By: Senator(s) Horhn

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2881

1 AN ACT TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972,
2 TO AUTHORIZE MEDICAID RECIPIENTS WHO ARE DUALLY ELIGIBLE FOR
3 MEDICARE AND MEDICAID TO APPLY FOR MEDICARE PART C BENEFITS UNDER
4 THE MEDICAID PROGRAM; TO PROVIDE THAT ELIGIBILITY FOR PAYMENT OF
5 THE MEDICARE PART C SUBSIDY SHALL BE DETERMINED BY THE DIVISION
6 PURSUANT TO A CONTRACT WITH A LEGAL ENTITY APPROVED BY THE FEDERAL
7 CENTER FOR MEDICARE AND MEDICAID SERVICES (CMS); TO AMEND SECTION
8 43-13-117, MISSISSIPPI CODE OF 1972, TO AUTHORIZE THE DIVISION OF
9 MEDICAID TO PAY THE MEDICARE PART C PREMIUM, DEDUCTIBLE AND
10 COINSURANCE AMOUNTS; AND FOR RELATED PURPOSES.

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

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

14 43-13-115. Recipients of Medicaid shall be the following
15 persons only:

16 (1) Those who are qualified for public assistance
17 grants under provisions of Title IV-A and E of the federal Social
18 Security Act, as amended, including those statutorily deemed to be
19 IV-A and low-income families and children under Section 1931 of
20 the federal Social Security Act. For the purposes of this
21 paragraph (1) and paragraphs (8), (17) and (18) of this section,
22 any reference to Title IV-A or to Part A of Title IV of the
23 federal Social Security Act, as amended, or the state plan under
24 Title IV-A or Part A of Title IV, shall be considered as a
25 reference to Title IV-A of the federal Social Security Act, as
26 amended, and the state plan under Title IV-A, including the income
27 and resource standards and methodologies under Title IV-A and the
28 state plan, as they existed on July 16, 1996. The Department of
29 Human Services shall determine Medicaid eligibility for children
30 receiving public assistance grants under Title IV-E. The division
31 shall determine eligibility for low-income families under Section

32 1931 of the federal Social Security Act and shall redetermine
33 eligibility for those continuing under Title IV-A grants.
34 (2) Those qualified for Supplemental Security Income
35 (SSI) benefits under Title XVI of the federal Social Security Act,
36 as amended, and those who are deemed SSI eligible as contained in
37 federal statute. The eligibility of individuals covered in this
38 paragraph shall be determined by the Social Security
39 Administration and certified to the Division of Medicaid.
40 (3) Qualified pregnant women who would be eligible for
41 Medicaid as a low-income family member under Section 1931 of the
42 federal Social Security Act if her child were born. The
43 eligibility of the individuals covered under this paragraph shall
44 be determined by the division.
45 (4) [Deleted]
46 (5) A child born on or after October 1, 1984, to a
47 woman eligible for and receiving Medicaid under the state plan on
48 the date of the child's birth shall be deemed to have applied for
49 Medicaid and to have been found eligible for Medicaid under the
50 plan on the date of that birth, and will remain eligible for
51 Medicaid for a period of one (1) year so long as the child is a
52 member of the woman's household and the woman remains eligible for
53 Medicaid or would be eligible for Medicaid if pregnant. The
54 eligibility of individuals covered in this paragraph shall be
55 determined by the Division of Medicaid.
56 (6) Children certified by the State Department of Human
57 Services to the Division of Medicaid of whom the state and county
58 departments of human services have custody and financial
59 responsibility, and children who are in adoptions subsidized in
60 full or part by the Department of Human Services, including
61 special needs children in non-Title IV-E adoption assistance, who
62 are approvable under Title XIX of the Medicaid program. The
63 eligibility of the children covered under this paragraph shall be
64 determined by the State Department of Human Services.

65 (7) Persons certified by the Division of Medicaid who
66 are patients in a medical facility (nursing home, hospital,
67 tuberculosis sanatorium or institution for treatment of mental
68 diseases), and who, except for the fact that they are patients in
69 that medical facility, would qualify for grants under Title IV,
70 Supplementary Security Income (SSI) benefits under Title XVI or
71 state supplements, and those aged, blind and disabled persons who
72 would not be eligible for Supplemental Security Income (SSI)
73 benefits under Title XVI or state supplements if they were not
74 institutionalized in a medical facility but whose income is below
75 the maximum standard set by the Division of Medicaid, which
76 standard shall not exceed that prescribed by federal regulation.
77 (8) Children under eighteen (18) years of age and
78 pregnant women (including those in intact families) who meet the
79 financial standards of the state plan approved under Title IV-A of
80 the federal Social Security Act, as amended. The eligibility of
81 children covered under this paragraph shall be determined by the
82 Division of Medicaid.
83 (9) Individuals who are:
84 (a) Children born after September 30, 1983, who
85 have not attained the age of nineteen (19), with family income
86 that does not exceed one hundred percent (100%) of the nonfarm
87 official poverty level;
88 (b) Pregnant women, infants and children who have
89 not attained the age of six (6), with family income that does not
90 exceed one hundred thirty-three percent (133%) of the federal
91 poverty level; and
92 (c) Pregnant women and infants who have not
93 attained the age of one (1), with family income that does not
94 exceed one hundred eighty-five percent (185%) of the federal
95 poverty level.
96 The eligibility of individuals covered in (a), (b) and (c) of
97 this paragraph shall be determined by the division.

98 (10) Certain disabled children age eighteen (18) or
99 under who are living at home, who would be eligible, if in a
100 medical institution, for SSI or a state supplemental payment under
101 Title XVI of the federal Social Security Act, as amended, and
102 therefore for Medicaid under the plan, and for whom the state has
103 made a determination as required under Section 1902(e)(3)(b) of
104 the federal Social Security Act, as amended. The eligibility of
105 individuals under this paragraph shall be determined by the
106 Division of Medicaid.
107 (11) Until the end of the day on December 31, 2005,
108 individuals who are sixty-five (65) years of age or older or are
109 disabled as determined under Section 1614(a)(3) of the federal
110 Social Security Act, as amended, and whose income does not exceed
111 one hundred thirty-five percent (135%) of the nonfarm official
112 poverty level as defined by the Office of Management and Budget
113 and revised annually, and whose resources do not exceed those
114 established by the Division of Medicaid. The eligibility of
115 individuals covered under this paragraph shall be determined by
116 the Division of Medicaid. After December 31, 2005, only those
117 individuals covered under the 1115(c) Healthier Mississippi waiver
118 will be covered under this category.
119 Any individual who applied for Medicaid during the period
120 from July 1, 2004, through March 31, 2005, who otherwise would
121 have been eligible for coverage under this paragraph (11) if it
122 had been in effect at the time the individual submitted his or her
123 application and is still eligible for coverage under this
124 paragraph (11) on March 31, 2005, shall be eligible for Medicaid
125 coverage under this paragraph (11) from March 31, 2005, through
126 December 31, 2005. The division shall give priority in processing
127 the applications for those individuals to determine their
128 eligibility under this paragraph (11).
129 (12) Individuals who are qualified Medicare
130 beneficiaries (QMB) entitled to Part A Medicare as defined under

131 Section 301, Public Law 100-360, known as the Medicare
132 Catastrophic Coverage Act of 1988, and whose income does not
133 exceed one hundred percent (100%) of the nonfarm official poverty
134 level as defined by the Office of Management and Budget and
135 revised annually.

136 The eligibility of individuals covered under this paragraph
137 shall be determined by the Division of Medicaid, and those
138 individuals determined eligible shall receive Medicare
139 cost-sharing expenses only as more fully defined by the Medicare
140 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
141 1997.

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

149 (b) Individuals entitled to Part A of Medicare,
150 with income above one hundred twenty percent (120%), but less than
151 one hundred thirty-five percent (135%) of the federal poverty
152 level, and not otherwise eligible for Medicaid Eligibility for
153 Medicaid benefits is limited to full payment of Medicare Part B
154 premiums. The number of eligible individuals is limited by the
155 availability of the federal capped allocation at one hundred
156 percent (100%) of federal matching funds, as more fully defined in
157 the Balanced Budget Act of 1997.

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

160 (14) [Deleted]

161 (15) Disabled workers who are eligible to enroll in
162 Part A Medicare as required by Public Law 101-239, known as the
163 Omnibus Budget Reconciliation Act of 1989, and whose income does

164 not exceed two hundred percent (200%) of the federal poverty level
165 as determined in accordance with the Supplemental Security Income
166 (SSI) program. The eligibility of individuals covered under this
167 paragraph shall be determined by the Division of Medicaid and
168 those individuals shall be entitled to buy-in coverage of Medicare
169 Part A premiums only under the provisions of this paragraph (15).
170 (16) In accordance with the terms and conditions of
171 approved Title XIX waiver from the United States Department of
172 Health and Human Services, persons provided home- and
173 community-based services who are physically disabled and certified
174 by the Division of Medicaid as eligible due to applying the income
175 and deeming requirements as if they were institutionalized.
176 (17) In accordance with the terms of the federal
177 Personal Responsibility and Work Opportunity Reconciliation Act of
178 1996 (Public Law 104-193), persons who become ineligible for
179 assistance under Title IV-A of the federal Social Security Act, as
180 amended, because of increased income from or hours of employment
181 of the caretaker relative or because of the expiration of the
182 applicable earned income disregards, who were eligible for
183 Medicaid for at least three (3) of the six (6) months preceding
184 the month in which the ineligibility begins, shall be eligible for
185 Medicaid for up to twelve (12) months. The eligibility of the
186 individuals covered under this paragraph shall be determined by
187 the division.
188 (18) Persons who become ineligible for assistance under
189 Title IV-A of the federal Social Security Act, as amended, as a
190 result, in whole or in part, of the collection or increased
191 collection of child or spousal support under Title IV-D of the
192 federal Social Security Act, as amended, who were eligible for
193 Medicaid for at least three (3) of the six (6) months immediately
194 preceding the month in which the ineligibility begins, shall be
195 eligible for Medicaid for an additional four (4) months beginning
196 with the month in which the ineligibility begins. The eligibility

197 of the individuals covered under this paragraph shall be
198 determined by the division.
199 (19) Disabled workers, whose incomes are above the
200 Medicaid eligibility limits, but below two hundred fifty percent
201 (250%) of the federal poverty level, shall be allowed to purchase
202 Medicaid coverage on a sliding fee scale developed by the Division
203 of Medicaid.
204 (20) Medicaid eligible children under age eighteen (18)
205 shall remain eligible for Medicaid benefits until the end of a
206 period of twelve (12) months following an eligibility
207 determination, or until such time that the individual exceeds age
208 eighteen (18).
209 (21) Women of childbearing age whose family income does
210 not exceed one hundred eighty-five percent (185%) of the federal
211 poverty level. The eligibility of individuals covered under this
212 paragraph (21) shall be determined by the Division of Medicaid,
213 and those individuals determined eligible shall only receive
214 family planning services covered under Section 43-13-117(13) and
215 not any other services covered under Medicaid. However, any
216 individual eligible under this paragraph (21) who is also eligible
217 under any other provision of this section shall receive the
218 benefits to which he or she is entitled under that other
219 provision, in addition to family planning services covered under
220 Section 43-13-117(13).
221 The Division of Medicaid shall apply to the United States
222 Secretary of Health and Human Services for a federal waiver of the
223 applicable provisions of Title XIX of the federal Social Security
224 Act, as amended, and any other applicable provisions of federal
225 law as necessary to allow for the implementation of this paragraph
226 (21). The provisions of this paragraph (21) shall be implemented
227 from and after the date that the Division of Medicaid receives the
228 federal waiver.

229 (22) Persons who are workers with a potentially severe
230 disability, as determined by the division, shall be allowed to
231 purchase Medicaid coverage. The term "worker with a potentially
232 severe disability" means a person who is at least sixteen (16)
233 years of age but under sixty-five (65) years of age, who has a
234 physical or mental impairment that is reasonably expected to cause
235 the person to become blind or disabled as defined under Section
236 1614(a) of the federal Social Security Act, as amended, if the
237 person does not receive items and services provided under
238 Medicaid.

239 The eligibility of persons under this paragraph (22) shall be
240 conducted as a demonstration project that is consistent with
241 Section 204 of the Ticket to Work and Work Incentives Improvement
242 Act of 1999, Public Law 106-170, for a certain number of persons
243 as specified by the division. The eligibility of individuals
244 covered under this paragraph (22) shall be determined by the
245 Division of Medicaid.

246 (23) Children certified by the Mississippi Department
247 of Human Services for whom the state and county departments of
248 human services have custody and financial responsibility who are
249 in foster care on their eighteenth birthday as reported by the
250 Mississippi Department of Human Services shall be certified
251 Medicaid eligible by the Division of Medicaid until their
252 twenty-first birthday.

253 (24) Individuals who have not attained age sixty-five
254 (65), are not otherwise covered by creditable coverage as defined
255 in the Public Health Services Act, and have been screened for
256 breast and cervical cancer under the Centers for Disease Control
257 and Prevention Breast and Cervical Cancer Early Detection Program
258 established under Title XV of the Public Health Service Act in
259 accordance with the requirements of that act and who need
260 treatment for breast or cervical cancer. Eligibility of

261 individuals under this paragraph (24) shall be determined by the
262 Division of Medicaid.

263 (25) The division shall apply to the Centers for
264 Medicare and Medicaid Services (CMS) for any necessary waivers to
265 provide services to individuals who are sixty-five (65) years of
266 age or older or are disabled as determined under Section
267 1614(a)(3) of the federal Social Security Act, as amended, and
268 whose income does not exceed one hundred thirty-five percent
269 (135%) of the nonfarm official poverty level as defined by the
270 Office of Management and Budget and revised annually, and whose
271 resources do not exceed those established by the Division of
272 Medicaid, and who are not otherwise covered by Medicare. Nothing
273 contained in this paragraph (25) shall entitle an individual to
274 benefits. The eligibility of individuals covered under this
275 paragraph shall be determined by the Division of Medicaid.

276 (26) The division shall apply to the Centers for
277 Medicare and Medicaid Services (CMS) for any necessary waivers to
278 provide services to individuals who are sixty-five (65) years of
279 age or older or are disabled as determined under Section
280 1614(a)(3) of the federal Social Security Act, as amended, who are
281 end stage renal disease patients on dialysis, cancer patients on
282 chemotherapy or organ transplant recipients on anti-rejection
283 drugs, whose income does not exceed one hundred thirty-five
284 percent (135%) of the nonfarm official poverty level as defined by
285 the Office of Management and Budget and revised annually, and
286 whose resources do not exceed those established by the division.
287 Nothing contained in this paragraph (26) shall entitle an
288 individual to benefits. The eligibility of individuals covered
289 under this paragraph shall be determined by the Division of
290 Medicaid.

291 (27) Individuals who are entitled to Medicare Part D
292 and whose income does not exceed one hundred fifty percent (150%)
293 of the nonfarm official poverty level as defined by the Office of

294 Management and Budget and revised annually. Eligibility for
295 payment of the Medicare Part D subsidy under this paragraph shall
296 be determined by the division.
297 (28) Individuals over sixty-five (65) years of age who
298 are entitled to Medicare Part C (Medicare Advantage Plan).
299 Eligibility for payment of the Medicare Part C premiums,
300 deductibles and coinsurance shall be determined by the division
301 under a contract with a legal entity as fiscal agent which has
302 been approved to offer and receive applications for Medicare Part
303 C plans by the Centers for Medicare and Medicaid Services (CMS).
304 The division shall redetermine eligibility for all categories
305 of recipients described in each paragraph of this section not less
306 frequently than required by federal law.
307 **SECTION 2.** Section 43-13-117, Mississippi Code of 1972, is
308 amended as follows:
309 43-13-117. Medicaid as authorized by this article shall
310 include payment of part or all of the costs, at the discretion of
311 the division, with approval of the Governor, of the following
312 types of care and services rendered to eligible applicants who
313 have been determined to be eligible for that care and services,
314 within the limits of state appropriations and federal matching
315 funds:
316 (1) Inpatient hospital services.
317 (a) The division shall allow thirty (30) days of
318 inpatient hospital care annually for all Medicaid recipients.
319 Precertification of inpatient days must be obtained as required by
320 the division. The division may allow unlimited days in
321 disproportionate hospitals as defined by the division for eligible
322 infants and children under the age of six (6) years if certified
323 as medically necessary as required by the division.
324 (b) From and after July 1, 1994, the Executive
325 Director of the Division of Medicaid shall amend the Mississippi
326 Title XIX Inpatient Hospital Reimbursement Plan to remove the

327 occupancy rate penalty from the calculation of the Medicaid
328 Capital Cost Component utilized to determine total hospital costs
329 allocated to the Medicaid program.
330 (c) Hospitals will receive an additional payment
331 for the implantable programmable baclofen drug pump used to treat
332 spasticity that is implanted on an inpatient basis. The payment
333 pursuant to written invoice will be in addition to the facility's
334 per diem reimbursement and will represent a reduction of costs on
335 the facility's annual cost report, and shall not exceed Ten
336 Thousand Dollars ($10,000.00) per year per recipient.
337 (2) Outpatient hospital services.
338 (a) Emergency services. The division shall allow
339 six (6) medically necessary emergency room visits per beneficiary
340 per fiscal year.
341 (b) Other outpatient hospital services. The
342 division shall allow benefits for other medically necessary
343 outpatient hospital services (such as chemotherapy, radiation,
344 surgery and therapy). Where the same services are reimbursed as
345 clinic services, the division may revise the rate or methodology
346 of outpatient reimbursement to maintain consistency, efficiency,
347 economy and quality of care.
348 (3) Laboratory and x-ray services.
349 (4) Nursing facility services.
350 (a) The division shall make full payment to
351 nursing facilities for each day, not exceeding fifty-two (52) days
352 per year, that a patient is absent from the facility on home
353 leave. Payment may be made for the following home leave days in
354 addition to the fifty-two-day limitation: Christmas, the day
355 before Christmas, the day after Christmas, Thanksgiving, the day
356 before Thanksgiving and the day after Thanksgiving.
357 (b) From and after July 1, 1997, the division
358 shall implement the integrated case-mix payment and quality
359 monitoring system, which includes the fair rental system for

360 property costs and in which recapture of depreciation is
361 eliminated. The division may reduce the payment for hospital
362 leave and therapeutic home leave days to the lower of the case-mix
363 category as computed for the resident on leave using the
364 assessment being utilized for payment at that point in time, or a
365 case-mix score of 1.000 for nursing facilities, and shall compute
366 case-mix scores of residents so that only services provided at the
367 nursing facility are considered in calculating a facility's per
368 diem.

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

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

392 from the Centers for Medicare and Medicaid Services (CMS) of the
393 change in the state Medicaid plan providing for the reimbursement.
394 (e) The division shall develop and implement, not
395 later than January 1, 2001, a case-mix payment add-on determined
396 by time studies and other valid statistical data that will
397 reimburse a nursing facility for the additional cost of caring for
398 a resident who has a diagnosis of Alzheimer's or other related
399 dementia and exhibits symptoms that require special care. Any
400 such case-mix add-on payment shall be supported by a determination
401 of additional cost. The division shall also develop and implement
402 as part of the fair rental reimbursement system for nursing
403 facility beds, an Alzheimer's resident bed depreciation enhanced
404 reimbursement system that will provide an incentive to encourage
405 nursing facilities to convert or construct beds for residents with
406 Alzheimer's or other related dementia.
407 (f) The division shall develop and implement an
408 assessment process for long-term care services. The division may
409 provide the assessment and related functions directly or through
410 contract with the area agencies on aging.
411 The division shall apply for necessary federal waivers to
412 assure that additional services providing alternatives to nursing
413 facility care are made available to applicants for nursing
414 facility care.
415 (5) Periodic screening and diagnostic services for
416 individuals under age twenty-one (21) years as are needed to
417 identify physical and mental defects and to provide health care
418 treatment and other measures designed to correct or ameliorate
419 defects and physical and mental illness and conditions discovered
420 by the screening services, regardless of whether these services
421 are included in the state plan. The division may include in its
422 periodic screening and diagnostic program those discretionary
423 services authorized under the federal regulations adopted to
424 implement Title XIX of the federal Social Security Act, as

425 amended. The division, in obtaining physical therapy services,
426 occupational therapy services, and services for individuals with
427 speech, hearing and language disorders, may enter into a
428 cooperative agreement with the State Department of Education for
429 the provision of those services to handicapped students by public
430 school districts using state funds that are provided from the
431 appropriation to the Department of Education to obtain federal
432 matching funds through the division. The division, in obtaining
433 medical and psychological evaluations for children in the custody
434 of the State Department of Human Services may enter into a
435 cooperative agreement with the State Department of Human Services
436 for the provision of those services using state funds that are
437 provided from the appropriation to the Department of Human
438 Services to obtain federal matching funds through the division.
439 (6) Physician's services. The division shall allow
440 twelve (12) physician visits annually. All fees for physicians'
441 services that are covered only by Medicaid shall be reimbursed at
442 ninety percent (90%) of the rate established on January 1, 1999,
443 and as may be adjusted each July thereafter, under Medicare (Title
444 XVIII of the federal Social Security Act, as amended). The
445 division may develop and implement a different reimbursement model
446 or schedule for physician's services provided by physicians based
447 at an academic health care center and by physicians at rural
448 health centers that are associated with an academic health care
449 center.
450 (7) (a) Home health services for eligible persons, not
451 to exceed in cost the prevailing cost of nursing facility
452 services, not to exceed twenty-five (25) visits per year. All
453 home health visits must be precertified as required by the
454 division.
455 (b) Repealed.
456 (8) Emergency medical transportation services. On
457 January 1, 1994, emergency medical transportation services shall

458 be reimbursed at seventy percent (70%) of the rate established
459 under Medicare (Title XVIII of the federal Social Security Act, as
460 amended). "Emergency medical transportation services" shall mean,
461 but shall not be limited to, the following services by a properly
462 permitted ambulance operated by a properly licensed provider in
463 accordance with the Emergency Medical Services Act of 1974
464 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
465 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
466 (vi) disposable supplies, (vii) similar services.
467 (9) (a) Legend and other drugs as may be determined by
468 the division.
469 The division shall establish a mandatory preferred drug list.
470 Drugs not on the mandatory preferred drug list shall be made
471 available by utilizing prior authorization procedures established
472 by the division.
473 The division may seek to establish relationships with other
474 states in order to lower acquisition costs of prescription drugs
475 to include single source and innovator multiple source drugs or
476 generic drugs. In addition, if allowed by federal law or
477 regulation, the division may seek to establish relationships with
478 and negotiate with other countries to facilitate the acquisition
479 of prescription drugs to include single source and innovator
480 multiple source drugs or generic drugs, if that will lower the
481 acquisition costs of those prescription drugs.
482 The division shall allow for a combination of prescriptions
483 for single source and innovator multiple source drugs and generic
484 drugs to meet the needs of the beneficiaries, not to exceed five
485 (5) prescriptions per month for each noninstitutionalized Medicaid
486 beneficiary, with not more than two (2) of those prescriptions
487 being for single source or innovator multiple source drugs.
488 The executive director may approve specific maintenance drugs
489 for beneficiaries with certain medical conditions, which may be
490 prescribed and dispensed in three-month supply increments. The

491 executive director may allow a state agency or agencies to be the
492 sole source purchaser and distributor of hemophilia factor
493 medications, HIV/AIDS medications and other medications as
494 determined by the executive director as allowed by federal
495 regulations.

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

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

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

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

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

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

532 The division shall develop and implement a method or methods
533 by which the division will provide on a regular basis to Medicaid
534 providers who are authorized to prescribe drugs, information about
535 the costs to the Medicaid program of single source drugs and
536 innovator multiple source drugs, and information about other drugs
537 that may be prescribed as alternatives to those single source
538 drugs and innovator multiple source drugs and the costs to the
539 Medicaid program of those alternative drugs.

540 Notwithstanding any law or regulation, information obtained
541 or maintained by the division regarding the prescription drug
542 program, including trade secrets and manufacturer or labeler
543 pricing, is confidential and not subject to disclosure except to
544 other state agencies.

545 (b) Payment by the division for covered
546 multisource drugs shall be limited to the lower of the upper
547 limits established and published by the Centers for Medicare and
548 Medicaid Services (CMS) plus a dispensing fee, or the estimated
549 acquisition cost (EAC) as determined by the division, plus a
550 dispensing fee, or the providers' usual and customary charge to
551 the general public.

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

555 fee or the providers' usual and customary charge to the general
556 public.
557 Payment for nonlegend or over-the-counter drugs covered by
558 the division shall be reimbursed at the lower of the division's
559 estimated shelf price or the providers' usual and customary charge
560 to the general public.
561 The dispensing fee for each new or refill prescription,
562 including nonlegend or over-the-counter drugs covered by the
563 division, shall be not less than Three Dollars and Ninety-one
564 Cents ($3.91), as determined by the division.
565 The division shall not reimburse for single source or
566 innovator multiple source drugs if there are equally effective
567 generic equivalents available and if the generic equivalents are
568 the least expensive.
569 It is the intent of the Legislature that the pharmacists
570 providers be reimbursed for the reasonable costs of filling and
571 dispensing prescriptions for Medicaid beneficiaries.
572 (10) Dental care that is an adjunct to treatment of an
573 acute medical or surgical condition; services of oral surgeons and
574 dentists in connection with surgery related to the jaw or any
575 structure contiguous to the jaw or the reduction of any fracture
576 of the jaw or any facial bone; and emergency dental extractions
577 and treatment related thereto. On July 1, 1999, all fees for
578 dental care and surgery under authority of this paragraph (10)
579 shall be increased to one hundred sixty percent (160%) of the
580 amount of the reimbursement rate that was in effect on June 30,
581 1999. It is the intent of the Legislature to encourage more
582 dentists to participate in the Medicaid program.
583 (11) Eyeglasses for all Medicaid beneficiaries who have
584 (a) had surgery on the eyeball or ocular muscle that results in a
585 vision change for which eyeglasses or a change in eyeglasses is
586 medically indicated within six (6) months of the surgery and is in
587 accordance with policies established by the division, or (b) one

588 (1) pair every five (5) years and in accordance with policies
589 established by the division. In either instance, the eyeglasses
590 must be prescribed by a physician skilled in diseases of the eye
591 or an optometrist, whichever the beneficiary may select.
592 (12) Intermediate care facility services.
593 (a) The division shall make full payment to all
594 intermediate care facilities for the mentally retarded for each
595 day, not exceeding eighty-four (84) days per year, that a patient
596 is absent from the facility on home leave. Payment may be made
597 for the following home leave days in addition to the
598 eighty-four-day limitation: Christmas, the day before Christmas,
599 the day after Christmas, Thanksgiving, the day before Thanksgiving
600 and the day after Thanksgiving.
601 (b) All state-owned intermediate care facilities
602 for the mentally retarded shall be reimbursed on a full reasonable
603 cost basis.
604 (13) Family planning services, including drugs,
605 supplies and devices, when those services are under the
606 supervision of a physician or nurse practitioner.
607 (14) Clinic services. Such diagnostic, preventive,
608 therapeutic, rehabilitative or palliative services furnished to an
609 outpatient by or under the supervision of a physician or dentist
610 in a facility that is not a part of a hospital but that is
611 organized and operated to provide medical care to outpatients.
612 Clinic services shall include any services reimbursed as
613 outpatient hospital services that may be rendered in such a
614 facility, including those that become so after July 1, 1991. On
615 July 1, 1999, all fees for physicians' services reimbursed under
616 authority of this paragraph (14) shall be reimbursed at ninety
617 percent (90%) of the rate established on January 1, 1999, and as
618 may be adjusted each July thereafter, under Medicare (Title XVIII
619 of the federal Social Security Act, as amended). The division may
620 develop and implement a different reimbursement model or schedule

621 for physician's services provided by physicians based at an
622 academic health care center and by physicians at rural health
623 centers that are associated with an academic health care center.
624 On July 1, 1999, all fees for dentists' services reimbursed under
625 authority of this paragraph (14) shall be increased to one hundred
626 sixty percent (160%) of the amount of the reimbursement rate that
627 was in effect on June 30, 1999.
628 (15) Home- and community-based services for the elderly
629 and disabled, as provided under Title XIX of the federal Social
630 Security Act, as amended, under waivers, subject to the
631 availability of funds specifically appropriated for that purpose
632 by the Legislature.
633 (16) Mental health services. Approved therapeutic and
634 case management services (a) provided by an approved regional
635 mental health/retardation center established under Sections
636 41-19-31 through 41-19-39, or by another community mental health
637 service provider meeting the requirements of the Department of
638 Mental Health to be an approved mental health/retardation center
639 if determined necessary by the Department of Mental Health, using
640 state funds that are provided from the appropriation to the State
641 Department of Mental Health and/or funds transferred to the
642 department by a political subdivision or instrumentality of the
643 state and used to match federal funds under a cooperative
644 agreement between the division and the department, or (b) provided
645 by a facility that is certified by the State Department of Mental
646 Health to provide therapeutic and case management services, to be
647 reimbursed on a fee for service basis, or (c) provided in the
648 community by a facility or program operated by the Department of
649 Mental Health. Any such services provided by a facility described
650 in subparagraph (b) must have the prior approval of the division
651 to be reimbursable under this section. After June 30, 1997,
652 mental health services provided by regional mental
653 health/retardation centers established under Sections 41-19-31

654 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
655 and/or their subsidiaries and divisions, or by psychiatric
656 residential treatment facilities as defined in Section 43-11-1, or
657 by another community mental health service provider meeting the
658 requirements of the Department of Mental Health to be an approved
659 mental health/retardation center if determined necessary by the
660 Department of Mental Health, shall not be included in or provided
661 under any capitated managed care pilot program provided for under
662 paragraph (24) of this section.

663 (17) Durable medical equipment services and medical
664 supplies. Precertification of durable medical equipment and
665 medical supplies must be obtained as required by the division.
666 The Division of Medicaid may require durable medical equipment
667 providers to obtain a surety bond in the amount and to the
668 specifications as established by the Balanced Budget Act of 1997.

669 (18) (a) Notwithstanding any other provision of this
670 section to the contrary, the division shall make additional
671 reimbursement to hospitals that serve a disproportionate share of
672 low-income patients and that meet the federal requirements for
673 those payments as provided in Section 1923 of the federal Social
674 Security Act and any applicable regulations. However, from and
675 after January 1, 1999, no public hospital shall participate in the
676 Medicaid disproportionate share program unless the public hospital
677 participates in an intergovernmental transfer program as provided
678 in Section 1903 of the federal Social Security Act and any
679 applicable regulations.

680 (b) The division shall establish a Medicare Upper
681 Payment Limits Program, as defined in Section 1902(a)(30) of the
682 federal Social Security Act and any applicable federal
683 regulations, for hospitals, and may establish a Medicare Upper
684 Payments Limits Program for nursing facilities. The division
685 shall assess each hospital and, if the program is established for
686 nursing facilities, shall assess each nursing facility, based on

687 Medicaid utilization or other appropriate method consistent with
688 federal regulations. The assessment will remain in effect as long
689 as the state participates in the Medicare Upper Payment Limits
690 Program. The division shall make additional reimbursement to
691 hospitals and, if the program is established for nursing
692 facilities, shall make additional reimbursement to nursing
693 facilities, for the Medicare Upper Payment Limits, as defined in
694 Section 1902(a)(30) of the federal Social Security Act and any
695 applicable federal regulations.

696 (19) (a) Perinatal risk management services. The
697 division shall promulgate regulations to be effective from and
698 after October 1, 1988, to establish a comprehensive perinatal
699 system for risk assessment of all pregnant and infant Medicaid
700 recipients and for management, education and follow-up for those
701 who are determined to be at risk. Services to be performed
702 include case management, nutrition assessment/counseling,
703 psychosocial assessment/counseling and health education.

704 (b) Early intervention system services. The
705 division shall cooperate with the State Department of Health,
706 acting as lead agency, in the development and implementation of a
707 statewide system of delivery of early intervention services, under
708 Part C of the Individuals with Disabilities Education Act (IDEA).
709 The State Department of Health shall certify annually in writing
710 to the executive director of the division the dollar amount of
711 state early intervention funds available that will be utilized as
712 a certified match for Medicaid matching funds. Those funds then
713 shall be used to provide expanded targeted case management
714 services for Medicaid eligible children with special needs who are
715 eligible for the state's early intervention system.
716 Qualifications for persons providing service coordination shall be
717 determined by the State Department of Health and the Division of
718 Medicaid.

719 (20) Home- and community-based services for physically
720 disabled approved services as allowed by a waiver from the United
721 States Department of Health and Human Services for home- and
722 community-based services for physically disabled people using
723 state funds that are provided from the appropriation to the State
724 Department of Rehabilitation Services and used to match federal
725 funds under a cooperative agreement between the division and the
726 department, provided that funds for these services are
727 specifically appropriated to the Department of Rehabilitation
728 Services.
729 (21) Nurse practitioner services. Services furnished
730 by a registered nurse who is licensed and certified by the
731 Mississippi Board of Nursing as a nurse practitioner, including,
732 but not limited to, nurse anesthetists, nurse midwives, family
733 nurse practitioners, family planning nurse practitioners,
734 pediatric nurse practitioners, obstetrics-gynecology nurse
735 practitioners and neonatal nurse practitioners, under regulations
736 adopted by the division. Reimbursement for those services shall
737 not exceed ninety percent (90%) of the reimbursement rate for
738 comparable services rendered by a physician.
739 (22) Ambulatory services delivered in federally
740 qualified health centers, rural health centers and clinics of the
741 local health departments of the State Department of Health for
742 individuals eligible for Medicaid under this article based on
743 reasonable costs as determined by the division.
744 (23) Inpatient psychiatric services. Inpatient
745 psychiatric services to be determined by the division for
746 recipients under age twenty-one (21) that are provided under the
747 direction of a physician in an inpatient program in a licensed
748 acute care psychiatric facility or in a licensed psychiatric
749 residential treatment facility, before the recipient reaches age
750 twenty-one (21) or, if the recipient was receiving the services
751 immediately before he or she reached age twenty-one (21), before

752 the earlier of the date he or she no longer requires the services
753 or the date he or she reaches age twenty-two (22), as provided by
754 federal regulations. Precertification of inpatient days and
755 residential treatment days must be obtained as required by the
756 division.
757 (24) [Deleted]
758 (25) [Deleted]
759 (26) Hospice care. As used in this paragraph, the term
760 "hospice care" means a coordinated program of active professional
761 medical attention within the home and outpatient and inpatient
762 care that treats the terminally ill patient and family as a unit,
763 employing a medically directed interdisciplinary team. The
764 program provides relief of severe pain or other physical symptoms
765 and supportive care to meet the special needs arising out of
766 physical, psychological, spiritual, social and economic stresses
767 that are experienced during the final stages of illness and during
768 dying and bereavement and meets the Medicare requirements for
769 participation as a hospice as provided in federal regulations.
770 (27) Group health plan premiums and cost sharing if it
771 is cost effective as defined by the United States Secretary of
772 Health and Human Services.
773 (28) Other health insurance premiums that are cost
774 effective as defined by the United States Secretary of Health and
775 Human Services. Medicare eligible must have Medicare Part B
776 before other insurance premiums can be paid.
777 (29) The Division of Medicaid may apply for a waiver
778 from the United States Department of Health and Human Services for
779 home- and community-based services for developmentally disabled
780 people using state funds that are provided from the appropriation
781 to the State Department of Mental Health and/or funds transferred
782 to the department by a political subdivision or instrumentality of
783 the state and used to match federal funds under a cooperative
784 agreement between the division and the department, provided that

785 funds for these services are specifically appropriated to the
786 Department of Mental Health and/or transferred to the department
787 by a political subdivision or instrumentality of the state.
788 (30) Pediatric skilled nursing services for eligible
789 persons under twenty-one (21) years of age.
790 (31) Targeted case management services for children
791 with special needs, under waivers from the United States
792 Department of Health and Human Services, using state funds that
793 are provided from the appropriation to the Mississippi Department
794 of Human Services and used to match federal funds under a
795 cooperative agreement between the division and the department.
796 (32) Care and services provided in Christian Science
797 Sanatoria listed and certified by the Commission for Accreditation
798 of Christian Science Nursing Organizations/Facilities, Inc.,
799 rendered in connection with treatment by prayer or spiritual means
800 to the extent that those services are subject to reimbursement
801 under Section 1903 of the federal Social Security Act.
802 (33) Podiatrist services.
803 (34) Assisted living services as provided through home-
804 and community-based services under Title XIX of the federal Social
805 Security Act, as amended, subject to the availability of funds
806 specifically appropriated for that purpose by the Legislature.
807 (35) Services and activities authorized in Sections
808 43-27-101 and 43-27-103, using state funds that are provided from
809 the appropriation to the State Department of Human Services and
810 used to match federal funds under a cooperative agreement between
811 the division and the department.
812 (36) Nonemergency transportation services for
813 Medicaid-eligible persons, to be provided by the Division of
814 Medicaid. The division may contract with additional entities to
815 administer nonemergency transportation services as it deems
816 necessary. All providers shall have a valid driver's license,
817 vehicle inspection sticker, valid vehicle license tags and a

818 standard liability insurance policy covering the vehicle. The
819 division may pay providers a flat fee based on mileage tiers, or
820 in the alternative, may reimburse on actual miles traveled. The
821 division may apply to the Center for Medicare and Medicaid
822 Services (CMS) for a waiver to draw federal matching funds for
823 nonemergency transportation services as a covered service instead
824 of an administrative cost.

825 (37) [Deleted]

826 (38) Chiropractic services. A chiropractor's manual
827 manipulation of the spine to correct a subluxation, if x-ray
828 demonstrates that a subluxation exists and if the subluxation has
829 resulted in a neuromusculoskeletal condition for which
830 manipulation is appropriate treatment, and related spinal x-rays
831 performed to document these conditions. Reimbursement for
832 chiropractic services shall not exceed Seven Hundred Dollars
833 ($700.00) per year per beneficiary.

834 (39) Dually eligible Medicare/Medicaid beneficiaries.
835 The division shall pay the Medicare deductible and coinsurance
836 amounts for services available under Medicare, as determined by
837 the division. <u>The division shall pay the Medicare premiums,</u>
838 <u>deductible and coinsurance amounts for services available under</u>
839 <u>Medicare Part C, as determined by the division.</u>

840 (40) [Deleted]

841 (41) Services provided by the State Department of
842 Rehabilitation Services for the care and rehabilitation of persons
843 with spinal cord injuries or traumatic brain injuries, as allowed
844 under waivers from the United States Department of Health and
845 Human Services, using up to seventy-five percent (75%) of the
846 funds that are appropriated to the Department of Rehabilitation
847 Services from the Spinal Cord and Head Injury Trust Fund
848 established under Section 37-33-261 and used to match federal
849 funds under a cooperative agreement between the division and the
850 department.

851 (42) Notwithstanding any other provision in this
852 article to the contrary, the division may develop a population
853 health management program for women and children health services
854 through the age of one (1) year. This program is primarily for
855 obstetrical care associated with low birth weight and pre-term
856 babies. The division may apply to the federal Centers for
857 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
858 any other waivers that may enhance the program. In order to
859 effect cost savings, the division may develop a revised payment
860 methodology that may include at-risk capitated payments, and may
861 require member participation in accordance with the terms and
862 conditions of an approved federal waiver.
863 (43) The division shall provide reimbursement,
864 according to a payment schedule developed by the division, for
865 smoking cessation medications for pregnant women during their
866 pregnancy and other Medicaid-eligible women who are of
867 child-bearing age.
868 (44) Nursing facility services for the severely
869 disabled.
870 (a) Severe disabilities include, but are not
871 limited to, spinal cord injuries, closed head injuries and
872 ventilator dependent patients.
873 (b) Those services must be provided in a long-term
874 care nursing facility dedicated to the care and treatment of
875 persons with severe disabilities, and shall be reimbursed as a
876 separate category of nursing facilities.
877 (45) Physician assistant services. Services furnished
878 by a physician assistant who is licensed by the State Board of
879 Medical Licensure and is practicing with physician supervision
880 under regulations adopted by the board, under regulations adopted
881 by the division. Reimbursement for those services shall not
882 exceed ninety percent (90%) of the reimbursement rate for
883 comparable services rendered by a physician.

884 (46) The division shall make application to the federal
885 Centers for Medicare and Medicaid Services (CMS) for a waiver to
886 develop and provide services for children with serious emotional
887 disturbances as defined in Section 43-14-1(1), which may include
888 home- and community-based services, case management services or
889 managed care services through mental health providers certified by
890 the Department of Mental Health. The division may implement and
891 provide services under this waivered program only if funds for
892 these services are specifically appropriated for this purpose by
893 the Legislature, or if funds are voluntarily provided by affected
894 agencies.
895 (47) (a) Notwithstanding any other provision in this
896 article to the contrary, the division, in conjunction with the
897 State Department of Health, may develop and implement disease
898 management programs for individuals with high-cost chronic
899 diseases and conditions, including the use of grants, waivers,
900 demonstrations or other projects as necessary.
901 (b) Participation in any disease management
902 program implemented under this paragraph (47) is optional with the
903 individual. An individual must affirmatively elect to participate
904 in the disease management program in order to participate.
905 (c) An individual who participates in the disease
906 management program has the option of participating in the
907 prescription drug home delivery component of the program at any
908 time while participating in the program. An individual must
909 affirmatively elect to participate in the prescription drug home
910 delivery component in order to participate.
911 (d) An individual who participates in the disease
912 management program may elect to discontinue participation in the
913 program at any time. An individual who participates in the
914 prescription drug home delivery component may elect to discontinue
915 participation in the prescription drug home delivery component at
916 any time.

917 (e) The division shall send written notice to all
918 individuals who participate in the disease management program
919 informing them that they may continue using their local pharmacy
920 or any other pharmacy of their choice to obtain their prescription
921 drugs while participating in the program.
922 (f) Prescription drugs that are provided to
923 individuals under the prescription drug home delivery component
924 shall be limited only to those drugs that are used for the
925 treatment, management or care of asthma, diabetes or hypertension.
926 (48) Pediatric long-term acute care hospital services.
927 (a) Pediatric long-term acute care hospital
928 services means services provided to eligible persons under
929 twenty-one (21) years of age by a freestanding Medicare-certified
930 hospital that has an average length of inpatient stay greater than
931 twenty-five (25) days and that is primarily engaged in providing
932 chronic or long-term medical care to persons under twenty-one (21)
933 years of age.
934 (b) The services under this paragraph (48) shall
935 be reimbursed as a separate category of hospital services.
936 (49) The division shall establish co-payments and/or
937 coinsurance for all Medicaid services for which co-payments and/or
938 coinsurance are allowable under federal law or regulation, and
939 shall set the amount of the co-payment and/or coinsurance for each
940 of those services at the maximum amount allowable under federal
941 law or regulation.
942 (50) Services provided by the State Department of
943 Rehabilitation Services for the care and rehabilitation of persons
944 who are deaf and blind, as allowed under waivers from the United
945 States Department of Health and Human Services to provide home-
946 and community-based services using state funds that are provided
947 from the appropriation to the State Department of Rehabilitation
948 Services or if funds are voluntarily provided by another agency.

949 (51) Upon determination of Medicaid eligibility and in
950 association with annual redetermination of Medicaid eligibility,
951 beneficiaries shall be encouraged to undertake a physical
952 examination that will establish a base-line level of health and
953 identification of a usual and customary source of care (a medical
954 home) to aid utilization of disease management tools. This
955 physical examination and utilization of these disease management
956 tools shall be consistent with current United States Preventive
957 Services Task Force or other recognized authority recommendations.
958 For persons who are determined ineligible for Medicaid, the
959 division will provide information and direction for accessing
960 medical care and services in the area of their residence.
961 (52) Notwithstanding any provisions of this article,
962 the division may pay enhanced reimbursement fees related to trauma
963 care, as determined by the division in conjunction with the State
964 Department of Health, using funds appropriated to the State
965 Department of Health for trauma care and services and used to
966 match federal funds under a cooperative agreement between the
967 division and the State Department of Health. The division, in
968 conjunction with the State Department of Health, may use grants,
969 waivers, demonstrations, or other projects as necessary in the
970 development and implementation of this reimbursement program.
971 (53) Targeted case management services for high-cost
972 beneficiaries shall be developed by the division for all services
973 under this section.
974 Notwithstanding any other provision of this article to the
975 contrary, the division shall reduce the rate of reimbursement to
976 providers for any service provided under this section by five
977 percent (5%) of the allowed amount for that service. However, the
978 reduction in the reimbursement rates required by this paragraph
979 shall not apply to inpatient hospital services, nursing facility
980 services, intermediate care facility services, psychiatric
981 residential treatment facility services, pharmacy services

982 provided under paragraph (9) of this section, or any service
983 provided by the University of Mississippi Medical Center or a
984 state agency, a state facility or a public agency that either
985 provides its own state match through intergovernmental transfer or
986 certification of funds to the division, or a service for which the
987 federal government sets the reimbursement methodology and rate.
988 In addition, the reduction in the reimbursement rates required by
989 this paragraph shall not apply to case management services and
990 home-delivered meals provided under the home- and community-based
991 services program for the elderly and disabled by a planning and
992 development district (PDD). Planning and development districts
993 participating in the home- and community-based services program
994 for the elderly and disabled as case management providers shall be
995 reimbursed for case management services at the maximum rate
996 approved by the Centers for Medicare and Medicaid Services (CMS).
997 The division may pay to those providers who participate in
998 and accept patient referrals from the division's emergency room
999 redirection program a percentage, as determined by the division,
1000 of savings achieved according to the performance measures and
1001 reduction of costs required of that program. Federally qualified
1002 health centers may participate in the emergency room redirection
1003 program, and the division may pay those centers a percentage of
1004 any savings to the Medicaid program achieved by the centers'
1005 accepting patient referrals through the program, as provided in
1006 this paragraph.
1007 Notwithstanding any provision of this article, except as
1008 authorized in the following paragraph and in Section 43-13-139,
1009 neither (a) the limitations on quantity or frequency of use of or
1010 the fees or charges for any of the care or services available to
1011 recipients under this section, nor (b) the payments or rates of
1012 reimbursement to providers rendering care or services authorized
1013 under this section to recipients, may be increased, decreased or
1014 otherwise changed from the levels in effect on July 1, 1999,

1015 unless they are authorized by an amendment to this section by the
1016 Legislature. However, the restriction in this paragraph shall not
1017 prevent the division from changing the payments or rates of
1018 reimbursement to providers without an amendment to this section
1019 whenever those changes are required by federal law or regulation,
1020 or whenever those changes are necessary to correct administrative
1021 errors or omissions in calculating those payments or rates of
1022 reimbursement.

1023 Notwithstanding any provision of this article, no new groups
1024 or categories of recipients and new types of care and services may
1025 be added without enabling legislation from the Mississippi
1026 Legislature, except that the division may authorize those changes
1027 without enabling legislation when the addition of recipients or
1028 services is ordered by a court of proper authority.

1029 The executive director shall keep the Governor advised on a
1030 timely basis of the funds available for expenditure and the
1031 projected expenditures. If current or projected expenditures of
1032 the division are reasonably anticipated to exceed the amount of
1033 funds appropriated to the division for any fiscal year, the
1034 Governor, after consultation with the executive director, shall
1035 discontinue any or all of the payment of the types of care and
1036 services as provided in this section that are deemed to be
1037 optional services under Title XIX of the federal Social Security
1038 Act, as amended, and when necessary, shall institute any other
1039 cost containment measures on any program or programs authorized
1040 under the article to the extent allowed under the federal law
1041 governing that program or programs. However, the Governor shall
1042 not be authorized to discontinue or eliminate any service under
1043 this section that is mandatory under federal law, or to
1044 discontinue or eliminate, or adjust income limits or resource
1045 limits for, any eligibility category or group under Section
1046 43-13-115. It is the intent of the Legislature that the
1047 expenditures of the division during any fiscal year shall not

1048 exceed the amounts appropriated to the division for that fiscal
1049 year.

1050 Notwithstanding any other provision of this article, it shall
1051 be the duty of each nursing facility, intermediate care facility
1052 for the mentally retarded, psychiatric residential treatment
1053 facility, and nursing facility for the severely disabled that is
1054 participating in the Medicaid program to keep and maintain books,
1055 documents and other records as prescribed by the Division of
1056 Medicaid in substantiation of its cost reports for a period of
1057 three (3) years after the date of submission to the Division of
1058 Medicaid of an original cost report, or three (3) years after the
1059 date of submission to the Division of Medicaid of an amended cost
1060 report.

1061 **SECTION 3.** This act shall take effect and be in force from
1062 and after July 1, 2007.

ST: Medicaid assistance program; authorize DOM to provide Medicare Part C benefits for dually eligible recipients under contract.