MISSISSIPPI LEGISLATURE REGULAR SESSION 2003

By: Representatives Moody, Holland

To: Public Health and Welfare; Appropriations

COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 897

1 AN ACT RELATIVE TO THE MISSISSIPPI MEDICAID PROGRAM; TO AMEND
2 SECTION 43-13-115, MISSISSIPPI CODE OF 1972, TO CLARIFY
3 ELIGIBILITY FOR MEDICAID; TO AUTHORIZE THE DIVISION OF MEDICAID TO
4 APPLY FOR APPLICABLE WAIVERS FOR BENEFITS AND BUY-IN OPTIONS FOR
5 THE DISABLED CHILDREN LIVING AT HOME AND POVERTY LEVEL AGED AND
6 DISABLED (PLADS) ELIGIBILITY CATEGORIES AND TO ESTABLISH AN
7 EXPENDITURE/ENROLLMENT CAP FOR THESE CATEGORIES; TO AMEND SECTION
8 43-13-117, MISSISSIPPI CODE OF 1972, TO REDUCE THE NURSING
9 FACILITY BED DAYS ELIGIBLE FOR MEDICAID REIMBURSEMENT; TO
10 AUTHORIZE THE DIVISION TO DEVELOP AN ASSESSMENT PROCESS FOR
11 LONG-TERM CARE SERVICES AND DELETE THE REFERRAL PHYSICIAN
12 CERTIFICATION PROCESS; TO DELETE THE NECESSITY TO COMPARE HOME
13 HEALTH COSTS TO NURSING FACILITY SERVICES FOR REIMBURSEMENT; TO
14 DELETE AUTHORITY FOR THE DIVISION TO OPT OUT OF THE FEDERAL DRUG
15 REBATE PROGRAM AND CREATE A CLOSED DRUG FORMULARY; TO DELETE PRIOR
16 APPROVAL OF MONTHLY DRUG PRESCRIPTIONS OVER FIVE; TO ALLOW A
17 DISPENSING FEE FOR OVER-THE-COUNTER DRUGS; TO REDUCE THE ICF/MR
18 BED DAYS ELIGIBLE FOR REIMBURSEMENT; TO DELETE CERTAIN
19 RESTRICTIONS ON THE HOME- AND COMMUNITY-BASED SERVICES WAIVER
20 PROGRAM; TO DELETE THE AUTHORITY FOR REIMBURSEMENT FOR BIRTHING
21 CENTER SERVICES; TO CLARIFY THE ASSISTED LIVING SERVICES WAIVER
22 PROVISION; TO GIVE THE DIVISION DISCRETION IN PAYING MEDICARE
23 COINSURANCE AMOUNTS; TO AUTHORIZE CHILDREN UP TO TWO YEARS OF AGE
24 FOR THE OBSTETRICAL CARE WAIVER PROGRAM; TO DELETE CERTAIN
25 RESTRICTIONS IN THE DISEASE MANAGEMENT PROGRAM AUTHORITY; TO
26 REMOVE THE FIVE PERCENT REIMBURSEMENT REDUCTION FOR CASE
27 MANAGEMENT SERVICES PROVIDED UNDER THE HOME- AND COMMUNITY-BASED
28 SERVICES PROGRAM BY A PLANNING AND DEVELOPMENT DISTRICT; TO
29 AUTHORIZE THE DIVISION TO REMOVE THE FIVE PERCENT REDUCTION IN
30 REIMBURSEMENT FOR PROVIDERS WHO PARTICIPATE IN THE EMERGENCY ROOM
31 REDIRECTION PROGRAM; TO AMEND SECTION 43-13-122, MISSISSIPPI CODE
32 OF 1972, TO DELETE CERTAIN OBSOLETE LANGUAGE; TO AMEND SECTION
33 43-13-107, MISSISSIPPI CODE OF 1972, TO AUTHORIZE THE DIVISION TO
34 SUBMIT EMERGENCY DRUG ISSUES TO THE PHARMACY AND THERAPEUTICS
35 COMMITTEE WITHOUT PUBLIC COMMENT; TO AMEND SECTION 43-13-145,
36 MISSISSIPPI CODE OF 1972, TO INCREASE THE PER BED ASSESSMENT
37 LEVIED UPON NURSING FACILITIES FOR SUPPORT OF THE MEDICAID
38 PROGRAM; AND FOR RELATED PURPOSES.

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

40 **SECTION 1.** Section 43-13-115, Mississippi Code of 1972, is
41 amended as follows:

42 43-13-115. Recipients of Medicaid shall be the following
43 persons only:

44 (1) Who are qualified for public assistance grants
45 under provisions of Title IV-A and E of the federal Social

46 Security Act, as amended, as determined by the State Department of
47 Human Services, including those statutorily deemed to be IV-A and
48 low-income families and children under Section 1931 of the Social
49 Security Act as determined by the State Department of Human
50 Services and certified to the Division of Medicaid, but not
51 optional groups except as specifically covered in this section.
52 For the purposes of this paragraph (1) and paragraphs (8), (17)
53 and (18) of this section, any reference to Title IV-A or to Part A
54 of Title IV of the federal Social Security Act, as amended, or the
55 state plan under Title IV-A or Part A of Title IV, shall be
56 considered as a reference to Title IV-A of the federal Social
57 Security Act, as amended, and the state plan under Title IV-A,
58 including the income and resource standards and methodologies
59 under Title IV-A and the state plan, as they existed on July 16,
60 1996.

61 (2) Those qualified for Supplemental Security Income
62 (SSI) benefits under Title XVI of the federal Social Security Act,
63 as amended, and those who are deemed SSI eligible as contained in
64 federal statute. The eligibility of individuals covered in this
65 paragraph shall be determined by the Social Security
66 Administration and certified to the Division of Medicaid.

67 (3) Qualified pregnant women who would be eligible for
68 Medicaid as a low income family member under Section 1931 of the
69 Social Security Act if her child was born.

70 (4) [Deleted]

71 (5) A child born on or after October 1, 1984, to a
72 woman eligible for and receiving Medicaid under the state plan on
73 the date of the child's birth shall be deemed to have applied for
74 Medicaid and to have been found eligible for Medicaid under the
75 plan on the date of that birth and will remain eligible for
76 Medicaid for a period of one (1) year so long as the child is a
77 member of the woman's household and the woman remains eligible for
78 Medicaid or would be eligible for Medicaid if pregnant. The

79 eligibility of individuals covered in this paragraph shall be
80 determined by the State Department of Human Services and certified
81 to the Division of Medicaid.

82 (6) Children certified by the State Department of Human
83 Services to the Division of Medicaid of whom the state and county
84 departments of human services have custody and financial
85 responsibility, and children who are in adoptions subsidized in
86 full or part by the Department of Human Services, including
87 special needs children in non-Title IV-E adoption assistance, who
88 are approvable under Title XIX of the Medicaid program.

89 (7) (a) Persons certified by the Division of Medicaid
90 who are patients in a medical facility (nursing home, hospital,
91 tuberculosis sanatorium or institution for treatment of mental
92 diseases), and who, except for the fact that they are patients in
93 that medical facility, would qualify for grants under Title IV,
94 Supplementary Security Income (SSI) benefits under Title XVI or
95 state supplements, and those aged, blind and disabled persons who
96 would not be eligible for Supplemental Security Income (SSI)
97 benefits under Title XVI or state supplements if they were not
98 institutionalized in a medical facility but whose income is below
99 the maximum standard set by the Division of Medicaid, which
100 standard shall not exceed that prescribed by federal regulation;

101 (b) Individuals who have elected to receive
102 hospice care benefits and who are eligible using the same criteria
103 and special income limits as those in institutions as described in
104 subparagraph (a) of this paragraph (7).

105 (8) Children under eighteen (18) years of age and
106 pregnant women (including those in intact families) who meet
107 the *** * *** financial standards of the state plan approved under
108 Title IV-A of the federal Social Security Act, as amended. The
109 eligibility of children covered under this paragraph shall be
110 determined by the State Department of Human Services and certified
111 to the Division of Medicaid.

112 (9) Individuals who are:

113 (a) Children born after September 30, 1983, who
114 have not attained the age of nineteen (19), with family income
115 that does not exceed one hundred percent (100%) of the nonfarm
116 official poverty level;

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

121 (c) Pregnant women and infants who have not
122 attained the age of one (1), with family income that does not
123 exceed one hundred eighty-five percent (185%) of the federal
124 poverty level.

125 The eligibility of individuals covered in (a), (b) and (c) of
126 this paragraph shall be determined by the Department of Human
127 Services.

128 (10) Certain disabled children age eighteen (18) or
129 under who are living at home, who would be eligible, if in a
130 medical institution, for SSI or a state supplemental payment under
131 Title XVI of the federal Social Security Act, as amended, and
132 therefore for Medicaid under the plan, and for whom the state has
133 made a determination as required under Section 1902(e)(3)(b) of
134 the federal Social Security Act, as amended. The eligibility of
135 individuals under this paragraph shall be determined by the
136 Division of Medicaid; however, the division may apply to the
137 federal Centers for Medicare and Medicaid Services (CMS) for a
138 waiver that will allow flexibility in the benefit design for the
139 Disabled Children Living at Home eligibility category authorized
140 in this paragraph (10), and the division may establish an
141 expenditure/enrollment cap for this category. Nothing contained
142 in this paragraph (10) shall entitle an individual to benefits.

143 (11) Individuals who are sixty-five (65) years of age
144 or older or are disabled as determined under Section 1614(a)(3) of

145 the federal Social Security Act, as amended, and whose income does
146 not exceed one hundred thirty-five percent (135%) of the nonfarm
147 official poverty level as defined by the Office of Management and
148 Budget and revised annually, and whose resources do not exceed
149 those established by the Division of Medicaid.
150 The eligibility of individuals covered under this paragraph
151 shall be determined by the Division of Medicaid; however, the
152 division may apply to the federal Centers for Medicare and
153 Medicaid Services (CMS) for a waiver that will allow flexibility
154 in the benefit design and buy-in options for the Poverty Level
155 Aged and Disabled (PLAD) eligibility category authorized in this
156 paragraph (11), and the division may establish an
157 expenditure/enrollment cap for this category. Nothing contained
158 in this paragraph (11) shall entitle an individual to benefits.
159 (12) Individuals who are qualified Medicare
160 beneficiaries (QMB) entitled to Part A Medicare as defined under
161 Section 301, Public Law 100-360, known as the Medicare
162 Catastrophic Coverage Act of 1988, and whose income does not
163 exceed one hundred percent (100%) of the nonfarm official poverty
164 level as defined by the Office of Management and Budget and
165 revised annually.
166 The eligibility of individuals covered under this paragraph
167 shall be determined by the Division of Medicaid, and those
168 individuals determined eligible shall receive Medicare
169 cost-sharing expenses only as more fully defined by the Medicare
170 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
171 1997.
172 (13) *** * *** Individuals who are entitled to Medicare
173 Part A as defined in Section 4501 of the Omnibus Budget
174 Reconciliation Act of 1990, and whose income does not exceed one
175 hundred twenty percent (120%) of the nonfarm official poverty
176 level as defined by the Office of Management and Budget and

177 revised annually. Eligibility for Medicaid benefits is limited to
178 full payment of Medicare Part B premiums.
179 * * *
180 The eligibility of individuals covered under this paragraph
181 shall be determined by the Division of Medicaid.
182 (14) [Deleted]
183 (15) Disabled workers who are eligible to enroll in
184 Part A Medicare as required by Public Law 101-239, known as the
185 Omnibus Budget Reconciliation Act of 1989, and whose income does
186 not exceed two hundred percent (200%) of the federal poverty level
187 as determined in accordance with the Supplemental Security Income
188 (SSI) program. The eligibility of individuals covered under this
189 paragraph shall be determined by the Division of Medicaid and
190 those individuals shall be entitled to buy-in coverage of Medicare
191 Part A premiums only under the provisions of this paragraph (15).
192 (16) In accordance with the terms and conditions of
193 approved Title XIX waiver from the United States Department of
194 Health and Human Services, persons provided home- and
195 community-based services who are physically disabled and certified
196 by the Division of Medicaid as eligible due to applying the income
197 and deeming requirements as if they were institutionalized.
198 (17) In accordance with the terms of the federal
199 Personal Responsibility and Work Opportunity Reconciliation Act of
200 1996 (Public Law 104-193), persons who become ineligible for
201 assistance under Title IV-A of the federal Social Security Act, as
202 amended, because of increased income from or hours of employment
203 of the caretaker relative or because of the expiration of the
204 applicable earned income disregards, who were eligible for
205 Medicaid for at least three (3) of the six (6) months preceding
206 the month in which the ineligibility begins, shall be eligible for
207 Medicaid * * * for up to twelve (12) months * * *.
208 (18) Persons who become ineligible for assistance under
209 Title IV-A of the federal Social Security Act, as amended, as a

210 result, in whole or in part, of the collection or increased
211 collection of child or spousal support under Title IV-D of the
212 federal Social Security Act, as amended, who were eligible for
213 Medicaid for at least three (3) of the six (6) months immediately
214 preceding the month in which the ineligibility begins, shall be
215 eligible for Medicaid for an additional four (4) months beginning
216 with the month in which the ineligibility begins.

217 (19) Disabled workers, whose incomes are above the
218 Medicaid eligibility limits, but below two hundred fifty percent
219 (250%) of the federal poverty level, shall be allowed to purchase
220 Medicaid coverage on a sliding fee scale developed by the Division
221 of Medicaid.

222 (20) Medicaid eligible children under age eighteen (18)
223 shall remain eligible for Medicaid benefits until the end of a
224 period of twelve (12) months following an eligibility
225 determination, or until such time that the individual exceeds age
226 eighteen (18).

227 (21) Women of childbearing age whose family income does
228 not exceed one hundred eighty-five percent (185%) of the federal
229 poverty level. The eligibility of individuals covered under this
230 paragraph (21) shall be determined by the Division of Medicaid,
231 and those individuals determined eligible shall only receive
232 family planning services covered under Section 43-13-117(13) and
233 not any other services covered under Medicaid. However, any
234 individual eligible under this paragraph (21) who is also eligible
235 under any other provision of this section shall receive the
236 benefits to which he or she is entitled under that other
237 provision, in addition to family planning services covered under
238 Section 43-13-117(13).

239 The Division of Medicaid shall apply to the United States
240 Secretary of Health and Human Services for a federal waiver of the
241 applicable provisions of Title XIX of the federal Social Security
242 Act, as amended, and any other applicable provisions of federal

243 law as necessary to allow for the implementation of this paragraph
244 (21). The provisions of this paragraph (21) shall be implemented
245 from and after the date that the Division of Medicaid receives the
246 federal waiver.
247 (22) Persons who are workers with a potentially severe
248 disability, as determined by the division, shall be allowed to
249 purchase Medicaid coverage. The term "worker with a potentially
250 severe disability" means a person who is at least sixteen (16)
251 years of age but under sixty-five (65) years of age, who has a
252 physical or mental impairment that is reasonably expected to cause
253 the person to become blind or disabled as defined under Section
254 1614(a) of the federal Social Security Act, as amended, if the
255 person does not receive items and services provided under
256 Medicaid.
257 The eligibility of persons under this paragraph (22) shall be
258 conducted as a demonstration project that is consistent with
259 Section 204 of the Ticket to Work and Work Incentives Improvement
260 Act of 1999, Public Law 106-170, for a certain number of persons
261 as specified by the division. The eligibility of individuals
262 covered under this paragraph (22) shall be determined by the
263 Division of Medicaid.
264 * * *
265 (23) Children certified by the Mississippi Department
266 of Human Services for whom the state and county departments of
267 human services have custody and financial responsibility who are
268 in foster care on their eighteenth birthday as reported by the
269 Mississippi Department of Human Services shall be certified
270 Medicaid eligible by the Division of Medicaid until their
271 twenty-first birthday.
272 (24) Individuals who have not attained age sixty-five
273 (65), are not otherwise covered by creditable coverage as defined
274 in the Public Health Services Act, and have been screened for
275 breast and cervical cancer under the Centers for Disease Control

276 and Prevention Breast and Cervical Cancer Early Detection Program
277 established under Title XV of the Public Health Service Act in
278 accordance with the requirements of that act and who need
279 treatment for breast or cervical cancer. Eligibility of
280 individuals under this paragraph (24) shall be determined by the
281 Division of Medicaid.
282 * * *
283 **SECTION 2.** Section 43-13-117, Mississippi Code of 1972, is
284 amended as follows:
285 43-13-117. Medicaid as authorized by this article shall
286 include payment of part or all of the costs, at the discretion of
287 the division or its successor, with approval of the Governor, of
288 the following types of care and services rendered to eligible
289 applicants who have been determined to be eligible for that care
290 and services, within the limits of state appropriations and
291 federal matching funds:
292 (1) Inpatient hospital services.
293 (a) The division shall allow thirty (30) days of
294 inpatient hospital care annually for all Medicaid recipients.
295 Precertification of inpatient days must be obtained as required by
296 the division. The division may allow unlimited days in
297 disproportionate hospitals as defined by the division for eligible
298 infants under the age of six (6) years if certified as medically
299 necessary as required by the division.
300 (b) From and after July 1, 1994, the Executive
301 Director of the Division of Medicaid shall amend the Mississippi
302 Title XIX Inpatient Hospital Reimbursement Plan to remove the
303 occupancy rate penalty from the calculation of the Medicaid
304 Capital Cost Component utilized to determine total hospital costs
305 allocated to the Medicaid program.
306 (c) Hospitals will receive an additional payment
307 for the implantable programmable baclofen drug pump used to treat
308 spasticity which is implanted on an inpatient basis. The payment

309 pursuant to written invoice will be in addition to the facility's
310 per diem reimbursement and will represent a reduction of costs on
311 the facility's annual cost report, and shall not exceed Ten
312 Thousand Dollars ($10,000.00) per year per recipient. This
313 subparagraph (c) shall stand repealed on July 1, 2005.
314 (2) Outpatient hospital services. Where the same
315 services are reimbursed as clinic services, the division may
316 revise the rate or methodology of outpatient reimbursement to
317 maintain consistency, efficiency, economy and quality of care.
318 (3) Laboratory and x-ray services.
319 (4) Nursing facility services.
320 (a) The division shall make full payment to
321 nursing facilities for each day, not exceeding fifty-two (52) days
322 per year, that a patient is absent from the facility on home
323 leave. *** * ***
324 (b) From and after July 1, 1997, the division
325 shall implement the integrated case-mix payment and quality
326 monitoring system, which includes the fair rental system for
327 property costs and in which recapture of depreciation is
328 eliminated. The division may reduce the payment for hospital
329 leave and therapeutic home leave days to the lower of the case-mix
330 category as computed for the resident on leave using the
331 assessment being utilized for payment at that point in time, or a
332 case-mix score of 1.000 for nursing facilities, and shall compute
333 case-mix scores of residents so that only services provided at the
334 nursing facility are considered in calculating a facility's per
335 diem.
336 During the period between May 1, 2002, and December 1, 2002,
337 the Chairmen of the Public Health and Welfare Committees of the
338 Senate and the House of Representatives may appoint a joint study
339 committee to consider the issue of setting uniform reimbursement
340 rates for nursing facilities. The study committee will consist of
341 the Chairmen of the Public Health and Welfare Committees, three

342 (3) members of the Senate and three (3) members of the House. The
343 study committee shall complete its work in not more than three (3)
344 meetings.
345 (c) From and after July 1, 1997, all state-owned
346 nursing facilities shall be reimbursed on a full reasonable cost
347 basis.
348 (d) When a facility of a category that does not
349 require a certificate of need for construction and that could not
350 be eligible for Medicaid reimbursement is constructed to nursing
351 facility specifications for licensure and certification, and the
352 facility is subsequently converted to a nursing facility under a
353 certificate of need that authorizes conversion only and the
354 applicant for the certificate of need was assessed an application
355 review fee based on capital expenditures incurred in constructing
356 the facility, the division shall allow reimbursement for capital
357 expenditures necessary for construction of the facility that were
358 incurred within the twenty-four (24) consecutive calendar months
359 immediately preceding the date that the certificate of need
360 authorizing the conversion was issued, to the same extent that
361 reimbursement would be allowed for construction of a new nursing
362 facility under a certificate of need that authorizes that
363 construction. The reimbursement authorized in this subparagraph
364 (d) may be made only to facilities the construction of which was
365 completed after June 30, 1989. Before the division shall be
366 authorized to make the reimbursement authorized in this
367 subparagraph (d), the division first must have received approval
368 from the Health Care Financing Administration of the United States
369 Department of Health and Human Services of the change in the state
370 Medicaid plan providing for the reimbursement.
371 (e) The division shall develop and implement, not
372 later than January 1, 2001, a case-mix payment add-on determined
373 by time studies and other valid statistical data that will
374 reimburse a nursing facility for the additional cost of caring for

375 a resident who has a diagnosis of Alzheimer's or other related
376 dementia and exhibits symptoms that require special care. Any
377 such case-mix add-on payment shall be supported by a determination
378 of additional cost. The division shall also develop and implement
379 as part of the fair rental reimbursement system for nursing
380 facility beds, an Alzheimer's resident bed depreciation enhanced
381 reimbursement system that will provide an incentive to encourage
382 nursing facilities to convert or construct beds for residents with
383 Alzheimer's or other related dementia.

384 (f) The division shall develop and implement an
385 assessment process for long-term care services.

386 * * *

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

391 (5) Periodic screening and diagnostic services for
392 individuals under age twenty-one (21) years as are needed to
393 identify physical and mental defects and to provide health care
394 treatment and other measures designed to correct or ameliorate
395 defects and physical and mental illness and conditions discovered
396 by the screening services regardless of whether these services are
397 included in the state plan. The division may include in its
398 periodic screening and diagnostic program those discretionary
399 services authorized under the federal regulations adopted to
400 implement Title XIX of the federal Social Security Act, as
401 amended. The division, in obtaining physical therapy services,
402 occupational therapy services, and services for individuals with
403 speech, hearing and language disorders, may enter into a
404 cooperative agreement with the State Department of Education for
405 the provision of those services to handicapped students by public
406 school districts using state funds that are provided from the
407 appropriation to the Department of Education to obtain federal

408 matching funds through the division. The division, in obtaining
409 medical and psychological evaluations for children in the custody
410 of the State Department of Human Services may enter into a
411 cooperative agreement with the State Department of Human Services
412 for the provision of those services using state funds that are
413 provided from the appropriation to the Department of Human
414 Services to obtain federal matching funds through the division.
415 (6) Physician's services. The division shall allow
416 twelve (12) physician visits annually. All fees for physicians'
417 services that are covered only by Medicaid shall be reimbursed at
418 ninety percent (90%) of the rate established on January 1, 1999,
419 and as adjusted each January thereafter, under Medicare (Title
420 XVIII of the Social Security Act, as amended), and which shall in
421 no event be less than seventy percent (70%) of the rate
422 established on January 1, 1994. All fees for physicians' services
423 that are covered by both Medicare and Medicaid shall be reimbursed
424 at ten percent (10%) of the adjusted Medicare payment established
425 on January 1, 1999, and as adjusted each January thereafter, under
426 Medicare (Title XVIII of the Social Security Act, as amended), and
427 which shall in no event be less than seventy percent (70%) of the
428 adjusted Medicare payment established on January 1, 1994.
429 (7) (a) Home health services for eligible persons, not
430 to exceed in cost the prevailing cost of nursing facility
431 services, not to exceed sixty (60) visits per year. All home
432 health visits must be precertified as required by the division.
433 (b) Repealed.
434 (8) Emergency medical transportation services. On
435 January 1, 1994, emergency medical transportation services shall
436 be reimbursed at seventy percent (70%) of the rate established
437 under Medicare (Title XVIII of the Social Security Act, as
438 amended). "Emergency medical transportation services" shall mean,
439 but shall not be limited to, the following services by a properly
440 permitted ambulance operated by a properly licensed provider in

441 accordance with the Emergency Medical Services Act of 1974
442 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
443 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
444 (vi) disposable supplies, (vii) similar services.
445 (9) (a) Legend and other drugs as may be determined by
446 the division. *** * *** The division may implement a program of prior
447 approval for drugs to the extent permitted by law. The division
448 shall allow seven (7) prescriptions per month for each
449 noninstitutionalized Medicaid recipient *** * ***. The division shall
450 not reimburse for any portion of a prescription that exceeds a
451 thirty-four-day supply of the drug based on the daily dosage.
452 *** * ***
453 The division shall develop and implement a program of payment
454 for additional pharmacist services, with payment to be based on
455 demonstrated savings, but in no case shall the total payment
456 exceed twice the amount of the dispensing fee.
457 All claims for drugs for dually eligible Medicare/Medicaid
458 beneficiaries that are paid for by Medicare must be submitted to
459 Medicare for payment before they may be processed by the
460 division's on-line payment system.
461 The division shall develop a pharmacy policy in which drugs
462 in tamper-resistant packaging that are prescribed for a resident
463 of a nursing facility but are not dispensed to the resident shall
464 be returned to the pharmacy and not billed to Medicaid, in
465 accordance with guidelines of the State Board of Pharmacy.
466 (b) *** * *** Payment by the division for covered
467 multiple source drugs shall be limited to the lower of the upper
468 limits established and published by the Centers for Medicare and
469 Medicaid Services (CMS) plus a dispensing fee, or the estimated
470 acquisition cost (EAC) plus a dispensing fee, or the providers'
471 usual and customary charge to the general public. *** * ***
472 Payment for other covered drugs, other than multiple source
473 drugs with CMS upper limits, shall not exceed the lower of the

474 estimated acquisition cost plus a dispensing fee or the providers'
475 usual and customary charge to the general public.
476 Payment for nonlegend or over-the-counter drugs covered by
477 the division shall be reimbursed at the lower of the division's
478 estimated shelf price or the providers' usual and customary charge
479 to the general public. *** * ***
480 The dispensing fee for each new or refill prescription,
481 including nonlegend or over-the-counter drugs covered by the
482 division, shall be Three Dollars and Ninety-one Cents ($3.91).
483 The Medicaid provider shall not prescribe, the Medicaid
484 pharmacy shall not bill, and the division shall not reimburse for
485 name brand drugs if there are equally effective generic
486 equivalents available and if the generic equivalents are the least
487 expensive.
488 *** * ***
489 As used in this paragraph (9), "estimated acquisition cost"
490 means twelve percent (12%) less than the average wholesale price
491 for a drug.
492 *** * ***
493 (10) Dental care that is an adjunct to treatment of an
494 acute medical or surgical condition; services of oral surgeons and
495 dentists in connection with surgery related to the jaw or any
496 structure contiguous to the jaw or the reduction of any fracture
497 of the jaw or any facial bone; and emergency dental extractions
498 and treatment related thereto. On July 1, 1999, all fees for
499 dental care and surgery under authority of this paragraph (10)
500 shall be increased to one hundred sixty percent (160%) of the
501 amount of the reimbursement rate that was in effect on June 30,
502 1999. It is the intent of the Legislature to encourage more
503 dentists to participate in the Medicaid program.
504 (11) Eyeglasses for all Medicaid beneficiaries who have
505 (a) had surgery on the eyeball or ocular muscle that results in a
506 vision change for which eyeglasses or a change in eyeglasses is

507 medically indicated within six (6) months of the surgery and is in
508 accordance with policies established by the division, or (b) one
509 (1) pair every five (5) years and in accordance with policies
510 established by the division. In either instance, the eyeglasses
511 must be prescribed by a physician skilled in diseases of the eye
512 or an optometrist, whichever the beneficiary may select.
513 (12) Intermediate care facility services.
514 (a) The division shall make full payment to all
515 intermediate care facilities for the mentally retarded for each
516 day, not exceeding eighty-four (84) days per year, that a patient
517 is absent from the facility on home leave. *** * ***
518 (b) All state-owned intermediate care facilities
519 for the mentally retarded shall be reimbursed on a full reasonable
520 cost basis.
521 (13) Family planning services, including drugs,
522 supplies and devices, when those services are under the
523 supervision of a physician.
524 (14) Clinic services. Such diagnostic, preventive,
525 therapeutic, rehabilitative or palliative services furnished to an
526 outpatient by or under the supervision of a physician or dentist
527 in a facility that is not a part of a hospital but that is
528 organized and operated to provide medical care to outpatients.
529 Clinic services shall include any services reimbursed as
530 outpatient hospital services that may be rendered in such a
531 facility, including those that become so after July 1, 1991. On
532 July 1, 1999, all fees for physicians' services reimbursed under
533 authority of this paragraph (14) shall be reimbursed at ninety
534 percent (90%) of the rate established on January 1, 1999, and as
535 adjusted each January thereafter, under Medicare (Title XVIII of
536 the Social Security Act, as amended), and which shall in no event
537 be less than seventy percent (70%) of the rate established on
538 January 1, 1994. All fees for physicians' services that are
539 covered by both Medicare and Medicaid shall be reimbursed at ten

540 percent (10%) of the adjusted Medicare payment established on
541 January 1, 1999, and as adjusted each January thereafter, under
542 Medicare (Title XVIII of the Social Security Act, as amended), and
543 which shall in no event be less than seventy percent (70%) of the
544 adjusted Medicare payment established on January 1, 1994. On July
545 1, 1999, all fees for dentists' services reimbursed under
546 authority of this paragraph (14) shall be increased to one hundred
547 sixty percent (160%) of the amount of the reimbursement rate that
548 was in effect on June 30, 1999.
549 (15) Home- and community-based services for the elderly
550 and disabled, as provided under Title XIX of the federal Social
551 Security Act, as amended, under waivers, subject to the
552 availability of funds specifically appropriated therefor by the
553 Legislature. *** * ***
554 (16) Mental health services. Approved therapeutic and
555 case management services (a) provided by an approved regional
556 mental health/retardation center established under Sections
557 41-19-31 through 41-19-39, or by another community mental health
558 service provider meeting the requirements of the Department of
559 Mental Health to be an approved mental health/retardation center
560 if determined necessary by the Department of Mental Health, using
561 state funds that are provided from the appropriation to the State
562 Department of Mental Health and/or funds transferred to the
563 department by a political subdivision or instrumentality of the
564 state and used to match federal funds under a cooperative
565 agreement between the division and the department, or (b) provided
566 by a facility that is certified by the State Department of Mental
567 Health to provide therapeutic and case management services, to be
568 reimbursed on a fee for service basis, or (c) provided in the
569 community by a facility or program operated by the Department of
570 Mental Health. Any such services provided by a facility described
571 in subparagraph (b) must have the prior approval of the division
572 to be reimbursable under this section. After June 30, 1997,

573 mental health services provided by regional mental
574 health/retardation centers established under Sections 41-19-31
575 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
576 and/or their subsidiaries and divisions, or by psychiatric
577 residential treatment facilities as defined in Section 43-11-1, or
578 by another community mental health service provider meeting the
579 requirements of the Department of Mental Health to be an approved
580 mental health/retardation center if determined necessary by the
581 Department of Mental Health, shall not be included in or provided
582 under any capitated managed care pilot program provided for under
583 paragraph (24) of this section.
584 (17) Durable medical equipment services and medical
585 supplies. Precertification of durable medical equipment and
586 medical supplies must be obtained as required by the division.
587 The Division of Medicaid may require durable medical equipment
588 providers to obtain a surety bond in the amount and to the
589 specifications as established by the Balanced Budget Act of 1997.
590 (18) (a) Notwithstanding any other provision of this
591 section to the contrary, the division shall make additional
592 reimbursement to hospitals that serve a disproportionate share of
593 low-income patients and that meet the federal requirements for
594 those payments as provided in Section 1923 of the federal Social
595 Security Act and any applicable regulations. However, from and
596 after January 1, 1999, no public hospital shall participate in the
597 Medicaid disproportionate share program unless the public hospital
598 participates in an intergovernmental transfer program as provided
599 in Section 1903 of the federal Social Security Act and any
600 applicable regulations. Administration and support for
601 participating hospitals shall be provided by the Mississippi
602 Hospital Association.
603 (b) The division shall establish a Medicare Upper
604 Payment Limits Program, as defined in Section 1902(a)(30) of the
605 federal Social Security Act and any applicable federal

606 regulations, for hospitals, and may establish a Medicare Upper
607 Payments Limits Program for nursing facilities. The division
608 shall assess each hospital and, if the program is established for
609 nursing facilities, shall assess each nursing facility, for the
610 sole purpose of financing the state portion of the Medicare Upper
611 Payment Limits Program. This assessment shall be based on
612 Medicaid utilization, or other appropriate method consistent with
613 federal regulations, and will remain in effect as long as the
614 state participates in the Medicare Upper Payment Limits Program.
615 The division shall make additional reimbursement to hospitals and,
616 if the program is established for nursing facilities, shall make
617 additional reimbursement to nursing facilities, for the Medicare
618 Upper Payment Limits, as defined in Section 1902(a)(30) of the
619 federal Social Security Act and any applicable federal
620 regulations. This subparagraph (b) shall stand repealed from and
621 after July 1, 2005.

622 (c) The division shall contract with the
623 Mississippi Hospital Association to provide administrative support
624 for the operation of the disproportionate share hospital program
625 and the Medicare Upper Payment Limits Program. This subparagraph
626 (c) shall stand repealed from and after July 1, 2005.

627 (19) (a) Perinatal risk management services. The
628 division shall promulgate regulations to be effective from and
629 after October 1, 1988, to establish a comprehensive perinatal
630 system for risk assessment of all pregnant and infant Medicaid
631 recipients and for management, education and follow-up for those
632 who are determined to be at risk. Services to be performed
633 include case management, nutrition assessment/counseling,
634 psychosocial assessment/counseling and health education. The
635 division shall set reimbursement rates for providers in
636 conjunction with the State Department of Health.

637 (b) Early intervention system services. The
638 division shall cooperate with the State Department of Health,

639 acting as lead agency, in the development and implementation of a
640 statewide system of delivery of early intervention services, under
641 Part C of the Individuals with Disabilities Education Act (IDEA).
642 The State Department of Health shall certify annually in writing
643 to the executive director of the division the dollar amount of
644 state early intervention funds available that will be utilized as
645 a certified match for Medicaid matching funds. Those funds then
646 shall be used to provide expanded targeted case management
647 services for Medicaid eligible children with special needs who are
648 eligible for the state's early intervention system.
649 Qualifications for persons providing service coordination shall be
650 determined by the State Department of Health and the Division of
651 Medicaid.

652 (20) Home- and community-based services for physically
653 disabled approved services as allowed by a waiver from the United
654 States Department of Health and Human Services for home- and
655 community-based services for physically disabled people using
656 state funds that are provided from the appropriation to the State
657 Department of Rehabilitation Services and used to match federal
658 funds under a cooperative agreement between the division and the
659 department, provided that funds for these services are
660 specifically appropriated to the Department of Rehabilitation
661 Services.

662 (21) Nurse practitioner services. Services furnished
663 by a registered nurse who is licensed and certified by the
664 Mississippi Board of Nursing as a nurse practitioner, including,
665 but not limited to, nurse anesthetists, nurse midwives, family
666 nurse practitioners, family planning nurse practitioners,
667 pediatric nurse practitioners, obstetrics-gynecology nurse
668 practitioners and neonatal nurse practitioners, under regulations
669 adopted by the division. Reimbursement for those services shall
670 not exceed ninety percent (90%) of the reimbursement rate for
671 comparable services rendered by a physician.

672 (22) Ambulatory services delivered in federally
673 qualified health centers, rural health centers and clinics of the
674 local health departments of the State Department of Health for
675 individuals eligible for Medicaid under this article based on
676 reasonable costs as determined by the division.
677 (23) Inpatient psychiatric services. Inpatient
678 psychiatric services to be determined by the division for
679 recipients under age twenty-one (21) that are provided under the
680 direction of a physician in an inpatient program in a licensed
681 acute care psychiatric facility or in a licensed psychiatric
682 residential treatment facility, before the recipient reaches age
683 twenty-one (21) or, if the recipient was receiving the services
684 immediately before he reached age twenty-one (21), before the
685 earlier of the date he no longer requires the services or the date
686 he reaches age twenty-two (22), as provided by federal
687 regulations. Precertification of inpatient days and residential
688 treatment days must be obtained as required by the division.
689 (24) [Deleted]
690 (25) [Deleted]
691 (26) Hospice care. As used in this paragraph, the term
692 "hospice care" means a coordinated program of active professional
693 medical attention within the home and outpatient and inpatient
694 care that treats the terminally ill patient and family as a unit,
695 employing a medically directed interdisciplinary team. The
696 program provides relief of severe pain or other physical symptoms
697 and supportive care to meet the special needs arising out of
698 physical, psychological, spiritual, social and economic stresses
699 that are experienced during the final stages of illness and during
700 dying and bereavement and meets the Medicare requirements for
701 participation as a hospice as provided in federal regulations.
702 (27) Group health plan premiums and cost sharing if it
703 is cost effective as defined by the Secretary of Health and Human
704 Services.

705 (28) Other health insurance premiums that are cost
706 effective as defined by the Secretary of Health and Human
707 Services. Medicare eligible must have Medicare Part B before
708 other insurance premiums can be paid.
709 (29) The Division of Medicaid may apply for a waiver
710 from the Department of Health and Human Services for home- and
711 community-based services for developmentally disabled people using
712 state funds that are provided from the appropriation to the State
713 Department of Mental Health and/or funds transferred to the
714 department by a political subdivision or instrumentality of the
715 state and used to match federal funds under a cooperative
716 agreement between the division and the department, provided that
717 funds for these services are specifically appropriated to the
718 Department of Mental Health and/or transferred to the department
719 by a political subdivision or instrumentality of the state.
720 (30) Pediatric skilled nursing services for eligible
721 persons under twenty-one (21) years of age.
722 (31) Targeted case management services for children
723 with special needs, under waivers from the United States
724 Department of Health and Human Services, using state funds that
725 are provided from the appropriation to the Mississippi Department
726 of Human Services and used to match federal funds under a
727 cooperative agreement between the division and the department.
728 (32) Care and services provided in Christian Science
729 Sanatoria listed and certified by the Commission for Accreditation
730 of Christian Science Nursing Organizations/Facilities, Inc.,
731 rendered in connection with treatment by prayer or spiritual means
732 to the extent that those services are subject to reimbursement
733 under Section 1903 of the Social Security Act.
734 (33) Podiatrist services.
735 (34) Assisted living services as provided through home-
736 and community-based services under Title XIX of the Social

737 Security Act, as amended, subject to the availability of funds
738 specifically appropriated therefor by the Legislature.
739 (35) Services and activities authorized in Sections
740 43-27-101 and 43-27-103, using state funds that are provided from
741 the appropriation to the State Department of Human Services and
742 used to match federal funds under a cooperative agreement between
743 the division and the department.
744 (36) Nonemergency transportation services for
745 Medicaid-eligible persons, to be provided by the Division of
746 Medicaid. The division may contract with additional entities to
747 administer nonemergency transportation services as it deems
748 necessary. All providers shall have a valid driver's license,
749 vehicle inspection sticker, valid vehicle license tags and a
750 standard liability insurance policy covering the vehicle.
751 (37) [Deleted]
752 (38) Chiropractic services. A chiropractor's manual
753 manipulation of the spine to correct a subluxation, if x-ray
754 demonstrates that a subluxation exists and if the subluxation has
755 resulted in a neuromusculoskeletal condition for which
756 manipulation is appropriate treatment, and related spinal x-rays
757 performed to document these conditions. Reimbursement for
758 chiropractic services shall not exceed Seven Hundred Dollars
759 ($700.00) per year per beneficiary.
760 (39) Dually eligible Medicare/Medicaid beneficiaries.
761 The division shall pay the Medicare deductible and * * *
762 coinsurance amounts for services available under Medicare, as
763 determined by the division.
764 (40) [Deleted]
765 (41) Services provided by the State Department of
766 Rehabilitation Services for the care and rehabilitation of persons
767 with spinal cord injuries or traumatic brain injuries, as allowed
768 under waivers from the United States Department of Health and
769 Human Services, using up to seventy-five percent (75%) of the

770 funds that are appropriated to the Department of Rehabilitation
771 Services from the Spinal Cord and Head Injury Trust Fund
772 established under Section 37-33-261 and used to match federal
773 funds under a cooperative agreement between the division and the
774 department.

775 (42) Notwithstanding any other provision in this
776 article to the contrary, the division may develop a population
777 health management program for women and children health services
778 through the age of one (1) year. This program is primarily for
779 obstetrical care associated with low birth weight and pre-term
780 babies. The division may apply to the federal Centers for
781 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
782 any other waivers that may enhance the program. In order to
783 effect cost savings, the division may develop a revised payment
784 methodology that may include at-risk capitated payments, and may
785 require member participation in accordance with the terms and
786 conditions of an approved federal waiver.

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

792 (44) Nursing facility services for the severely
793 disabled.

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

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

801 (45) Physician assistant services. Services furnished
802 by a physician assistant who is licensed by the State Board of

803 Medical Licensure and is practicing with physician supervision
804 under regulations adopted by the board, under regulations adopted
805 by the division. Reimbursement for those services shall not
806 exceed ninety percent (90%) of the reimbursement rate for
807 comparable services rendered by a physician.

808 (46) The division shall make application to the federal
809 Centers for Medicare and Medicaid Services (CMS) for a waiver to
810 develop and provide services for children with serious emotional
811 disturbances as defined in Section 43-14-1(1), which may include
812 home- and community-based services, case management services or
813 managed care services through mental health providers certified by
814 the Department of Mental Health. The division may implement and
815 provide services under this waivered program only if funds for
816 these services are specifically appropriated for this purpose by
817 the Legislature, or if funds are voluntarily provided by affected
818 agencies.

819 (47) Notwithstanding any other provision in this
820 article to the contrary, the division *** * *** shall develop and
821 implement disease management programs *** * ***.

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

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

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

832 (49) The division shall establish copayments for all
833 Medicaid services for which copayments are allowable under federal
834 law or regulation, except for nonemergency transportation
835 services, and shall set the amount of the copayment for each of

836 those services at the maximum amount allowable under federal law
837 or regulation.

838 Notwithstanding any other provision of this article to the
839 contrary, the division shall reduce the rate of reimbursement to
840 providers for any service provided under this section by five
841 percent (5%) of the allowed amount for that service. However, the
842 reduction in the reimbursement rates required by this paragraph
843 shall not apply to inpatient hospital services, nursing facility
844 services, intermediate care facility services, psychiatric
845 residential treatment facility services, pharmacy services
846 provided under paragraph (9) of this section, or any service
847 provided by the University of Mississippi Medical Center or a
848 state agency, a state facility or a public agency that either
849 provides its own state match through intergovernmental transfer or
850 certification of funds to the division, or a service for which the
851 federal government sets the reimbursement methodology and rate.
852 In addition, the reduction in the reimbursement rates required by
853 this paragraph shall not apply to case management services ***
854 provided under the home- and community-based services program for
855 the elderly and disabled by a planning and development district
856 (PDD). PDDs participating in the home- and community-based
857 services program for the elderly and disabled as case management
858 providers shall be reimbursed for case management services at the
859 maximum rate approved by the federal Centers for Medicare and
860 Medicaid Services (CMS). PDDs shall transfer to the division the
861 state match from nonfederal public funds in an amount equal to the
862 difference between the maximum case management reimbursement rate
863 approved by CMS and a five percent (5%) reduction in that rate.
864 The division shall invoice each PDD fifteen (15) days after the
865 end of each quarter for the intergovernmental transfer based on
866 the number of Medicaid home- and community-based clients that the
867 PDD served during the quarter. The division may remove the five
868 percent (5%) reduction in reimbursement for those providers who

869 participate in the division's emergency room redirection program
870 and achieve the performance measures and reduction of costs
871 required of that program.

872 Notwithstanding any provision of this article, except as
873 authorized in the following paragraph and in Section 43-13-139,
874 neither (a) the limitations on quantity or frequency of use of or
875 the fees or charges for any of the care or services available to
876 recipients under this section, nor (b) the payments or rates of
877 reimbursement to providers rendering care or services authorized
878 under this section to recipients, may be increased, decreased or
879 otherwise changed from the levels in effect on July 1, 1999,
880 unless they are authorized by an amendment to this section by the
881 Legislature. However, the restriction in this paragraph shall not
882 prevent the division from changing the payments or rates of
883 reimbursement to providers without an amendment to this section
884 whenever those changes are required by federal law or regulation,
885 or whenever those changes are necessary to correct administrative
886 errors or omissions in calculating those payments or rates of
887 reimbursement.

888 Notwithstanding any provision of this article, no new groups
889 or categories of recipients and new types of care and services may
890 be added without enabling legislation from the Mississippi
891 Legislature, except that the division may authorize those changes
892 without enabling legislation when the addition of recipients or
893 services is ordered by a court of proper authority. The executive
894 director shall keep the Governor advised on a timely basis of the
895 funds available for expenditure and the projected expenditures.
896 If current or projected expenditures of the division can be
897 reasonably anticipated to exceed the amounts appropriated for any
898 fiscal year, the Governor, after consultation with the executive
899 director, shall discontinue any or all of the payment of the types
900 of care and services as provided in this section that are deemed
901 to be optional services under Title XIX of the federal Social

902 Security Act, as amended, for any period necessary to not exceed
903 appropriated funds, and when necessary shall institute any other
904 cost containment measures on any program or programs authorized
905 under the article to the extent allowed under the federal law
906 governing that program or programs, it being the intent of the
907 Legislature that expenditures during any fiscal year shall not
908 exceed the amounts appropriated for that fiscal year.
909 Notwithstanding any other provision of this article, it shall
910 be the duty of each nursing facility, intermediate care facility
911 for the mentally retarded, psychiatric residential treatment
912 facility, and nursing facility for the severely disabled that is
913 participating in the Medicaid program to keep and maintain books,
914 documents and other records as prescribed by the Division of
915 Medicaid in substantiation of its cost reports for a period of
916 three (3) years after the date of submission to the Division of
917 Medicaid of an original cost report, or three (3) years after the
918 date of submission to the Division of Medicaid of an amended cost
919 report.
920 This section shall stand repealed on July 1, 2004.
921 **SECTION 3.** Section 43-13-107, Mississippi Code of 1972, is
922 amended as follows:
923 43-13-107. (1) The Division of Medicaid is created in the
924 Office of the Governor and established to administer this article
925 and perform such other duties as are prescribed by law.
926 (2) (a) The Governor shall appoint a full-time executive
927 director, with the advice and consent of the Senate, who shall be
928 either (i) a physician with administrative experience in a medical
929 care or health program, or (ii) a person holding a graduate degree
930 in medical care administration, public health, hospital
931 administration, or the equivalent, or (iii) a person holding a
932 bachelor's degree in business administration or hospital
933 administration, with at least ten (10) years' experience in
934 management-level administration of Medicaid programs, and who

935 shall serve at the will and pleasure of the Governor. The
936 executive director shall be the official secretary and legal
937 custodian of the records of the division; shall be the agent of
938 the division for the purpose of receiving all service of process,
939 summons and notices directed to the division; and shall perform
940 such other duties as the Governor may prescribe from time to time.
941 (b) The executive director, with the approval of the
942 Governor and subject to the rules and regulations of the State
943 Personnel Board, shall employ such professional, administrative,
944 stenographic, secretarial, clerical and technical assistance as
945 may be necessary to perform the duties required in administering
946 this article and fix the compensation therefor, all in accordance
947 with a state merit system meeting federal requirements when the
948 salary of the executive director is not set by law, that salary
949 shall be set by the State Personnel Board. No employees of the
950 Division of Medicaid shall be considered to be staff members of
951 the immediate Office of the Governor; however, the provisions of
952 Section 25-9-107(c)(xv) shall apply to the executive director and
953 other administrative heads of the division.
954 (3) (a) There is established a Medical Care Advisory
955 Committee, which shall be the committee that is required by
956 federal regulation to advise the Division of Medicaid about health
957 and medical care services.
958 (b) The advisory committee shall consist of not less
959 than eleven (11) members, as follows:
960 (i) The Governor shall appoint five (5) members,
961 one (1) from each congressional district and one (1) from the
962 state at large;
963 (ii) The Lieutenant Governor shall appoint three
964 (3) members, one (1) from each Supreme Court district;
965 (iii) The Speaker of the House of Representatives
966 shall appoint three (3) members, one (1) from each Supreme Court
967 district.

968 All members appointed under this paragraph shall either be
969 health care providers or consumers of health care services. One
970 (1) member appointed by each of the appointing authorities shall
971 be a board certified physician.
972 (c) The respective chairmen of the House Public Health
973 and Welfare Committee, the House Appropriations Committee, the
974 Senate Public Health and Welfare Committee and the Senate
975 Appropriations Committee, or their designees, one (1) member of
976 the State Senate appointed by the Lieutenant Governor and one (1)
977 member of the House of Representatives appointed by the Speaker of
978 the House, shall serve as ex officio nonvoting members of the
979 advisory committee.
980 (d) In addition to the committee members required by
981 paragraph (b), the advisory committee shall consist of such other
982 members as are necessary to meet the requirements of the federal
983 regulation applicable to the advisory committee, who shall be
984 appointed as provided in the federal regulation.
985 (e) The chairmanship of the advisory committee shall
986 alternate for twelve-month periods between the chairmen of the
987 House and Senate Public Health and Welfare Committees, with the
988 Chairman of the House Public Health and Welfare Committee serving
989 as the first chairman.
990 (f) The members of the advisory committee specified in
991 paragraph (b) shall serve for terms that are concurrent with the
992 terms of members of the Legislature, and any member appointed
993 under paragraph (b) may be reappointed to the advisory committee.
994 The members of the advisory committee specified in paragraph (b)
995 shall serve without compensation, but shall receive reimbursement
996 to defray actual expenses incurred in the performance of committee
997 business as authorized by law. Legislators shall receive per diem
998 and expenses which may be paid from the contingent expense funds
999 of their respective houses in the same amounts as provided for
1000 committee meetings when the Legislature is not in session.

1001 (g) The advisory committee shall meet not less than
1002 quarterly, and advisory committee members shall be furnished
1003 written notice of the meetings at least ten (10) days before the
1004 date of the meeting.
1005 (h) The executive director shall submit to the advisory
1006 committee all amendments, modifications and changes to the state
1007 plan for the operation of the Medicaid program, for review by the
1008 advisory committee before the amendments, modifications or changes
1009 may be implemented by the division.
1010 (i) The advisory committee, among its duties and
1011 responsibilities, shall:
1012 (i) Advise the division with respect to
1013 amendments, modifications and changes to the state plan for the
1014 operation of the Medicaid program;
1015 (ii) Advise the division with respect to issues
1016 concerning receipt and disbursement of funds and eligibility for
1017 Medicaid;
1018 (iii) Advise the division with respect to
1019 determining the quantity, quality and extent of medical care
1020 provided under this article;
1021 (iv) Communicate the views of the medical care
1022 professions to the division and communicate the views of the
1023 division to the medical care professions;
1024 (v) Gather information on reasons that medical
1025 care providers do not participate in the Medicaid program and
1026 changes that could be made in the program to encourage more
1027 providers to participate in the Medicaid program, and advise the
1028 division with respect to encouraging physicians and other medical
1029 care providers to participate in the Medicaid program;
1030 (vi) Provide a written report on or before
1031 November 30 of each year to the Governor, Lieutenant Governor and
1032 Speaker of the House of Representatives.

1033 (4) (a) There is established a Drug Use Review Board, which
1034 shall be the board that is required by federal law to:
1035 (i) Review and initiate retrospective drug use,
1036 review including ongoing periodic examination of claims data and
1037 other records in order to identify patterns of fraud, abuse, gross
1038 overuse, or inappropriate or medically unnecessary care, among
1039 physicians, pharmacists and individuals receiving Medicaid
1040 benefits or associated with specific drugs or groups of drugs.
1041 (ii) Review and initiate ongoing interventions for
1042 physicians and pharmacists, targeted toward therapy problems or
1043 individuals identified in the course of retrospective drug use
1044 reviews.
1045 (iii) On an ongoing basis, assess data on drug use
1046 against explicit predetermined standards using the compendia and
1047 literature set forth in federal law and regulations.
1048 (b) The board shall consist of not less than twelve
1049 (12) members appointed by the Governor, or his designee.
1050 (c) The board shall meet at least quarterly, and board
1051 members shall be furnished written notice of the meetings at least
1052 ten (10) days before the date of the meeting.
1053 (d) The board meetings shall be open to the public,
1054 members of the press, legislators and consumers. Additionally,
1055 all documents provided to board members shall be available to
1056 members of the Legislature in the same manner, and shall be made
1057 available to others for a reasonable fee for copying. However,
1058 patient confidentiality and provider confidentiality shall be
1059 protected by blinding patient names and provider names with
1060 numerical or other anonymous identifiers. The board meetings
1061 shall be subject to the Open Meetings Act (Section 25-41-1 et
1062 seq.). Board meetings conducted in violation of this section
1063 shall be deemed unlawful.

1064 (5) (a) There is established a Pharmacy and Therapeutics
1065 Committee, which shall be appointed by the Governor, or his
1066 designee.
1067 (b) The committee shall meet at least quarterly, and
1068 committee members shall be furnished written notice of the
1069 meetings at least ten (10) days before the date of the meeting.
1070 (c) The committee meetings shall be open to the public,
1071 members of the press, legislators and consumers. Additionally,
1072 all documents provided to committee members shall be available to
1073 members of the Legislature in the same manner, and shall be made
1074 available to others for a reasonable fee for copying. However,
1075 patient confidentiality and provider confidentiality shall be
1076 protected by blinding patient names and provider names with
1077 numerical or other anonymous identifiers. The committee meetings
1078 shall be subject to the Open Meetings Act (Section 25-41-1 et
1079 seq.). Committee meetings conducted in violation of this section
1080 shall be deemed unlawful.
1081 (d) After a thirty-day public notice, the executive
1082 director or his or her designee shall present the division's
1083 recommendation regarding prior approval for a therapeutic class of
1084 drugs to the committee. However, in circumstances where the
1085 division deems it necessary for the health and safety of Medicaid
1086 beneficiaries, the division may present to the committee its
1087 recommendations regarding a particular drug without a thirty-day
1088 public notice. In making the presentation, the division shall
1089 state to the committee the circumstances that precipitate the need
1090 for the committee to review the status of a particular drug
1091 without a thirty-day public notice. The committee may determine
1092 whether or not to review the particular drug under the
1093 circumstances stated by the division without a thirty-day public
1094 notice. If the committee determines to review the status of the
1095 particular drug, it shall make its recommendations to the
1096 division, after which the division shall file the recommendations

1097 for a thirty-day public comment under the provisions of Section
1098 25-43-7(1).
1099 (e) Upon reviewing the information and recommendations,
1100 the committee shall forward a written recommendation approved by a
1101 majority of the committee to the executive director or his or her
1102 designee. The decisions of the committee regarding any
1103 limitations to be imposed on any drug or its use for a specified
1104 indication shall be based on sound clinical evidence found in
1105 labeling, drug compendia, and peer reviewed clinical literature
1106 pertaining to use of the drug in the relevant population.
1107 (f) Upon reviewing and considering all recommendations
1108 including recommendation of the committee, comments, and data, the
1109 executive director shall make a final determination whether to
1110 require prior approval of a therapeutic class of drugs, or modify
1111 existing prior approval requirements for a therapeutic class of
1112 drugs.
1113 (g) At least thirty (30) days before the executive
1114 director implements new or amended prior authorization decisions,
1115 written notice of the executive director's decision shall be
1116 provided to all prescribing Medicaid providers, all Medicaid
1117 enrolled pharmacies, and any other party who has requested the
1118 notification. However, notice given under Section 25-43-7(1) will
1119 substitute for and meet the requirement for notice under this
1120 subsection.
1121 (6) This section shall stand repealed on July 1, 2004.
1122 **SECTION 4.** Section 43-13-122, Mississippi Code of 1972, is
1123 amended as follows:
1124 43-13-122. (1) The division may apply to the federal
1125 Centers for Medicare and Medicaid Services (CMS) of the United
1126 States Department of Health and Human Services for waivers and
1127 research and demonstration grants *** * ***.
1128 (2) The division may accept and expend any grants, donations
1129 or contributions from any public or private organization, together

1130 with any additional federal matching funds that may accrue and
1131 including, but not limited to, one hundred percent (100%) federal
1132 grant funds or funds from any governmental entity or
1133 instrumentality thereof in furthering the purposes and objectives
1134 of the Mississippi Medicaid program, provided that those receipts
1135 and expenditures are reported and otherwise handled in accordance
1136 with the General Fund Stabilization Act. The Department of
1137 Finance and Administration may transfer monies to the division
1138 from special funds in the State Treasury in amounts not exceeding
1139 the amounts authorized in the appropriation to the division.

1140 **SECTION 5.** Section 43-13-145, Mississippi Code of 1972, is
1141 amended as follows:

1142 43-13-145. (1) (a) Upon each nursing facility and each
1143 intermediate care facility for the mentally retarded licensed by
1144 the State of Mississippi, there is levied an assessment in the
1145 amount of Four Dollars ($4.00) per day for each licensed and/or
1146 certified bed of the facility. The division may apply for a
1147 waiver from the United States Secretary of Health and Human
1148 Services to exempt nonprofit, public, charitable or religious
1149 facilities from the assessment levied under this subsection, and
1150 if a waiver is granted, those facilities shall be exempt from any
1151 assessment levied under this subsection after the date that the
1152 division receives notice that the waiver has been granted.

1153 (b) A nursing facility or intermediate care facility
1154 for the mentally retarded is exempt from the assessment levied
1155 under this subsection if the facility is operated under the
1156 direction and control of:

1157 (i) The United States Veterans Administration or
1158 other agency or department of the United States government;

1159 (ii) The State Veterans Affairs Board;

1160 (iii) The University of Mississippi Medical
1161 Center; or

1162 (iv) A state agency or a state facility that
1163 either provides its own state match through intergovernmental
1164 transfer or certification of funds to the division.
1165 (2) (a) Upon each psychiatric residential treatment
1166 facility licensed by the State of Mississippi, there is levied an
1167 assessment in the amount of Three Dollars ($3.00) per day for each
1168 licensed and/or certified bed of the facility.
1169 (b) A psychiatric residential treatment facility is
1170 exempt from the assessment levied under this subsection if the
1171 facility is operated under the direction and control of:
1172 (i) The United States Veterans Administration or
1173 other agency or department of the United States government;
1174 (ii) The University of Mississippi Medical Center;
1175 (iii) A state agency or a state facility that
1176 either provides its own state match through intergovernmental
1177 transfer or certification of funds to the division.
1178 (3) (a) Upon each hospital licensed by the State of
1179 Mississippi, there is levied an assessment in the amount of One
1180 Dollar and Fifty Cents ($1.50) per day for each licensed inpatient
1181 acute care bed of the hospital.
1182 (b) A hospital is exempt from the assessment levied
1183 under this subsection if the hospital is operated under the
1184 direction and control of:
1185 (i) The United States Veterans Administration or
1186 other agency or department of the United States government;
1187 (ii) The University of Mississippi Medical Center;
1188 or
1189 (iii) A state agency or a state facility that
1190 either provides its own state match through intergovernmental
1191 transfer or certification of funds to the division.
1192 (4) Each health care facility that is subject to the
1193 provisions of this section shall keep and preserve such suitable
1194 books and records as may be necessary to determine the amount of

1195 assessment for which it is liable under this section. The books
1196 and records shall be kept and preserved for a period of not less
1197 than five (5) years, and those books and records shall be open for
1198 examination during business hours by the division, the State Tax
1199 Commission, the Office of the Attorney General and the State
1200 Department of Health.
1201 (5) The assessment levied under this section shall be
1202 collected by the division each month beginning on April 12, 2002.
1203 (6) All assessments collected under this section shall be
1204 deposited in the Medical Care Fund created by Section 43-13-143.
1205 (7) The assessment levied under this section shall be in
1206 addition to any other assessments, taxes or fees levied by law,
1207 and the assessment shall constitute a debt due the State of
1208 Mississippi from the time the assessment is due until it is paid.
1209 (8) (a) If a health care facility that is liable for
1210 payment of the assessment levied under this section does not pay
1211 the assessment when it is due, the division shall give written
1212 notice to the health care facility by certified or registered mail
1213 demanding payment of the assessment within ten (10) days from the
1214 date of delivery of the notice. If the health care facility
1215 fails or refuses to pay the assessment after receiving the notice
1216 and demand from the division, the division shall withhold from any
1217 Medicaid reimbursement payments that are due to the health care
1218 facility the amount of the unpaid assessment and a penalty of ten
1219 percent (10%) of the amount of the assessment, plus the legal rate
1220 of interest until the assessment is paid in full. If the health
1221 care facility does not participate in the Medicaid program, the
1222 division shall turn over to the Office of the Attorney General the
1223 collection of the unpaid assessment by civil action. In any such
1224 civil action, the Office of the Attorney General shall collect the
1225 amount of the unpaid assessment and a penalty of ten percent (10%)
1226 of the amount of the assessment, plus the legal rate of interest
1227 until the assessment is paid in full.

1228 (b) As an additional or alternative method for
1229 collecting unpaid assessments under this section, if a health care
1230 facility fails or refuses to pay the assessment after receiving
1231 notice and demand from the division, the division may file a
1232 notice of a tax lien with the circuit clerk of the county in which
1233 the health care facility is located, for the amount of the unpaid
1234 assessment and a penalty of ten percent (10%) of the amount of the
1235 assessment, plus the legal rate of interest until the assessment
1236 is paid in full. Immediately upon receipt of notice of the tax
1237 lien for the assessment, the circuit clerk shall enter the notice
1238 of the tax lien as a judgment upon the judgment roll and show in
1239 the appropriate columns the name of the health care facility as
1240 judgment debtor, the name of the division as judgment creditor,
1241 the amount of the unpaid assessment, and the date and time or
1242 enrollment. The judgment shall be valid as against mortgagees,
1243 pledgees, entrusters, purchasers, judgment creditors and other
1244 persons from the time of filing with the clerk. The amount of the
1245 judgment shall be a debt due the State of Mississippi and remain a
1246 lien upon the tangible property of the health care facility until
1247 the judgment is satisfied. The judgment shall be the equivalent
1248 of any enrolled judgment of a court of record and shall serve as
1249 authority for the issuance of writs of execution, writs of
1250 attachment or other remedial writs.
1251 **SECTION 6**. This act shall take effect and be in force from
1252 and after its passage.

ST: Medicaid; make technical amendments to Medicaid laws.