

By: Representative Dedeaux

To: Medicaid

HOUSE BILL NO. 71

1 AN ACT RELATING TO THE ADMINISTRATION OF THE MISSISSIPPI
2 MEDICAID LAW; TO AMEND SECTION 43-13-107, MISSISSIPPI CODE OF
3 1972, WHICH CREATES THE DIVISION OF MEDICAID AND PRESCRIBES ITS
4 DUTIES AND RESPONSIBILITIES, TO EXTEND THE DATE OF THE REPEALER ON
5 THIS SECTION TO JULY 1, 2012; TO AMEND SECTION 43-13-117,
6 MISSISSIPPI CODE OF 1972, TO CLARIFY THE LIMITATION ON INPATIENT
7 HOSPITAL CARE REIMBURSEMENT FOR RECIPIENTS REQUIRING TRANSPLANTS;
8 TO DELETE THE AUTHORITY FOR UNLIMITED INPATIENT HOSPITAL CARE
9 REIMBURSEMENT FOR ELIGIBLE INFANTS IN DISPROPORTIONATE SHARE
10 HOSPITALS; TO PROVIDE MEDICAID REIMBURSEMENT FOR OUTPATIENT
11 SERVICES IN A CLINIC OR OTHER FACILITY THAT IS NOT LOCATED INSIDE
12 A HOSPITAL, BUT THAT HAS BEEN DESIGNATED AS AN OUTPATIENT FACILITY
13 BY THE HOSPITAL, AND THAT WAS IN OPERATION OR UNDER CONSTRUCTION
14 ON JULY 1, 2009; TO PROVIDE THAT THE DIVISION OF MEDICAID, IN
15 OBTAINING MEDICAL AND MENTAL HEALTH ASSESSMENTS FOR CHILDREN WHO
16 ARE IN, OR AT RISK FOR BEING PUT IN, THE CUSTODY OF THE DEPARTMENT
17 OF HUMAN SERVICES MAY ENTER A COOPERATIVE AGREEMENT WITH THE
18 DEPARTMENT FOR THE PROVISION OF THOSE SERVICES; TO PROVIDE FOR AN
19 INCREASE IN FEES FOR PHYSICIANS' SERVICES ON JANUARY 1, 2010; TO
20 PROVIDE THAT THE ASSESSMENT ON HOSPITALS UNDER THE AUTHORITY OF
21 THE MEDICARE UPPER PAYMENT LIMITS PROGRAM SHALL BE USED FOR THE
22 SOLE PURPOSE OF FINANCING THE STATE PORTION OF THAT PROGRAM; TO
23 PROVIDE THAT STATE-OWNED AND STATE-OPERATED FACILITIES THAT
24 PROVIDE INPATIENT PSYCHIATRIC SERVICES TO PERSONS UNDER AGE 21 WHO
25 ARE ELIGIBLE FOR MEDICAID REIMBURSEMENT SHALL BE REIMBURSED FOR
26 THOSE SERVICES ON A FULL REASONABLE COST BASIS; TO PROHIBIT THE
27 DIVISION FROM IMPLEMENTATION OF LOWER OF LOGIC REIMBURSEMENT FOR
28 INPATIENT HOSPITAL SERVICES AND CROSSOVER CLAIMS COVERED UNDER
29 MEDICARE PART B FOR DUALY ELIGIBLE BENEFICIARIES WITHOUT
30 LEGISLATIVE APPROVAL; TO PROHIBIT THE DIVISION FROM CHANGING THE
31 PAYMENT METHODOLOGY TO CERTAIN MEDICAID PROVIDERS WITHOUT
32 LEGISLATIVE APPROVAL; TO PROVIDE THAT CUTS UNDER THE MEDICAID
33 PROGRAM DUE TO SHORTFALLS SHALL BE VERIFIED BY THE PEER COMMITTEE
34 AND SHALL ONLY BE EFFECTIVE ON FEBRUARY 1 IN FY2010; TO PROHIBIT
35 THE DIVISION FROM IMPLEMENTING ANY MANAGED CARE PROGRAM BEYOND THE
36 LEVEL, SCOPE OR LOCATION OF THE PROGRAM AS IT EXISTED ON OCTOBER
37 1, 2008, UNTIL JANUARY 1, 2010; TO PROVIDE THAT ANY MANAGED CARE
38 PROGRAM SHALL BE LIMITED TO A CERTAIN PERCENTAGE OF MEDICAID
39 BENEFICIARIES; TO PROVIDE THAT ANY MEDICAID BENEFICIARY ENROLLED
40 IN A MANAGED CARE PROGRAM SHALL HAVE AN ANNUAL WINDOW DURING WHICH
41 THE BENEFICIARY MAY DISENROLL; TO PROVIDE THAT THE DIVISION SHALL
42 NOT BE AUTHORIZED TO IMPLEMENT A MANAGED CARE PROGRAM IF IT DOES
43 NOT RECEIVE FEDERAL WAIVERS NECESSARY FOR THE PROGRAM TO INCLUDE
44 ALL OF THE REQUIREMENTS OF THIS ACT; TO PROVIDE THAT THE PEER
45 COMMITTEE SHALL CONDUCT A COMPREHENSIVE PERFORMANCE EVALUATION OF
46 THE MANAGED CARE PROGRAM, AND PROVIDE THE PERFORMANCE EVALUATION



TO THE LEGISLATURE NOT LATER THAN DECEMBER 15, 2011; TO AUTHORIZE THE DIVISION TO PUBLISH APR-DRG REIMBURSEMENT RATES BUT NOT IMPLEMENT THEM UNTIL AFTER JULY 1, 2010; TO PROVIDE THAT THE PEER COMMITTEE SHALL STUDY THE BENEFITS AND LIABILITIES OF USING APR-DRG REIMBURSEMENT RATES, AND REPORT ITS FINDINGS TO THE LEGISLATURE ON OR BEFORE DECEMBER 15, 2009; TO PROVIDE THAT THERE SHALL BE NO CUTS IN INPATIENT AND OUTPATIENT HOSPITAL PAYMENTS AS LONG AS THE HOSPITAL ASSESSMENT PROVIDED IN SECTION 43-13-145, MISSISSIPPI CODE OF 1972, IS IN EFFECT; TO AMEND SECTION 43-13-145, MISSISSIPPI CODE OF 1972, TO PROVIDE FOR AN ANNUAL ASSESSMENT IMPOSED ON EACH HOSPITAL LICENSED IN THE STATE BASED UPON NON-MEDICARE HOSPITAL INPATIENT DAYS WITH CERTAIN CONDITIONS; TO PROVIDE THAT THE PRESENT PER BED ASSESSMENT LEVIED ON HOSPITALS SHALL BE DELETED UNLESS THE HOSPITAL ASSESSMENT DOES NOT TAKE EFFECT; TO CLARIFY THE ANNUAL ASSESSMENT IMPOSED ON NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED; TO PROVIDE THAT TAX LIENS FOR ASSESSMENTS SHALL BE FILED WITH THE CHANCERY CLERK; TO AMEND SECTION 43-13-407, MISSISSIPPI CODE OF 1972, TO CONFORM; AND FOR RELATED PURPOSES.

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

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

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

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



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

90 (c) The executive director shall, before entering upon
91 the discharge of the duties of the office, take and subscribe to
92 the oath of office prescribed by the Mississippi Constitution and
93 shall file the same in the Office of the Secretary of State, and
94 shall execute a bond in some surety company authorized to do
95 business in the state in the penal sum of One Hundred Thousand
96 Dollars (\$100,000.00), conditioned for the faithful and impartial
97 discharge of the duties of the office. The premium on the bond
98 shall be paid as provided by law out of funds appropriated to the
99 Division of Medicaid for contractual services.

100 (d) The executive director, with the approval of the
101 Governor and subject to the rules and regulations of the State
102 Personnel Board, shall employ such professional, administrative,
103 stenographic, secretarial, clerical and technical assistance as
104 may be necessary to perform the duties required in administering
105 this article and fix the compensation for those persons, all in
106 accordance with a state merit system meeting federal requirements.
107 When the salary of the executive director is not set by law, that
108 salary shall be set by the State Personnel Board. No employees of
109 the Division of Medicaid shall be considered to be staff members
110 of the immediate Office of the Governor; however, * * * Section
111 25-9-107(c) (xv) shall apply to the executive director and other
112 administrative heads of the division.

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

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



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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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



shall be subject to the Open Meetings Act (Sections 25-41-1 through 25-41-17). Board meetings conducted in violation of this section shall be deemed unlawful.

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

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

(c) The committee meetings shall be open to the public, members of the press, legislators and consumers. Additionally, all documents provided to committee members shall be available to members of the Legislature in the same manner, and shall be made available to others for a reasonable fee for copying. However, patient confidentiality and provider confidentiality shall be protected by blinding patient names and provider names with numerical or other anonymous identifiers. The committee meetings shall be subject to the Open Meetings Act (Sections 25-41-1 through 25-41-17). Committee meetings conducted in violation of this section shall be deemed unlawful.

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



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

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

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

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

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



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

(6) This section shall stand repealed on July 1, 2012.

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

[The following amendments to this section shall not become effective until the hospital assessment provided for in the 2009 amendments to Section 43-13-145 becomes effective. If the hospital assessment shall not take effect and/or shall cease to be imposed, the provisions of Section 43-13-117 shall remain in effect as existed on June 30, 2009.]

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

(1) Inpatient hospital services.

(a) The division shall allow thirty (30) days of inpatient hospital care annually for all Medicaid recipients. Medicaid recipients requiring transplants shall not have those days included in the transplant hospital stay count against the thirty-day limit for inpatient hospital care. Precertification of inpatient days must be obtained as required by the division. * * *

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

(c) Hospitals will receive an additional payment for the implantable programmable baclofen drug pump used to treat



spasticity that is implanted on an inpatient basis. The payment pursuant to written invoice will be in addition to the facility's per diem reimbursement and will represent a reduction of costs on the facility's annual cost report, and shall not exceed Ten Thousand Dollars (\$10,000.00) per year per recipient.

(2) Outpatient hospital services.

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

(b) Other outpatient hospital services. The division shall allow benefits for other medically necessary outpatient hospital services (such as chemotherapy, radiation, surgery and therapy), including outpatient services in a clinic or other facility that is not located inside the hospital, but that has been designated as an outpatient facility by the hospital, and that was in operation or under construction on July 1, 2009, provided that the costs and charges associated with the operation of the hospital clinic are included in the hospital's cost report. In addition, the Medicare thirty-five-mile rule will apply to those hospital clinics not located inside the hospital that are constructed after July 1, 2009. Where the same services are reimbursed as clinic services, the division may revise the rate or methodology of outpatient reimbursement to maintain consistency, efficiency, economy and quality of care.

(3) Laboratory and x-ray services.

(4) Nursing facility services.

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



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

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

364 (d) When a facility of a category that does not
365 require a certificate of need for construction and that could not
366 be eligible for Medicaid reimbursement is constructed to nursing
367 facility specifications for licensure and certification, and the
368 facility is subsequently converted to a nursing facility under a
369 certificate of need that authorizes conversion only and the
370 applicant for the certificate of need was assessed an application
371 review fee based on capital expenditures incurred in constructing
372 the facility, the division shall allow reimbursement for capital
373 expenditures necessary for construction of the facility that were
374 incurred within the twenty-four (24) consecutive calendar months
375 immediately preceding the date that the certificate of need
376 authorizing the conversion was issued, to the same extent that
377 reimbursement would be allowed for construction of a new nursing
378 facility under a certificate of need that authorizes that
379 construction. The reimbursement authorized in this subparagraph
380 (d) may be made only to facilities the construction of which was
381 completed after June 30, 1989. Before the division shall be



authorized to make the reimbursement authorized in this subparagraph (d), the division first must have received approval from the Centers for Medicare and Medicaid Services (CMS) of the change in the state Medicaid plan providing for the reimbursement.

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

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

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

(5) Periodic screening and diagnostic services for individuals under age twenty-one (21) years as are needed to identify physical and mental defects and to provide health care treatment and other measures designed to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services, regardless of whether these services are included in the state plan. The division may include in its periodic screening and diagnostic program those discretionary



services authorized under the federal regulations adopted to implement Title XIX of the federal Social Security Act, as amended. The division, in obtaining physical therapy services, occupational therapy services, and services for individuals with speech, hearing and language disorders, may enter into a cooperative agreement with the State Department of Education for the provision of those services to handicapped students by public school districts using state funds that are provided from the appropriation to the Department of Education to obtain federal matching funds through the division. The division, in obtaining medical and mental health assessments for children who are in, or at risk of being put in, the custody of the Mississippi Department of Human Services may enter into a cooperative agreement with the Mississippi Department of Human Services for the provision of those services using state funds that are provided from the appropriation to the Department of Human Services to obtain federal matching funds through the division.

(6) Physician's services. The division shall allow twelve (12) physician visits annually. All fees for physicians' services that are covered only by Medicaid shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as may be adjusted each July thereafter, under Medicare (Title XVIII of the federal Social Security Act, as amended). The division may develop and implement a different reimbursement model or schedule for physician's services provided by physicians based at an academic health care center and by physicians at rural health centers that are associated with an academic health care center. From and after January 1, 2010, all fees for physicians' services that are covered only by Medicaid shall be increased to ninety percent (90%) of the rate established on January 1, 2010, and as may be adjusted each July thereafter, under Medicare.

(7) (a) Home health services for eligible persons, not to exceed in cost the prevailing cost of nursing facility



services, not to exceed twenty-five (25) visits per year. All home health visits must be precertified as required by the division.

(b) [Repealed]

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

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

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

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

The division shall allow for a combination of prescriptions for single source and innovator multiple source drugs and generic drugs to meet the needs of the beneficiaries, not to exceed five



(5) prescriptions per month for each noninstitutionalized Medicaid beneficiary, with not more than two (2) of those prescriptions being for single source or innovator multiple source drugs.

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

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

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

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

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



514 All claims for drugs for dually eligible Medicare/Medicaid
515 beneficiaries that are paid for by Medicare must be submitted to
516 Medicare for payment before they may be processed by the
517 division's online payment system.

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

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

531 Notwithstanding any law or regulation, information obtained
532 or maintained by the division regarding the prescription drug
533 program, including trade secrets and manufacturer or labeler
534 pricing, is confidential and not subject to disclosure except to
535 other state agencies.

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

543 Payment for other covered drugs, other than multisource drugs
544 with CMS upper limits, shall not exceed the lower of the estimated
545 acquisition cost as determined by the division, plus a dispensing



546 fee or the providers' usual and customary charge to the general
547 public.

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

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

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

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

563 (10) (a) Dental care that is an adjunct to treatment
564 of an acute medical or surgical condition; services of oral
565 surgeons and dentists in connection with surgery related to the
566 jaw or any structure contiguous to the jaw or the reduction of any
567 fracture of the jaw or any facial bone; and emergency dental
568 extractions and treatment related thereto. On July 1, 2007, fees
569 for dental care and surgery under authority of this paragraph (10)
570 shall be reimbursed as provided in subparagraph (b). It is the
571 intent of the Legislature that this rate revision for dental
572 services will be an incentive designed to increase the number of
573 dentists who actively provide Medicaid services. This dental
574 services rate revision shall be known as the "James Russell Dumas
575 Medicaid Dental Incentive Program."

576 The division shall annually determine the effect of this
577 incentive by evaluating the number of dentists who are Medicaid
578 providers, the number who and the degree to which they are



actively billing Medicaid, the geographic trends of where dentists are offering what types of Medicaid services and other statistics pertinent to the goals of this legislative intent. This data shall be presented to the Chair of the Senate Public Health and Welfare Committee and the Chair of the House Medicaid Committee.

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

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

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

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

(f) This paragraph (10) shall stand repealed on July 1, 2012.



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

620 (12) Intermediate care facility services.

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

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

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

635 (14) Clinic services. Such diagnostic, preventive,
636 therapeutic, rehabilitative or palliative services furnished to an
637 outpatient by or under the supervision of a physician or dentist
638 in a facility that is not a part of a hospital but that is
639 organized and operated to provide medical care to outpatients.
640 Clinic services shall include any services reimbursed as
641 outpatient hospital services that may be rendered in such a
642 facility, including those that become so after July 1, 1991. On
643 July 1, 1999, all fees for physicians' services reimbursed under



644 authority of this paragraph (14) shall be reimbursed at ninety
645 percent (90%) of the rate established on January 1, 1999, and as
646 may be adjusted each July thereafter, under Medicare (Title XVIII
647 of the federal Social Security Act, as amended). The division may
648 develop and implement a different reimbursement model or schedule
649 for physician's services provided by physicians based at an
650 academic health care center and by physicians at rural health
651 centers that are associated with an academic health care center.

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

657 (16) Mental health services. Approved therapeutic and
658 case management services (a) provided by an approved regional
659 mental health/retardation center established under Sections
660 41-19-31 through 41-19-39, or by another community mental health
661 service provider meeting the requirements of the Department of
662 Mental Health to be an approved mental health/retardation center
663 if determined necessary by the Department of Mental Health, using
664 state funds that are provided from the appropriation to the State
665 Department of Mental Health and/or funds transferred to the
666 department by a political subdivision or instrumentality of the
667 state and used to match federal funds under a cooperative
668 agreement between the division and the department, or (b) provided
669 by a facility that is certified by the State Department of Mental
670 Health to provide therapeutic and case management services, to be
671 reimbursed on a fee for service basis, or (c) provided in the
672 community by a facility or program operated by the Department of
673 Mental Health. Any such services provided by a facility described
674 in subparagraph (b) must have the prior approval of the division
675 to be reimbursable under this section. After June 30, 1997,
676 mental health services provided by regional mental



677 health/retardation centers established under Sections 41-19-31
678 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
679 and/or their subsidiaries and divisions, or by psychiatric
680 residential treatment facilities as defined in Section 43-11-1, or
681 by another community mental health service provider meeting the
682 requirements of the Department of Mental Health to be an approved
683 mental health/retardation center if determined necessary by the
684 Department of Mental Health, shall not be included in or provided
685 under any capitated managed care pilot program provided for under
686 paragraph (24) of this section.

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

693 (18) (a) Notwithstanding any other provision of this
694 section to the contrary, as provided in the Medicaid state plan
695 amendment or amendments as defined in Section 43-13-145(10), the
696 division shall make additional reimbursement to hospitals that
697 serve a disproportionate share of low-income patients and that
698 meet the federal requirements for those payments as provided in
699 Section 1923 of the federal Social Security Act and any applicable
700 regulations. It is the intent of the Legislature that the
701 division shall draw down all available federal funds allotted to
702 the state for disproportionate share hospitals. However, from and
703 after January 1, 1999, * * * public hospitals participating in the
704 Medicaid disproportionate share program may be required to
705 participate in an intergovernmental transfer program as provided
706 in Section 1903 of the federal Social Security Act and any
707 applicable regulations.

708 (b) The division shall establish a Medicare Upper
709 Payment Limits Program, as defined in Section 1902(a)(30) of the



710 federal Social Security Act and any applicable federal
711 regulations, for hospitals, and may establish a Medicare Upper
712 Payment Limits Program for nursing facilities. The division shall
713 assess each hospital and, if the program is established for
714 nursing facilities, shall assess each nursing facility, for the
715 sole purpose of financing the state portion of the Medicare Upper
716 Payment Limits Program. The hospital assessment shall be as
717 provided in Section 43-13-145(4)(a) and the nursing facility
718 assessment, if established, shall be based on Medicaid utilization
719 or other appropriate method consistent with federal regulations.
720 The assessment will remain in effect as long as the state
721 participates in the Medicare Upper Payment Limits Program. As
722 provided in the Medicaid state plan amendment or amendments as
723 defined in Section 43-13-145(10), the division shall make
724 additional reimbursement to hospitals and, if the program is
725 established for nursing facilities, shall make additional
726 reimbursement to nursing facilities, for the Medicare Upper
727 Payment Limits, as defined in Section 1902(a)(30) of the federal
728 Social Security Act and any applicable federal regulations.

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

737 (b) Early intervention system services. The
738 division shall cooperate with the State Department of Health,
739 acting as lead agency, in the development and implementation of a
740 statewide system of delivery of early intervention services, under
741 Part C of the Individuals with Disabilities Education Act (IDEA).
742 The State Department of Health shall certify annually in writing



743 to the executive director of the division the dollar amount of
744 state early intervention funds available that will be utilized as
745 a certified match for Medicaid matching funds. Those funds then
746 shall be used to provide expanded targeted case management
747 services for Medicaid eligible children with special needs who are
748 eligible for the state's early intervention system.

749 Qualifications for persons providing service coordination shall be
750 determined by the State Department of Health and the Division of
751 Medicaid.

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

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

772 (22) Ambulatory services delivered in federally
773 qualified health centers, rural health centers and clinics of the
774 local health departments of the State Department of Health for



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

777 (23) Inpatient psychiatric services. Inpatient
778 psychiatric services to be determined by the division for
779 recipients under age twenty-one (21) that are provided under the
780 direction of a physician in an inpatient program in a licensed
781 acute care psychiatric facility or in a licensed psychiatric
782 residential treatment facility, before the recipient reaches age
783 twenty-one (21) or, if the recipient was receiving the services
784 immediately before he or she reached age twenty-one (21), before
785 the earlier of the date he or she no longer requires the services
786 or the date he or she reaches age twenty-two (22), as provided by
787 federal regulations. Precertification of inpatient days and
788 residential treatment days must be obtained as required by the
789 division. From and after July 1, 2009, all state-owned and
790 state-operated facilities that provide inpatient psychiatric
791 services to persons under age twenty-one (21) who are eligible for
792 Medicaid reimbursement shall be reimbursed for those services on a
793 full reasonable cost basis.

794 (24) [Deleted]

795 (25) [Deleted]

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



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

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

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

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

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

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

839 (33) Podiatrist services.



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

844 (35) Services and activities authorized in Sections
845 43-27-101 and 43-27-103, using state funds that are provided from
846 the appropriation to the Mississippi Department of Human Services
847 and used to match federal funds under a cooperative agreement
848 between the division and the department.

849 (36) Nonemergency transportation services for
850 Medicaid-eligible persons, to be provided by the Division of
851 Medicaid. The division may contract with additional entities to
852 administer nonemergency transportation services as it deems
853 necessary. All providers shall have a valid driver's license,
854 vehicle inspection sticker, valid vehicle license tags and a
855 standard liability insurance policy covering the vehicle. The
856 division may pay providers a flat fee based on mileage tiers, or
857 in the alternative, may reimburse on actual miles traveled. The
858 division may apply to the Center for Medicare and Medicaid
859 Services (CMS) for a waiver to draw federal matching funds for
860 nonemergency transportation services as a covered service instead
861 of an administrative cost. The PEER Committee shall conduct a
862 performance evaluation of the nonemergency transportation program
863 to evaluate the administration of the program and the providers of
864 transportation services to determine the most cost-effective ways
865 of providing nonemergency transportation services to the patients
866 served under the program. The performance evaluation shall be
867 completed and provided to the members of the Senate Public Health
868 and Welfare Committee and the House Medicaid Committee not later
869 than January 15, 2008.

870 (37) [Deleted]

871 (38) Chiropractic services. A chiropractor's manual
872 manipulation of the spine to correct a subluxation, if x-ray



873 demonstrates that a subluxation exists and if the subluxation has
874 resulted in a neuromusculoskeletal condition for which
875 manipulation is appropriate treatment, and related spinal x-rays
876 performed to document these conditions. Reimbursement for
877 chiropractic services shall not exceed Seven Hundred Dollars
878 (\$700.00) per year per beneficiary.

879 (39) Dually eligible Medicare/Medicaid beneficiaries.
880 The division shall pay the Medicare deductible and coinsurance
881 amounts for services available under Medicare, as determined by
882 the division. From and after July 1, 2009, the division shall
883 reimburse crossover claims for inpatient hospital services and
884 crossover claims covered under Medicare Part B in the same manner
885 that was in effect on January 1, 2008, unless specifically
886 authorized by the Legislature to change this method.

887 (40) [Deleted]

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

898 (42) Notwithstanding any other provision in this
899 article to the contrary, the division may develop a population
900 health management program for women and children health services
901 through the age of one (1) year. This program is primarily for
902 obstetrical care associated with low birth weight and preterm
903 babies. The division may apply to the federal Centers for
904 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
905 any other waivers that may enhance the program. In order to



effect cost savings, the division may develop a revised payment methodology that may include at-risk capitated payments, and may require member participation in accordance with the terms and conditions of an approved federal waiver.

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

(44) Nursing facility services for the severely disabled.

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

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

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

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



these services are specifically appropriated for this purpose by the Legislature, or if funds are voluntarily provided by affected agencies.

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

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

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

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

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

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

(50) Services provided by the State Department of Rehabilitation Services for the care and rehabilitation of persons who are deaf and blind, as allowed under waivers from the United States Department of Health and Human Services to provide home-



and community-based services using state funds that are provided from the appropriation to the State Department of Rehabilitation Services or if funds are voluntarily provided by another agency.

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

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

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

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

(54) Adult foster care services pilot program. Social and protective services on a pilot program basis in an approved foster care facility for vulnerable adults who would otherwise need care in a long-term care facility, to be implemented in an area of the state with the greatest need for such program, under



the Medicaid Waivers for the Elderly and Disabled program or an assisted living waiver. The division may use grants, waivers, demonstrations or other projects as necessary in the development and implementation of this adult foster care services pilot program.

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

(B) Notwithstanding any other provision of this article to the contrary, the division shall reduce the rate of reimbursement to providers for any service provided under this section by five percent (5%) of the allowed amount for that service. However, the reduction in the reimbursement rates required by this subsection (B) shall not apply to inpatient hospital services, nursing facility services, intermediate care facility services, psychiatric residential treatment facility services, pharmacy services provided under subsection (A) (9) of this section, or any service provided by the University of Mississippi Medical Center or a state agency, a state facility or a public agency that either provides its own state match through intergovernmental transfer or certification of funds to the division, or a service for which the federal government sets the reimbursement methodology and rate. From and after January 1, 2010, the reduction in the reimbursement rates required by this subsection (B) shall not apply to



1038 physicians' services. In addition, the reduction in the
1039 reimbursement rates required by this subsection (B) shall not
1040 apply to case management services and home-delivered meals
1041 provided under the home- and community-based services program for
1042 the elderly and disabled by a planning and development district
1043 (PDD). Planning and development districts participating in the
1044 home- and community-based services program for the elderly and
1045 disabled as case management providers shall be reimbursed for case
1046 management services at the maximum rate approved by the Centers
1047 for Medicare and Medicaid Services (CMS).

1048 (C) The division may pay to those providers who participate
1049 in and accept patient referrals from the division's emergency room
1050 redirection program a percentage, as determined by the division,
1051 of savings achieved according to the performance measures and
1052 reduction of costs required of that program. Federally qualified
1053 health centers may participate in the emergency room redirection
1054 program, and the division may pay those centers a percentage of
1055 any savings to the Medicaid program achieved by the centers'
1056 accepting patient referrals through the program, as provided in
1057 this subsection (C).

1058 (D) Notwithstanding any provision of this article, except as
1059 authorized in the following subsection and in Section 43-13-139,
1060 neither (a) the limitations on quantity or frequency of use of or
1061 the fees or charges for any of the care or services available to
1062 recipients under this section, nor (b) the payments, payment
1063 methodology as provided below in this subsection (D), or rates of
1064 reimbursement to providers rendering care or services authorized
1065 under this section to recipients, may be increased, decreased or
1066 otherwise changed from the levels in effect on July 1, 1999,
1067 unless they are authorized by an amendment to this section by the
1068 Legislature. However, the restriction in this subsection shall
1069 not prevent the division from changing the payments, payment
1070 methodology as provided below in this subsection (D), or rates of



reimbursement to providers without an amendment to this section whenever those changes are required by federal law or regulation, or whenever those changes are necessary to correct administrative errors or omissions in calculating those payments or rates of reimbursement. The prohibition on any changes in payment methodology provided in this subsection (D) shall apply only to payment methodologies used for determining the rates of reimbursement for inpatient hospital services, outpatient hospital services and/or nursing facility services, except as required by federal law, and the federally mandated rebasing of rates as required by the Centers for Medicare and Medicaid Services (CMS) shall not be considered payment methodology for purposes of this subsection (D).

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

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



1104 this section that is mandatory under federal law, or to
1105 discontinue or eliminate, or adjust income limits or resource
1106 limits for, any eligibility category or group under Section
1107 43-13-115. Applicable in fiscal year 2010 only, no expenditure
1108 reductions or cost containments or increases in assessments
1109 recommended by the Executive Director of the Division of Medicaid
1110 shall be implemented before February 1, unless the division
1111 projects a shortfall so great that the entire Health Care
1112 Expendable Fund balance would be reduced to zero. Beginning in
1113 fiscal year 2010 and in fiscal years thereafter, when Medicaid
1114 expenditures are projected to exceed funds available for any
1115 quarter in the fiscal year, the division shall submit the expected
1116 shortfall information to the PEER Committee, which shall review
1117 the computations of the division and report its findings to the
1118 Legislative Budget Office within thirty (30) days of such
1119 notification by the division, and not later than January 7 in any
1120 year. If expenditure reductions or cost containments are
1121 implemented, the Governor may implement a maximum amount of state
1122 share expenditure reductions to providers, of which hospitals will
1123 be responsible for twenty-five percent (25%) of provider
1124 reductions as follows: in fiscal year 2010, the maximum amount
1125 shall be Twenty-four Million Dollars (\$24,000,000.00); in fiscal
1126 year 2011, the maximum amount shall be Thirty-two Million Dollars
1127 (\$32,000,000.00); and in fiscal year 2012 and thereafter, the
1128 maximum amount shall be Forty Million Dollars (\$40,000,000.00).
1129 However, instead of implementing cuts, the hospital share shall be
1130 in the form of an additional assessment not to exceed Ten Million
1131 Dollars (\$10,000,000.00) as provided in Section
1132 43-13-145(4)(a)(ii). If Medicaid expenditures are projected to
1133 exceed the amount of funds appropriated to the division in any
1134 fiscal year in excess of the expenditure reductions to providers,
1135 then funds shall be transferred by the State Fiscal Officer from
1136 the Health Care Trust Fund into the Health Care Expendable Fund



and to the Governor's Office, Division of Medicaid, from the Health Care Expendable Fund, in the amount and at such time as requested by the Governor to reconcile the deficit. If the cost containment measures described above have been implemented and there are insufficient funds in the Health Care Trust Fund to reconcile any remaining deficit in any fiscal year, the Governor shall institute any other additional cost containment measures on any program or programs authorized under this article to the extent allowed under federal law. Hospitals shall be responsible for twenty-five percent (25%) of any additional imposed provider cuts. However, instead of implementing hospital expenditure reductions, the hospital reductions shall be in the form of an additional assessment not to exceed twenty-five percent (25%) of provider expenditure reductions as provided in Section 43-13-145(4)(a)(ii). It is the intent of the Legislature that the expenditures of the division during any fiscal year shall not exceed the amounts appropriated to the division for that fiscal year.

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

(H) (1) Notwithstanding any other provision of this article, the division shall not be authorized to implement any managed care program, coordinated care program, coordinated care organization, health maintenance organization or similar program



1170 in which services are paid for on a capitated basis, beyond the
1171 level, scope or location of the program as it existed on October
1172 1, 2008, until on or after January 1, 2010. Any managed care
1173 program or coordinated care program implemented by the division
1174 under this section shall be limited to a maximum of fifteen
1175 percent (15%) of all Medicaid beneficiaries, and any Medicaid
1176 beneficiary who is enrolled in the program shall have an annual
1177 window of at least thirty (30) days in length during which the
1178 beneficiary may disenroll from the program. In addition, any
1179 payments made to providers by a managed care organization,
1180 coordinated care organization, health maintenance organization or
1181 other similar organization under a managed care program or
1182 coordinated care program implemented by the division under this
1183 section shall be considered to be regular Medicaid payments for
1184 the purposes of calculating Medicare Upper Payment Limits (UPL)
1185 payments and Disproportionate Share Hospital (DSH) payments to
1186 hospitals. The division shall apply for any federal waiver or
1187 waivers necessary to implement a managed care program or
1188 coordinated care program that meets all of the requirements in
1189 this paragraph. If the division does not receive a federal waiver
1190 or waivers that authorizes it to implement a managed care program
1191 or coordinated care program that meets all of the requirements in
1192 this paragraph, then the division shall not be authorized to
1193 implement a managed care program or coordinated care program.

1194 (2) All health maintenance organizations, coordinated
1195 care organizations or other organizations paid for services on a
1196 capitated basis by the division under any managed care program or
1197 coordinated care program implemented by the division under this
1198 section shall reimburse all providers in those organizations at
1199 rates no lower than those provided under this section for
1200 beneficiaries who are not participating in those programs.

1201 (3) No health maintenance organization, coordinated
1202 care organization or other organization paid for services on a



1203 capitated basis by the division under any managed care program or
1204 coordinated care program implemented by the division under this
1205 section shall require its providers or beneficiaries to use any
1206 pharmacy that ships, mails or delivers prescription drugs or
1207 legend drugs or devices.

1208 (4) After a managed care program or coordinated care
1209 program is implemented by the division under this section, the
1210 PEER Committee shall conduct a comprehensive performance
1211 evaluation of the managed care program or coordinated care
1212 program, which shall include, but not be limited to, a
1213 determination of any cost savings to the division, quality of care
1214 to the beneficiaries, and access to care by the beneficiaries.
1215 The PEER Committee shall provide regular reports on the status of
1216 the managed care program or coordinated care program to the
1217 members of the Senate Public Health and Welfare Committee and the
1218 House Medicaid Committee, and shall complete the performance
1219 evaluation and provide it to the members of those committees not
1220 later than December 15, 2011. As a condition of participation in
1221 a managed care program or coordinated care program implemented by
1222 the division under this section, a provider must agree to provide
1223 any information that the PEER Committee requests to conduct the
1224 performance evaluation of the program, and all those providers
1225 shall fully cooperate with the PEER Committee in any request to
1226 provide information to the committee.

1227 (I) The division shall develop and publish reimbursement
1228 rates for each APR-DRG proposed by the division at least equal to
1229 the prevailing corresponding Medicare DRG rate or a closely
1230 related Medicare DRG rate, applying to each hospital, the
1231 applicable federal wage index being used by CMS for the hospital's
1232 geographic location, but the division shall not implement that
1233 rate schedule or APR-DRG methodology until after July 1, 2010.
1234 The PEER Committee shall study the benefits and liabilities of
1235 implementing an APR-DRG reimbursement rate schedule, and report



its findings to the members of the Senate Public Health and Welfare Committee and the House Medicaid Committee on or before December 15, 2009.

(J) There shall be no cuts in inpatient and outpatient hospital payments, or allowable days or volumes, as long as the hospital assessment provided in Section 43-13-145 is in effect.

(K) This section shall stand repealed on July 1, 2012.

[If the hospital assessment in the 2009 amendments to Section 43-13-145 does not take effect and/or shall cease to be imposed, the provisions of Section 43-13-117 shall remain in effect as existed on June 30, 2009, and this section shall read as follows:]

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

(1) Inpatient hospital services.

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

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



1269 Capital Cost Component utilized to determine total hospital costs
1270 allocated to the Medicaid program.

1271 (c) Hospitals will receive an additional payment
1272 for the implantable programmable baclofen drug pump used to treat
1273 spasticity that is implanted on an inpatient basis. The payment
1274 pursuant to written invoice will be in addition to the facility's
1275 per diem reimbursement and will represent a reduction of costs on
1276 the facility's annual cost report, and shall not exceed Ten
1277 Thousand Dollars (\$10,000.00) per year per recipient.

1278 (2) Outpatient hospital services.

1279 (a) Emergency services. The division shall allow
1280 six (6) medically necessary emergency room visits per beneficiary
1281 per fiscal year.

1282 (b) Other outpatient hospital services. The
1283 division shall allow benefits for other medically necessary
1284 outpatient hospital services (such as chemotherapy, radiation,
1285 surgery and therapy). Where the same services are reimbursed as
1286 clinic services, the division may revise the rate or methodology
1287 of outpatient reimbursement to maintain consistency, efficiency,
1288 economy and quality of care.

1289 (3) Laboratory and x-ray services.

1290 (4) Nursing facility services.

1291 (a) The division shall make full payment to
1292 nursing facilities for each day, not exceeding fifty-two (52) days
1293 per year, that a patient is absent from the facility on home
1294 leave. Payment may be made for the following home leave days in
1295 addition to the fifty-two-day limitation: Christmas, the day
1296 before Christmas, the day after Christmas, Thanksgiving, the day
1297 before Thanksgiving and the day after Thanksgiving.

1298 (b) From and after July 1, 1997, the division
1299 shall implement the integrated case-mix payment and quality
1300 monitoring system, which includes the fair rental system for
1301 property costs and in which recapture of depreciation is



1302 eliminated. The division may reduce the payment for hospital
1303 leave and therapeutic home leave days to the lower of the case-mix
1304 category as computed for the resident on leave using the
1305 assessment being utilized for payment at that point in time, or a
1306 case-mix score of 1.000 for nursing facilities, and shall compute
1307 case-mix scores of residents so that only services provided at the
1308 nursing facility are considered in calculating a facility's per
1309 diem.

1310 (c) From and after July 1, 1997, all state-owned
1311 nursing facilities shall be reimbursed on a full reasonable cost
1312 basis.

1313 (d) When a facility of a category that does not
1314 require a certificate of need for construction and that could not
1315 be eligible for Medicaid reimbursement is constructed to nursing
1316 facility specifications for licensure and certification, and the
1317 facility is subsequently converted to a nursing facility under a
1318 certificate of need that authorizes conversion only and the
1319 applicant for the certificate of need was assessed an application
1320 review fee based on capital expenditures incurred in constructing
1321 the facility, the division shall allow reimbursement for capital
1322 expenditures necessary for construction of the facility that were
1323 incurred within the twenty-four (24) consecutive calendar months
1324 immediately preceding the date that the certificate of need
1325 authorizing the conversion was issued, to the same extent that
1326 reimbursement would be allowed for construction of a new nursing
1327 facility under a certificate of need that authorizes that
1328 construction. The reimbursement authorized in this subparagraph
1329 (d) may be made only to facilities the construction of which was
1330 completed after June 30, 1989. Before the division shall be
1331 authorized to make the reimbursement authorized in this
1332 subparagraph (d), the division first must have received approval
1333 from the Centers for Medicare and Medicaid Services (CMS) of the
1334 change in the state Medicaid plan providing for the reimbursement.



1335 (e) The division shall develop and implement, not
1336 later than January 1, 2001, a case-mix payment add-on determined
1337 by time studies and other valid statistical data that will
1338 reimburse a nursing facility for the additional cost of caring for
1339 a resident who has a diagnosis of Alzheimer's or other related
1340 dementia and exhibits symptoms that require special care. Any
1341 such case-mix add-on payment shall be supported by a determination
1342 of additional cost. The division shall also develop and implement
1343 as part of the fair rental reimbursement system for nursing
1344 facility beds, an Alzheimer's resident bed depreciation enhanced
1345 reimbursement system that will provide an incentive to encourage
1346 nursing facilities to convert or construct beds for residents with
1347 Alzheimer's or other related dementia.

1348 (f) The division shall develop and implement an
1349 assessment process for long-term care services. The division may
1350 provide the assessment and related functions directly or through
1351 contract with the area agencies on aging.

1352 The division shall apply for necessary federal waivers to
1353 assure that additional services providing alternatives to nursing
1354 facility care are made available to applicants for nursing
1355 facility care.

1356 (5) Periodic screening and diagnostic services for
1357 individuals under age twenty-one (21) years as are needed to
1358 identify physical and mental defects and to provide health care
1359 treatment and other measures designed to correct or ameliorate
1360 defects and physical and mental illness and conditions discovered
1361 by the screening services, regardless of whether these services
1362 are included in the state plan. The division may include in its
1363 periodic screening and diagnostic program those discretionary
1364 services authorized under the federal regulations adopted to
1365 implement Title XIX of the federal Social Security Act, as
1366 amended. The division, in obtaining physical therapy services,
1367 occupational therapy services, and services for individuals with



1368 speech, hearing and language disorders, may enter into a
1369 cooperative agreement with the State Department of Education for
1370 the provision of those services to handicapped students by public
1371 school districts using state funds that are provided from the
1372 appropriation to the Department of Education to obtain federal
1373 matching funds through the division. The division, in obtaining
1374 medical and psychological evaluations for children in the custody
1375 of the Mississippi Department of Human Services may enter into a
1376 cooperative agreement with the Mississippi Department of Human
1377 Services for the provision of those services using state funds
1378 that are provided from the appropriation to the Department of
1379 Human Services to obtain federal matching funds through the
1380 division.

1381 (6) Physician's services. The division shall allow
1382 twelve (12) physician visits annually. All fees for physicians'
1383 services that are covered only by Medicaid shall be reimbursed at
1384 ninety percent (90%) of the rate established on January 1, 1999,
1385 and as may be adjusted each July thereafter, under Medicare (Title
1386 XVIII of the federal Social Security Act, as amended). The
1387 division may develop and implement a different reimbursement model
1388 or schedule for physician's services provided by physicians based
1389 at an academic health care center and by physicians at rural
1390 health centers that are associated with an academic health care
1391 center.

1392 (7) (a) Home health services for eligible persons, not
1393 to exceed in cost the prevailing cost of nursing facility
1394 services, not to exceed twenty-five (25) visits per year. All
1395 home health visits must be precertified as required by the
1396 division.

1397 (b) [Repealed]

1398 (8) Emergency medical transportation services. On
1399 January 1, 1994, emergency medical transportation services shall
1400 be reimbursed at seventy percent (70%) of the rate established



1401 under Medicare (Title XVIII of the federal Social Security Act, as
1402 amended). "Emergency medical transportation services" shall mean,
1403 but shall not be limited to, the following services by a properly
1404 permitted ambulance operated by a properly licensed provider in
1405 accordance with the Emergency Medical Services Act of 1974
1406 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
1407 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
1408 (vi) disposable supplies, (vii) similar services.

1409 (9) (a) Legend and other drugs as may be determined by
1410 the division.

1411 The division shall establish a mandatory preferred drug list.
1412 Drugs not on the mandatory preferred drug list shall be made
1413 available by utilizing prior authorization procedures established
1414 by the division.

1415 The division may seek to establish relationships with other
1416 states in order to lower acquisition costs of prescription drugs
1417 to include single source and innovator multiple source drugs or
1418 generic drugs. In addition, if allowed by federal law or
1419 regulation, the division may seek to establish relationships with
1420 and negotiate with other countries to facilitate the acquisition
1421 of prescription drugs to include single source and innovator
1422 multiple source drugs or generic drugs, if that will lower the
1423 acquisition costs of those prescription drugs.

1424 The division shall allow for a combination of prescriptions
1425 for single source and innovator multiple source drugs and generic
1426 drugs to meet the needs of the beneficiaries, not to exceed five
1427 (5) prescriptions per month for each noninstitutionalized Medicaid
1428 beneficiary, with not more than two (2) of those prescriptions
1429 being for single source or innovator multiple source drugs.

1430 The executive director may approve specific maintenance drugs
1431 for beneficiaries with certain medical conditions, which may be
1432 prescribed and dispensed in three-month supply increments.



1433 Drugs prescribed for a resident of a psychiatric residential
1434 treatment facility must be provided in true unit doses when
1435 available. The division may require that drugs not covered by
1436 Medicare Part D for a resident of a long-term care facility be
1437 provided in true unit doses when available. Those drugs that were
1438 originally billed to the division but are not used by a resident
1439 in any of those facilities shall be returned to the billing
1440 pharmacy for credit to the division, in accordance with the
1441 guidelines of the State Board of Pharmacy and any requirements of
1442 federal law and regulation. Drugs shall be dispensed to a
1443 recipient and only one (1) dispensing fee per month may be
1444 charged. The division shall develop a methodology for reimbursing
1445 for restocked drugs, which shall include a restock fee as
1446 determined by the division not exceeding Seven Dollars and
1447 Eighty-two Cents (\$7.82).

1448 The voluntary preferred drug list shall be expanded to
1449 function in the interim in order to have a manageable prior
1450 authorization system, thereby minimizing disruption of service to
1451 beneficiaries.

1452 Except for those specific maintenance drugs approved by the
1453 executive director, the division shall not reimburse for any
1454 portion of a prescription that exceeds a thirty-one-day supply of
1455 the drug based on the daily dosage.

1456 The division shall develop and implement a program of payment
1457 for additional pharmacist services, with payment to be based on
1458 demonstrated savings, but in no case shall the total payment
1459 exceed twice the amount of the dispensing fee.

1460 All claims for drugs for dually eligible Medicare/Medicaid
1461 beneficiaries that are paid for by Medicare must be submitted to
1462 Medicare for payment before they may be processed by the
1463 division's online payment system.

1464 The division shall develop a pharmacy policy in which drugs
1465 in tamper-resistant packaging that are prescribed for a resident



1466 of a nursing facility but are not dispensed to the resident shall
1467 be returned to the pharmacy and not billed to Medicaid, in
1468 accordance with guidelines of the State Board of Pharmacy.

1469 The division shall develop and implement a method or methods
1470 by which the division will provide on a regular basis to Medicaid
1471 providers who are authorized to prescribe drugs, information about
1472 the costs to the Medicaid program of single source drugs and
1473 innovator multiple source drugs, and information about other drugs
1474 that may be prescribed as alternatives to those single source
1475 drugs and innovator multiple source drugs and the costs to the
1476 Medicaid program of those alternative drugs.

1477 Notwithstanding any law or regulation, information obtained
1478 or maintained by the division regarding the prescription drug
1479 program, including trade secrets and manufacturer or labeler
1480 pricing, is confidential and not subject to disclosure except to
1481 other state agencies.

1482 (b) Payment by the division for covered
1483 multisource drugs shall be limited to the lower of the upper
1484 limits established and published by the Centers for Medicare and
1485 Medicaid Services (CMS) plus a dispensing fee, or the estimated
1486 acquisition cost (EAC) as determined by the division, plus a
1487 dispensing fee, or the providers' usual and customary charge to
1488 the general public.

1489 Payment for other covered drugs, other than multisource drugs
1490 with CMS upper limits, shall not exceed the lower of the estimated
1491 acquisition cost as determined by the division, plus a dispensing
1492 fee or the providers' usual and customary charge to the general
1493 public.

1494 Payment for nonlegend or over-the-counter drugs covered by
1495 the division shall be reimbursed at the lower of the division's
1496 estimated shelf price or the providers' usual and customary charge
1497 to the general public.



1498 The dispensing fee for each new or refill prescription,
1499 including nonlegend or over-the-counter drugs covered by the
1500 division, shall be not less than Three Dollars and Ninety-one
1501 Cents (\$3.91), as determined by the division.

1502 The division shall not reimburse for single source or
1503 innovator multiple source drugs if there are equally effective
1504 generic equivalents available and if the generic equivalents are
1505 the least expensive.

1506 It is the intent of the Legislature that the pharmacists
1507 providers be reimbursed for the reasonable costs of filling and
1508 dispensing prescriptions for Medicaid beneficiaries.

1509 (10) (a) Dental care that is an adjunct to treatment
1510 of an acute medical or surgical condition; services of oral
1511 surgeons and dentists in connection with surgery related to the
1512 jaw or any structure contiguous to the jaw or the reduction of any
1513 fracture of the jaw or any facial bone; and emergency dental
1514 extractions and treatment related thereto. On July 1, 2007, fees
1515 for dental care and surgery under authority of this paragraph (10)
1516 shall be reimbursed as provided in subparagraph (b). It is the
1517 intent of the Legislature that this rate revision for dental
1518 services will be an incentive designed to increase the number of
1519 dentists who actively provide Medicaid services. This dental
1520 services rate revision shall be known as the "James Russell Dumas
1521 Medicaid Dental Incentive Program."

1522 The division shall annually determine the effect of this
1523 incentive by evaluating the number of dentists who are Medicaid
1524 providers, the number who and the degree to which they are
1525 actively billing Medicaid, the geographic trends of where dentists
1526 are offering what types of Medicaid services and other statistics
1527 pertinent to the goals of this legislative intent. This data
1528 shall be presented to the Chair of the Senate Public Health and
1529 Welfare Committee and the Chair of the House Medicaid Committee.



1530 (b) The Division of Medicaid shall establish a fee
1531 schedule, to be effective from and after July 1, 2007, for dental
1532 services. The schedule shall provide for a fee for each dental
1533 service that is equal to a percentile of normal and customary
1534 private provider fees, as defined by the Ingenix Customized Fee
1535 Analyzer Report, which percentile shall be determined by the
1536 division. The schedule shall be reviewed annually by the division
1537 and dental fees shall be adjusted to reflect the percentile
1538 determined by the division.

1539 (c) For fiscal year 2008, the amount of state
1540 funds appropriated for reimbursement for dental care and surgery
1541 shall be increased by ten percent (10%) of the amount of state
1542 fund expenditures for that purpose for fiscal year 2007. For each
1543 of fiscal years 2009 and 2010, the amount of state funds
1544 appropriated for reimbursement for dental care and surgery shall
1545 be increased by ten percent (10%) of the amount of state fund
1546 expenditures for that purpose for the preceding fiscal year.

1547 (d) The division shall establish an annual benefit
1548 limit of Two Thousand Five Hundred Dollars (\$2,500.00) in dental
1549 expenditures per Medicaid-eligible recipient; however, a recipient
1550 may exceed the annual limit on dental expenditures provided in
1551 this paragraph with prior approval of the division.

1552 (e) The division shall include dental services as
1553 a necessary component of overall health services provided to
1554 children who are eligible for services.

1555 (f) This paragraph (10) shall stand repealed on
1556 July 1, 2010.

1557 (11) Eyeglasses for all Medicaid beneficiaries who have
1558 (a) had surgery on the eyeball or ocular muscle that results in a
1559 vision change for which eyeglasses or a change in eyeglasses is
1560 medically indicated within six (6) months of the surgery and is in
1561 accordance with policies established by the division, or (b) one
1562 (1) pair every five (5) years and in accordance with policies



1563 established by the division. In either instance, the eyeglasses
1564 must be prescribed by a physician skilled in diseases of the eye
1565 or an optometrist, whichever the beneficiary may select.

1566 (12) Intermediate care facility services.

1567 (a) The division shall make full payment to all
1568 intermediate care facilities for the mentally retarded for each
1569 day, not exceeding eighty-four (84) days per year, that a patient
1570 is absent from the facility on home leave. Payment may be made
1571 for the following home leave days in addition to the
1572 eighty-four-day limitation: Christmas, the day before Christmas,
1573 the day after Christmas, Thanksgiving, the day before Thanksgiving
1574 and the day after Thanksgiving.

1575 (b) All state-owned intermediate care facilities
1576 for the mentally retarded shall be reimbursed on a full reasonable
1577 cost basis.

1578 (13) Family planning services, including drugs,
1579 supplies and devices, when those services are under the
1580 supervision of a physician or nurse practitioner.

1581 (14) Clinic services. Such diagnostic, preventive,
1582 therapeutic, rehabilitative or palliative services furnished to an
1583 outpatient by or under the supervision of a physician or dentist
1584 in a facility that is not a part of a hospital but that is
1585 organized and operated to provide medical care to outpatients.
1586 Clinic services shall include any services reimbursed as
1587 outpatient hospital services that may be rendered in such a
1588 facility, including those that become so after July 1, 1991. On
1589 July 1, 1999, all fees for physicians' services reimbursed under
1590 authority of this paragraph (14) shall be reimbursed at ninety
1591 percent (90%) of the rate established on January 1, 1999, and as
1592 may be adjusted each July thereafter, under Medicare (Title XVIII
1593 of the federal Social Security Act, as amended). The division may
1594 develop and implement a different reimbursement model or schedule
1595 for physician's services provided by physicians based at an



1596 academic health care center and by physicians at rural health
1597 centers that are associated with an academic health care center.

1598 (15) Home- and community-based services for the elderly
1599 and disabled, as provided under Title XIX of the federal Social
1600 Security Act, as amended, under waivers, subject to the
1601 availability of funds specifically appropriated for that purpose
1602 by the Legislature.

1603 (16) Mental health services. Approved therapeutic and
1604 case management services (a) provided by an approved regional
1605 mental health/retardation center established under Sections
1606 41-19-31 through 41-19-39, or by another community mental health
1607 service provider meeting the requirements of the Department of
1608 Mental Health to be an approved mental health/retardation center
1609 if determined necessary by the Department of Mental Health, using
1610 state funds that are provided from the appropriation to the State
1611 Department of Mental Health and/or funds transferred to the
1612 department by a political subdivision or instrumentality of the
1613 state and used to match federal funds under a cooperative
1614 agreement between the division and the department, or (b) provided
1615 by a facility that is certified by the State Department of Mental
1616 Health to provide therapeutic and case management services, to be
1617 reimbursed on a fee for service basis, or (c) provided in the
1618 community by a facility or program operated by the Department of
1619 Mental Health. Any such services provided by a facility described
1620 in subparagraph (b) must have the prior approval of the division
1621 to be reimbursable under this section. After June 30, 1997,
1622 mental health services provided by regional mental
1623 health/retardation centers established under Sections 41-19-31
1624 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
1625 and/or their subsidiaries and divisions, or by psychiatric
1626 residential treatment facilities as defined in Section 43-11-1, or
1627 by another community mental health service provider meeting the
1628 requirements of the Department of Mental Health to be an approved



1629 mental health/retardation center if determined necessary by the
1630 Department of Mental Health, shall not be included in or provided
1631 under any capitated managed care pilot program provided for under
1632 paragraph (24) of this section.

1633 (17) Durable medical equipment services and medical
1634 supplies. Precertification of durable medical equipment and
1635 medical supplies must be obtained as required by the division.
1636 The Division of Medicaid may require durable medical equipment
1637 providers to obtain a surety bond in the amount and to the
1638 specifications as established by the Balanced Budget Act of 1997.

1639 (18) (a) Notwithstanding any other provision of this
1640 section to the contrary, the division shall make additional
1641 reimbursement to hospitals that serve a disproportionate share of
1642 low-income patients and that meet the federal requirements for
1643 those payments as provided in Section 1923 of the federal Social
1644 Security Act and any applicable regulations. It is the intent of
1645 the Legislature that the division shall draw down all available
1646 federal funds allotted to the state for disproportionate share
1647 hospitals. However, from and after January 1, 1999, no public
1648 hospital shall participate in the Medicaid disproportionate share
1649 program unless the public hospital participates in an
1650 intergovernmental transfer program as provided in Section 1903 of
1651 the federal Social Security Act and any applicable regulations.

1652 (b) The division shall establish a Medicare Upper
1653 Payment Limits Program, as defined in Section 1902(a)(30) of the
1654 federal Social Security Act and any applicable federal
1655 regulations, for hospitals, and may establish a Medicare Upper
1656 Payment Limits Program for nursing facilities. The division shall
1657 assess each hospital and, if the program is established for
1658 nursing facilities, shall assess each nursing facility, based on
1659 Medicaid utilization or other appropriate method consistent with
1660 federal regulations. The assessment will remain in effect as long
1661 as the state participates in the Medicare Upper Payment Limits



1662 Program. The division shall make additional reimbursement to
1663 hospitals and, if the program is established for nursing
1664 facilities, shall make additional reimbursement to nursing
1665 facilities, for the Medicare Upper Payment Limits, as defined in
1666 Section 1902(a)(30) of the federal Social Security Act and any
1667 applicable federal regulations.

1668 (19) (a) Perinatal risk management services. The
1669 division shall promulgate regulations to be effective from and
1670 after October 1, 1988, to establish a comprehensive perinatal
1671 system for risk assessment of all pregnant and infant Medicaid
1672 recipients and for management, education and follow-up for those
1673 who are determined to be at risk. Services to be performed
1674 include case management, nutrition assessment/counseling,
1675 psychosocial assessment/counseling and health education.

1676 (b) Early intervention system services. The
1677 division shall cooperate with the State Department of Health,
1678 acting as lead agency, in the development and implementation of a
1679 statewide system of delivery of early intervention services, under
1680 Part C of the Individuals with Disabilities Education Act (IDEA).
1681 The State Department of Health shall certify annually in writing
1682 to the executive director of the division the dollar amount of
1683 state early intervention funds available that will be utilized as
1684 a certified match for Medicaid matching funds. Those funds then
1685 shall be used to provide expanded targeted case management
1686 services for Medicaid eligible children with special needs who are
1687 eligible for the state's early intervention system.

1688 Qualifications for persons providing service coordination shall be
1689 determined by the State Department of Health and the Division of
1690 Medicaid.

1691 (20) Home- and community-based services for physically
1692 disabled approved services as allowed by a waiver from the United
1693 States Department of Health and Human Services for home- and
1694 community-based services for physically disabled people using



1695 state funds that are provided from the appropriation to the State
1696 Department of Rehabilitation Services and used to match federal
1697 funds under a cooperative agreement between the division and the
1698 department, provided that funds for these services are
1699 specifically appropriated to the Department of Rehabilitation
1700 Services.

1701 (21) Nurse practitioner services. Services furnished
1702 by a registered nurse who is licensed and certified by the
1703 Mississippi Board of Nursing as a nurse practitioner, including,
1704 but not limited to, nurse anesthetists, nurse midwives, family
1705 nurse practitioners, family planning nurse practitioners,
1706 pediatric nurse practitioners, obstetrics-gynecology nurse
1707 practitioners and neonatal nurse practitioners, under regulations
1708 adopted by the division. Reimbursement for those services shall
1709 not exceed ninety percent (90%) of the reimbursement rate for
1710 comparable services rendered by a physician.

1711 (22) Ambulatory services delivered in federally
1712 qualified health centers, rural health centers and clinics of the
1713 local health departments of the State Department of Health for
1714 individuals eligible for Medicaid under this article based on
1715 reasonable costs as determined by the division.

1716 (23) Inpatient psychiatric services. Inpatient
1717 psychiatric services to be determined by the division for
1718 recipients under age twenty-one (21) that are provided under the
1719 direction of a physician in an inpatient program in a licensed
1720 acute care psychiatric facility or in a licensed psychiatric
1721 residential treatment facility, before the recipient reaches age
1722 twenty-one (21) or, if the recipient was receiving the services
1723 immediately before he or she reached age twenty-one (21), before
1724 the earlier of the date he or she no longer requires the services
1725 or the date he or she reaches age twenty-two (22), as provided by
1726 federal regulations. Precertification of inpatient days and



1727 residential treatment days must be obtained as required by the
1728 division.

1729 (24) [Deleted]

1730 (25) [Deleted]

1731 (26) Hospice care. As used in this paragraph, the term
1732 "hospice care" means a coordinated program of active professional
1733 medical attention within the home and outpatient and inpatient
1734 care that treats the terminally ill patient and family as a unit,
1735 employing a medically directed interdisciplinary team. The
1736 program provides relief of severe pain or other physical symptoms
1737 and supportive care to meet the special needs arising out of
1738 physical, psychological, spiritual, social and economic stresses
1739 that are experienced during the final stages of illness and during
1740 dying and bereavement and meets the Medicare requirements for
1741 participation as a hospice as provided in federal regulations.

1742 (27) Group health plan premiums and cost sharing if it
1743 is cost effective as defined by the United States Secretary of
1744 Health and Human Services.

1745 (28) Other health insurance premiums that are cost
1746 effective as defined by the United States Secretary of Health and
1747 Human Services. Medicare eligible must have Medicare Part B
1748 before other insurance premiums can be paid.

1749 (29) The Division of Medicaid may apply for a waiver
1750 from the United States Department of Health and Human Services for
1751 home- and community-based services for developmentally disabled
1752 people using state funds that are provided from the appropriation
1753 to the State Department of Mental Health and/or funds transferred
1754 to the department by a political subdivision or instrumentality of
1755 the state and used to match federal funds under a cooperative
1756 agreement between the division and the department, provided that
1757 funds for these services are specifically appropriated to the
1758 Department of Mental Health and/or transferred to the department
1759 by a political subdivision or instrumentality of the state.



1760 (30) Pediatric skilled nursing services for eligible
1761 persons under twenty-one (21) years of age.

1762 (31) Targeted case management services for children
1763 with special needs, under waivers from the United States
1764 Department of Health and Human Services, using state funds that
1765 are provided from the appropriation to the Mississippi Department
1766 of Human Services and used to match federal funds under a
1767 cooperative agreement between the division and the department.

1768 (32) Care and services provided in Christian Science
1769 Sanatoria listed and certified by the Commission for Accreditation
1770 of Christian Science Nursing Organizations/Facilities, Inc.,
1771 rendered in connection with treatment by prayer or spiritual means
1772 to the extent that those services are subject to reimbursement
1773 under Section 1903 of the federal Social Security Act.

1774 (33) Podiatrist services.

1775 (34) Assisted living services as provided through home-
1776 and community-based services under Title XIX of the federal Social
1777 Security Act, as amended, subject to the availability of funds
1778 specifically appropriated for that purpose by the Legislature.

1779 (35) Services and activities authorized in Sections
1780 43-27-101 and 43-27-103, using state funds that are provided from
1781 the appropriation to the Mississippi Department of Human Services
1782 and used to match federal funds under a cooperative agreement
1783 between the division and the department.

1784 (36) Nonemergency transportation services for
1785 Medicaid-eligible persons, to be provided by the Division of
1786 Medicaid. The division may contract with additional entities to
1787 administer nonemergency transportation services as it deems
1788 necessary. All providers shall have a valid driver's license,
1789 vehicle inspection sticker, valid vehicle license tags and a
1790 standard liability insurance policy covering the vehicle. The
1791 division may pay providers a flat fee based on mileage tiers, or
1792 in the alternative, may reimburse on actual miles traveled. The



1793 division may apply to the Center for Medicare and Medicaid
1794 Services (CMS) for a waiver to draw federal matching funds for
1795 nonemergency transportation services as a covered service instead
1796 of an administrative cost. The PEER Committee shall conduct a
1797 performance evaluation of the nonemergency transportation program
1798 to evaluate the administration of the program and the providers of
1799 transportation services to determine the most cost-effective ways
1800 of providing nonemergency transportation services to the patients
1801 served under the program. The performance evaluation shall be
1802 completed and provided to the members of the Senate Public Health
1803 and Welfare Committee and the House Medicaid Committee not later
1804 than January 15, 2008.

1805 (37) [Deleted]

1806 (38) Chiropractic services. A chiropractor's manual
1807 manipulation of the spine to correct a subluxation, if x-ray
1808 demonstrates that a subluxation exists and if the subluxation has
1809 resulted in a neuromusculoskeletal condition for which
1810 manipulation is appropriate treatment, and related spinal x-rays
1811 performed to document these conditions. Reimbursement for
1812 chiropractic services shall not exceed Seven Hundred Dollars
1813 (\$700.00) per year per beneficiary.

1814 (39) Dually eligible Medicare/Medicaid beneficiaries.
1815 The division shall pay the Medicare deductible and coinsurance
1816 amounts for services available under Medicare, as determined by
1817 the division.

1818 (40) [Deleted]

1819 (41) Services provided by the State Department of
1820 Rehabilitation Services for the care and rehabilitation of persons
1821 with spinal cord injuries or traumatic brain injuries, as allowed
1822 under waivers from the United States Department of Health and
1823 Human Services, using up to seventy-five percent (75%) of the
1824 funds that are appropriated to the Department of Rehabilitation
1825 Services from the Spinal Cord and Head Injury Trust Fund



1826 established under Section 37-33-261 and used to match federal
1827 funds under a cooperative agreement between the division and the
1828 department.

1829 (42) Notwithstanding any other provision in this
1830 article to the contrary, the division may develop a population
1831 health management program for women and children health services
1832 through the age of one (1) year. This program is primarily for
1833 obstetrical care associated with low birth weight and pre-term
1834 babies. The division may apply to the federal Centers for
1835 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
1836 any other waivers that may enhance the program. In order to
1837 effect cost savings, the division may develop a revised payment
1838 methodology that may include at-risk capitated payments, and may
1839 require member participation in accordance with the terms and
1840 conditions of an approved federal waiver.

1841 (43) The division shall provide reimbursement,
1842 according to a payment schedule developed by the division, for
1843 smoking cessation medications for pregnant women during their
1844 pregnancy and other Medicaid-eligible women who are of
1845 child-bearing age.

1846 (44) Nursing facility services for the severely
1847 disabled.

1848 (a) Severe disabilities include, but are not
1849 limited to, spinal cord injuries, closed head injuries and
1850 ventilator dependent patients.

1851 (b) Those services must be provided in a long-term
1852 care nursing facility dedicated to the care and treatment of
1853 persons with severe disabilities, and shall be reimbursed as a
1854 separate category of nursing facilities.

1855 (45) Physician assistant services. Services furnished
1856 by a physician assistant who is licensed by the State Board of
1857 Medical Licensure and is practicing with physician supervision
1858 under regulations adopted by the board, under regulations adopted



1859 by the division. Reimbursement for those services shall not
1860 exceed ninety percent (90%) of the reimbursement rate for
1861 comparable services rendered by a physician.

1862 (46) The division shall make application to the federal
1863 Centers for Medicare and Medicaid Services (CMS) for a waiver to
1864 develop and provide services for children with serious emotional
1865 disturbances as defined in Section 43-14-1(1), which may include
1866 home- and community-based services, case management services or
1867 managed care services through mental health providers certified by
1868 the Department of Mental Health. The division may implement and
1869 provide services under this waived program only if funds for
1870 these services are specifically appropriated for this purpose by
1871 the Legislature, or if funds are voluntarily provided by affected
1872 agencies.

1873 (47) (a) Notwithstanding any other provision in this
1874 article to the contrary, the division may develop and implement
1875 disease management programs for individuals with high-cost chronic
1876 diseases and conditions, including the use of grants, waivers,
1877 demonstrations or other projects as necessary.

1878 (b) Participation in any disease management
1879 program implemented under this paragraph (47) is optional with the
1880 individual. An individual must affirmatively elect to participate
1881 in the disease management program in order to participate, and
1882 may elect to discontinue participation in the program at any time.

1883 (48) Pediatric long-term acute care hospital services.

1884 (a) Pediatric long-term acute care hospital
1885 services means services provided to eligible persons under
1886 twenty-one (21) years of age by a freestanding Medicare-certified
1887 hospital that has an average length of inpatient stay greater than
1888 twenty-five (25) days and that is primarily engaged in providing
1889 chronic or long-term medical care to persons under twenty-one (21)
1890 years of age.



1891 (b) The services under this paragraph (48) shall
1892 be reimbursed as a separate category of hospital services.

1893 (49) The division shall establish copayments and/or
1894 coinsurance for all Medicaid services for which copayments and/or
1895 coinsurance are allowable under federal law or regulation, and
1896 shall set the amount of the copayment and/or coinsurance for each
1897 of those services at the maximum amount allowable under federal
1898 law or regulation.

1899 (50) Services provided by the State Department of
1900 Rehabilitation Services for the care and rehabilitation of persons
1901 who are deaf and blind, as allowed under waivers from the United
1902 States Department of Health and Human Services to provide home-
1903 and community-based services using state funds that are provided
1904 from the appropriation to the State Department of Rehabilitation
1905 Services or if funds are voluntarily provided by another agency.

1906 (51) Upon determination of Medicaid eligibility and in
1907 association with annual redetermination of Medicaid eligibility,
1908 beneficiaries shall be encouraged to undertake a physical
1909 examination that will establish a base-line level of health and
1910 identification of a usual and customary source of care (a medical
1911 home) to aid utilization of disease management tools. This
1912 physical examination and utilization of these disease management
1913 tools shall be consistent with current United States Preventive
1914 Services Task Force or other recognized authority recommendations.

1915 For persons who are determined ineligible for Medicaid, the
1916 division will provide information and direction for accessing
1917 medical care and services in the area of their residence.

1918 (52) Notwithstanding any provisions of this article,
1919 the division may pay enhanced reimbursement fees related to trauma
1920 care, as determined by the division in conjunction with the State
1921 Department of Health, using funds appropriated to the State
1922 Department of Health for trauma care and services and used to
1923 match federal funds under a cooperative agreement between the



1924 division and the State Department of Health. The division, in
1925 conjunction with the State Department of Health, may use grants,
1926 waivers, demonstrations, or other projects as necessary in the
1927 development and implementation of this reimbursement program.

1928 (53) Targeted case management services for high-cost
1929 beneficiaries shall be developed by the division for all services
1930 under this section.

1931 (54) Adult foster care services pilot program. Social
1932 and protective services on a pilot program basis in an approved
1933 foster care facility for vulnerable adults who would otherwise
1934 need care in a long-term care facility, to be implemented in an
1935 area of the state with the greatest need for such program, under
1936 the Medicaid Waivers for the Elderly and Disabled program or an
1937 assisted living waiver. The division may use grants, waivers,
1938 demonstrations or other projects as necessary in the development
1939 and implementation of this adult foster care services pilot
1940 program.

1941 (55) Therapy services. The plan of care for therapy
1942 services may be developed to cover a period of treatment for up to
1943 six (6) months, but in no event shall the plan of care exceed a
1944 six-month period of treatment. The projected period of treatment
1945 must be indicated on the initial plan of care and must be updated
1946 with each subsequent revised plan of care. Based on medical
1947 necessity, the division shall approve certification periods for
1948 less than or up to six (6) months, but in no event shall the
1949 certification period exceed the period of treatment indicated on
1950 the plan of care. The appeal process for any reduction in therapy
1951 services shall be consistent with the appeal process in federal
1952 regulations.

1953 Notwithstanding any other provision of this article to the
1954 contrary, the division shall reduce the rate of reimbursement to
1955 providers for any service provided under this section by five
1956 percent (5%) of the allowed amount for that service. However, the



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

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

Notwithstanding any provision of this article, except as authorized in the following paragraph and in Section 43-13-139, neither (a) the limitations on quantity or frequency of use of or the fees or charges for any of the care or services available to



1990 recipients under this section, nor (b) the payments or rates of
1991 reimbursement to providers rendering care or services authorized
1992 under this section to recipients, may be increased, decreased or
1993 otherwise changed from the levels in effect on July 1, 1999,
1994 unless they are authorized by an amendment to this section by the
1995 Legislature. However, the restriction in this paragraph shall not
1996 prevent the division from changing the payments or rates of
1997 reimbursement to providers without an amendment to this section
1998 whenever those changes are required by federal law or regulation,
1999 or whenever those changes are necessary to correct administrative
2000 errors or omissions in calculating those payments or rates of
2001 reimbursement.

2002 Notwithstanding any provision of this article, no new groups
2003 or categories of recipients and new types of care and services may
2004 be added without enabling legislation from the Mississippi
2005 Legislature, except that the division may authorize those changes
2006 without enabling legislation when the addition of recipients or
2007 services is ordered by a court of proper authority.

2008 The executive director shall keep the Governor advised on a
2009 timely basis of the funds available for expenditure and the
2010 projected expenditures. If current or projected expenditures of
2011 the division are reasonably anticipated to exceed the amount of
2012 funds appropriated to the division for any fiscal year, the
2013 Governor, after consultation with the executive director, shall
2014 discontinue any or all of the payment of the types of care and
2015 services as provided in this section that are deemed to be
2016 optional services under Title XIX of the federal Social Security
2017 Act, as amended, and when necessary, shall institute any other
2018 cost containment measures on any program or programs authorized
2019 under the article to the extent allowed under the federal law
2020 governing that program or programs. However, the Governor shall
2021 not be authorized to discontinue or eliminate any service under
2022 this section that is mandatory under federal law, or to



2023 discontinue or eliminate, or adjust income limits or resource
2024 limits for, any eligibility category or group under Section
2025 43-13-115. It is the intent of the Legislature that the
2026 expenditures of the division during any fiscal year shall not
2027 exceed the amounts appropriated to the division for that fiscal
2028 year.

2029 Notwithstanding any other provision of this article, it shall
2030 be the duty of each nursing facility, intermediate care facility
2031 for the mentally retarded, psychiatric residential treatment
2032 facility, and nursing facility for the severely disabled that is
2033 participating in the Medicaid program to keep and maintain books,
2034 documents and other records as prescribed by the Division of
2035 Medicaid in substantiation of its cost reports for a period of
2036 three (3) years after the date of submission to the Division of
2037 Medicaid of an original cost report, or three (3) years after the
2038 date of submission to the Division of Medicaid of an amended cost
2039 report.

2040 **SECTION 3.** Section 43-13-145, Mississippi Code of 1972, is
2041 amended as follows:

2042 **[If the hospital assessment provided in the following**
2043 **amendment to subsection (4) of this section is approved by the**
2044 **Centers for Medicare and Medicaid Services (CMS), this section**
2045 **shall read as follows. If the hospital assessment provided in**
2046 **subsection (4) of this section does not take effect or cease to be**
2047 **imposed, the provisions of Section 43-13-145 shall remain in**
2048 **effect as existed on June 30, 2009.]**

2049 43-13-145. (1) (a) Upon each nursing facility licensed by
2050 the State of Mississippi, there is levied an assessment in an
2051 amount set by the division, equal to the maximum rate allowed by
2052 federal law or regulation, for each licensed and occupied bed of
2053 the facility.



2054 (b) A nursing facility is exempt from the assessment
2055 levied under this subsection if the facility is operated under the
2056 direction and control of:

2057 (i) The United States Veterans Administration or
2058 other agency or department of the United States government;

2059 (ii) The State Veterans Affairs Board; or

2060 (iii) The University of Mississippi Medical
2061 Center.

2062 * * *

2063 (2) (a) Upon each intermediate care facility for the
2064 mentally retarded licensed by the State of Mississippi, there is
2065 levied an assessment in an amount set by the division, equal to
2066 the maximum rate allowed by federal law or regulation, for each
2067 licensed and occupied bed of the facility.

2068 (b) An intermediate care facility for the mentally
2069 retarded is exempt from the assessment levied under this
2070 subsection if the facility is operated under the direction and
2071 control of:

2072 (i) The United States Veterans Administration or
2073 other agency or department of the United States government;

2074 (ii) The State Veterans Affairs Board; or

2075 (iii) The University of Mississippi Medical
2076 Center.

2077 (3) (a) Upon each psychiatric residential treatment
2078 facility licensed by the State of Mississippi, there is levied an
2079 assessment in an amount set by the division, equal to the maximum
2080 rate allowed by federal law or regulation, for each licensed and
2081 occupied bed of the facility.

2082 (b) A psychiatric residential treatment facility is
2083 exempt from the assessment levied under this subsection if the
2084 facility is operated under the direction and control of:

2085 (i) The United States Veterans Administration or
2086 other agency or department of the United States government;



2087 (ii) The University of Mississippi Medical Center;
2088 or
2089 (iii) A state agency or a state facility that
2090 either provides its own state match through intergovernmental
2091 transfer or certification of funds to the division.

2092 (4) Hospital assessment.

2093 (a) (i) Subject to and upon fulfillment of the
2094 requirements and conditions of paragraph (f) below, and
2095 notwithstanding any other provisions of this section, effective
2096 for state fiscal years 2010, 2011 and 2012, an annual assessment
2097 on each hospital licensed in the state is imposed on each
2098 non-Medicare hospital inpatient day as defined below at a rate
2099 that is determined by dividing the sum prescribed in this
2100 subparagraph (i), plus the nonfederal share necessary to maximize
2101 the Disproportionate Share Hospital (DSH) and inpatient Medicare
2102 Upper Payment Limits (UPL) payments, by the total number of
2103 non-Medicare hospital inpatient days as defined below for all
2104 licensed Mississippi hospitals, except as provided in paragraph
2105 (d) below. If the state matching funds percentage for the
2106 Mississippi Medicaid program is sixteen percent (16%) or less, the
2107 sum used in the formula under this subparagraph (i) shall be
2108 Seventy-four Million Dollars (\$74,000,000.00). If the state
2109 matching funds percentage for the Mississippi Medicaid program is
2110 twenty-four percent (24%) or higher, the sum used in the formula
2111 under this subparagraph (i) shall be One Hundred Four Million
2112 Dollars (\$104,000,000.00). If the state matching funds percentage
2113 for the Mississippi Medicaid program is between sixteen percent
2114 (16%) and twenty-four percent (24%), the sum used in the formula
2115 under this subparagraph (i) shall be a pro rata amount determined
2116 as follows: the current state matching funds percentage rate
2117 minus sixteen percent (16%) divided by eight percent (8%)
2118 multiplied by Thirty Million Dollars (\$30,000,000.00) and add that
2119 amount to Seventy-four Million Dollars (\$74,000,000.00). However,



no assessment in a quarter under this subparagraph (i) may exceed the assessment in the previous quarter by more than Three Million Seven Hundred Fifty Thousand Dollars (\$3,750,000.00) (which would be Fifteen Million Dollars (\$15,000,000.00) on an annualized basis). The division shall publish the state matching funds percentage rate applicable to the Mississippi Medicaid program on the tenth day of the first month of each quarter and the assessment determined under the formula prescribed above shall be applicable in the quarter following any adjustment in that state matching funds percentage rate. The division shall notify each hospital licensed in the state as to any projected increases or decreases in the assessment determined under this subparagraph (i). However, if the Centers for Medicare and Medicaid Services (CMS) does not approve the provision in Section 43-13-117(39) requiring the division to reimburse crossover claims for inpatient hospital services and crossover claims covered under Medicare Part B for dually eligible beneficiaries in the same manner that was in effect on January 1, 2008, the sum that otherwise would have been used in the formula under this subparagraph (i) shall be reduced by Seven Million Dollars (\$7,000,000.00).

(ii) In addition to the assessment provided under subparagraph (i), effective for state fiscal years 2010, 2011 and 2012 and thereafter, an additional annual assessment on each hospital licensed in the state is imposed on each non-Medicare hospital inpatient day as defined below at a rate that is determined by dividing twenty-five percent (25%) of any provider reductions in the Medicaid program as authorized in Section 43-13-117(F) for that fiscal year up to the following maximum amount, plus the nonfederal share necessary to maximize the Disproportionate Share Hospital (DSH) and inpatient Medicare Upper Payment Limits (UPL) payments, by the total number of non-Medicare hospital inpatient days as defined below for all licensed Mississippi hospitals: in fiscal year 2010, the maximum amount



shall be Twenty-four Million Dollars (\$24,000,000.00); in fiscal year 2011, the maximum amount shall be Thirty-two Million Dollars (\$32,000,000.00); and in fiscal year 2012 and thereafter, the maximum amount shall be Forty Million Dollars (\$40,000,000.00). Any such deficit in the Medicaid program shall be reviewed by the PEER Committee as provided in Section 43-13-117(F).

(iii) In addition to the assessments provided in subparagraphs (i) and (ii), effective for state fiscal years 2010, 2011, 2012 and thereafter, an additional annual assessment on each hospital licensed in the state is imposed pursuant to the provisions of Section 43-13-117(F) if the cost containment measures described therein have been implemented and there are insufficient funds in the Health Care Trust Fund to reconcile any remaining deficit in any fiscal year. If the Governor institutes any other additional cost containment measures on any program or programs authorized under the Medicaid program pursuant to Section 43-13-117(F), hospitals shall be responsible for twenty-five percent (25%) of any such additional imposed provider cuts, which shall be in the form of an additional assessment not to exceed the twenty-five percent (25%) of provider expenditure reductions. Such additional assessment shall be imposed on each non-Medicare hospital inpatient day in the same manner as assessments are imposed under subparagraphs (i) and (ii).

(b) Payment and definitions.

(i) Payment. Upon approval of the State Plan Amendment for the division's DSH and inpatient UPL payment methodology by CMS, the assessment shall be paid in three (3) installments due no later than ten (10) days before the payment of the DSH and UPL payments required by Section 43-13-117(18), which shall be paid during the second, third and fourth quarters of the state fiscal year.

(ii) Definitions. For purposes of this subsection (4):



2186 1. "Non-Medicare hospital inpatient day"
2187 means total hospital inpatient days including subcomponent days
2188 less Medicare inpatient days including subcomponent days from the
2189 hospital's Medicare cost report on file with CMS (for hospital
2190 fiscal year 2006) as of May 31, 2008.

2191 a. Total hospital inpatient days shall
2192 be the sum of Worksheet S-3, Part 1, column 6 row 12, column 6 row
2193 14.00, and column 6 row 14.01, excluding column 6 rows 3 and 4.

2194 b. Hospital Medicare inpatient days
2195 shall be the sum of Worksheet S-3, Part 1, column 4 row 12, column
2196 4 row 14.00, and column 4 row 14.01, excluding column 4 rows 3 and
2197 4.

2198 c. Inpatient days shall not include
2199 residential treatment or long-term care days.

2200 2. "Subcomponent inpatient day" means the
2201 number of days of care charged to a beneficiary for inpatient
2202 hospital rehabilitation and psychiatric care services in units of
2203 full days. A day begins at midnight and ends twenty-four (24)
2204 hours later. A part of a day, including the day of admission and
2205 day on which a patient returns from leave of absence, counts as a
2206 full day. However, the day of discharge, death, or a day on which
2207 a patient begins a leave of absence is not counted as a day unless
2208 discharge or death occur on the day of admission. If admission
2209 and discharge or death occur on the same day, the day is
2210 considered a day of admission and counts as one (1) subcomponent
2211 inpatient day.

2212 (c) The assessment provided in this subsection is
2213 intended to satisfy and not be in addition to the assessment and
2214 intergovernmental transfers provided in Section 43-13-117(18).
2215 Nothing in this act shall be construed to authorize any state
2216 agency, division or department, or county, municipality or other
2217 local governmental unit to license for revenue, levy or impose any



2218 other tax, fee or assessment upon hospitals in this state not
2219 authorized by a specific statute.

2220 (d) Hospitals operated by the United States Department
2221 of Veterans Affairs and state-operated facilities that provide
2222 only inpatient and outpatient psychiatric services shall not be
2223 subject to the hospital assessment provided in this subsection.

2224 (e) Multihospital systems, closure, merger and new
2225 hospitals.

2226 (i) If a hospital conducts, operates or maintains
2227 more than one (1) hospital licensed by the State Department of
2228 Health, the provider shall pay the hospital assessment for each
2229 hospital separately.

2230 (ii) Notwithstanding any other provision in this
2231 section, if a hospital subject to this assessment operates or
2232 conducts business only for a portion of a fiscal year, the
2233 assessment for the state fiscal year shall be adjusted by
2234 multiplying the assessment by a fraction, the numerator of which
2235 is the number of days in the year during which the hospital
2236 operates, and the denominator of which is three hundred sixty-five
2237 (365). Immediately upon ceasing to operate, the hospital shall
2238 pay the assessment for the year as so adjusted (to the extent not
2239 previously paid).

2240 (f) Applicability.

2241 The hospital assessment imposed by this subsection shall not
2242 take effect and/or shall cease to be imposed if:

2243 (i) The assessment is determined to be an
2244 impermissible tax under Title XIX of the Social Security Act; or,

2245 (ii) CMS does not approve the division's 2009
2246 Medicaid State Plan Amendment for its methodology for DSH and
2247 inpatient UPL payments to hospitals under Section 43-13-117(18).

2248 This subsection (4) is repealed on July 1, 2012.

2249 (5) Each health care facility that is subject to the
2250 provisions of this section shall keep and preserve such suitable



books and records as may be necessary to determine the amount of assessment for which it is liable under this section. The books and records shall be kept and preserved for a period of not less than five (5) years, during which time those books and records shall be open for examination during business hours by the division, the State Tax Commission, the Office of the Attorney General and the State Department of Health.

(6) Except as provided in subsection (4) of this section, the assessment levied under this section shall be collected by the division each month beginning on March 31, 2005.

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

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

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



of the amount of the assessment, plus the legal rate of interest until the assessment is paid in full.

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

(10) As soon as possible after the effective date of this act, the Division of Medicaid shall submit to the Centers for Medicare and Medicaid Services (CMS) a state plan amendment or amendments (SPA) regarding the hospital assessment established under subsection (4) of this section. Before submission to CMS, the division shall transmit the SPA to the Medicaid Hospital Advisory Board created by Executive Order of the Governor, which



2317 shall review and make comment on the state plan amendment or
2318 amendments submitted to CMS, and if any of the amendments are
2319 rejected, the Medicaid Hospital Advisory Board shall recommend
2320 necessary revisions to secure approval, provided that the plan is
2321 substantially intact. In addition to defining the assessment
2322 established in subsection (4) of this section, the state plan
2323 amendment or amendments shall include any amendments necessitated
2324 by House Bill No. 71, 2009 Second Extraordinary Session, and shall
2325 further provide for the following additional annual Medicare Upper
2326 Payment Limits (UPL) and Disproportionate Share Hospital (DSH)
2327 payments to hospitals located in Mississippi that participate in
2328 the Medicaid program:

2329 (a) Privately operated and nonstate government operated
2330 general acute care hospitals, within the meaning of 42 CFR Section
2331 447.272, that have fifty (50) or fewer licensed beds as of January
2332 1, 2009, shall receive an additional inpatient UPL payment equal
2333 to sixty-five percent (65%) of their fiscal year 2010 hospital
2334 specific inpatient UPL gap, before any payments under this
2335 subsection.

2336 (b) General acute care hospitals licensed within the
2337 class of state hospitals shall receive an additional inpatient UPL
2338 payment equal to twenty-eight percent (28%) of their fiscal year
2339 2007 inpatient payments, excluding DSH and UPL payments.

2340 (c) General acute care hospitals licensed within the
2341 class of nonstate government hospitals shall receive:

2342 (i) For fiscal year 2010, an additional inpatient
2343 UPL payment equal to fifty-six percent (56%) of their fiscal year
2344 2007 inpatient payments, excluding DSH and UPL payments, and

2345 (ii) For state fiscal year 2011 and after, an
2346 additional inpatient UPL payment determined by multiplying
2347 inpatient payments, excluding DSH and UPL, by the uniform
2348 percentage necessary to exhaust the maximum amount of inpatient
2349 UPL payments permissible under federal regulations. (For state



2350 fiscal year 2011, the state shall use 2008 inpatient payment data.
2351 For state fiscal year 2012, the state shall use 2009 inpatient
2352 payment data.)

2353 (d) Free-standing psychiatric hospitals shall receive
2354 an additional inpatient UPL payment equal to Seven Hundred Sixty
2355 Dollars (\$760.00) for fiscal years 2010 and 2011, and Seven
2356 Hundred Eighty Dollars (\$780.00), for fiscal year 2012 and
2357 thereafter, less the hospital's fiscal year 2007 average Medicaid
2358 inpatient per diem rate, multiplied by the hospital's fiscal year
2359 2007 Medicaid inpatient days. Residential treatment days and
2360 payments shall be excluded from this calculation. The base rate
2361 for private free-standing psychiatric hospitals shall be that in
2362 use January 1, 2009, which shall not be revised or recalculated so
2363 long as the hospital assessment is in effect.

2364 (e) If for any reason the 2009 Medicaid state plan
2365 amendment or amendments are not approved by CMS, not implemented,
2366 discontinued, or otherwise not in effect, the following
2367 reimbursement methodology for inpatient psychiatric services shall
2368 immediately become effective:

2369 (i) If the services are provided by a nonpublic
2370 licensed acute care psychiatric facility, the services shall be
2371 reimbursed by the division using the prospective payment system
2372 used by CMS to reimburse inpatient psychiatric services, as set
2373 forth in Part 412, Subpart N of Title 42 of the Code of Federal
2374 Regulations.

2375 (ii) If the services are provided by a nonpublic
2376 hospital (as defined in Section 41-9-3(a)) that has fifty (50) or
2377 more licensed psychiatric beds, the division shall allow the
2378 hospital to elect whether to be reimbursed for these services
2379 using the prospective payment system used by CMS to reimburse
2380 psychiatric services, as set forth in Part 412, Subpart N of Title
2381 42 of the Code of Federal Regulations. If a hospital included in
2382 this subparagraph (ii) does not provide an affirmative election to



the division, the division shall continue to reimburse the hospital under the principles outlined in Section 43-13-117.

(iii) If the services are provided by a provider other than those specified in subparagraphs (i) and (ii) of this paragraph, the division shall continue to reimburse the provider under the principles outlined in Section 43-13-117.

(f) In addition to other payments provided above, all hospitals licensed within the class of private hospitals, other than free-standing psychiatric hospitals, shall receive:

(i) For fiscal year 2010, an additional inpatient UPL payment equal to forty-nine and forty-five one-hundredths percent (49.45%) of their fiscal year 2007 inpatient payments, excluding DSH and UPL payments, and

(ii) For state fiscal year 2011 and after, an additional inpatient UPL payment determined by multiplying inpatient payments, excluding DSH and UPL, by the uniform percentage necessary to exhaust the maximum amount of UPL inpatient payments permissible under federal regulations. (For state fiscal year 2011, the state shall use 2008 inpatient payment data. For state fiscal year 2012, the state shall use 2009 inpatient payment data.)

(g) All hospitals satisfying the minimum federal DSH eligibility requirements (Section 1923(d) of the Social Security Act) shall, subject to OBRA 1993 payment limitations, receive an additional DSH payment. This additional DSH payment shall expend the balance of the federal DSH allotment and associated state share not utilized in DSH payments to state-owned institutions for treatment of mental diseases. The payment to each hospital shall be calculated by applying a uniform percentage to the uninsured costs of each eligible hospital, excluding state-owned institutions for treatment of mental diseases; however, that percentage for a state-owned teaching hospital located in Hinds County shall be multiplied by a factor of two (2).



2416 (h) Public hospitals permanently classified in (but not
2417 reclassified to) the Gulfport-Biloxi, MS Core-Based Statistical
2418 Area (CBSA) for hospital wage index purposes and eligible for
2419 Deficit Reduction Act Hurricane Katrina Related Stabilization
2420 Grants under Section 6201(a)(4) of the Deficit Reduction Act of
2421 2005 shall qualify for DSH payments as follows: (i) critical
2422 access hospitals that were forced to cease operations for more
2423 than thirty (30) days as a direct result of Hurricane Katrina
2424 shall receive a multiple of two (2) times the DSH amount, and (ii)
2425 hospitals with more than four hundred (400) licensed beds and
2426 greater than thirty-five percent (35%) of total patient days
2427 during 2007 from Medicaid patients shall receive a multiple of one
2428 and one-half (1-1/2) times the DSH amount. This paragraph shall
2429 stand repealed on July 1, 2011.

2430 (For state fiscal year 2010, the state shall use uninsured
2431 costs from the 2009 hospital survey. For state fiscal year 2011,
2432 the state shall use costs from the 2010 hospital survey.)

2433 (11) The hospital assessment provided in subsection (4) of
2434 this section shall not be in effect or implemented until the SPA
2435 is approved by CMS.

2436 (12) The division shall implement DSH and UPL calculation
2437 methodologies that result in the maximization of available federal
2438 funds.

2439 (13) The DSH and inpatient UPL payments shall be paid on or
2440 before December 31, March 31, and June 30 of each fiscal year, in
2441 increments of one-third (1/3) of the total calculated DSH and
2442 inpatient UPL amounts.

2443 (14) The hospital assessment as described in subsection (4)
2444 above shall be assessed and collected quarterly a maximum of ten
2445 (10) days before making the DSH and inpatient UPL payments;
2446 provided, however, that the first quarterly payment shall be
2447 assessed but not be collected until collection is made for the
2448 second quarterly payment.



2449 (15) Hospitals shall receive the Medicare published market
2450 basket inflationary index payment increase annually.

2451 (16) If for any reason any part of the plan for additional
2452 annual DSH and inpatient UPL payments to hospitals provided under
2453 subsection (10) of this section is not approved by CMS, the
2454 remainder of the plan shall remain in full force and effect.

2455 (17) Subsections (10) through (16) of this section shall
2456 stand repealed on July 1, 2012.

2457 **[If the hospital assessment provided in the above amendment**
2458 **to subsection (4) does not take effect or cease to be imposed, the**
2459 **provisions of Section 43-13-145 shall remain in effect as existed**
2460 **on June 30, 2009, and this section shall read as follows:]**

2461 43-13-145. (1) (a) Upon each nursing facility licensed by
2462 the State of Mississippi, there is levied an assessment in an
2463 amount set by the division, not exceeding the maximum rate allowed
2464 by federal law or regulation, for each licensed and occupied bed
2465 of the facility.

2466 (b) A nursing facility is exempt from the assessment
2467 levied under this subsection if the facility is operated under the
2468 direction and control of:

2469 (i) The United States Veterans Administration or
2470 other agency or department of the United States government;

2471 (ii) The State Veterans Affairs Board;

2472 (iii) The University of Mississippi Medical
2473 Center; or

2474 (iv) A state agency or a state facility that
2475 either provides its own state match through intergovernmental
2476 transfer or certification of funds to the division.

2477 (2) (a) Upon each intermediate care facility for the
2478 mentally retarded licensed by the State of Mississippi, there is
2479 levied an assessment in an amount set by the division, not
2480 exceeding the maximum rate allowed by federal law or regulation,
2481 for each licensed and occupied bed of the facility.



2482 (b) An intermediate care facility for the mentally
2483 retarded is exempt from the assessment levied under this
2484 subsection if the facility is operated under the direction and
2485 control of:

2486 (i) The United States Veterans Administration or
2487 other agency or department of the United States government;

2488 (ii) The State Veterans Affairs Board; or

2489 (iii) The University of Mississippi Medical
2490 Center.

2491 (3) (a) Upon each psychiatric residential treatment
2492 facility licensed by the State of Mississippi, there is levied an
2493 assessment in an amount set by the division, not exceeding the
2494 maximum rate allowed by federal law or regulation, for each
2495 licensed and occupied bed of the facility.

2496 (b) A psychiatric residential treatment facility is
2497 exempt from the assessment levied under this subsection if the
2498 facility is operated under the direction and control of:

2499 (i) The United States Veterans Administration or
2500 other agency or department of the United States government;

2501 (ii) The University of Mississippi Medical Center;
2502 or

2503 (iii) A state agency or a state facility that
2504 either provides its own state match through intergovernmental
2505 transfer or certification of funds to the division.

2506 (4) (a) Upon each hospital licensed by the State of
2507 Mississippi, there is levied an assessment in the amount of Three
2508 Dollars and Twenty-five Cents (\$3.25) per bed for each licensed
2509 inpatient acute care bed of the hospital.

2510 (b) A hospital is exempt from the assessment levied
2511 under this subsection if the hospital is operated under the
2512 direction and control of:

2513 (i) The United States Veterans Administration or
2514 other agency or department of the United States government;



2515 (ii) The University of Mississippi Medical Center;
2516 or

2517 (iii) A state agency or a state facility that
2518 either provides its own state match through intergovernmental
2519 transfer or certification of funds to the division.

2520 (5) Each health care facility that is subject to the
2521 provisions of this section shall keep and preserve such suitable
2522 books and records as may be necessary to determine the amount of
2523 assessment for which it is liable under this section. The books
2524 and records shall be kept and preserved for a period of not less
2525 than five (5) years, and those books and records shall be open for
2526 examination during business hours by the division, the State Tax
2527 Commission, the Office of the Attorney General and the State
2528 Department of Health.

2529 (6) The assessment levied under this section shall be
2530 collected by the division each month beginning on March 31, 2005.

2531 (7) All assessments collected under this section shall be
2532 deposited in the Medical Care Fund created by Section 43-13-143.

2533 (8) The assessment levied under this section shall be in
2534 addition to any other assessments, taxes or fees levied by law,
2535 and the assessment shall constitute a debt due the State of
2536 Mississippi from the time the assessment is due until it is paid.

2537 (9) (a) If a health care facility that is liable for
2538 payment of an assessment levied by the division does not pay the
2539 assessment when it is due, the division shall give written notice
2540 to the health care facility by certified or registered mail
2541 demanding payment of the assessment within ten (10) days from the
2542 date of delivery of the notice. If the health care facility
2543 fails or refuses to pay the assessment after receiving the notice
2544 and demand from the division, the division shall withhold from any
2545 Medicaid reimbursement payments that are due to the health care
2546 facility the amount of the unpaid assessment and a penalty of ten
2547 percent (10%) of the amount of the assessment, plus the legal rate



2548 of interest until the assessment is paid in full. If the health
2549 care facility does not participate in the Medicaid program, the
2550 division shall turn over to the Office of the Attorney General the
2551 collection of the unpaid assessment by civil action. In any such
2552 civil action, the Office of the Attorney General shall collect the
2553 amount of the unpaid assessment and a penalty of ten percent (10%)
2554 of the amount of the assessment, plus the legal rate of interest
2555 until the assessment is paid in full.

2556 (b) As an additional or alternative method for
2557 collecting unpaid assessments levied by the division, if a health
2558 care facility fails or refuses to pay the assessment after
2559 receiving notice and demand from the division, the division may
2560 file a notice of a tax lien with the circuit clerk of the county
2561 in which the health care facility is located, for the amount of
2562 the unpaid assessment and a penalty of ten percent (10%) of the
2563 amount of the assessment, plus the legal rate of interest until
2564 the assessment is paid in full. Immediately upon receipt of
2565 notice of the tax lien for the assessment, the circuit clerk shall
2566 enter the notice of the tax lien as a judgment upon the judgment
2567 roll and show in the appropriate columns the name of the health
2568 care facility as judgment debtor, the name of the division as
2569 judgment creditor, the amount of the unpaid assessment, and the
2570 date and time of enrollment. The judgment shall be valid as
2571 against mortgagees, pledgees, entrusters, purchasers, judgment
2572 creditors and other persons from the time of filing with the
2573 clerk. The amount of the judgment shall be a debt due the State
2574 of Mississippi and remain a lien upon the tangible property of the
2575 health care facility until the judgment is satisfied. The
2576 judgment shall be the equivalent of any enrolled judgment of a
2577 court of record and shall serve as authority for the issuance of
2578 writs of execution, writs of attachment or other remedial writs.



2579 **SECTION 4.** Section 43-13-407, Mississippi Code of 1972, as
2580 amended by House Bill No. 1505, 2009 Regular Session, is amended
2581 as follows:

2582 43-13-407. (1) In accordance with the purposes of this
2583 article, there is established in the State Treasury the Health
2584 Care Expendable Fund, into which shall be transferred from the
2585 Health Care Trust Fund the following sums:

2586 (a) In fiscal year 2005, Four Hundred Fifty-six Million
2587 Dollars (\$456,000,000.00);

2588 (b) In fiscal year 2006, One Hundred Eighty-six Million
2589 Dollars (\$186,000,000.00);

2590 (c) In fiscal year 2007, One Hundred Eighty-six Million
2591 Dollars (\$186,000,000.00);

2592 (d) In fiscal year 2008, One Hundred Six Million
2593 Dollars (\$106,000,000.00);

2594 (e) In fiscal year 2009, Ninety-two Million Two Hundred
2595 Fifty Thousand Dollars (\$92,250,000.00);

2596 (f) In the fiscal year beginning after the calendar
2597 year in which none of the amount of the annual tobacco settlement
2598 installment payment will be deposited into the Health Care
2599 Expendable Fund as provided in subsection (3) (d) of this section,
2600 and in each fiscal year thereafter, a sum equal to the average
2601 annual amount of the dividends, interest and other income,
2602 including increases in value of the principal, earned on the funds
2603 in the Health Care Trust Fund during the preceding four (4) fiscal
2604 years.

2605 (2) In any fiscal year in which interest, dividends and
2606 other income from the investment of the funds in the Health Care
2607 Trust Fund are not sufficient to fund the full amount of the
2608 annual transfer into the Health Care Expendable Fund as required
2609 in subsection (1) (f) of this section, the State Treasurer shall
2610 transfer from tobacco settlement installment payments an amount



2611 that is sufficient to fully fund the amount of the annual
2612 transfer.

2613 (3) Beginning with calendar year 2009, at the time that the
2614 State of Mississippi receives the tobacco settlement installment
2615 payment for each calendar year, the State Treasurer shall deposit
2616 the following amounts of each of those installment payments into
2617 the Health Care Expendable Fund:

2618 (a) In calendar years 2009 and 2010, the total amount
2619 of the installment payment;

2620 (b) In calendar year 2011, the amount of the
2621 installment payment less Ten Million Dollars (\$10,000,000.00);

2622 (c) In calendar year 2012, the amount of the
2623 installment payment less Twenty Million Dollars (\$20,000,000.00);

2624 (d) In calendar year 2013, and each calendar year
2625 thereafter, the amount of the installment payment to be deposited
2626 into the Health Care Expendable Fund shall be reduced by an
2627 additional Ten Million Dollars (\$10,000,000.00) each calendar year
2628 until the calendar year that the amount of the installment payment
2629 that otherwise would be deposited into the Health Care Expendable
2630 Fund is less than the average annual amount of the dividends,
2631 interest and other income, including increases in value of the
2632 principal, earned on the funds in the Health Care Trust Fund
2633 during the preceding four (4) fiscal years. Beginning with that
2634 calendar year and each calendar year thereafter, none of the
2635 amount of the installment payment shall be deposited into the
2636 Health Care Expendable Fund.

2637 (4) The total sum of Two Hundred Forty Million Dollars
2638 (\$240,000,000.00) plus interest at the rate of five percent (5%)
2639 per annum shall be transferred into the Health Care Trust Fund
2640 from the State General Fund during fiscal years 2011 through 2018
2641 to repay the trust fund for Two Hundred Forty Million Dollars
2642 (\$240,000,000.00) of the total sum that is transferred from the
2643 trust fund to the Health Care Expendable Fund during fiscal year



2644 2005 under subsection (1)(a) of this section. The repayment shall
2645 be made according to the following schedule: During each of
2646 fiscal years 2011 through 2017, the State Fiscal Officer shall
2647 transfer from the General Fund to the Health Care Trust Fund the
2648 sum of Thirty-eight Million Dollars (\$38,000,000.00), and during
2649 fiscal year 2018 the State Fiscal Officer shall transfer from the
2650 State General Fund to the Health Care Trust Fund a sum in the
2651 amount certified by the State Treasurer as necessary to fully
2652 repay the balance of the Two Hundred Forty Million Dollars
2653 (\$240,000,000.00) plus interest at the rate of five percent (5%)
2654 per annum.

2655 (5) If Medicaid expenditures are projected to exceed the
2656 amount of funds appropriated to the Division of Medicaid in any
2657 fiscal year in excess of the expenditure reductions to providers,
2658 funds shall be transferred by the State Fiscal Officer from the
2659 Health Care Trust Fund into the Health Care Expendable Fund and
2660 then to the Governor's Office, Division of Medicaid, in the amount
2661 and at such time as requested by the Governor to reconcile the
2662 deficit.

2663 (6) All income from the investment of the funds in the
2664 Health Care Expendable Fund shall be credited to the account of
2665 the Health Care Expendable Fund. Any funds in the Health Care
2666 Expendable Fund at the end of a fiscal year shall not lapse into
2667 the State General Fund.

2668 (7) The funds in the Health Care Expendable Fund shall be
2669 available for expenditure under specific appropriation by the
2670 Legislature beginning in fiscal year 2000, and shall be expended
2671 exclusively for health care purposes.

2672 (8) The provisions of subsection (1) of this section may not
2673 be changed in any manner except upon amendment to that subsection
2674 by a bill enacted by the Legislature with a vote of not less than
2675 three-fifths (3/5) of the members of each house present and
2676 voting.



2677 (9) Subsections (1), (2), (5), (6) and (7) of this section
2678 shall stand repealed on July 1, 2012.

2679 **SECTION 5.** This act shall take effect and be in force from
2680 and after July 1, 2009.

