

By: Senator(s) Nunnelee, Burton,
Gordon

To: Public Health and
Welfare

SENATE BILL NO. 2003

1 AN ACT TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972,
2 TO DELETE FROM MEDICAID ELIGIBILITY THE CATEGORY OF CERTAIN
3 INDIVIDUALS WHO RECEIVE HOSPICE CARE BENEFITS; TO REINSTATE
4 MEDICAID ELIGIBILITY FOR THE POVERTY-LEVEL, AGED AND DISABLED
5 (PLAD) GROUP UNTIL JANUARY 1, 2006; TO DEFINE MEDICAID ELIGIBILITY
6 FOR INDIVIDUALS WHO ARE ENTITLED TO MEDICARE PART D; TO AMEND
7 SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO DEFINE THE AGE
8 LIMITATION FOR UNLIMITED DAYS IN DISPROPORTIONATE SHARE HOSPITALS;
9 TO DELETE THE AUTOMATIC REPEALER ON THE PROVISION FOR AN
10 ADDITIONAL PAYMENT TO BE MADE TO HOSPITALS FOR IMPLANTABLE
11 PROGRAMMABLE BACLOFEN DRUG PUMPS; TO ESTABLISH A REIMBURSEMENT
12 LIMIT FOR EMERGENCY ROOM VISITS; TO PROVIDE THAT CERTAIN
13 NONEMERGENCY OUTPATIENT HOSPITAL SERVICES SHALL BE REIMBURSABLE
14 UNDER MEDICAID; TO AUTHORIZE THE DIVISION TO REVISE RATES AND
15 METHODOLOGY FOR OUTPATIENT HOSPITAL SERVICES; TO DELETE CERTAIN
16 RESTRICTIONS ON THE REIMBURSEMENT RATE FOR PHYSICIAN'S SERVICES
17 AND CLINIC SERVICES; TO AUTHORIZE THE DIVISION OF MEDICAID TO
18 DEVELOP AND IMPLEMENT A DIFFERENT REIMBURSEMENT SCHEDULE FOR
19 PHYSICIAN'S SERVICES PROVIDED BY PHYSICIANS AT AN ACADEMIC HEALTH
20 CARE CENTER AND ASSOCIATED RURAL HEALTH CENTERS; TO REDUCE THE
21 NUMBER OF HOME HEALTH SERVICE VISITS ALLOWED ANNUALLY FOR MEDICAID
22 RECIPIENTS; TO REVISE THE MONTHLY LIMIT ON PRESCRIPTION DRUGS THAT
23 ARE REIMBURSABLE UNDER MEDICAID; TO DELETE THE AUTHORITY FOR
24 UNLIMITED PRESCRIPTIONS FOR GENERIC DRUGS; TO AUTHORIZE THE
25 DIVISION TO APPROVE SPECIFIC MAINTENANCE DRUGS FOR CERTAIN MEDICAL
26 CONDITIONS; TO AUTHORIZE THE DIVISION TO ALLOW A STATE AGENCY TO
27 BE THE SOLE SOURCE PURCHASER AND DISTRIBUTOR OF CERTAIN
28 MEDICATIONS; TO PROVIDE THAT DRUGS PRESCRIBED FOR PSYCHIATRIC
29 RESIDENTIAL TREATMENT FACILITY RESIDENTS MUST BE PROVIDED IN TRUE
30 UNIT DOSES WHEN AVAILABLE; TO AUTHORIZE THE DIVISION TO REQUIRE
31 THAT CERTAIN DRUGS PRESCRIBED FOR LONG-TERM CARE FACILITY
32 RESIDENTS BE PROVIDED IN TRUE UNIT DOSES WHEN AVAILABLE; TO
33 PROVIDE FOR THE RETURN OF UNUSED DRUGS BY RESIDENTS IN ANY OF
34 THOSE FACILITIES THAT WERE ORIGINALLY BILLED TO THE DIVISION TO BE
35 RETURNED TO THE BILLING PHARMACY FOR CREDIT TO THE DIVISION; TO
36 PROVIDE THAT ONLY ONE DISPENSING FEE PER MONTH MAY BE CHARGED; TO
37 PROVIDE THAT THE DIVISION SHALL DEVELOP A METHODOLOGY FOR
38 REIMBURSING FOR RESTOCKED DRUGS; TO REDUCE THE MAXIMUM PORTION OF
39 A PRESCRIPTION FOR WHICH THE DIVISION WILL REIMBURSE FROM A
40 THIRTY-FOUR-DAY SUPPLY TO A THIRTY-ONE-DAY SUPPLY; TO DELETE THE
41 PROVISION REQUIRING MEDICAID PROVIDERS WHO PRESCRIBE DRUGS TO USE
42 COUNTERFEIT-PROOF PRESCRIPTION PADS FOR MEDICAID PRESCRIPTIONS FOR
43 CONTROLLED SUBSTANCES; TO REQUIRE THE DIVISION TO PROVIDE TO
44 MEDICAID PROVIDERS ON A REGULAR BASIS CERTAIN INFORMATION ABOUT
45 THE COSTS TO THE MEDICAID PROGRAM OF BRAND NAME DRUGS; TO PROVIDE
46 FOR THE CONFIDENTIALITY OF INFORMATION REGARDING THE PRESCRIPTION
47 DRUG PROGRAM; TO DELETE THE AUTOMATIC REPEALER ON THE MEDICARE
48 UPPER PAYMENT LIMITS PROGRAM; TO CLARIFY THE DISEASES AND
49 CONDITIONS ELIGIBLE FOR THE MEDICAID DISEASE MANAGEMENT PROGRAM;
50 TO AUTHORIZE THE DIVISION TO PROVIDE TARGETED CASE MANAGEMENT
51 SERVICES FOR CERTAIN HIGH-COST CASES; TO PROVIDE THAT FEDERALLY
52 QUALIFIED HEALTH CENTERS MAY PARTICIPATE IN THE DIVISION'S

53 EMERGENCY ROOM REDIRECTION PROGRAM, AND THE DIVISION MAY PAY THOSE
54 CENTERS A PERCENTAGE OF ANY SAVINGS TO THE MEDICAID PROGRAM
55 ACHIEVED BY THE CENTERS' ACCEPTING PATIENT REFERRALS THROUGH THE
56 PROGRAM; TO REVISE THE AUTHORITY OF THE GOVERNOR TO DISCONTINUE
57 PAYMENT FOR SERVICES AND TAKE COST CONTAINMENT MEASURES WHEN THE
58 EXPENDITURES OF THE DIVISION EXCEED THE AMOUNT OF FUNDS
59 APPROPRIATED; TO DELETE THE AUTOMATIC REPEALER ON THIS SECTION; TO
60 AMEND SECTION 43-13-145, MISSISSIPPI CODE OF 1972, TO INCREASE THE
61 AMOUNT OF THE ASSESSMENT LEVIED ON BEDS IN NURSING FACILITIES,
62 INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED,
63 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES AND HOSPITALS; TO
64 DELETE THE EXEMPTION FROM THE ASSESSMENT FOR INTERMEDIATE CARE
65 FACILITIES FOR THE MENTALLY RETARDED OPERATED BY STATE AGENCIES;
66 TO PROVIDE THAT THE ENFORCEMENT AUTHORITY OF THE DIVISION TO
67 COLLECT ASSESSMENTS FROM HEALTH CARE FACILITIES APPLIES TO ANY
68 ASSESSMENTS IMPOSED ON THOSE FACILITIES BY THE DIVISION; AND FOR
69 RELATED PURPOSES.

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

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

73 43-13-115. Recipients of Medicaid shall be the following
74 persons only:

75 (1) Those who are qualified for public assistance
76 grants under provisions of Title IV-A and E of the federal Social
77 Security Act, as amended, including those statutorily deemed to be
78 IV-A and low income families and children under Section 1931 of
79 the federal Social Security Act. For the purposes of this
80 paragraph (1) and paragraphs (8), (17) and (18) of this section,
81 any reference to Title IV-A or to Part A of Title IV of the
82 federal Social Security Act, as amended, or the state plan under
83 Title IV-A or Part A of Title IV, shall be considered as a
84 reference to Title IV-A of the federal Social Security Act, as
85 amended, and the state plan under Title IV-A, including the income
86 and resource standards and methodologies under Title IV-A and the
87 state plan, as they existed on July 16, 1996. The Department of
88 Human Services shall determine Medicaid eligibility for children
89 receiving public assistance grants under Title IV-E. The division
90 shall determine eligibility for low income families under Section
91 1931 of the federal Social Security Act and shall redetermine
92 eligibility for those continuing under Title IV-A grants.

93 (2) Those qualified for Supplemental Security Income
94 (SSI) benefits under Title XVI of the federal Social Security Act,
95 as amended, and those who are deemed SSI eligible as contained in
96 federal statute. The eligibility of individuals covered in this
97 paragraph shall be determined by the Social Security
98 Administration and certified to the Division of Medicaid.

99 (3) Qualified pregnant women who would be eligible for
100 Medicaid as a low income family member under Section 1931 of the
101 federal Social Security Act if her child were born. The
102 eligibility of the individuals covered under this paragraph shall
103 be determined by the division.

104 (4) [Deleted]

105 (5) A child born on or after October 1, 1984, to a
106 woman eligible for and receiving Medicaid under the state plan on
107 the date of the child's birth shall be deemed to have applied for
108 Medicaid and to have been found eligible for Medicaid under the
109 plan on the date of that birth, and will remain eligible for
110 Medicaid for a period of one (1) year so long as the child is a
111 member of the woman's household and the woman remains eligible for
112 Medicaid or would be eligible for Medicaid if pregnant. The
113 eligibility of individuals covered in this paragraph shall be
114 determined by the Division of Medicaid.

115 (6) Children certified by the State Department of Human
116 Services to the Division of Medicaid of whom the state and county
117 departments of human services have custody and financial
118 responsibility, and children who are in adoptions subsidized in
119 full or part by the Department of Human Services, including
120 special needs children in non-Title IV-E adoption assistance, who
121 are approvable under Title XIX of the Medicaid program. The
122 eligibility of the children covered under this paragraph shall be
123 determined by the State Department of Human Services.

124 (7) * * * Persons certified by the Division of Medicaid
125 who are patients in a medical facility (nursing home, hospital,

126 tuberculosis sanatorium or institution for treatment of mental
127 diseases), and who, except for the fact that they are patients in
128 that medical facility, would qualify for grants under Title IV,
129 Supplementary Security Income (SSI) benefits under Title XVI or
130 state supplements, and those aged, blind and disabled persons who
131 would not be eligible for Supplemental Security Income (SSI)
132 benefits under Title XVI or state supplements if they were not
133 institutionalized in a medical facility but whose income is below
134 the maximum standard set by the Division of Medicaid, which
135 standard shall not exceed that prescribed by federal regulation.

136 * * *

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

143 (9) Individuals who are:

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

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

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

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

158 (10) Certain disabled children age eighteen (18) or
159 under who are living at home, who would be eligible, if in a
160 medical institution, for SSI or a state supplemental payment under
161 Title XVI of the federal Social Security Act, as amended, and
162 therefore for Medicaid under the plan, and for whom the state has
163 made a determination as required under Section 1902(e)(3)(b) of
164 the federal Social Security Act, as amended. The eligibility of
165 individuals under this paragraph shall be determined by the
166 Division of Medicaid.

167 (11) Until the end of the day on December 31, 2005,
168 individuals who are sixty-five (65) years of age or older or are
169 disabled as determined under Section 1614(a)(3) of the federal
170 Social Security Act, as amended, and whose income does not exceed
171 one hundred thirty-five percent (135%) of the nonfarm official
172 poverty level as defined by the Office of Management and Budget
173 and revised annually, and whose resources do not exceed those
174 established by the Division of Medicaid. The eligibility of
175 individuals covered under this paragraph shall be determined by
176 the Division of Medicaid. After December 31, 2005, only those
177 individuals covered under the 1115(c) Healthier Mississippi waiver
178 will be covered under this category.

179 Any individual who applied for Medicaid during the period
180 from July 1, 2004, through the effective date of Senate Bill No.
181 2003, 2005 First Extraordinary Session, who otherwise would have
182 been eligible for coverage under this paragraph (11) if it had
183 been in effect at the time the individual submitted his or her
184 application and is still eligible for coverage under this
185 paragraph (11) on the effective date of Senate Bill No. 2003, 2005
186 First Extraordinary Session, shall be eligible for Medicaid
187 coverage under this paragraph (11) from the effective date of
188 Senate Bill No. 2003, 2005 First Extraordinary Session, through
189 December 31, 2005. The division shall give priority in processing

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

192 (12) Individuals who are qualified Medicare
193 beneficiaries (QMB) entitled to Part A Medicare as defined under
194 Section 301, Public Law 100-360, known as the Medicare
195 Catastrophic Coverage Act of 1988, and whose income does not
196 exceed one hundred percent (100%) of the nonfarm official poverty
197 level as defined by the Office of Management and Budget and
198 revised annually.

199 The eligibility of individuals covered under this paragraph
200 shall be determined by the Division of Medicaid, and those
201 individuals determined eligible shall receive Medicare
202 cost-sharing expenses only as more fully defined by the Medicare
203 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
204 1997.

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

212 (b) Individuals entitled to Part A of Medicare,
213 with income above one hundred twenty percent (120%), but less than
214 one hundred thirty-five percent (135%) of the federal poverty
215 level, and not otherwise eligible for Medicaid Eligibility for
216 Medicaid benefits is limited to full payment of Medicare Part B
217 premiums. The number of eligible individuals is limited by the
218 availability of the federal capped allocation at one hundred
219 percent (100%) of federal matching funds, as more fully defined in
220 the Balanced Budget Act of 1997.

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

223 (14) [Deleted]

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

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

239 (17) In accordance with the terms of the federal
240 Personal Responsibility and Work Opportunity Reconciliation Act of
241 1996 (Public Law 104-193), persons who become ineligible for
242 assistance under Title IV-A of the federal Social Security Act, as
243 amended, because of increased income from or hours of employment
244 of the caretaker relative or because of the expiration of the
245 applicable earned income disregards, who were eligible for
246 Medicaid for at least three (3) of the six (6) months preceding
247 the month in which the ineligibility begins, shall be eligible for
248 Medicaid for up to twelve (12) months. The eligibility of the
249 individuals covered under this paragraph shall be determined by
250 the division.

251 (18) Persons who become ineligible for assistance under
252 Title IV-A of the federal Social Security Act, as amended, as a
253 result, in whole or in part, of the collection or increased
254 collection of child or spousal support under Title IV-D of the
255 federal Social Security Act, as amended, who were eligible for

256 Medicaid for at least three (3) of the six (6) months immediately
257 preceding the month in which the ineligibility begins, shall be
258 eligible for Medicaid for an additional four (4) months beginning
259 with the month in which the ineligibility begins. The eligibility
260 of the individuals covered under this paragraph shall be
261 determined by the division.

262 (19) Disabled workers, whose incomes are above the
263 Medicaid eligibility limits, but below two hundred fifty percent
264 (250%) of the federal poverty level, shall be allowed to purchase
265 Medicaid coverage on a sliding fee scale developed by the Division
266 of Medicaid.

267 (20) Medicaid eligible children under age eighteen (18)
268 shall remain eligible for Medicaid benefits until the end of a
269 period of twelve (12) months following an eligibility
270 determination, or until such time that the individual exceeds age
271 eighteen (18).

272 (21) Women of childbearing age whose family income does
273 not exceed one hundred eighty-five percent (185%) of the federal
274 poverty level. The eligibility of individuals covered under this
275 paragraph (21) shall be determined by the Division of Medicaid,
276 and those individuals determined eligible shall only receive
277 family planning services covered under Section 43-13-117(13) and
278 not any other services covered under Medicaid. However, any
279 individual eligible under this paragraph (21) who is also eligible
280 under any other provision of this section shall receive the
281 benefits to which he or she is entitled under that other
282 provision, in addition to family planning services covered under
283 Section 43-13-117(13).

284 The Division of Medicaid shall apply to the United States
285 Secretary of Health and Human Services for a federal waiver of the
286 applicable provisions of Title XIX of the federal Social Security
287 Act, as amended, and any other applicable provisions of federal
288 law as necessary to allow for the implementation of this paragraph

289 (21). The provisions of this paragraph (21) shall be implemented
290 from and after the date that the Division of Medicaid receives the
291 federal waiver.

292 (22) Persons who are workers with a potentially severe
293 disability, as determined by the division, shall be allowed to
294 purchase Medicaid coverage. The term "worker with a potentially
295 severe disability" means a person who is at least sixteen (16)
296 years of age but under sixty-five (65) years of age, who has a
297 physical or mental impairment that is reasonably expected to cause
298 the person to become blind or disabled as defined under Section
299 1614(a) of the federal Social Security Act, as amended, if the
300 person does not receive items and services provided under
301 Medicaid.

302 The eligibility of persons under this paragraph (22) shall be
303 conducted as a demonstration project that is consistent with
304 Section 204 of the Ticket to Work and Work Incentives Improvement
305 Act of 1999, Public Law 106-170, for a certain number of persons
306 as specified by the division. The eligibility of individuals
307 covered under this paragraph (22) shall be determined by the
308 Division of Medicaid.

309 (23) Children certified by the Mississippi Department
310 of Human Services for whom the state and county departments of
311 human services have custody and financial responsibility who are
312 in foster care on their eighteenth birthday as reported by the
313 Mississippi Department of Human Services shall be certified
314 Medicaid eligible by the Division of Medicaid until their
315 twenty-first birthday.

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

322 accordance with the requirements of that act and who need
323 treatment for breast or cervical cancer. Eligibility of
324 individuals under this paragraph (24) shall be determined by the
325 Division of Medicaid.

326 (25) The division shall apply to the Centers for
327 Medicare and Medicaid Services (CMS) for any necessary waivers to
328 provide services to individuals who are sixty-five (65) years of
329 age or older or are disabled as determined under Section
330 1614(a)(3) of the federal Social Security Act, as amended, and
331 whose income does not exceed one hundred thirty-five percent
332 (135%) of the nonfarm official poverty level as defined by the
333 Office of Management and Budget and revised annually, and whose
334 resources do not exceed those established by the Division of
335 Medicaid, and who are not otherwise covered by Medicare. Nothing
336 contained in this paragraph (25) shall entitle an individual to
337 benefits. The eligibility of individuals covered under this
338 paragraph shall be determined by the Division of Medicaid.

339 (26) The division shall apply to the Centers for
340 Medicare and Medicaid Services (CMS) for any necessary waivers to
341 provide services to individuals who are sixty-five (65) years of
342 age or older or are disabled as determined under Section
343 1614(a)(3) of the federal Social Security Act, as amended, who are
344 end stage renal disease patients on dialysis, cancer patients on
345 chemotherapy or organ transplant recipients on anti-rejection
346 drugs, whose income does not exceed one hundred thirty-five
347 percent (135%) of the nonfarm official poverty level as defined by
348 the Office of Management and Budget and revised annually, and
349 whose resources do not exceed those established by the division.
350 Nothing contained in this paragraph (26) shall entitle an
351 individual to benefits. The eligibility of individuals covered
352 under this paragraph shall be determined by the Division of
353 Medicaid.

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

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

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

365 43-13-117. Medicaid as authorized by this article shall
366 include payment of part or all of the costs, at the discretion of
367 the division, with approval of the Governor, of the following
368 types of care and services rendered to eligible applicants who
369 have been determined to be eligible for that care and services,
370 within the limits of state appropriations and federal matching
371 funds:

372 (1) Inpatient hospital services.

373 (a) The division shall allow thirty (30) days of
374 inpatient hospital care annually for all Medicaid recipients.
375 Precertification of inpatient days must be obtained as required by
376 the division. The division may allow unlimited days in
377 disproportionate hospitals as defined by the division for eligible
378 infants and children under the age of six (6) years if certified
379 as medically necessary as required by the division.

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

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

393 (2) Outpatient hospital services.

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

397 (b) Other outpatient hospital services. The
398 division shall allow benefits for other medically necessary
399 outpatient hospital services (such as chemotherapy, radiation,
400 surgery and therapy). Where the same services are reimbursed as
401 clinic services, the division may revise the rate or methodology
402 of outpatient reimbursement to maintain consistency, efficiency,
403 economy and quality of life.

404 (c) Where the same services are reimbursed as
405 clinic services, the division may revise the rate or methodology
406 of outpatient reimbursement to maintain consistency, efficiency,
407 economy and quality of care.

408 (3) Laboratory and x-ray services.

409 (4) Nursing facility services.

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

417 (b) From and after July 1, 1997, the division
418 shall implement the integrated case-mix payment and quality

419 monitoring system, which includes the fair rental system for
420 property costs and in which recapture of depreciation is
421 eliminated. The division may reduce the payment for hospital
422 leave and therapeutic home leave days to the lower of the case-mix
423 category as computed for the resident on leave using the
424 assessment being utilized for payment at that point in time, or a
425 case-mix score of 1.000 for nursing facilities, and shall compute
426 case-mix scores of residents so that only services provided at the
427 nursing facility are considered in calculating a facility's per
428 diem.

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

432 (d) When a facility of a category that does not
433 require a certificate of need for construction and that could not
434 be eligible for Medicaid reimbursement is constructed to nursing
435 facility specifications for licensure and certification, and the
436 facility is subsequently converted to a nursing facility under a
437 certificate of need that authorizes conversion only and the
438 applicant for the certificate of need was assessed an application
439 review fee based on capital expenditures incurred in constructing
440 the facility, the division shall allow reimbursement for capital
441 expenditures necessary for construction of the facility that were
442 incurred within the twenty-four (24) consecutive calendar months
443 immediately preceding the date that the certificate of need
444 authorizing the conversion was issued, to the same extent that
445 reimbursement would be allowed for construction of a new nursing
446 facility under a certificate of need that authorizes that
447 construction. The reimbursement authorized in this subparagraph
448 (d) may be made only to facilities the construction of which was
449 completed after June 30, 1989. Before the division shall be
450 authorized to make the reimbursement authorized in this
451 subparagraph (d), the division first must have received approval

452 from the Centers for Medicare and Medicaid Services (CMS) of the
453 change in the state Medicaid plan providing for the reimbursement.

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

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

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

475 (5) Periodic screening and diagnostic services for
476 individuals under age twenty-one (21) years as are needed to
477 identify physical and mental defects and to provide health care
478 treatment and other measures designed to correct or ameliorate
479 defects and physical and mental illness and conditions discovered
480 by the screening services, regardless of whether these services
481 are included in the state plan. The division may include in its
482 periodic screening and diagnostic program those discretionary
483 services authorized under the federal regulations adopted to
484 implement Title XIX of the federal Social Security Act, as

485 amended. The division, in obtaining physical therapy services,
486 occupational therapy services, and services for individuals with
487 speech, hearing and language disorders, may enter into a
488 cooperative agreement with the State Department of Education for
489 the provision of those services to handicapped students by public
490 school districts using state funds that are provided from the
491 appropriation to the Department of Education to obtain federal
492 matching funds through the division. The division, in obtaining
493 medical and psychological evaluations for children in the custody
494 of the State Department of Human Services may enter into a
495 cooperative agreement with the State Department of Human Services
496 for the provision of those services using state funds that are
497 provided from the appropriation to the Department of Human
498 Services to obtain federal matching funds through the division.

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

510 (7) (a) Home health services for eligible persons, not
511 to exceed in cost the prevailing cost of nursing facility
512 services, not to exceed twenty-five (25) visits per year. All
513 home health visits must be precertified as required by the
514 division.

515 (b) Repealed.

516 (8) Emergency medical transportation services. On
517 January 1, 1994, emergency medical transportation services shall

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

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

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

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

542 The division shall allow for a combination of prescriptions
543 for single source and innovator multiple source drugs and generic
544 drugs to meet the needs of the beneficiaries, not to exceed five
545 (5) prescriptions * * * per month for each noninstitutionalized
546 Medicaid beneficiary, with not more than two (2) of those
547 prescriptions being for single source or innovator multiple source
548 drugs.

549 The executive director may approve specific maintenance drugs
550 for with certain medical conditions, which may be prescribed and

551 dispensed in three-month supply increments. The executive
552 director may allow a state agency or agencies to be the sole
553 source purchaser and distributor of hemophilia factor medications,
554 HIV/AIDS medications and other medications as determined by the
555 executive director.

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

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

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

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

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

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

592 The division shall develop and implement a method or methods
593 by which the division will provide on a regular basis to Medicaid
594 providers who are authorized to prescribe drugs, information about
595 the costs to the Medicaid program of single source drugs and
596 innovator multiple source drugs, and information about other drugs
597 that may be prescribed as alternatives to those single source
598 drugs and innovator multiple source drugs and the costs to the
599 Medicaid program of those alternative drugs.

600 Notwithstanding any other state law, information obtained or
601 maintained by the division regarding the prescription drug
602 program, including trade secrets and manufacturer or labeler
603 pricing, is confidential and not subject to disclosure.

604 (b) Payment by the division for covered
605 multisource drugs shall be limited to the lower of the upper
606 limits established and published by the Centers for Medicare and
607 Medicaid Services (CMS) plus a dispensing fee, or the estimated
608 acquisition cost (EAC) as determined by the division, plus a
609 dispensing fee, or the providers' usual and customary charge to
610 the general public.

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

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

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

624 The division shall not reimburse for single source or
625 innovator multiple source drugs if there are equally effective
626 generic equivalents available and if the generic equivalents are
627 the least expensive.

628 It is the intent of the Legislature that the pharmacists
629 providers be reimbursed for the reasonable costs of filling and
630 dispensing prescriptions for Medicaid beneficiaries.

631 (10) Dental care that is an adjunct to treatment of an
632 acute medical or surgical condition; services of oral surgeons and
633 dentists in connection with surgery related to the jaw or any
634 structure contiguous to the jaw or the reduction of any fracture
635 of the jaw or any facial bone; and emergency dental extractions
636 and treatment related thereto. On July 1, 1999, all fees for
637 dental care and surgery under authority of this paragraph (10)
638 shall be increased to one hundred sixty percent (160%) of the
639 amount of the reimbursement rate that was in effect on June 30,
640 1999. It is the intent of the Legislature to encourage more
641 dentists to participate in the Medicaid program.

642 (11) Eyeglasses for all Medicaid beneficiaries who have
643 (a) had surgery on the eyeball or ocular muscle that results in a
644 vision change for which eyeglasses or a change in eyeglasses is
645 medically indicated within six (6) months of the surgery and is in
646 accordance with policies established by the division, or (b) one
647 (1) pair every five (5) years and in accordance with policies
648 established by the division. In either instance, the eyeglasses

649 must be prescribed by a physician skilled in diseases of the eye
650 or an optometrist, whichever the beneficiary may select.

651 (12) Intermediate care facility services.

652 (a) The division shall make full payment to all
653 intermediate care facilities for the mentally retarded for each
654 day, not exceeding eighty-four (84) days per year, that a patient
655 is absent from the facility on home leave. Payment may be made
656 for the following home leave days in addition to the
657 eighty-four-day limitation: Christmas, the day before Christmas,
658 the day after Christmas, Thanksgiving, the day before Thanksgiving
659 and the day after Thanksgiving.

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

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

666 (14) Clinic services. Such diagnostic, preventive,
667 therapeutic, rehabilitative or palliative services furnished to an
668 outpatient by or under the supervision of a physician or dentist
669 in a facility that is not a part of a hospital but that is
670 organized and operated to provide medical care to outpatients.
671 Clinic services shall include any services reimbursed as
672 outpatient hospital services that may be rendered in such a
673 facility, including those that become so after July 1, 1991. On
674 July 1, 1999, all fees for physicians' services reimbursed under
675 authority of this paragraph (14) shall be reimbursed at ninety
676 percent (90%) of the rate established on January 1, 1999, and as
677 may be adjusted each July thereafter, under Medicare (Title XVIII
678 of the federal Social Security Act, as amended) * * *. The
679 division may develop and implement a different reimbursement model
680 or schedule for physician's services provided by physicians based
681 at an academic health care center and by physicians at rural

682 health centers that are associated with an academic health care
683 center. On July 1, 1999, all fees for dentists' services
684 reimbursed under authority of this paragraph (14) shall be
685 increased to one hundred sixty percent (160%) of the amount of the
686 reimbursement rate that was in effect on June 30, 1999.

687 (15) Home- and community-based services for the elderly
688 and disabled, as provided under Title XIX of the federal Social
689 Security Act, as amended, under waivers, subject to the
690 availability of funds specifically appropriated for that purpose
691 by the Legislature.

692 (16) Mental health services. Approved therapeutic and
693 case management services (a) provided by an approved regional
694 mental health/retardation center established under Sections
695 41-19-31 through 41-19-39, or by another community mental health
696 service provider meeting the requirements of the Department of
697 Mental Health to be an approved mental health/retardation center
698 if determined necessary by the Department of Mental Health, using
699 state funds that are provided from the appropriation to the State
700 Department of Mental Health and/or funds transferred to the
701 department by a political subdivision or instrumentality of the
702 state and used to match federal funds under a cooperative
703 agreement between the division and the department, or (b) provided
704 by a facility that is certified by the State Department of Mental
705 Health to provide therapeutic and case management services, to be
706 reimbursed on a fee for service basis, or (c) provided in the
707 community by a facility or program operated by the Department of
708 Mental Health. Any such services provided by a facility described
709 in subparagraph (b) must have the prior approval of the division
710 to be reimbursable under this section. After June 30, 1997,
711 mental health services provided by regional mental
712 health/retardation centers established under Sections 41-19-31
713 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
714 and/or their subsidiaries and divisions, or by psychiatric

715 residential treatment facilities as defined in Section 43-11-1, or
716 by another community mental health service provider meeting the
717 requirements of the Department of Mental Health to be an approved
718 mental health/retardation center if determined necessary by the
719 Department of Mental Health, shall not be included in or provided
720 under any capitated managed care pilot program provided for under
721 paragraph (24) of this section.

722 (17) Durable medical equipment services and medical
723 supplies. Precertification of durable medical equipment and
724 medical supplies must be obtained as required by the division.
725 The Division of Medicaid may require durable medical equipment
726 providers to obtain a surety bond in the amount and to the
727 specifications as established by the Balanced Budget Act of 1997.

728 (18) (a) Notwithstanding any other provision of this
729 section to the contrary, the division shall make additional
730 reimbursement to hospitals that serve a disproportionate share of
731 low-income patients and that meet the federal requirements for
732 those payments as provided in Section 1923 of the federal Social
733 Security Act and any applicable regulations. However, from and
734 after January 1, 1999, no public hospital shall participate in the
735 Medicaid disproportionate share program unless the public hospital
736 participates in an intergovernmental transfer program as provided
737 in Section 1903 of the federal Social Security Act and any
738 applicable regulations.

739 (b) The division shall establish a Medicare Upper
740 Payment Limits Program, as defined in Section 1902(a)(30) of the
741 federal Social Security Act and any applicable federal
742 regulations, for hospitals, and may establish a Medicare Upper
743 Payments Limits Program for nursing facilities. The division
744 shall assess each hospital and, if the program is established for
745 nursing facilities, shall assess each nursing facility, based on
746 Medicaid utilization or other appropriate method consistent with
747 federal regulations. The assessment will remain in effect as long

748 as the state participates in the Medicare Upper Payment Limits
749 Program. The division shall make additional reimbursement to
750 hospitals and, if the program is established for nursing
751 facilities, shall make additional reimbursement to nursing
752 facilities, for the Medicare Upper Payment Limits, as defined in
753 Section 1902(a)(30) of the federal Social Security Act and any
754 applicable federal regulations. * * *

755 (19) (a) Perinatal risk management services. The
756 division shall promulgate regulations to be effective from and
757 after October 1, 1988, to establish a comprehensive perinatal
758 system for risk assessment of all pregnant and infant Medicaid
759 recipients and for management, education and follow-up for those
760 who are determined to be at risk. Services to be performed
761 include case management, nutrition assessment/counseling,
762 psychosocial assessment/counseling and health education.

763 (b) Early intervention system services. The
764 division shall cooperate with the State Department of Health,
765 acting as lead agency, in the development and implementation of a
766 statewide system of delivery of early intervention services, under
767 Part C of the Individuals with Disabilities Education Act (IDEA).
768 The State Department of Health shall certify annually in writing
769 to the executive director of the division the dollar amount of
770 state early intervention funds available that will be utilized as
771 a certified match for Medicaid matching funds. Those funds then
772 shall be used to provide expanded targeted case management
773 services for Medicaid eligible children with special needs who are
774 eligible for the state's early intervention system.
775 Qualifications for persons providing service coordination shall be
776 determined by the State Department of Health and the Division of
777 Medicaid.

778 (20) Home- and community-based services for physically
779 disabled approved services as allowed by a waiver from the United
780 States Department of Health and Human Services for home- and

781 community-based services for physically disabled people using
782 state funds that are provided from the appropriation to the State
783 Department of Rehabilitation Services and used to match federal
784 funds under a cooperative agreement between the division and the
785 department, provided that funds for these services are
786 specifically appropriated to the Department of Rehabilitation
787 Services.

788 (21) Nurse practitioner services. Services furnished
789 by a registered nurse who is licensed and certified by the
790 Mississippi Board of Nursing as a nurse practitioner, including,
791 but not limited to, nurse anesthetists, nurse midwives, family
792 nurse practitioners, family planning nurse practitioners,
793 pediatric nurse practitioners, obstetrics-gynecology nurse
794 practitioners and neonatal nurse practitioners, under regulations
795 adopted by the division. Reimbursement for those services shall
796 not exceed ninety percent (90%) of the reimbursement rate for
797 comparable services rendered by a physician.

798 (22) Ambulatory services delivered in federally
799 qualified health centers, rural health centers and clinics of the
800 local health departments of the State Department of Health for
801 individuals eligible for Medicaid under this article based on
802 reasonable costs as determined by the division.

803 (23) Inpatient psychiatric services. Inpatient
804 psychiatric services to be determined by the division for
805 recipients under age twenty-one (21) that are provided under the
806 direction of a physician in an inpatient program in a licensed
807 acute care psychiatric facility or in a licensed psychiatric
808 residential treatment facility, before the recipient reaches age
809 twenty-one (21) or, if the recipient was receiving the services
810 immediately before he or she reached age twenty-one (21), before
811 the earlier of the date he or she no longer requires the services
812 or the date he or she reaches age twenty-two (22), as provided by
813 federal regulations. Precertification of inpatient days and

814 residential treatment days must be obtained as required by the
815 division.

816 (24) [Deleted]

817 (25) [Deleted]

818 (26) Hospice care. As used in this paragraph, the term
819 "hospice care" means a coordinated program of active professional
820 medical attention within the home and outpatient and inpatient
821 care that treats the terminally ill patient and family as a unit,
822 employing a medically directed interdisciplinary team. The
823 program provides relief of severe pain or other physical symptoms
824 and supportive care to meet the special needs arising out of
825 physical, psychological, spiritual, social and economic stresses
826 that are experienced during the final stages of illness and during
827 dying and bereavement and meets the Medicare requirements for
828 participation as a hospice as provided in federal regulations.

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

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

836 (29) The Division of Medicaid may apply for a waiver
837 from the United States Department of Health and Human Services for
838 home- and community-based services for developmentally disabled
839 people using state funds that are provided from the appropriation
840 to the State Department of Mental Health and/or funds transferred
841 to the department by a political subdivision or instrumentality of
842 the state and used to match federal funds under a cooperative
843 agreement between the division and the department, provided that
844 funds for these services are specifically appropriated to the
845 Department of Mental Health and/or transferred to the department
846 by a political subdivision or instrumentality of the state.

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

849 (31) Targeted case management services for children
850 with special needs, under waivers from the United States
851 Department of Health and Human Services, using state funds that
852 are provided from the appropriation to the Mississippi Department
853 of Human Services and used to match federal funds under a
854 cooperative agreement between the division and the department.

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

861 (33) Podiatrist services.

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

866 (35) Services and activities authorized in Sections
867 43-27-101 and 43-27-103, using state funds that are provided from
868 the appropriation to the State Department of Human Services and
869 used to match federal funds under a cooperative agreement between
870 the division and the department.

871 (36) Nonemergency transportation services for
872 Medicaid-eligible persons, to be provided by the Division of
873 Medicaid. The division may contract with additional entities to
874 administer nonemergency transportation services as it deems
875 necessary. All providers shall have a valid driver's license,
876 vehicle inspection sticker, valid vehicle license tags and a
877 standard liability insurance policy covering the vehicle. The
878 division may pay providers a flat fee based on mileage tiers, or
879 in the alternative, may reimburse on actual miles traveled. The

880 division may apply to the Center for Medicare and Medicaid
881 Services (CMS) for a waiver to draw federal matching funds for
882 nonemergency transportation services as a covered service instead
883 of an administrative cost.

884 (37) [Deleted]

885 (38) Chiropractic services. A chiropractor's manual
886 manipulation of the spine to correct a subluxation, if x-ray
887 demonstrates that a subluxation exists and if the subluxation has
888 resulted in a neuromusculoskeletal condition for which
889 manipulation is appropriate treatment, and related spinal x-rays
890 performed to document these conditions. Reimbursement for
891 chiropractic services shall not exceed Seven Hundred Dollars
892 (\$700.00) per year per beneficiary.

893 (39) Dually eligible Medicare/Medicaid beneficiaries.
894 The division shall pay the Medicare deductible and coinsurance
895 amounts for services available under Medicare, as determined by
896 the division.

897 (40) [Deleted]

898 (41) Services provided by the State Department of
899 Rehabilitation Services for the care and rehabilitation of persons
900 with spinal cord injuries or traumatic brain injuries, as allowed
901 under waivers from the United States Department of Health and
902 Human Services, using up to seventy-five percent (75%) of the
903 funds that are appropriated to the Department of Rehabilitation
904 Services from the Spinal Cord and Head Injury Trust Fund
905 established under Section 37-33-261 and used to match federal
906 funds under a cooperative agreement between the division and the
907 department.

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

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

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

925 (44) Nursing facility services for the severely
926 disabled.

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

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

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

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

946 managed care services through mental health providers certified by
947 the Department of Mental Health. The division may implement and
948 provide services under this waived program only if funds for
949 these services are specifically appropriated for this purpose by
950 the Legislature, or if funds are voluntarily provided by affected
951 agencies.

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

958 (b) Participation in any disease management
959 program implemented under this paragraph (47) is optional with the
960 individual. An individual must affirmatively elect to participate
961 in the disease management program in order to participate.

962 (c) An individual who participates in the disease
963 management program has the option of participating in the
964 prescription drug home delivery component of the program at any
965 time while participating in the program. An individual must
966 affirmatively elect to participate in the prescription drug home
967 delivery component in order to participate.

968 (d) An individual who participates in the disease
969 management program may elect to discontinue participation in the
970 program at any time. An individual who participates in the
971 prescription drug home delivery component may elect to discontinue
972 participation in the prescription drug home delivery component at
973 any time.

974 (e) The division shall send written notice to all
975 individuals who participate in the disease management program
976 informing them that they may continue using their local pharmacy
977 or any other pharmacy of their choice to obtain their prescription
978 drugs while participating in the program.

979 (f) Prescription drugs that are provided to
980 individuals under the prescription drug home delivery component
981 shall be limited only to those drugs that are used for the
982 treatment, management or care of asthma, diabetes or hypertension.

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

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

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

993 (49) The division shall establish co-payments and/or
994 coinsurance for all Medicaid services for which co-payments and/or
995 coinsurance are allowable under federal law or regulation, and
996 shall set the amount of the co-payment and/or coinsurance for each
997 of those services at the maximum amount allowable under federal
998 law or regulation.

999 (50) Services provided by the State Department of
1000 Rehabilitation Services for the care and rehabilitation of persons
1001 who are deaf and blind, as allowed under waivers from the United
1002 States Department of Health and Human Services to provide home-
1003 and community-based services using state funds that are provided
1004 from the appropriation to the State Department of Rehabilitation
1005 Services or if funds are voluntarily provided by another agency.

1006 (51) Upon determination of Medicaid eligibility and in
1007 association with annual redetermination of Medicaid eligibility,
1008 beneficiaries shall be encouraged to undertake a physical
1009 examination that will establish a base-line level of health and
1010 identification of a usual and customary source of care (a medical
1011 home) to aid utilization of disease management tools. This

1012 physical examination and utilization of these disease management
1013 tools shall be consistent with current United States Preventive
1014 Services Task Force or other recognized authority recommendations.

1015 For persons who are determined ineligible for Medicaid, the
1016 division will provide information and direction for accessing
1017 medical care and services in the area of their residence.

1018 (52) Notwithstanding any provisions of this article,
1019 the division may pay enhanced reimbursement fees related to trauma
1020 care, as determined by the division in conjunction with the State
1021 Department of Health, using funds appropriated to the State
1022 Department of Health for trauma care and services and used to
1023 match federal funds under a cooperative agreement between the
1024 division and the State Department of Health. The division, in
1025 conjunction with the State Department of Health, may use grants,
1026 waivers, demonstrations, or other projects as necessary in the
1027 development and implementation of this reimbursement program.

1028 (53) Targeted case management services for high-cost
1029 beneficiaries shall be developed by the division for all services
1030 under this section.

1031 Notwithstanding any other provision of this article to the
1032 contrary, the division shall reduce the rate of reimbursement to
1033 providers for any service provided under this section by five
1034 percent (5%) of the allowed amount for that service. However, the
1035 reduction in the reimbursement rates required by this paragraph
1036 shall not apply to inpatient hospital services, nursing facility
1037 services, intermediate care facility services, psychiatric
1038 residential treatment facility services, pharmacy services
1039 provided under paragraph (9) of this section, or any service
1040 provided by the University of Mississippi Medical Center or a
1041 state agency, a state facility or a public agency that either
1042 provides its own state match through intergovernmental transfer or
1043 certification of funds to the division, or a service for which the
1044 federal government sets the reimbursement methodology and rate.

1045 In addition, the reduction in the reimbursement rates required by
1046 this paragraph shall not apply to case management services and
1047 home-delivered meals provided under the home- and community-based
1048 services program for the elderly and disabled by a planning and
1049 development district (PDD). Planning and development districts
1050 participating in the home- and community-based services program
1051 for the elderly and disabled as case management providers shall be
1052 reimbursed for case management services at the maximum rate
1053 approved by the Centers for Medicare and Medicaid Services (CMS).

1054 The division may pay to those providers who participate in
1055 and accept patient referrals from the division's emergency room
1056 redirection program a percentage, as determined by the division,
1057 of savings achieved according to the performance measures and
1058 reduction of costs required of that program. Federally qualified
1059 health centers may participate in the emergency room redirection
1060 program, and the division may pay those centers a percentage of
1061 any savings to the Medicaid program achieved by the centers'
1062 accepting patient referrals through the program, as provided in
1063 this paragraph.

1064 Notwithstanding any provision of this article, except as
1065 authorized in the following paragraph and in Section 43-13-139,
1066 neither (a) the limitations on quantity or frequency of use of or
1067 the fees or charges for any of the care or services available to
1068 recipients under this section, nor (b) the payments or rates of
1069 reimbursement to providers rendering care or services authorized
1070 under this section to recipients, may be increased, decreased or
1071 otherwise changed from the levels in effect on July 1, 1999,
1072 unless they are authorized by an amendment to this section by the
1073 Legislature. However, the restriction in this paragraph shall not
1074 prevent the division from changing the payments or rates of
1075 reimbursement to providers without an amendment to this section
1076 whenever those changes are required by federal law or regulation,
1077 or whenever those changes are necessary to correct administrative

1078 errors or omissions in calculating those payments or rates of
1079 reimbursement.

1080 Notwithstanding any provision of this article, no new groups
1081 or categories of recipients and new types of care and services may
1082 be added without enabling legislation from the Mississippi
1083 Legislature, except that the division may authorize those changes
1084 without enabling legislation when the addition of recipients or
1085 services is ordered by a court of proper authority.

1086 The executive director shall keep the Governor advised on a
1087 timely basis of the funds available for expenditure and the
1088 projected expenditures. If current or projected expenditures of
1089 the division * * * are reasonably anticipated to exceed the amount
1090 of * * * funds appropriated to the division for any fiscal year,
1091 the Governor, after consultation with the executive director,
1092 shall discontinue any or all of the payment of the types of care
1093 and services as provided in this section that are deemed to be
1094 optional services under Title XIX of the federal Social Security
1095 Act, as amended, and when necessary, shall institute any other
1096 cost containment measures on any program or programs authorized
1097 under the article to the extent allowed under the federal law
1098 governing that program or programs. However, the Governor shall
1099 not be authorized to discontinue or eliminate any service under
1100 this section that is mandatory under federal law, or to
1101 discontinue or eliminate, or adjust income limits or resource
1102 limits for, any eligibility category or group under Section
1103 43-13-115. It is the intent of the Legislature that the
1104 expenditures of the division during any fiscal year shall not
1105 exceed the amounts appropriated to the division for that fiscal
1106 year.

1107 Notwithstanding any other provision of this article, it shall
1108 be the duty of each nursing facility, intermediate care facility
1109 for the mentally retarded, psychiatric residential treatment
1110 facility, and nursing facility for the severely disabled that is

1111 participating in the Medicaid program to keep and maintain books,
1112 documents and other records as prescribed by the Division of
1113 Medicaid in substantiation of its cost reports for a period of
1114 three (3) years after the date of submission to the Division of
1115 Medicaid of an original cost report, or three (3) years after the
1116 date of submission to the Division of Medicaid of an amended cost
1117 report.

1118 * * *

1119 **SECTION 3.** Section 43-13-145, Mississippi Code of 1972, is
1120 amended as follows:

1121 43-13-145. (1) (a) Upon each nursing facility * * *
1122 licensed by the State of Mississippi, there is levied an
1123 assessment in an amount set by division, not exceeding the maximum
1124 rate allowed by federal law or regulation, for each licensed and
1125 occupied bed of the facility.

1126 (b) A nursing facility * * * is exempt from the
1127 assessment levied under this subsection if the facility is
1128 operated under the direction and control of:

1129 (i) The United States Veterans Administration or
1130 other agency or department of the United States government;

1131 (ii) The State Veterans Affairs Board;

1132 (iii) The University of Mississippi Medical
1133 Center; or

1134 (iv) A state agency or a state facility that
1135 either provides its own state match through intergovernmental
1136 transfer or certification of funds to the division.

1137 (2) (a) Upon each intermediate care facility for the
1138 mentally retarded licensed by the State of Mississippi, there is
1139 levied an assessment in an amount set by the division, not
1140 exceeding the maximum rate allowed by federal law or regulation,
1141 for each licensed and occupied bed of the facility.

1142 (b) An intermediate care facility for the mentally
1143 retarded is exempt from the assessment levied under this

1144 subsection if the facility is operated under the direction and
1145 control of:

1146 (i) The United States Veterans Administration or
1147 other agency or department of the United States government;

1148 (ii) The State Veterans Affairs Board; or

1149 (iii) The University of Mississippi Medical
1150 Center.

1151 (3) (a) Upon each psychiatric residential treatment
1152 facility licensed by the State of Mississippi, there is levied an
1153 assessment in an amount set by the division, not exceeding the
1154 maximum rate allowed by federal law or regulation, for each
1155 licensed and occupied bed of the facility.

1156 (b) A psychiatric residential treatment facility is
1157 exempt from the assessment levied under this subsection if the
1158 facility is operated under the direction and control of:

1159 (i) The United States Veterans Administration or
1160 other agency or department of the United States government;

1161 (ii) The University of Mississippi Medical Center;

1162 (iii) 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 (4) (a) Upon each hospital licensed by the State of
1166 Mississippi, there is levied an assessment in the amount of Three
1167 Dollars and Twenty-five Cents (\$3.25) per bed for each licensed
1168 inpatient acute care bed of the hospital.

1169 (b) A hospital is exempt from the assessment levied
1170 under this subsection if the hospital is operated under the
1171 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 or

1176 (iii) A state agency or a state facility that
1177 either provides its own state match through intergovernmental
1178 transfer or certification of funds to the division.

1179 (5) Each health care facility that is subject to the
1180 provisions of this section shall keep and preserve such suitable
1181 books and records as may be necessary to determine the amount of
1182 assessment for which it is liable under this section. The books
1183 and records shall be kept and preserved for a period of not less
1184 than five (5) years, and those books and records shall be open for
1185 examination during business hours by the division, the State Tax
1186 Commission, the Office of the Attorney General and the State
1187 Department of Health.

1188 (6) The assessment levied under this section shall be
1189 collected by the division each month beginning on the effective
1190 date of Senate Bill No. 2003, 2005 First Extraordinary Session.

1191 (7) All assessments collected under this section shall be
1192 deposited in the Medical Care Fund created by Section 43-13-143.

1193 (8) The assessment levied under this section shall be in
1194 addition to any other assessments, taxes or fees levied by law,
1195 and the assessment shall constitute a debt due the State of
1196 Mississippi from the time the assessment is due until it is paid.

1197 (9) (a) If a health care facility that is liable for
1198 payment of an assessment levied by the division does not pay the
1199 assessment when it is due, the division shall give written notice
1200 to the health care facility by certified or registered mail
1201 demanding payment of the assessment within ten (10) days from the
1202 date of delivery of the notice. If the health care facility
1203 fails or refuses to pay the assessment after receiving the notice
1204 and demand from the division, the division shall withhold from any
1205 Medicaid reimbursement payments that are due to the health care
1206 facility the amount of the unpaid assessment and a penalty of ten
1207 percent (10%) of the amount of the assessment, plus the legal rate
1208 of interest until the assessment is paid in full. If the health

1209 care facility does not participate in the Medicaid program, the
1210 division shall turn over to the Office of the Attorney General the
1211 collection of the unpaid assessment by civil action. In any such
1212 civil action, the Office of the Attorney General shall collect the
1213 amount of the unpaid assessment and a penalty of ten percent (10%)
1214 of the amount of the assessment, plus the legal rate of interest
1215 until the assessment is paid in full.

1216 (b) As an additional or alternative method for
1217 collecting unpaid assessments levied by the division, if a health
1218 care facility fails or refuses to pay the assessment after
1219 receiving notice and demand from the division, the division may
1220 file a notice of a tax lien with the circuit clerk of the county
1221 in which the health care facility is located, for the amount of
1222 the unpaid assessment and a penalty of ten percent (10%) of the
1223 amount of the assessment, plus the legal rate of interest until
1224 the assessment is paid in full. Immediately upon receipt of
1225 notice of the tax lien for the assessment, the circuit clerk shall
1226 enter the notice of the tax lien as a judgment upon the judgment
1227 roll and show in the appropriate columns the name of the health
1228 care facility as judgment debtor, the name of the division as
1229 judgment creditor, the amount of the unpaid assessment, and the
1230 date and time of enrollment. The judgment shall be valid as
1231 against mortgagees, pledgees, entrusters, purchasers, judgment
1232 creditors and other persons from the time of filing with the
1233 clerk. The amount of the judgment shall be a debt due the State
1234 of Mississippi and remain a lien upon the tangible property of the
1235 health care facility until the judgment is satisfied. The
1236 judgment shall be the equivalent of any enrolled judgment of a
1237 court of record and shall serve as authority for the issuance of
1238 writs of execution, writs of attachment or other remedial writs.

1239 **SECTION 4.** This act shall take effect and be in force from
1240 and after its passage.