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



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

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

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

169 (c) The committee meetings shall be open to the public,  
170 members of the press, legislators and consumers. Additionally,  
171 all documents provided to committee members shall be available to  
172 members of the Legislature in the same manner, and shall be made  
173 available to others for a reasonable fee for copying. However,  
174 patient confidentiality and provider confidentiality shall be  
175 protected by blinding patient names and provider names with  
176 numerical or other anonymous identifiers. The committee meetings  
177 shall be subject to the Open Meetings Act (Section 25-41-1 et  
178 seq.). Committee meetings conducted in violation of this section  
179 shall be deemed unlawful.

180 (d) After a thirty-day public notice, the executive  
181 director, or his or her designee, shall present the division's  
182 recommendation regarding prior approval for a therapeutic class of  
183 drugs to the committee. However, in circumstances where the  
184 division deems it necessary for the health and safety of Medicaid  
185 beneficiaries, the division may present to the committee its  
186 recommendations regarding a particular drug without a thirty-day  
187 public notice. In making that presentation, the division shall  
188 state to the committee the circumstances that precipitate the need  
189 for the committee to review the status of a particular drug  
190 without a thirty-day public notice. The committee may determine  
191 whether or not to review the particular drug under the  
192 circumstances stated by the division without a thirty-day public



193 notice. If the committee determines to review the status of the  
194 particular drug, it shall make its recommendations to the  
195 division, after which the division shall file those  
196 recommendations for a thirty-day public comment under the  
197 provisions of Section 25-43-7(1).

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

206 (f) Upon reviewing and considering all recommendations  
207 including recommendation of the committee, comments, and data, the  
208 executive director shall make a final determination whether to  
209 require prior approval of a therapeutic class of drugs, or modify  
210 existing prior approval requirements for a therapeutic class of  
211 drugs.

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

220 (h) Members of the committee shall dispose of matters  
221 before the committee in an unbiased and professional manner. If a  
222 matter being considered by the committee presents a real or  
223 apparent conflict of interest for any member of the committee,  
224 that member shall disclose the conflict in writing to the



225 committee chair and recuse himself or herself from any discussions  
226 and/or actions on the matter.

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

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

230 43-13-117. Medicaid as authorized by this article shall  
231 include payment of part or all of the costs, at the discretion of  
232 the division, with approval of the Governor, of the following  
233 types of care and services rendered to eligible applicants who  
234 have been determined to be eligible for that care and services,  
235 within the limits of state appropriations and federal matching  
236 funds:

237 (1) Inpatient hospital services.

238 (a) The division shall allow thirty (30) days of  
239 inpatient hospital care annually for all Medicaid recipients.  
240 Medicaid recipients requiring transplants shall not have those  
241 days included in the transplant case rate count against the  
242 thirty-day limit for inpatient hospital care. Precertification of  
243 inpatient days must be obtained as required by the division. The  
244 division may allow unlimited days in disproportionate hospitals as  
245 defined by the division for eligible infants and children under  
246 the age of six (6) years if certified as medically necessary as  
247 required by the division.

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

254 (c) Hospitals will receive an additional payment  
255 for the implantable programmable baclofen drug pump used to treat  
256 spasticity that is implanted on an inpatient basis. The payment  
257 pursuant to written invoice will be in addition to the facility's



258 per diem reimbursement and will represent a reduction of costs on  
259 the facility's annual cost report, and shall not exceed Ten  
260 Thousand Dollars (\$10,000.00) per year per recipient.

261 (2) Outpatient hospital services.

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

265 (b) Other outpatient hospital services. The  
266 division shall allow benefits for other medically necessary  
267 outpatient hospital services (such as chemotherapy, radiation,  
268 surgery and therapy). Where the same services are reimbursed as  
269 clinic services, the division may revise the rate or methodology  
270 of outpatient reimbursement to maintain consistency, efficiency,  
271 economy and quality of care.

272 (3) Laboratory and x-ray services.

273 (4) Nursing facility services.

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

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



291 nursing facility are considered in calculating a facility's per  
292 diem.

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

296 (d) When a facility of a category that does not  
297 require a certificate of need for construction and that could not  
298 be eligible for Medicaid reimbursement is constructed to nursing  
299 facility specifications for licensure and certification, and the  
300 facility is subsequently converted to a nursing facility under a  
301 certificate of need that authorizes conversion only and the  
302 applicant for the certificate of need was assessed an application  
303 review fee based on capital expenditures incurred in constructing  
304 the facility, the division shall allow reimbursement for capital  
305 expenditures necessary for construction of the facility that were  
306 incurred within the twenty-four (24) consecutive calendar months  
307 immediately preceding the date that the certificate of need  
308 authorizing the conversion was issued, to the same extent that  
309 reimbursement would be allowed for construction of a new nursing  
310 facility under a certificate of need that authorizes that  
311 construction. The reimbursement authorized in this subparagraph  
312 (d) may be made only to facilities the construction of which was  
313 completed after June 30, 1989. Before the division shall be  
314 authorized to make the reimbursement authorized in this  
315 subparagraph (d), the division first must have received approval  
316 from the Centers for Medicare and Medicaid Services (CMS) of the  
317 change in the state Medicaid plan providing for the reimbursement.

318 (e) The division shall develop and implement, not  
319 later than January 1, 2001, a case-mix payment add-on determined  
320 by time studies and other valid statistical data that will  
321 reimburse a nursing facility for the additional cost of caring for  
322 a resident who has a diagnosis of Alzheimer's or other related  
323 dementia and exhibits symptoms that require special care. Any



324 such case-mix add-on payment shall be supported by a determination  
325 of additional cost. The division shall also develop and implement  
326 as part of the fair rental reimbursement system for nursing  
327 facility beds, an Alzheimer's resident bed depreciation enhanced  
328 reimbursement system that will provide an incentive to encourage  
329 nursing facilities to convert or construct beds for residents with  
330 Alzheimer's or other related dementia.

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

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

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



357 medical and psychological evaluations for children in the custody  
358 of the Mississippi Department of Human Services may enter into a  
359 cooperative agreement with the Mississippi Department of Human  
360 Services for the provision of those services using state funds  
361 that are provided from the appropriation to the Department of  
362 Human Services to obtain federal matching funds through the  
363 division.

364 (6) Physician's services. The division shall allow  
365 twelve (12) physician visits annually. All fees for physicians'  
366 services that are covered only by Medicaid shall be reimbursed at  
367 ninety percent (90%) of the rate established on January 1, 1999,  
368 and as may be adjusted each July thereafter, under Medicare (Title  
369 XVIII of the federal Social Security Act, as amended). The  
370 division may develop and implement a different reimbursement model  
371 or schedule for physician's services provided by physicians based  
372 at an academic health care center and by physicians at rural  
373 health centers that are associated with an academic health care  
374 center.

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

380 (b) [Repealed]

381 (8) Emergency medical transportation services. On  
382 January 1, 1994, emergency medical transportation services shall  
383 be reimbursed at seventy percent (70%) of the rate established  
384 under Medicare (Title XVIII of the federal Social Security Act, as  
385 amended). "Emergency medical transportation services" shall mean,  
386 but shall not be limited to, the following services by a properly  
387 permitted ambulance operated by a properly licensed provider in  
388 accordance with the Emergency Medical Services Act of 1974  
389 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced



390 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,  
391 (vi) disposable supplies, (vii) similar services.

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

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

398 The division may seek to establish relationships with other  
399 states in order to lower acquisition costs of prescription drugs  
400 to include single source and innovator multiple source drugs or  
401 generic drugs. In addition, if allowed by federal law or  
402 regulation, the division may seek to establish relationships with  
403 and negotiate with other countries to facilitate the acquisition  
404 of prescription drugs to include single source and innovator  
405 multiple source drugs or generic drugs, if that will lower the  
406 acquisition costs of those prescription drugs.

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

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

416 Drugs prescribed for a resident of a psychiatric residential  
417 treatment facility must be provided in true unit doses when  
418 available. The division may require that drugs not covered by  
419 Medicare Part D for a resident of a long-term care facility be  
420 provided in true unit doses when available. Those drugs that were  
421 originally billed to the division but are not used by a resident  
422 in any of those facilities shall be returned to the billing



423 pharmacy for credit to the division, in accordance with the  
424 guidelines of the State Board of Pharmacy and any requirements of  
425 federal law and regulation. Drugs shall be dispensed to a  
426 recipient and only one (1) dispensing fee per month may be  
427 charged. The division shall develop a methodology for reimbursing  
428 for restocked drugs, which shall include a restock fee as  
429 determined by the division not exceeding Seven Dollars and  
430 Eighty-two Cents (\$7.82).

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

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

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

443 All claims for drugs for dually eligible Medicare/Medicaid  
444 beneficiaries that are paid for by Medicare must be submitted to  
445 Medicare for payment before they may be processed by the  
446 division's online payment system.

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

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



456 innovator multiple source drugs, and information about other drugs  
457 that may be prescribed as alternatives to those single source  
458 drugs and innovator multiple source drugs and the costs to the  
459 Medicaid program of those alternative drugs.

460 Notwithstanding any law or regulation, information obtained  
461 or maintained by the division regarding the prescription drug  
462 program, including trade secrets and manufacturer or labeler  
463 pricing, is confidential and not subject to disclosure except to  
464 other state agencies.

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

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

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

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

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



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

492           (10) (a) Dental care that is an adjunct to treatment  
493 of an acute medical or surgical condition; services of oral  
494 surgeons and dentists in connection with surgery related to the  
495 jaw or any structure contiguous to the jaw or the reduction of any  
496 fracture of the jaw or any facial bone; and emergency dental  
497 extractions and treatment related thereto. On July 1, 2007, fees  
498 for dental care and surgery under authority of this paragraph (10)  
499 shall be reimbursed as provided in paragraph (b). It is the  
500 intent of the Legislature that this rate revision for dental  
501 services will be an incentive designed to increase the number of  
502 dentists who actively provide Medicaid services. This dental  
503 services rate revision shall be known as the "James Russell Dumas  
504 Medicaid Dental Incentive Program."

505           The division shall annually determine the effect of this  
506 incentive by evaluating the number of dentists who are Medicaid  
507 providers, the number who and the degree to which they are  
508 actively billing Medicaid, the geographic trends of where dentists  
509 are offering what types of Medicaid services and other statistics  
510 pertinent to the goals of this legislative intent. This data  
511 shall be presented to the Chair of the Senate Public Health and  
512 Welfare Committee and the Chair of the House Medicaid Committee.

513           (b) The Division of Medicaid shall establish a fee  
514 schedule, to be effective from and after July 1, 2007, for dental  
515 services. The schedule shall provide for a fee for each dental  
516 service that is equal to a percentile of normal and customary  
517 private provider fees, as defined by the Ingenix Customized Fee  
518 Analyzer Report, which percentile shall be determined by the  
519 division. The schedule shall be reviewed annually by the division  
520 and dental fees shall be adjusted to reflect the percentile  
521 determined by the division.



522 (c) For fiscal year 2008, the amount of state  
523 funds appropriated for reimbursement for dental care and surgery  
524 shall be increased by ten percent (10%) of the amount of state  
525 fund expenditures for that purpose for fiscal year 2007. For each  
526 of fiscal years 2009 and 2010, the amount of state funds  
527 appropriated for reimbursement for dental care and surgery shall  
528 be increased by ten percent (10%) of the amount of state fund  
529 expenditures for that purpose for the preceding fiscal year.

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

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

538 (f) This paragraph (10) shall stand repealed on  
539 July 1, 2010.

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

549 (12) Intermediate care facility services.

550 (a) The division shall make full payment to all  
551 intermediate care facilities for the mentally retarded for each  
552 day, not exceeding eighty-four (84) days per year, that a patient  
553 is absent from the facility on home leave. Payment may be made  
554 for the following home leave days in addition to the



555 eighty-four-day limitation: Christmas, the day before Christmas,  
556 the day after Christmas, Thanksgiving, the day before Thanksgiving  
557 and the day after Thanksgiving.

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

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

564 (14) Clinic services. Such diagnostic, preventive,  
565 therapeutic, rehabilitative or palliative services furnished to an  
566 outpatient by or under the supervision of a physician or dentist  
567 in a facility that is not a part of a hospital but that is  
568 organized and operated to provide medical care to outpatients.  
569 Clinic services shall include any services reimbursed as  
570 outpatient hospital services that may be rendered in such a  
571 facility, including those that become so after July 1, 1991. On  
572 July 1, 1999, all fees for physicians' services reimbursed under  
573 authority of this paragraph (14) shall be reimbursed at ninety  
574 percent (90%) of the rate established on January 1, 1999, and as  
575 may be adjusted each July thereafter, under Medicare (Title XVIII  
576 of the federal Social Security Act, as amended). The division may  
577 develop and implement a different reimbursement model or schedule  
578 for physician's services provided by physicians based at an  
579 academic health care center and by physicians at rural health  
580 centers that are associated with an academic health care center.

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

586 (16) Mental health services. Approved therapeutic and  
587 case management services (a) provided by an approved regional



588 mental health/retardation center established under Sections  
589 41-19-31 through 41-19-39, or by another community mental health  
590 service provider meeting the requirements of the Department of  
591 Mental Health to be an approved mental health/retardation center  
592 if determined necessary by the Department of Mental Health, using  
593 state funds that are provided from the appropriation to the State  
594 Department of Mental Health and/or funds transferred to the  
595 department by a political subdivision or instrumentality of the  
596 state and used to match federal funds under a cooperative  
597 agreement between the division and the department, or (b) provided  
598 by a facility that is certified by the State Department of Mental  
599 Health to provide therapeutic and case management services, to be  
600 reimbursed on a fee for service basis, or (c) provided in the  
601 community by a facility or program operated by the Department of  
602 Mental Health. Any such services provided by a facility described  
603 in subparagraph (b) must have the prior approval of the division  
604 to be reimbursable under this section. After June 30, 1997,  
605 mental health services provided by regional mental  
606 health/retardation centers established under Sections 41-19-31  
607 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)  
608 and/or their subsidiaries and divisions, or by psychiatric  
609 residential treatment facilities as defined in Section 43-11-1, or  
610 by another community mental health service provider meeting the  
611 requirements of the Department of Mental Health to be an approved  
612 mental health/retardation center if determined necessary by the  
613 Department of Mental Health, shall not be included in or provided  
614 under any capitated managed care pilot program provided for under  
615 paragraph (24) of this section.

616 (17) Durable medical equipment services and medical  
617 supplies. Precertification of durable medical equipment and  
618 medical supplies must be obtained as required by the division.  
619 The Division of Medicaid may require durable medical equipment



620 providers to obtain a surety bond in the amount and to the  
621 specifications as established by the Balanced Budget Act of 1997.

622 (18) (a) Notwithstanding any other provision of this  
623 section to the contrary, the division shall make additional  
624 reimbursement to hospitals that serve a disproportionate share of  
625 low-income patients and that meet the federal requirements for  
626 those payments as provided in Section 1923 of the federal Social  
627 Security Act and any applicable regulations. It is the intent of  
628 the Legislature that the division shall draw down all available  
629 federal funds allotted to the state for disproportionate share  
630 hospitals. However, from and after January 1, 1999, no public  
631 hospital shall participate in the Medicaid disproportionate share  
632 program unless the public hospital participates in an  
633 intergovernmental transfer program as provided in Section 1903 of  
634 the federal Social Security Act and any applicable regulations.

635 (b) The division shall establish a Medicare Upper  
636 Payment Limits Program, as defined in Section 1902(a)(30) of the  
637 federal Social Security Act and any applicable federal  
638 regulations, for hospitals, and may establish a Medicare Upper  
639 Payment Limits Program for nursing facilities. The division shall  
640 assess each hospital and, if the program is established for  
641 nursing facilities, shall assess each nursing facility, based on  
642 Medicaid utilization or other appropriate method consistent with  
643 federal regulations. The assessment will remain in effect as long  
644 as the state participates in the Medicare Upper Payment Limits  
645 Program. The division shall make additional reimbursement to  
646 hospitals and, if the program is established for nursing  
647 facilities, shall make additional reimbursement to nursing  
648 facilities, for the Medicare Upper Payment Limits, as defined in  
649 Section 1902(a)(30) of the federal Social Security Act and any  
650 applicable federal regulations.

651 (19) (a) Perinatal risk management services. The  
652 division shall promulgate regulations to be effective from and



653 after October 1, 1988, to establish a comprehensive perinatal  
654 system for risk assessment of all pregnant and infant Medicaid  
655 recipients and for management, education and follow-up for those  
656 who are determined to be at risk. Services to be performed  
657 include case management, nutrition assessment/counseling,  
658 psychosocial assessment/counseling and health education.

659 (b) Early intervention system services. The  
660 division shall cooperate with the State Department of Health,  
661 acting as lead agency, in the development and implementation of a  
662 statewide system of delivery of early intervention services, under  
663 Part C of the Individuals with Disabilities Education Act (IDEA).  
664 The State Department of Health shall certify annually in writing  
665 to the executive director of the division the dollar amount of  
666 state early intervention funds available that will be utilized as  
667 a certified match for Medicaid matching funds. Those funds then  
668 shall be used to provide expanded targeted case management  
669 services for Medicaid eligible children with special needs who are  
670 eligible for the state's early intervention system.

671 Qualifications for persons providing service coordination shall be  
672 determined by the State Department of Health and the Division of  
673 Medicaid.

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

684 (21) Nurse practitioner services. Services furnished  
685 by a registered nurse who is licensed and certified by the



686 Mississippi Board of Nursing as a nurse practitioner, including,  
687 but not limited to, nurse anesthetists, nurse midwives, family  
688 nurse practitioners, family planning nurse practitioners,  
689 pediatric nurse practitioners, obstetrics-gynecology nurse  
690 practitioners and neonatal nurse practitioners, under regulations  
691 adopted by the division. Reimbursement for those services shall  
692 not exceed ninety percent (90%) of the reimbursement rate for  
693 comparable services rendered by a physician.

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

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

712 (24) [Deleted]

713 (25) [Deleted]

714 (26) Hospice care. As used in this paragraph, the term  
715 "hospice care" means a coordinated program of active professional  
716 medical attention within the home and outpatient and inpatient  
717 care that treats the terminally ill patient and family as a unit,  
718 employing a medically directed interdisciplinary team. The



719 program provides relief of severe pain or other physical symptoms  
720 and supportive care to meet the special needs arising out of  
721 physical, psychological, spiritual, social and economic stresses  
722 that are experienced during the final stages of illness and during  
723 dying and bereavement and meets the Medicare requirements for  
724 participation as a hospice as provided in federal regulations.

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

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

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

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

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



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

757           (33) Podiatrist services.

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

762           (35) Services and activities authorized in Sections  
763 43-27-101 and 43-27-103, using state funds that are provided from  
764 the appropriation to the Mississippi Department of Human Services  
765 and used to match federal funds under a cooperative agreement  
766 between the division and the department.

767           (36) Nonemergency transportation services for  
768 Medicaid-eligible persons, to be provided by the Division of  
769 Medicaid. The division may contract with additional entities to  
770 administer nonemergency transportation services as it deems  
771 necessary. All providers shall have a valid driver's license,  
772 vehicle inspection sticker, valid vehicle license tags and a  
773 standard liability insurance policy covering the vehicle. The  
774 division may pay providers a flat fee based on mileage tiers, or  
775 in the alternative, may reimburse on actual miles traveled. The  
776 division may apply to the Center for Medicare and Medicaid  
777 Services (CMS) for a waiver to draw federal matching funds for  
778 nonemergency transportation services as a covered service instead  
779 of an administrative cost. The PEER Committee shall conduct a  
780 performance evaluation of the nonemergency transportation program  
781 to evaluate the administration of the program and the providers of  
782 transportation services to determine the most cost effective ways  
783 of providing nonemergency transportation services to the patients



784 served under the program. The performance evaluation shall be  
785 completed and provided to the members of the Senate Public Health  
786 and Welfare Committee and the House Medicaid Committee not later  
787 than January 15, 2008.

788 (37) [Deleted]

789 (38) Chiropractic services. A chiropractor's manual  
790 manipulation of the spine to correct a subluxation, if x-ray  
791 demonstrates that a subluxation exists and if the subluxation has  
792 resulted in a neuromusculoskeletal condition for which  
793 manipulation is appropriate treatment, and related spinal x-rays  
794 performed to document these conditions. Reimbursement for  
795 chiropractic services shall not exceed Seven Hundred Dollars  
796 (\$700.00) per year per beneficiary.

797 (39) Dually eligible Medicare/Medicaid beneficiaries.  
798 The division shall pay the Medicare deductible and coinsurance  
799 amounts for services available under Medicare, as determined by  
800 the division.

801 (40) [Deleted]

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

812 (42) Notwithstanding any other provision in this  
813 article to the contrary, the division may develop a population  
814 health management program for women and children health services  
815 through the age of one (1) year. This program is primarily for  
816 obstetrical care associated with low birth weight and pre-term



817 babies. The division may apply to the federal Centers for  
818 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or  
819 any other waivers that may enhance the program. In order to  
820 effect cost savings, the division may develop a revised payment  
821 methodology that may include at-risk capitated payments, and may  
822 require member participation in accordance with the terms and  
823 conditions of an approved federal waiver.

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

829 (44) Nursing facility services for the severely  
830 disabled.

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

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

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

845 (46) The division shall make application to the federal  
846 Centers for Medicare and Medicaid Services (CMS) for a waiver to  
847 develop and provide services for children with serious emotional  
848 disturbances as defined in Section 43-14-1(1), which may include  
849 home- and community-based services, case management services or



850 managed care services through mental health providers certified by  
851 the Department of Mental Health. The division may implement and  
852 provide services under this waived program only if funds for  
853 these services are specifically appropriated for this purpose by  
854 the Legislature, or if funds are voluntarily provided by affected  
855 agencies.

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

861 (b) Participation in any disease management  
862 program implemented under this paragraph (47) is optional with the  
863 individual. An individual must affirmatively elect to participate  
864 in the disease management program in order to participate, and  
865 may elect to discontinue participation in the program at any time.

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

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

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

876 (49) The division shall establish copayments and/or  
877 coinsurance for all Medicaid services for which copayments and/or  
878 coinsurance are allowable under federal law or regulation, and  
879 shall set the amount of the copayment and/or coinsurance for each  
880 of those services at the maximum amount allowable under federal  
881 law or regulation.



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

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

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

901           (52) Notwithstanding any provisions of this article,  
902 the division may pay enhanced reimbursement fees related to trauma  
903 care, as determined by the division in conjunction with the State  
904 Department of Health, using funds appropriated to the State  
905 Department of Health for trauma care and services and used to  
906 match federal funds under a cooperative agreement between the  
907 division and the State Department of Health. The division, in  
908 conjunction with the State Department of Health, may use grants,  
909 waivers, demonstrations, or other projects as necessary in the  
910 development and implementation of this reimbursement program.

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



914           (54) Adult foster care services pilot program. Social  
915 and protective services on a pilot program basis in an approved  
916 foster care facility for vulnerable adults who would otherwise  
917 need care in a long-term care facility, to be implemented in an  
918 area of the state with the greatest need for such program, under  
919 the Medicaid Waivers for the Elderly and Disabled program or an  
920 assisted living waiver. The division may use grants, waivers,  
921 demonstrations or other projects as necessary in the development  
922 and implementation of this adult foster care services pilot  
923 program.

924           (55) Therapy services. The plan of care for therapy  
925 services may be developed to cover a period of treatment for up to  
926 six (6) months, but in no event shall the plan of care exceed a  
927 six-month period of treatment. The projected period of treatment  
928 must be indicated on the initial plan of care and must be updated  
929 with each subsequent revised plan of care. Based on medical  
930 necessity, the division shall approve certification periods for  
931 less than or up to six (6) months, but in no event shall the  
932 certification period exceed the period of treatment indicated on  
933 the plan of care. The appeal process for any reduction in therapy  
934 services shall be consistent with the appeal process in federal  
935 regulations.

936           Notwithstanding any other provision of this article to the  
937 contrary, the division shall reduce the rate of reimbursement to  
938 providers for any service provided under this section by five  
939 percent (5%) of the allowed amount for that service. However, the  
940 reduction in the reimbursement rates required by this paragraph  
941 shall not apply to inpatient hospital services, nursing facility  
942 services, intermediate care facility services, psychiatric  
943 residential treatment facility services, pharmacy services  
944 provided under paragraph (9) of this section, or any service  
945 provided by the University of Mississippi Medical Center or a  
946 state agency, a state facility or a public agency that either



947 provides its own state match through intergovernmental transfer or  
948 certification of funds to the division, or a service for which the  
949 federal government sets the reimbursement methodology and rate.  
950 In addition, the reduction in the reimbursement rates required by  
951 this paragraph shall not apply to case management services and  
952 home-delivered meals provided under the home- and community-based  
953 services program for the elderly and disabled by a planning and  
954 development district (PDD). Planning and development districts  
955 participating in the home- and community-based services program  
956 for the elderly and disabled as case management providers shall be  
957 reimbursed for case management services at the maximum rate  
958 approved by the Centers for Medicare and Medicaid Services (CMS).

959 The division may pay to those providers who participate in  
960 and accept patient referrals from the division's emergency room  
961 redirection program a percentage, as determined by the division,  
962 of savings achieved according to the performance measures and  
963 reduction of costs required of that program. Federally qualified  
964 health centers may participate in the emergency room redirection  
965 program, and the division may pay those centers a percentage of  
966 any savings to the Medicaid program achieved by the centers'  
967 accepting patient referrals through the program, as provided in  
968 this paragraph.

969 Notwithstanding any provision of this article, except as  
970 authorized in the following paragraph and in Section 43-13-139,  
971 neither (a) the limitations on quantity or frequency of use of or  
972 the fees or charges for any of the care or services available to  
973 recipients under this section, nor (b) the payments or rates of  
974 reimbursement to providers rendering care or services authorized  
975 under this section to recipients, may be increased, decreased or  
976 otherwise changed from the levels in effect on July 1, 1999,  
977 unless they are authorized by an amendment to this section by the  
978 Legislature. However, the restriction in this paragraph shall not  
979 prevent the division from changing the payments or rates of



980 reimbursement to providers without an amendment to this section  
981 whenever those changes are required by federal law or regulation,  
982 or whenever those changes are necessary to correct administrative  
983 errors or omissions in calculating those payments or rates of  
984 reimbursement.

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

991 The executive director shall keep the Governor advised on a  
992 timely basis of the funds available for expenditure and the  
993 projected expenditures. If current or projected expenditures of  
994 the division are reasonably anticipated to exceed the amount of  
995 funds appropriated to the division for any fiscal year, the  
996 Governor, after consultation with the executive director, shall  
997 discontinue any or all of the payment of the types of care and  
998 services as provided in this section that are deemed to be  
999 optional services under Title XIX of the federal Social Security  
1000 Act, as amended, and when necessary, shall institute any other  
1001 cost containment measures on any program or programs authorized  
1002 under the article to the extent allowed under the federal law  
1003 governing that program or programs. However, the Governor shall  
1004 not be authorized to discontinue or eliminate any service under  
1005 this section that is mandatory under federal law, or to  
1006 discontinue or eliminate, or adjust income limits or resource  
1007 limits for, any eligibility category or group under Section  
1008 43-13-115. It is the intent of the Legislature that the  
1009 expenditures of the division during any fiscal year shall not  
1010 exceed the amounts appropriated to the division for that fiscal  
1011 year.



1012 Notwithstanding any other provision of this article, it shall  
1013 be the duty of each nursing facility, intermediate care facility  
1014 for the mentally retarded, psychiatric residential treatment  
1015 facility, and nursing facility for the severely disabled that is  
1016 participating in the Medicaid program to keep and maintain books,  
1017 documents and other records as prescribed by the Division of  
1018 Medicaid in substantiation of its cost reports for a period of  
1019 three (3) years after the date of submission to the Division of  
1020 Medicaid of an original cost report, or three (3) years after the  
1021 date of submission to the Division of Medicaid of an amended cost  
1022 report.

1023 **SECTION 3.** Section 43-13-145, Mississippi Code of 1972, is  
1024 brought forward as follows:

1025 43-13-145. (1) (a) Upon each nursing facility licensed by  
1026 the State of Mississippi, there is levied an assessment in an  
1027 amount set by the division, not exceeding the maximum rate allowed  
1028 by federal law or regulation, for each licensed and occupied bed  
1029 of the facility.

1030 (b) A nursing facility is exempt from the assessment  
1031 levied under this subsection if the facility is operated under the  
1032 direction and control of:

1033 (i) The United States Veterans Administration or  
1034 other agency or department of the United States government;

1035 (ii) The State Veterans Affairs Board;

1036 (iii) The University of Mississippi Medical  
1037 Center; or

1038 (iv) A state agency or a state facility that  
1039 either provides its own state match through intergovernmental  
1040 transfer or certification of funds to the division.

1041 (2) (a) Upon each intermediate care facility for the  
1042 mentally retarded licensed by the State of Mississippi, there is  
1043 levied an assessment in an amount set by the division, not



1044 exceeding the maximum rate allowed by federal law or regulation,  
1045 for each licensed and occupied bed of the facility.

1046 (b) An intermediate care facility for the mentally  
1047 retarded is exempt from the assessment levied under this  
1048 subsection if the facility is operated under the direction and  
1049 control of:

1050 (i) The United States Veterans Administration or  
1051 other agency or department of the United States government;

1052 (ii) The State Veterans Affairs Board; or

1053 (iii) The University of Mississippi Medical  
1054 Center.

1055 (3) (a) Upon each psychiatric residential treatment  
1056 facility licensed by the State of Mississippi, there is levied an  
1057 assessment in an amount set by the division, not exceeding the  
1058 maximum rate allowed by federal law or regulation, for each  
1059 licensed and occupied bed of the facility.

1060 (b) A psychiatric residential treatment facility is  
1061 exempt from the assessment levied under this subsection if the  
1062 facility is operated under the direction and control of:

1063 (i) The United States Veterans Administration or  
1064 other agency or department of the United States government;

1065 (ii) The University of Mississippi Medical Center;

1066 (iii) A state agency or a state facility that  
1067 either provides its own state match through intergovernmental  
1068 transfer or certification of funds to the division.

1069 (4) (a) Upon each hospital licensed by the State of  
1070 Mississippi, there is levied an assessment in the amount of Three  
1071 Dollars and Twenty-five Cents (\$3.25) per bed for each licensed  
1072 inpatient acute care bed of the hospital.

1073 (b) A hospital is exempt from the assessment levied  
1074 under this subsection if the hospital is operated under the  
1075 direction and control of:



1076 (i) The United States Veterans Administration or  
1077 other agency or department of the United States government;  
1078 (ii) The University of Mississippi Medical Center;  
1079 or  
1080 (iii) A state agency or a state facility that  
1081 either provides its own state match through intergovernmental  
1082 transfer or certification of funds to the division.

1083 (5) Each health care facility that is subject to the  
1084 provisions of this section shall keep and preserve such suitable  
1085 books and records as may be necessary to determine the amount of  
1086 assessment for which it is liable under this section. The books  
1087 and records shall be kept and preserved for a period of not less  
1088 than five (5) years, and those books and records shall be open for  
1089 examination during business hours by the division, the State Tax  
1090 Commission, the Office of the Attorney General and the State  
1091 Department of Health.

1092 (6) The assessment levied under this section shall be  
1093 collected by the division each month beginning on March 31, 2005.

1094 (7) All assessments collected under this section shall be  
1095 deposited in the Medical Care Fund created by Section 43-13-143.

1096 (8) The assessment levied under this section shall be in  
1097 addition to any other assessments, taxes or fees levied by law,  
1098 and the assessment shall constitute a debt due the State of  
1099 Mississippi from the time the assessment is due until it is paid.

1100 (9) (a) If a health care facility that is liable for  
1101 payment of an assessment levied by the division does not pay the  
1102 assessment when it is due, the division shall give written notice  
1103 to the health care facility by certified or registered mail  
1104 demanding payment of the assessment within ten (10) days from the  
1105 date of delivery of the notice. If the health care facility  
1106 fails or refuses to pay the assessment after receiving the notice  
1107 and demand from the division, the division shall withhold from any  
1108 Medicaid reimbursement payments that are due to the health care



1109 facility the amount of the unpaid assessment and a penalty of ten  
1110 percent (10%) of the amount of the assessment, plus the legal rate  
1111 of interest until the assessment is paid in full. If the health  
1112 care facility does not participate in the Medicaid program, the  
1113 division shall turn over to the Office of the Attorney General the  
1114 collection of the unpaid assessment by civil action. In any such  
1115 civil action, the Office of the Attorney General shall collect the  
1116 amount of the unpaid assessment and a penalty of ten percent (10%)  
1117 of the amount of the assessment, plus the legal rate of interest  
1118 until the assessment is paid in full.

1119 (b) As an additional or alternative method for  
1120 collecting unpaid assessments levied by the division, if a health  
1121 care facility fails or refuses to pay the assessment after  
1122 receiving notice and demand from the division, the division may  
1123 file a notice of a tax lien with the circuit clerk of the county  
1124 in which the health care facility is located, for the amount of  
1125 the unpaid assessment and a penalty of ten percent (10%) of the  
1126 amount of the assessment, plus the legal rate of interest until  
1127 the assessment is paid in full. Immediately upon receipt of  
1128 notice of the tax lien for the assessment, the circuit clerk shall  
1129 enter the notice of the tax lien as a judgment upon the judgment  
1130 roll and show in the appropriate columns the name of the health  
1131 care facility as judgment debtor, the name of the division as  
1132 judgment creditor, the amount of the unpaid assessment, and the  
1133 date and time of enrollment. The judgment shall be valid as  
1134 against mortgagees, pledgees, entrusters, purchasers, judgment  
1135 creditors and other persons from the time of filing with the  
1136 clerk. The amount of the judgment shall be a debt due the State  
1137 of Mississippi and remain a lien upon the tangible property of the  
1138 health care facility until the judgment is satisfied. The  
1139 judgment shall be the equivalent of any enrolled judgment of a  
1140 court of record and shall serve as authority for the issuance of  
1141 writs of execution, writs of attachment or other remedial writs.



1142           **SECTION 4.** This act shall take effect and be in force from  
1143 and after July 1, 2008.

