MISSISSIPPI LEGISLATURE REGULAR SESSION 2004

By: Representatives Morris, Holland To: Medicaid; Appropriations

HOUSE BILL NO. 1434
(As Sent to Governor)

1 AN ACT TO AMEND SECTION 43-13-107, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE FOR A FULL-TIME DEPUTY DIRECTOR OF ADMINISTRATION OF
3 THE DIVISION OF MEDICAID; TO ADD THE CHAIRMAN OF THE HOUSE
4 MEDICAID COMMITTEE AS A MEMBER OF THE MEDICAL CARE ADVISORY
5 COMMITTEE; TO ADD AN ADDITIONAL SENATE MEMBER TO THE MEDICAL CARE
6 ADVISORY COMMITTEE; TO REQUIRE MEMBERS OF THE PHARMACY AND
7 THERAPEUTICS COMMITTEE TO RECUSE THEMSELVES ON ACTIONS THAT
8 PRESENT CONFLICTS OF INTEREST; TO EXTEND THE DATE OF THE AUTOMATIC
9 REPEALER ON THAT SECTION; TO AMEND SECTION 43-13-115, MISSISSIPPI
10 CODE OF 1972, TO DELETE THE ELIGIBILITY OF THE PLAD CATEGORY OF
11 RECIPIENTS; TO DIRECT THE DIVISION TO APPLY FOR CERTAIN WAIVERS;
12 TO REQUIRE THE DIVISION TO REDETERMINE ELIGIBILITY FOR ALL
13 CATEGORIES OF MEDICAID RECIPIENTS NOT LESS FREQUENTLY THAN
14 REQUIRED BY FEDERAL LAW; TO DEFINE THE RESPONSIBILITY OF THE
15 DIVISION AND THE DEPARTMENT OF HUMAN SERVICES REGARDING
16 ELIGIBILITY DETERMINATION; TO AMEND SECTION 43-13-117, MISSISSIPPI
17 CODE OF 1972, TO PROVIDE THAT THE DIVISION MAY PROVIDE THE
18 ASSESSMENT PROCESS FOR LONG-TERM CARE SERVICES THROUGH CONTRACT
19 WITH THE AREA AGENCIES ON AGING; TO DELETE THE REIMBURSEMENT RATE
20 FOR PHYSICIANS SERVICES AND CLINIC SERVICES TO RECIPIENTS THAT ARE
21 DUALLY ELIGIBLE UNDER MEDICAID AND MEDICARE; TO DIRECT THE
22 DIVISION TO ESTABLISH A MANDATORY PREFERRED DRUG LIST FOR MEDICAID
23 REIMBURSEMENT; TO PROVIDE THAT DRUGS NOT ON THE MANDATORY
24 PREFERRED DRUG LIST SHALL BE MADE AVAILABLE BY UTILIZING PRIOR
25 AUTHORIZATION PROCEDURES; TO AUTHORIZE AGREEMENTS WITH OTHER
26 STATES TO LOWER THE ACQUISITION COSTS OF PRESCRIPTION DRUGS; TO
27 AUTHORIZE AGREEMENTS AND NEGOTIATIONS WITH OTHER COUNTRIES TO
28 FACILITATE THE ACQUISITION OF PRESCRIPTION DRUGS, IF ALLOWED BY
29 FEDERAL LAW AND IF IT WILL LOWER THE ACQUISITION COSTS OF THOSE
30 DRUGS; TO AUTHORIZE A COMBINATION OF PRESCRIPTIONS FOR SINGLE
31 SOURCE AND INNOVATOR MULTIPLE SOURCE DRUGS AND GENERIC DRUGS, WITH
32 MONTHLY LIMITATIONS; TO ALLOW UNLIMITED PRESCRIPTIONS FOR GENERIC
33 DRUGS; TO DIRECT THE DIVISION TO ESTABLISH A PRIOR AUTHORIZATION
34 PROCESS THAT WOULD ALLOW CERTAIN BENEFICIARIES TO EXCEED THE
35 MONTHLY LIMITATION ON PRESCRIPTIONS FOR SINGLE SOURCE AND
36 INNOVATOR MULTIPLE SOURCE DRUGS; TO DELETE THE REQUIREMENT FOR THE
37 DIVISION TO INCLUDE CERTAIN ANTIPSYCHOTIC DRUGS IN ANY PREFERRED
38 DRUG LIST DEVELOPED BY THE DIVISION; TO AUTHORIZE REIMBURSEMENT
39 FOR MULTISOURCE DRUGS AT THE ESTIMATED ACQUISITION COST AS
40 DETERMINED BY THE DIVISION; TO PROVIDE THAT THE DISPENSING FEE FOR
41 PRESCRIPTION DRUGS SHALL BE NOT LESS THAN A SPECIFIED AMOUNT; TO
42 REQUIRE MEDICAID PROVIDERS TO USE COUNTERFEIT-PROOF PRESCRIPTION
43 PADS FOR MEDICAID PRESCRIPTIONS FOR CONTROLLED SUBSTANCES; TO
44 DELETE CERTAIN PROVISIONS RELATING TO THE MEDICARE UPPER PAYMENT
45 LIMITS PROGRAM; TO DELETE THE AUTHORITY FOR THE DIVISION TO
46 CONTRACT WITH THE MISSISSIPPI HOSPITAL ASSOCIATION TO PROVIDE
47 ADMINISTRATIVE SUPPORT FOR THE DISPROPORTIONATE SHARE HOSPITAL
48 PROGRAM AND MEDICARE UPPER PAYMENT LIMITS PROGRAM; TO DELETE THE
49 AUTHORITY OF THE DIVISION TO SET REIMBURSEMENT RATES FOR PERINATAL
50 RISK MANAGEMENT SERVICES IN CONJUNCTION WITH THE STATE DEPARTMENT
51 OF HEALTH; TO DELETE THE EXEMPTION FOR NONEMERGENCY TRANSPORTATION
52 SERVICES FROM THE MANDATORY CO-PAYMENT REQUIREMENT; TO AUTHORIZE

53 MEDICAID REIMBURSEMENT FOR ANNUAL PHYSICAL EXAMINATIONS TO
54 ESTABLISH A BASE-LINE LEVEL OF HEALTH AND TO IDENTIFY A USUAL
55 SOURCE OF CARE IN CONJUNCTION WITH THE ANNUAL REDETERMINATION OF
56 MEDICAID ELIGIBILITY; TO AUTHORIZE THE DIVISION TO PAY ENHANCED
57 REIMBURSEMENT FEES RELATED TO TRAUMA CARE; TO PROVIDE THAT THE
58 FIVE PERCENT REDUCTION IN REIMBURSEMENT RATES SHALL NOT APPLY TO
59 HOME-DELIVERED MEALS PROVIDED UNDER THE HOME- AND COMMUNITY-BASED
60 SERVICES PROGRAM; TO DELETE THE REQUIREMENT THAT PLANNING AND
61 DEVELOPMENT DISTRICTS TRANSFER TO THE DIVISION CERTAIN FUNDS
62 RELATING TO CASE MANAGEMENT SERVICES UNDER THE HOME- AND
63 COMMUNITY-BASED SERVICES PROGRAM; TO AUTHORIZE THE GOVERNOR TO
64 DISCONTINUE ALL OR PART OF OPTIONAL SERVICES IF THE EXPENDITURES
65 OF THE DIVISION DURING THE FIRST SIX MONTHS OF A FISCAL YEAR ARE
66 NOT MORE THAN 12% ABOVE THE AMOUNT AUTHORIZED TO BE EXPENDED
67 DURING THOSE SIX MONTHS; TO REQUIRE THE GOVERNOR TO DISCONTINUE
68 ALL OR PART OF OPTIONAL SERVICES FOR ANY PERIOD NECESSARY TO
69 ENSURE THAT THE EXPENDITURES OF THE DIVISION DURING THE FIRST SIX
70 MONTHS OF A FISCAL YEAR WILL NOT EXCEED THE AMOUNT AUTHORIZED TO
71 BE EXPENDED DURING THOSE SIX MONTHS BY MORE THAN 12%; TO EXTEND
72 THE DATE OF THE AUTOMATIC REPEALER ON THAT SECTION; TO AMEND
73 SECTION 43-13-121, MISSISSIPPI CODE OF 1972, TO DIRECT THE STATE
74 TAX COMMISSION TO WITHHOLD UNREIMBURSED FUNDS FROM THE STATE TAX
75 REFUND OF AN INELIGIBLE MEDICAID RECIPIENT AND PAY THOSE AMOUNTS
76 TO THE DIVISION; TO DIRECT THE STATE TAX COMMISSION TO WITHHOLD
77 THE AMOUNT OF INCORRECTLY MADE PAYMENTS FROM THE STATE TAX REFUND
78 OF A MEDICAID PROVIDER AND PAY THOSE AMOUNTS TO THE DIVISION; TO
79 AMEND SECTION 43-13-125, MISSISSIPPI CODE OF 1972, TO CLARIFY THE
80 RECOVERY OF MEDICAID PAYMENTS FROM THIRD PARTIES AS AN ELEMENT OF
81 DAMAGES; TO AMEND SECTION 43-13-145, MISSISSIPPI CODE OF 1972, TO
82 INCREASE THE ASSESSMENT LEVIED UPON BEDS OF NURSING FACILITIES,
83 ICF-MR FACILITIES AND PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES
84 FOR THE SUPPORT OF THE MEDICAID PROGRAM; TO DELETE THE WAIVER
85 AUTHORITY FOR CERTAIN NONPROFIT CHARITABLE INSTITUTIONS; TO AMEND
86 SECTION 43-13-317, MISSISSIPPI CODE OF 1972, TO CLARIFY THE
87 PROCEDURES FOR RECOVERY OF MEDICAID PAYMENTS FROM THE ESTATE OF A
88 DECEASED RECIPIENT; TO REPEAL SECTION 43-13-141, MISSISSIPPI CODE
89 OF 1972, WHICH PROVIDES FOR AN ASSESSMENT UPON CERTAIN MEDICAID
90 REIMBURSEMENT PAYMENTS TO BE PAID INTO THE MEDICAL CARE ASSESSMENT
91 FUND; TO ESTABLISH THE MISSISSIPPI SENIORS AND INDIGENTS RX
92 PROGRAM IN THE DEPARTMENT OF HUMAN SERVICES; TO PROVIDE THAT THE
93 PURPOSE OF THE PROGRAM IS TO HELP SENIOR CITIZENS AND QUALIFIED
94 INDIGENTS ACCESS PHARMACEUTICAL MANUFACTURERS' DISCOUNT CARDS AND
95 PHARMACEUTICAL ASSISTANCE PROGRAMS AND TO PROVIDE SENIORS AND
96 QUALIFIED INDIGENTS WITH APPLICATIONS FOR THOSE PROGRAMS; TO
97 PROVIDE THAT THE DEPARTMENT SHALL COORDINATE THE OPERATION OF THE
98 PROGRAM WITH OTHER STATE AGENCIES TO MAXIMIZE THE SERVICES
99 AVAILABLE AND MINIMIZE THE PAPERWORK AND INCONVENIENCE TO THE
100 SENIORS AND QUALIFIED INDIGENTS; TO AUTHORIZE THE DEPARTMENT TO
101 DEVELOP, MAINTAIN AND MAKE AVAILABLE AN INTERNET-BASED APPLICATION
102 FORM TO THE GENERAL PUBLIC AND TO THOSE OTHER STATE AGENCIES SO
103 THAT SENIORS AND QUALIFIED INDIGENTS MAY GET APPLICATIONS FOR
104 PHARMACEUTICAL ASSISTANCE PROGRAMS AT THE LOCAL OFFICES OF ANY OF
105 THOSE STATE AGENCIES; TO PROVIDE THAT THE DEPARTMENT SHALL PREPARE
106 AND SUBMIT AN ANNUAL REPORT ON THE PROGRAM TO CERTAIN STATE
107 OFFICIALS; AND FOR RELATED PURPOSES.

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

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

111 43-13-107. (1) The Division of Medicaid is created in the
112 Office of the Governor and established to administer this article
113 and perform such other duties as are prescribed by law.
114 (2) (a) The Governor shall appoint a full-time executive
115 director, with the advice and consent of the Senate, who shall be
116 either (i) a physician with administrative experience in a medical
117 care or health program, or (ii) a person holding a graduate degree
118 in medical care administration, public health, hospital
119 administration, or the equivalent, or (iii) a person holding a
120 bachelor's degree in business administration or hospital
121 administration, with at least ten (10) years' experience in
122 management-level administration of Medicaid programs *** * ***. The
123 executive director shall be the official secretary and legal
124 custodian of the records of the division; shall be the agent of
125 the division for the purpose of receiving all service of process,
126 summons and notices directed to the division; and shall perform
127 such other duties as the Governor may prescribe from time to time.
128 (b) The Governor shall appoint a full-time Deputy
129 Director of Administration, with the advice and consent of the
130 Senate, who shall have at least a bachelor's degree from an
131 accredited college or university, and/or shall possess a special
132 knowledge of Medicaid as pertaining to the State of Mississippi.
133 The Deputy Director of Administration may perform those duties of
134 the executive director that the executive director has not
135 expressly retained for himself.
136 (c) The executive director and the Deputy Director of
137 Administration of the Division of Medicaid shall perform all other
138 duties that are now or may be imposed upon them by law.
139 (d) The terms of office of the executive director and
140 the Deputy Director of Administration shall be concurrent with the
141 terms of the Governor appointing them. In the event of a vacancy,
142 the same shall be filled by the Governor for the unexpired portion
143 of the term in which the vacancy occurs. However, the incumbent

144 executive director and Deputy Director of Administration shall
145 serve until the appointment and qualification of their successors.
146 (e) The executive director and the Deputy Director of
147 Administration shall, before entering upon the discharge of the
148 duties of their offices, take and subscribe to the oath of office
149 prescribed by the Constitution and shall file the same in the
150 Office of the Secretary of State, and each shall execute a bond in
151 some surety company authorized to do business in the state in the
152 penal sum of One Hundred Thousand Dollars ($100,000.00),
153 conditioned for the faithful and impartial discharge of the duties
154 of their offices. The premium on those bonds shall be paid as
155 provided by law out of funds appropriated to the Division of
156 Medicaid for contractual services.
157 (f) The executive director, with the approval of the
158 Governor and subject to the rules and regulations of the State
159 Personnel Board, shall employ such professional, administrative,
160 stenographic, secretarial, clerical and technical assistance as
161 may be necessary to perform the duties required in administering
162 this article and fix the compensation for those persons, all in
163 accordance with a state merit system meeting federal requirements.
164 When the salary of the executive director is not set by law, that
165 salary shall be set by the State Personnel Board. No employees of
166 the Division of Medicaid shall be considered to be staff members
167 of the immediate Office of the Governor; however, the provisions
168 of Section 25-9-107(c)(xv) shall apply to the executive director
169 and other administrative heads of the division.
170 (3) (a) There is established a Medical Care Advisory
171 Committee, which shall be the committee that is required by
172 federal regulation to advise the Division of Medicaid about health
173 and medical care services.
174 (b) The advisory committee shall consist of not less
175 than eleven (11) members, as follows:

176 (i) The Governor shall appoint five (5) members,
177 one (1) from each congressional district and one (1) from the
178 state at large;
179 (ii) The Lieutenant Governor shall appoint three
180 (3) members, one (1) from each Supreme Court district;
181 (iii) The Speaker of the House of Representatives
182 shall appoint three (3) members, one (1) from each Supreme Court
183 district.
184 All members appointed under this paragraph shall either be
185 health care providers or consumers of health care services. One
186 (1) member appointed by each of the appointing authorities shall
187 be a board certified physician.
188 (c) The respective Chairmen of the House Medicaid
189 Committee, the House Public Health and Human Services Committee,
190 the House Appropriations Committee, the Senate Public Health and
191 Welfare Committee and the Senate Appropriations Committee, or
192 their designees, two (2) members of the State Senate appointed by
193 the Lieutenant Governor and one (1) member of the House of
194 Representatives appointed by the Speaker of the House, shall serve
195 as ex officio nonvoting members of the advisory committee.
196 (d) In addition to the committee members required by
197 paragraph (b), the advisory committee shall consist of such other
198 members as are necessary to meet the requirements of the federal
199 regulation applicable to the advisory committee, who shall be
200 appointed as provided in the federal regulation.
201 (e) The chairmanship of the advisory committee shall
202 alternate for twelve-month periods between the Chairmen of the
203 House Medicaid Committee and the Senate Public Health and Welfare
204 Committee.
205 (f) The members of the advisory committee specified in
206 paragraph (b) shall serve for terms that are concurrent with the
207 terms of members of the Legislature, and any member appointed
208 under paragraph (b) may be reappointed to the advisory committee.

209 The members of the advisory committee specified in paragraph (b)
210 shall serve without compensation, but shall receive reimbursement
211 to defray actual expenses incurred in the performance of committee
212 business as authorized by law. Legislators shall receive per diem
213 and expenses, which may be paid from the contingent expense funds
214 of their respective houses in the same amounts as provided for
215 committee meetings when the Legislature is not in session.

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

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

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

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

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

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

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

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

242 providers to participate in the Medicaid program, and advise the
243 division with respect to encouraging physicians and other medical
244 care providers to participate in the Medicaid program;
245 (vi) Provide a written report on or before
246 November 30 of each year to the Governor, Lieutenant Governor and
247 Speaker of the House of Representatives.
248 (4) (a) There is established a Drug Use Review Board, which
249 shall be the board that is required by federal law to:
250 (i) Review and initiate retrospective drug use,
251 review including ongoing periodic examination of claims data and
252 other records in order to identify patterns of fraud, abuse, gross
253 overuse, or inappropriate or medically unnecessary care, among
254 physicians, pharmacists and individuals receiving Medicaid
255 benefits or associated with specific drugs or groups of drugs.
256 (ii) Review and initiate ongoing interventions for
257 physicians and pharmacists, targeted toward therapy problems or
258 individuals identified in the course of retrospective drug use
259 reviews.
260 (iii) On an ongoing basis, assess data on drug use
261 against explicit predetermined standards using the compendia and
262 literature set forth in federal law and regulations.
263 (b) The board shall consist of not less than twelve
264 (12) members appointed by the Governor, or his designee.
265 (c) The board shall meet at least quarterly, and board
266 members shall be furnished written notice of the meetings at least
267 ten (10) days before the date of the meeting.
268 (d) The board meetings shall be open to the public,
269 members of the press, legislators and consumers. Additionally,
270 all documents provided to board members shall be available to
271 members of the Legislature in the same manner, and shall be made
272 available to others for a reasonable fee for copying. However,
273 patient confidentiality and provider confidentiality shall be
274 protected by blinding patient names and provider names with

275 numerical or other anonymous identifiers. The board meetings
276 shall be subject to the Open Meetings Act (Section 25-41-1 et
277 seq.). Board meetings conducted in violation of this section
278 shall be deemed unlawful.
279 (5) (a) There is established a Pharmacy and Therapeutics
280 Committee, which shall be appointed by the Governor, or his
281 designee.
282 (b) The committee shall meet at least quarterly, and
283 committee members shall be furnished written notice of the
284 meetings at least ten (10) days before the date of the meeting.
285 (c) The committee meetings shall be open to the public,
286 members of the press, legislators and consumers. Additionally,
287 all documents provided to committee members shall be available to
288 members of the Legislature in the same manner, and shall be made
289 available to others for a reasonable fee for copying. However,
290 patient confidentiality and provider confidentiality shall be
291 protected by blinding patient names and provider names with
292 numerical or other anonymous identifiers. The committee meetings
293 shall be subject to the Open Meetings Act (Section 25-41-1 et
294 seq.). Committee meetings conducted in violation of this section
295 shall be deemed unlawful.
296 (d) After a thirty-day public notice, the executive
297 director, or his or her designee, shall present the division's
298 recommendation regarding prior approval for a therapeutic class of
299 drugs to the committee. However, in circumstances where the
300 division deems it necessary for the health and safety of Medicaid
301 beneficiaries, the division may present to the committee its
302 recommendations regarding a particular drug without a thirty-day
303 public notice. In making that presentation, the division shall
304 state to the committee the circumstances that precipitate the need
305 for the committee to review the status of a particular drug
306 without a thirty-day public notice. The committee may determine
307 whether or not to review the particular drug under the

308 circumstances stated by the division without a thirty-day public
309 notice. If the committee determines to review the status of the
310 particular drug, it shall make its recommendations to the
311 division, after which the division shall file <u>those</u>
312 recommendations for a thirty-day public comment under the
313 provisions of Section 25-43-7(1).
314 (e) Upon reviewing the information and recommendations,
315 the committee shall forward a written recommendation approved by a
316 majority of the committee to the executive director or his or her
317 designee. The decisions of the committee regarding any
318 limitations to be imposed on any drug or its use for a specified
319 indication shall be based on sound clinical evidence found in
320 labeling, drug compendia, and peer reviewed clinical literature
321 pertaining to use of the drug in the relevant population.
322 (f) Upon reviewing and considering all recommendations
323 including recommendation of the committee, comments, and data, the
324 executive director shall make a final determination whether to
325 require prior approval of a therapeutic class of drugs, or modify
326 existing prior approval requirements for a therapeutic class of
327 drugs.
328 (g) At least thirty (30) days before the executive
329 director implements new or amended prior authorization decisions,
330 written notice of the executive director's decision shall be
331 provided to all prescribing Medicaid providers, all Medicaid
332 enrolled pharmacies, and any other party who has requested the
333 notification. However, notice given under Section 25-43-7(1) will
334 substitute for and meet the requirement for notice under this
335 subsection.
336 <u>(h) Members of the committee shall dispose of matters</u>
337 <u>before the committee in an unbiased and professional manner. If a</u>
338 <u>matter being considered by the committee presents a real or</u>
339 <u>apparent conflict of interest for any member of the committee,</u>
340 <u>that member shall disclose the conflict in writing to the</u>

341 committee chair and recuse himself or herself from any discussions
342 and/or actions on the matter.
343 (6) This section shall stand repealed on July 1, 2007.
344 **SECTION 2.** Section 43-13-115, Mississippi Code of 1972, is
345 amended as follows:
346 43-13-115. Recipients of Medicaid shall be the following
347 persons only:
348 (1) Those who are qualified for public assistance
349 grants under provisions of Title IV-A and E of the federal Social
350 Security Act, as amended, *** * *** including those statutorily deemed
351 to be IV-A and low income families and children under Section 1931
352 of the federal Social Security Act *** * ***. For the purposes of
353 this paragraph (1) and paragraphs (8), (17) and (18) of this
354 section, any reference to Title IV-A or to Part A of Title IV of
355 the federal Social Security Act, as amended, or the state plan
356 under Title IV-A or Part A of Title IV, shall be considered as a
357 reference to Title IV-A of the federal Social Security Act, as
358 amended, and the state plan under Title IV-A, including the income
359 and resource standards and methodologies under Title IV-A and the
360 state plan, as they existed on July 16, 1996. The Department of
361 Human Services shall determine Medicaid eligibility for children
362 receiving public assistance grants under Title IV-E. The division
363 shall determine eligibility for low income families under Section
364 1931 of the federal Social Security Act and shall redetermine
365 eligibility for those continuing under Title IV-A grants.
366 (2) Those qualified for Supplemental Security Income
367 (SSI) benefits under Title XVI of the federal Social Security Act,
368 as amended, and those who are deemed SSI eligible as contained in
369 federal statute. The eligibility of individuals covered in this
370 paragraph shall be determined by the Social Security
371 Administration and certified to the Division of Medicaid.
372 (3) Qualified pregnant women who would be eligible for
373 Medicaid as a low income family member under Section 1931 of the

374 federal Social Security Act if her child were born. The
375 eligibility of the individuals covered under this paragraph shall
376 be determined by the division.
377 (4) [Deleted]
378 (5) A child born on or after October 1, 1984, to a
379 woman eligible for and receiving Medicaid under the state plan on
380 the date of the child's birth shall be deemed to have applied for
381 Medicaid and to have been found eligible for Medicaid under the
382 plan on the date of that birth, and will remain eligible for
383 Medicaid for a period of one (1) year so long as the child is a
384 member of the woman's household and the woman remains eligible for
385 Medicaid or would be eligible for Medicaid if pregnant. The
386 eligibility of individuals covered in this paragraph shall be
387 determined by *** * *** the Division of Medicaid.
388 (6) Children certified by the State Department of Human
389 Services to the Division of Medicaid of whom the state and county
390 departments of human services have custody and financial
391 responsibility, and children who are in adoptions subsidized in
392 full or part by the Department of Human Services, including
393 special needs children in non-Title IV-E adoption assistance, who
394 are approvable under Title XIX of the Medicaid program. The
395 eligibility of the children covered under this paragraph shall be
396 determined by the State Department of Human Services.
397 (7) (a) Persons certified by the Division of Medicaid
398 who are patients in a medical facility (nursing home, hospital,
399 tuberculosis sanatorium or institution for treatment of mental
400 diseases), and who, except for the fact that they are patients in
401 that medical facility, would qualify for grants under Title IV,
402 Supplementary Security Income (SSI) benefits under Title XVI or
403 state supplements, and those aged, blind and disabled persons who
404 would not be eligible for Supplemental Security Income (SSI)
405 benefits under Title XVI or state supplements if they were not
406 institutionalized in a medical facility but whose income is below

407 the maximum standard set by the Division of Medicaid, which
408 standard shall not exceed that prescribed by federal regulation;
409 (b) Individuals who have elected to receive
410 hospice care benefits and who are eligible using the same criteria
411 and special income limits as those in institutions as described in
412 subparagraph (a) of this paragraph (7).
413 (8) Children under eighteen (18) years of age and
414 pregnant women (including those in intact families) who meet the
415 financial standards of the state plan approved under Title IV-A of
416 the federal Social Security Act, as amended. The eligibility of
417 children covered under this paragraph shall be determined by ***
418 the Division of Medicaid.
419 (9) Individuals who are:
420 (a) Children born after September 30, 1983, who
421 have not attained the age of nineteen (19), with family income
422 that does not exceed one hundred percent (100%) of the nonfarm
423 official poverty level;
424 (b) Pregnant women, infants and children who have
425 not attained the age of six (6), with family income that does not
426 exceed one hundred thirty-three percent (133%) of the federal
427 poverty level; and
428 (c) Pregnant women and infants who have not
429 attained the age of one (1), with family income that does not
430 exceed one hundred eighty-five percent (185%) of the federal
431 poverty level.
432 The eligibility of individuals covered in (a), (b) and (c) of
433 this paragraph shall be determined by the division.
434 (10) Certain disabled children age eighteen (18) or
435 under who are living at home, who would be eligible, if in a
436 medical institution, for SSI or a state supplemental payment under
437 Title XVI of the federal Social Security Act, as amended, and
438 therefore for Medicaid under the plan, and for whom the state has
439 made a determination as required under Section 1902(e)(3)(b) of

440 the federal Social Security Act, as amended. The eligibility of
441 individuals under this paragraph shall be determined by the
442 Division of Medicaid * * *.
443 (11) * * *
444 (12) Individuals who are qualified Medicare
445 beneficiaries (QMB) entitled to Part A Medicare as defined under
446 Section 301, Public Law 100-360, known as the Medicare
447 Catastrophic Coverage Act of 1988, and whose income does not
448 exceed one hundred percent (100%) of the nonfarm official poverty
449 level as defined by the Office of Management and Budget and
450 revised annually.
451 The eligibility of individuals covered under this paragraph
452 shall be determined by the Division of Medicaid, and those
453 individuals determined eligible shall receive Medicare
454 cost-sharing expenses only as more fully defined by the Medicare
455 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
456 1997.
457 (13) (a) Individuals who are entitled to Medicare Part
458 A as defined in Section 4501 of the Omnibus Budget Reconciliation
459 Act of 1990, and whose income does not exceed one hundred twenty
460 percent (120%) of the nonfarm official poverty level as defined by
461 the Office of Management and Budget and revised annually.
462 Eligibility for Medicaid benefits is limited to full payment of
463 Medicare Part B premiums.
464 (b) Individuals entitled to Part A of Medicare, with
465 income above one hundred twenty percent (120%), but less than one
466 hundred thirty-five percent (135%) of the federal poverty level,
467 and not otherwise eligible for Medicaid Eligibility for Medicaid
468 benefits is limited to full payment of Medicare Part B premiums.
469 The number of eligible individuals is limited by the availability
470 of the federal capped allocation at one hundred percent (100%) of
471 federal matching funds, as more fully defined in the Balanced
472 Budget Act of 1997.

473 The eligibility of individuals covered under this paragraph
474 shall be determined by the Division of Medicaid.
475 (14) [Deleted]
476 (15) Disabled workers who are eligible to enroll in
477 Part A Medicare as required by Public Law 101-239, known as the
478 Omnibus Budget Reconciliation Act of 1989, and whose income does
479 not exceed two hundred percent (200%) of the federal poverty level
480 as determined in accordance with the Supplemental Security Income
481 (SSI) program. The eligibility of individuals covered under this
482 paragraph shall be determined by the Division of Medicaid and
483 those individuals shall be entitled to buy-in coverage of Medicare
484 Part A premiums only under the provisions of this paragraph (15).
485 (16) In accordance with the terms and conditions of
486 approved Title XIX waiver from the United States Department of
487 Health and Human Services, persons provided home- and
488 community-based services who are physically disabled and certified
489 by the Division of Medicaid as eligible due to applying the income
490 and deeming requirements as if they were institutionalized.
491 (17) In accordance with the terms of the federal
492 Personal Responsibility and Work Opportunity Reconciliation Act of
493 1996 (Public Law 104-193), persons who become ineligible for
494 assistance under Title IV-A of the federal Social Security Act, as
495 amended, because of increased income from or hours of employment
496 of the caretaker relative or because of the expiration of the
497 applicable earned income disregards, who were eligible for
498 Medicaid for at least three (3) of the six (6) months preceding
499 the month in which the ineligibility begins, shall be eligible for
500 Medicaid *** * *** for up to twelve (12) months. The eligibility of
501 the individuals covered under this paragraph shall be determined
502 by the division.
503 (18) Persons who become ineligible for assistance under
504 Title IV-A of the federal Social Security Act, as amended, as a
505 result, in whole or in part, of the collection or increased

506 collection of child or spousal support under Title IV-D of the
507 federal Social Security Act, as amended, who were eligible for
508 Medicaid for at least three (3) of the six (6) months immediately
509 preceding the month in which the ineligibility begins, shall be
510 eligible for Medicaid for an additional four (4) months beginning
511 with the month in which the ineligibility begins. The eligibility
512 of the individuals covered under this paragraph shall be
513 determined by the division.

514 (19) Disabled workers, whose incomes are above the
515 Medicaid eligibility limits, but below two hundred fifty percent
516 (250%) of the federal poverty level, shall be allowed to purchase
517 Medicaid coverage on a sliding fee scale developed by the Division
518 of Medicaid.

519 (20) Medicaid eligible children under age eighteen (18)
520 shall remain eligible for Medicaid benefits until the end of a
521 period of twelve (12) months following an eligibility
522 determination, or until such time that the individual exceeds age
523 eighteen (18).

524 (21) Women of childbearing age whose family income does
525 not exceed one hundred eighty-five percent (185%) of the federal
526 poverty level. The eligibility of individuals covered under this
527 paragraph (21) shall be determined by the Division of Medicaid,
528 and those individuals determined eligible shall only receive
529 family planning services covered under Section 43-13-117(13) and
530 not any other services covered under Medicaid. However, any
531 individual eligible under this paragraph (21) who is also eligible
532 under any other provision of this section shall receive the
533 benefits to which he or she is entitled under that other
534 provision, in addition to family planning services covered under
535 Section 43-13-117(13).

536 The Division of Medicaid shall apply to the United States
537 Secretary of Health and Human Services for a federal waiver of the
538 applicable provisions of Title XIX of the federal Social Security

539 Act, as amended, and any other applicable provisions of federal
540 law as necessary to allow for the implementation of this paragraph
541 (21). The provisions of this paragraph (21) shall be implemented
542 from and after the date that the Division of Medicaid receives the
543 federal waiver.
544 (22) Persons who are workers with a potentially severe
545 disability, as determined by the division, shall be allowed to
546 purchase Medicaid coverage. The term "worker with a potentially
547 severe disability" means a person who is at least sixteen (16)
548 years of age but under sixty-five (65) years of age, who has a
549 physical or mental impairment that is reasonably expected to cause
550 the person to become blind or disabled as defined under Section
551 1614(a) of the federal Social Security Act, as amended, if the
552 person does not receive items and services provided under
553 Medicaid.
554 The eligibility of persons under this paragraph (22) shall be
555 conducted as a demonstration project that is consistent with
556 Section 204 of the Ticket to Work and Work Incentives Improvement
557 Act of 1999, Public Law 106-170, for a certain number of persons
558 as specified by the division. The eligibility of individuals
559 covered under this paragraph (22) shall be determined by the
560 Division of Medicaid.
561 (23) Children certified by the Mississippi Department
562 of Human Services for whom the state and county departments of
563 human services have custody and financial responsibility who are
564 in foster care on their eighteenth birthday as reported by the
565 Mississippi Department of Human Services shall be certified
566 Medicaid eligible by the Division of Medicaid until their
567 twenty-first birthday.
568 (24) Individuals who have not attained age sixty-five
569 (65), are not otherwise covered by creditable coverage as defined
570 in the Public Health Services Act, and have been screened for
571 breast and cervical cancer under the Centers for Disease Control

572 and Prevention Breast and Cervical Cancer Early Detection Program
573 established under Title XV of the Public Health Service Act in
574 accordance with the requirements of that act and who need
575 treatment for breast or cervical cancer. Eligibility of
576 individuals under this paragraph (24) shall be determined by the
577 Division of Medicaid.

578 (25) The division shall apply to the Centers for
579 Medicare and Medicaid Services (CMS) for any necessary waivers to
580 provide services to individuals who are sixty-five (65) years of
581 age or older or are disabled as determined under Section
582 1614(a)(3) of the federal Social Security Act, as amended, and
583 whose income does not exceed one hundred thirty-five percent
584 (135%) of the nonfarm official poverty level as defined by the
585 Office of Management and Budget and revised annually, and whose
586 resources do not exceed those established by the Division of
587 Medicaid, and who are not otherwise covered by Medicare. Nothing
588 contained in this paragraph (25) shall entitle an individual to
589 benefits. The eligibility of individuals covered under this
590 paragraph shall be determined by the Division of Medicaid.

591 (26) The division shall apply to the Centers for
592 Medicare and Medicaid Services (CMS) for any necessary waivers to
593 provide services to individuals who are sixty-five (65) years of
594 age or older or are disabled as determined under Section
595 1614(a)(3) of the federal Social Security Act, as amended, who are
596 end stage renal disease patients on dialysis, cancer patients on
597 chemotherapy or organ transplant recipients on anti-rejection
598 drugs, whose income does not exceed one hundred thirty-five
599 percent (135%) of the nonfarm official poverty level as defined by
600 the Office of Management and Budget and revised annually, and
601 whose resources do not exceed those established by the division.
602 Nothing contained in this paragraph (26) shall entitle an
603 individual to benefits. The eligibility of individuals covered

604 under this paragraph shall be determined by the Division of
605 Medicaid.
606 The division shall redetermine eligibility for all categories
607 of recipients described in each paragraph of this section not less
608 frequently than required by federal law.
609 **SECTION 3.** Section 43-13-117, Mississippi Code of 1972, is
610 amended as follows:
611 43-13-117. Medicaid as authorized by this article shall
612 include payment of part or all of the costs, at the discretion of
613 the division *** * ***, with approval of the Governor, of the
614 following types of care and services rendered to eligible
615 applicants who have been determined to be eligible for that care
616 and services, within the limits of state appropriations and
617 federal matching funds:
618 (1) Inpatient hospital services.
619 (a) The division shall allow thirty (30) days of
620 inpatient hospital care annually for all Medicaid recipients.
621 Precertification of inpatient days must be obtained as required by
622 the division. The division may allow unlimited days in
623 disproportionate hospitals as defined by the division for eligible
624 infants under the age of six (6) years if certified as medically
625 necessary as required by the division.
626 (b) From and after July 1, 1994, the Executive
627 Director of the Division of Medicaid shall amend the Mississippi
628 Title XIX Inpatient Hospital Reimbursement Plan to remove the
629 occupancy rate penalty from the calculation of the Medicaid
630 Capital Cost Component utilized to determine total hospital costs
631 allocated to the Medicaid program.
632 (c) Hospitals will receive an additional payment
633 for the implantable programmable baclofen drug pump used to treat
634 spasticity that is implanted on an inpatient basis. The payment
635 pursuant to written invoice will be in addition to the facility's
636 per diem reimbursement and will represent a reduction of costs on

637 the facility's annual cost report, and shall not exceed Ten
638 Thousand Dollars ($10,000.00) per year per recipient. This
639 subparagraph (c) shall stand repealed on July 1, 2005.
640 (2) Outpatient hospital services. Where the same
641 services are reimbursed as clinic services, the division may
642 revise the rate or methodology of outpatient reimbursement to
643 maintain consistency, efficiency, economy and quality of care.
644 (3) Laboratory and x-ray services.
645 (4) Nursing facility services.
646 (a) The division shall make full payment to
647 nursing facilities for each day, not exceeding fifty-two (52) days
648 per year, that a patient is absent from the facility on home
649 leave. Payment may be made for the following home leave days in
650 addition to the fifty-two-day limitation: Christmas, the day
651 before Christmas, the day after Christmas, Thanksgiving, the day
652 before Thanksgiving and the day after Thanksgiving.
653 (b) From and after July 1, 1997, the division
654 shall implement the integrated case-mix payment and quality
655 monitoring system, which includes the fair rental system for
656 property costs and in which recapture of depreciation is
657 eliminated. The division may reduce the payment for hospital
658 leave and therapeutic home leave days to the lower of the case-mix
659 category as computed for the resident on leave using the
660 assessment being utilized for payment at that point in time, or a
661 case-mix score of 1.000 for nursing facilities, and shall compute
662 case-mix scores of residents so that only services provided at the
663 nursing facility are considered in calculating a facility's per
664 diem.
665 ***
666 (c) From and after July 1, 1997, all state-owned
667 nursing facilities shall be reimbursed on a full reasonable cost
668 basis.

669 (d) When a facility of a category that does not
670 require a certificate of need for construction and that could not
671 be eligible for Medicaid reimbursement is constructed to nursing
672 facility specifications for licensure and certification, and the
673 facility is subsequently converted to a nursing facility under a
674 certificate of need that authorizes conversion only and the
675 applicant for the certificate of need was assessed an application
676 review fee based on capital expenditures incurred in constructing
677 the facility, the division shall allow reimbursement for capital
678 expenditures necessary for construction of the facility that were
679 incurred within the twenty-four (24) consecutive calendar months
680 immediately preceding the date that the certificate of need
681 authorizing the conversion was issued, to the same extent that
682 reimbursement would be allowed for construction of a new nursing
683 facility under a certificate of need that authorizes that
684 construction. The reimbursement authorized in this subparagraph
685 (d) may be made only to facilities the construction of which was
686 completed after June 30, 1989. Before the division shall be
687 authorized to make the reimbursement authorized in this
688 subparagraph (d), the division first must have received approval
689 from the Centers for Medicare and Medicaid Services (CMS) of the
690 change in the state Medicaid plan providing for the reimbursement.
691 (e) The division shall develop and implement, not
692 later than January 1, 2001, a case-mix payment add-on determined
693 by time studies and other valid statistical data that will
694 reimburse a nursing facility for the additional cost of caring for
695 a resident who has a diagnosis of Alzheimer's or other related
696 dementia and exhibits symptoms that require special care. Any
697 such case-mix add-on payment shall be supported by a determination
698 of additional cost. The division shall also develop and implement
699 as part of the fair rental reimbursement system for nursing
700 facility beds, an Alzheimer's resident bed depreciation enhanced
701 reimbursement system that will provide an incentive to encourage

702 nursing facilities to convert or construct beds for residents with
703 Alzheimer's or other related dementia.

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

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

712 (5) Periodic screening and diagnostic services for
713 individuals under age twenty-one (21) years as are needed to
714 identify physical and mental defects and to provide health care
715 treatment and other measures designed to correct or ameliorate
716 defects and physical and mental illness and conditions discovered
717 by the screening services, regardless of whether these services
718 are included in the state plan. The division may include in its
719 periodic screening and diagnostic program those discretionary
720 services authorized under the federal regulations adopted to
721 implement Title XIX of the federal Social Security Act, as
722 amended. The division, in obtaining physical therapy services,
723 occupational therapy services, and services for individuals with
724 speech, hearing and language disorders, may enter into a
725 cooperative agreement with the State Department of Education for
726 the provision of those services to handicapped students by public
727 school districts using state funds that are provided from the
728 appropriation to the Department of Education to obtain federal
729 matching funds through the division. The division, in obtaining
730 medical and psychological evaluations for children in the custody
731 of the State Department of Human Services may enter into a
732 cooperative agreement with the State Department of Human Services
733 for the provision of those services using state funds that are

734 provided from the appropriation to the Department of Human
735 Services to obtain federal matching funds through the division.
736 (6) Physician's services. The division shall allow
737 twelve (12) physician visits annually. All fees for physicians'
738 services that are covered only by Medicaid shall be reimbursed at
739 ninety percent (90%) of the rate established on January 1, 1999,
740 and as adjusted each January thereafter, under Medicare (Title
741 XVIII of the federal Social Security Act, as amended), and which
742 shall in no event be less than seventy percent (70%) of the rate
743 established on January 1, 1994. *** * ***
744 (7) (a) Home health services for eligible persons, not
745 to exceed in cost the prevailing cost of nursing facility
746 services, not to exceed sixty (60) visits per year. All home
747 health visits must be precertified as required by the division.
748 (b) Repealed.
749 (8) Emergency medical transportation services. On
750 January 1, 1994, emergency medical transportation services shall
751 be reimbursed at seventy percent (70%) of the rate established
752 under Medicare (Title XVIII of the federal Social Security Act, as
753 amended). "Emergency medical transportation services" shall mean,
754 but shall not be limited to, the following services by a properly
755 permitted ambulance operated by a properly licensed provider in
756 accordance with the Emergency Medical Services Act of 1974
757 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
758 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
759 (vi) disposable supplies, (vii) similar services.
760 (9) (a) Legend and other drugs as may be determined by
761 the division. The division shall establish a mandatory preferred
762 drug list. Drugs not on the mandatory preferred drug list shall
763 be made available by utilizing prior authorization procedures
764 established by the division. The division may seek to establish
765 relationships with other states in order to lower acquisition
766 costs of prescription drugs to include single source and innovator

767 multiple source drugs or generic drugs. In addition, if allowed
768 by federal law or regulation, the division may seek to establish
769 relationships with and negotiate with other countries to
770 facilitate the acquisition of prescription drugs to include single
771 source and innovator multiple source drugs or generic drugs, if
772 that will lower the acquisition costs of those prescription drugs.
773 The division shall allow for a combination of prescriptions for
774 single source and innovator multiple source drugs and generic
775 drugs to meet the needs of the beneficiaries, not to exceed four
776 (4) prescriptions for single source or innovator multiple source
777 drugs per month for each noninstitutionalized Medicaid
778 beneficiary. The division shall allow for unlimited prescriptions
779 for generic drugs. The division shall establish a prior
780 authorization process under which the division may allow more than
781 four (4) prescriptions for single source or innovator multiple
782 source drugs per month for those beneficiaries whose conditions
783 require a medical regimen that will not be covered by the
784 combination of prescriptions for single source and innovator
785 multiple source drugs and generic drugs that are otherwise allowed
786 under this paragraph (9). The voluntary preferred drug list shall
787 be expanded to function in the interim in order to have a
788 manageable prior authorization system, thereby minimizing
789 disruption of service to beneficiaries. The division shall not
790 reimburse for any portion of a prescription that exceeds a
791 thirty-four-day supply of the drug based on the daily dosage.
792 * * *
793 The division shall develop and implement a program of payment
794 for additional pharmacist services, with payment to be based on
795 demonstrated savings, but in no case shall the total payment
796 exceed twice the amount of the dispensing fee.
797 All claims for drugs for dually eligible Medicare/Medicaid
798 beneficiaries that are paid for by Medicare must be submitted to

799 Medicare for payment before they may be processed by the
800 division's on-line payment system.
801 The division shall develop a pharmacy policy in which drugs
802 in tamper-resistant packaging that are prescribed for a resident
803 of a nursing facility but are not dispensed to the resident shall
804 be returned to the pharmacy and not billed to Medicaid, in
805 accordance with guidelines of the State Board of Pharmacy.
806 The division shall develop and implement a program that
807 requires Medicaid providers who prescribe drugs to use a
808 counterfeit-proof prescription pad for Medicaid prescriptions for
809 controlled substances; however, this shall not prevent the filling
810 of prescriptions for controlled substances by means of electronic
811 communications between a prescriber and pharmacist as allowed by
812 federal law.
813 (b) Payment by the division for covered
814 multisource drugs shall be limited to the lower of the upper
815 limits established and published by the Centers for Medicare and
816 Medicaid Services (CMS) plus a dispensing fee, or the estimated
817 acquisition cost (EAC) as determined by the division, plus a
818 dispensing fee, or the providers' usual and customary charge to
819 the general public.
820 Payment for other covered drugs, other than multisource drugs
821 with CMS upper limits, shall not exceed the lower of the estimated
822 acquisition cost as determined by the division, plus a dispensing
823 fee or the providers' usual and customary charge to the general
824 public.
825 Payment for nonlegend or over-the-counter drugs covered by
826 the division shall be reimbursed at the lower of the division's
827 estimated shelf price or the providers' usual and customary charge
828 to the general public.
829 The dispensing fee for each new or refill prescription,
830 including nonlegend or over-the-counter drugs covered by the

831 division, shall be not less than Three Dollars and Ninety-one
832 Cents ($3.91), as determined by the division.
833 * * * The division shall not reimburse for single source or
834 innovator multiple source drugs if there are equally effective
835 generic equivalents available and if the generic equivalents are
836 the least expensive.
837 * * *
838 It is the intent of the Legislature that the pharmacists
839 providers be reimbursed for the reasonable costs of filling and
840 dispensing prescriptions for Medicaid beneficiaries.
841 (10) Dental care that is an adjunct to treatment of an
842 acute medical or surgical condition; services of oral surgeons and
843 dentists in connection with surgery related to the jaw or any
844 structure contiguous to the jaw or the reduction of any fracture
845 of the jaw or any facial bone; and emergency dental extractions
846 and treatment related thereto. On July 1, 1999, all fees for
847 dental care and surgery under authority of this paragraph (10)
848 shall be increased to one hundred sixty percent (160%) of the
849 amount of the reimbursement rate that was in effect on June 30,
850 1999. It is the intent of the Legislature to encourage more
851 dentists to participate in the Medicaid program.
852 (11) Eyeglasses for all Medicaid beneficiaries who have
853 (a) had surgery on the eyeball or ocular muscle that results in a
854 vision change for which eyeglasses or a change in eyeglasses is
855 medically indicated within six (6) months of the surgery and is in
856 accordance with policies established by the division, or (b) one
857 (1) pair every five (5) years and in accordance with policies
858 established by the division. In either instance, the eyeglasses
859 must be prescribed by a physician skilled in diseases of the eye
860 or an optometrist, whichever the beneficiary may select.
861 (12) Intermediate care facility services.
862 (a) The division shall make full payment to all
863 intermediate care facilities for the mentally retarded for each

864 day, not exceeding eighty-four (84) days per year, that a patient
865 is absent from the facility on home leave. Payment may be made
866 for the following home leave days in addition to the
867 eighty-four-day limitation: Christmas, the day before Christmas,
868 the day after Christmas, Thanksgiving, the day before Thanksgiving
869 and the day after Thanksgiving.
870 (b) All state-owned intermediate care facilities
871 for the mentally retarded shall be reimbursed on a full reasonable
872 cost basis.
873 (13) Family planning services, including drugs,
874 supplies and devices, when those services are under the
875 supervision of a physician <u>or nurse practitioner</u>.
876 (14) Clinic services. Such diagnostic, preventive,
877 therapeutic, rehabilitative or palliative services furnished to an
878 outpatient by or under the supervision of a physician or dentist
879 in a facility that is not a part of a hospital but that is
880 organized and operated to provide medical care to outpatients.
881 Clinic services shall include any services reimbursed as
882 outpatient hospital services that may be rendered in such a
883 facility, including those that become so after July 1, 1991. On
884 July 1, 1999, all fees for physicians' services reimbursed under
885 authority of this paragraph (14) shall be reimbursed at ninety
886 percent (90%) of the rate established on January 1, 1999, and as
887 adjusted each January thereafter, under Medicare (Title XVIII of
888 the <u>federal</u> Social Security Act, as amended), and which shall in
889 no event be less than seventy percent (70%) of the rate
890 established on January 1, 1994. *** * *** On July 1, 1999, all fees
891 for dentists' services reimbursed under authority of this
892 paragraph (14) shall be increased to one hundred sixty percent
893 (160%) of the amount of the reimbursement rate that was in effect
894 on June 30, 1999.
895 (15) Home- and community-based services for the elderly
896 and disabled, as provided under Title XIX of the federal Social

897 Security Act, as amended, under waivers, subject to the
898 availability of funds specifically appropriated <u>for that purpose</u>
899 by the Legislature.
900 (16) Mental health services. Approved therapeutic and
901 case management services (a) provided by an approved regional
902 mental health/retardation center established under Sections
903 41-19-31 through 41-19-39, or by another community mental health
904 service provider meeting the requirements of the Department of
905 Mental Health to be an approved mental health/retardation center
906 if determined necessary by the Department of Mental Health, using
907 state funds that are provided from the appropriation to the State
908 Department of Mental Health and/or funds transferred to the
909 department by a political subdivision or instrumentality of the
910 state and used to match federal funds under a cooperative
911 agreement between the division and the department, or (b) provided
912 by a facility that is certified by the State Department of Mental
913 Health to provide therapeutic and case management services, to be
914 reimbursed on a fee for service basis, or (c) provided in the
915 community by a facility or program operated by the Department of
916 Mental Health. Any such services provided by a facility described
917 in subparagraph (b) must have the prior approval of the division
918 to be reimbursable under this section. After June 30, 1997,
919 mental health services provided by regional mental
920 health/retardation centers established under Sections 41-19-31
921 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
922 and/or their subsidiaries and divisions, or by psychiatric
923 residential treatment facilities as defined in Section 43-11-1, or
924 by another community mental health service provider meeting the
925 requirements of the Department of Mental Health to be an approved
926 mental health/retardation center if determined necessary by the
927 Department of Mental Health, shall not be included in or provided
928 under any capitated managed care pilot program provided for under
929 paragraph (24) of this section.

930 (17) Durable medical equipment services and medical
931 supplies. Precertification of durable medical equipment and
932 medical supplies must be obtained as required by the division.
933 The Division of Medicaid may require durable medical equipment
934 providers to obtain a surety bond in the amount and to the
935 specifications as established by the Balanced Budget Act of 1997.
936 (18) (a) Notwithstanding any other provision of this
937 section to the contrary, the division shall make additional
938 reimbursement to hospitals that serve a disproportionate share of
939 low-income patients and that meet the federal requirements for
940 those payments as provided in Section 1923 of the federal Social
941 Security Act and any applicable regulations. However, from and
942 after January 1, 1999, no public hospital shall participate in the
943 Medicaid disproportionate share program unless the public hospital
944 participates in an intergovernmental transfer program as provided
945 in Section 1903 of the federal Social Security Act and any
946 applicable regulations. *** * ***
947 (b) The division shall establish a Medicare Upper
948 Payment Limits Program, as defined in Section 1902(a)(30) of the
949 federal Social Security Act and any applicable federal
950 regulations, for hospitals, and may establish a Medicare Upper
951 Payments Limits Program for nursing facilities. The division
952 shall assess each hospital and, if the program is established for
953 nursing facilities, shall assess each nursing facility, *** * ***
954 based on Medicaid utilization or other appropriate method
955 consistent with federal regulations. The assessment will remain
956 in effect as long as the state participates in the Medicare Upper
957 Payment Limits Program. The division shall make additional
958 reimbursement to hospitals and, if the program is established for
959 nursing facilities, shall make additional reimbursement to nursing
960 facilities, for the Medicare Upper Payment Limits, as defined in
961 Section 1902(a)(30) of the federal Social Security Act and any

962 applicable federal regulations. This subparagraph (b) shall stand
963 repeated from and after July 1, 2005.
964 * * *
965 (19) (a) Perinatal risk management services. The
966 division shall promulgate regulations to be effective from and
967 after October 1, 1988, to establish a comprehensive perinatal
968 system for risk assessment of all pregnant and infant Medicaid
969 recipients and for management, education and follow-up for those
970 who are determined to be at risk. Services to be performed
971 include case management, nutrition assessment/counseling,
972 psychosocial assessment/counseling and health education. * * *
973 (b) Early intervention system services. The
974 division shall cooperate with the State Department of Health,
975 acting as lead agency, in the development and implementation of a
976 statewide system of delivery of early intervention services, under
977 Part C of the Individuals with Disabilities Education Act (IDEA).
978 The State Department of Health shall certify annually in writing
979 to the executive director of the division the dollar amount of
980 state early intervention funds available that will be utilized as
981 a certified match for Medicaid matching funds. Those funds then
982 shall be used to provide expanded targeted case management
983 services for Medicaid eligible children with special needs who are
984 eligible for the state's early intervention system.
985 Qualifications for persons providing service coordination shall be
986 determined by the State Department of Health and the Division of
987 Medicaid.
988 (20) Home- and community-based services for physically
989 disabled approved services as allowed by a waiver from the United
990 States Department of Health and Human Services for home- and
991 community-based services for physically disabled people using
992 state funds that are provided from the appropriation to the State
993 Department of Rehabilitation Services and used to match federal
994 funds under a cooperative agreement between the division and the

995 department, provided that funds for these services are
996 specifically appropriated to the Department of Rehabilitation
997 Services.

998 (21) Nurse practitioner services. Services furnished
999 by a registered nurse who is licensed and certified by the
1000 Mississippi Board of Nursing as a nurse practitioner, including,
1001 but not limited to, nurse anesthetists, nurse midwives, family
1002 nurse practitioners, family planning nurse practitioners,
1003 pediatric nurse practitioners, obstetrics-gynecology nurse
1004 practitioners and neonatal nurse practitioners, under regulations
1005 adopted by the division. Reimbursement for those services shall
1006 not exceed ninety percent (90%) of the reimbursement rate for
1007 comparable services rendered by a physician.

1008 (22) Ambulatory services delivered in federally
1009 qualified health centers, rural health centers and clinics of the
1010 local health departments of the State Department of Health for
1011 individuals eligible for Medicaid under this article based on
1012 reasonable costs as determined by the division.

1013 (23) Inpatient psychiatric services. Inpatient
1014 psychiatric services to be determined by the division for
1015 recipients under age twenty-one (21) that are provided under the
1016 direction of a physician in an inpatient program in a licensed
1017 acute care psychiatric facility or in a licensed psychiatric
1018 residential treatment facility, before the recipient reaches age
1019 twenty-one (21) or, if the recipient was receiving the services
1020 immediately before he or she reached age twenty-one (21), before
1021 the earlier of the date he or she no longer requires the services
1022 or the date he or she reaches age twenty-two (22), as provided by
1023 federal regulations. Precertification of inpatient days and
1024 residential treatment days must be obtained as required by the
1025 division.

1026 (24) [Deleted]

1027 (25) [Deleted]

1028 (26) Hospice care. As used in this paragraph, the term
1029 "hospice care" means a coordinated program of active professional
1030 medical attention within the home and outpatient and inpatient
1031 care that treats the terminally ill patient and family as a unit,
1032 employing a medically directed interdisciplinary team. The
1033 program provides relief of severe pain or other physical symptoms
1034 and supportive care to meet the special needs arising out of
1035 physical, psychological, spiritual, social and economic stresses
1036 that are experienced during the final stages of illness and during
1037 dying and bereavement and meets the Medicare requirements for
1038 participation as a hospice as provided in federal regulations.
1039 (27) Group health plan premiums and cost sharing if it
1040 is cost effective as defined by the United States Secretary of
1041 Health and Human Services.
1042 (28) Other health insurance premiums that are cost
1043 effective as defined by the United States Secretary of Health and
1044 Human Services. Medicare eligible must have Medicare Part B
1045 before other insurance premiums can be paid.
1046 (29) The Division of Medicaid may apply for a waiver
1047 from the United States Department of Health and Human Services for
1048 home- and community-based services for developmentally disabled
1049 people using state funds that are provided from the appropriation
1050 to the State Department of Mental Health and/or funds transferred
1051 to the department by a political subdivision or instrumentality of
1052 the state and used to match federal funds under a cooperative
1053 agreement between the division and the department, provided that
1054 funds for these services are specifically appropriated to the
1055 Department of Mental Health and/or transferred to the department
1056 by a political subdivision or instrumentality of the state.
1057 (30) Pediatric skilled nursing services for eligible
1058 persons under twenty-one (21) years of age.
1059 (31) Targeted case management services for children
1060 with special needs, under waivers from the United States

1061 Department of Health and Human Services, using state funds that
1062 are provided from the appropriation to the Mississippi Department
1063 of Human Services and used to match federal funds under a
1064 cooperative agreement between the division and the department.

1065 (32) Care and services provided in Christian Science
1066 Sanatoria listed and certified by the Commission for Accreditation
1067 of Christian Science Nursing Organizations/Facilities, Inc.,
1068 rendered in connection with treatment by prayer or spiritual means
1069 to the extent that those services are subject to reimbursement
1070 under Section 1903 of the federal Social Security Act.

1071 (33) Podiatrist services.

1072 (34) Assisted living services as provided through home-
1073 and community-based services under Title XIX of the federal Social
1074 Security Act, as amended, subject to the availability of funds
1075 specifically appropriated for that purpose by the Legislature.

1076 (35) Services and activities authorized in Sections
1077 43-27-101 and 43-27-103, using state funds that are provided from
1078 the appropriation to the State Department of Human Services and
1079 used to match federal funds under a cooperative agreement between
1080 the division and the department.

1081 (36) Nonemergency transportation services for
1082 Medicaid-eligible persons, to be provided by the Division of
1083 Medicaid. The division may contract with additional entities to
1084 administer nonemergency transportation services as it deems
1085 necessary. All providers shall have a valid driver's license,
1086 vehicle inspection sticker, valid vehicle license tags and a
1087 standard liability insurance policy covering the vehicle. The
1088 division may pay providers a flat fee based on mileage tiers, or
1089 in the alternative, may reimburse on actual miles traveled. The
1090 division may apply to the Center for Medicare and Medicaid
1091 Services (CMS) for a waiver to draw federal matching funds for
1092 nonemergency transportation services as a covered service instead
1093 of an administrative cost.

1094 (37) [Deleted]
1095 (38) Chiropractic services. A chiropractor's manual
1096 manipulation of the spine to correct a subluxation, if x-ray
1097 demonstrates that a subluxation exists and if the subluxation has
1098 resulted in a neuromusculoskeletal condition for which
1099 manipulation is appropriate treatment, and related spinal x-rays
1100 performed to document these conditions. Reimbursement for
1101 chiropractic services shall not exceed Seven Hundred Dollars
1102 ($700.00) per year per beneficiary.
1103 (39) Dually eligible Medicare/Medicaid beneficiaries.
1104 The division shall pay the Medicare deductible and coinsurance
1105 amounts for services available under Medicare, as determined by
1106 the division.
1107 (40) [Deleted]
1108 (41) Services provided by the State Department of
1109 Rehabilitation Services for the care and rehabilitation of persons
1110 with spinal cord injuries or traumatic brain injuries, as allowed
1111 under waivers from the United States Department of Health and
1112 Human Services, using up to seventy-five percent (75%) of the
1113 funds that are appropriated to the Department of Rehabilitation
1114 Services from the Spinal Cord and Head Injury Trust Fund
1115 established under Section 37-33-261 and used to match federal
1116 funds under a cooperative agreement between the division and the
1117 department.
1118 (42) Notwithstanding any other provision in this
1119 article to the contrary, the division may develop a population
1120 health management program for women and children health services
1121 through the age of one (1) year. This program is primarily for
1122 obstetrical care associated with low birth weight and pre-term
1123 babies. The division may apply to the federal Centers for
1124 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
1125 any other waivers that may enhance the program. In order to
1126 effect cost savings, the division may develop a revised payment

1127 methodology that may include at-risk capitated payments, and may
1128 require member participation in accordance with the terms and
1129 conditions of an approved federal waiver.
1130 (43) The division shall provide reimbursement,
1131 according to a payment schedule developed by the division, for
1132 smoking cessation medications for pregnant women during their
1133 pregnancy and other Medicaid-eligible women who are of
1134 child-bearing age.
1135 (44) Nursing facility services for the severely
1136 disabled.
1137 (a) Severe disabilities include, but are not
1138 limited to, spinal cord injuries, closed head injuries and
1139 ventilator dependent patients.
1140 (b) Those services must be provided in a long-term
1141 care nursing facility dedicated to the care and treatment of
1142 persons with severe disabilities, and shall be reimbursed as a
1143 separate category of nursing facilities.
1144 (45) Physician assistant services. Services furnished
1145 by a physician assistant who is licensed by the State Board of
1146 Medical Licensure and is practicing with physician supervision
1147 under regulations adopted by the board, under regulations adopted
1148 by the division. Reimbursement for those services shall not
1149 exceed ninety percent (90%) of the reimbursement rate for
1150 comparable services rendered by a physician.
1151 (46) The division shall make application to the federal
1152 Centers for Medicare and Medicaid Services (CMS) for a waiver to
1153 develop and provide services for children with serious emotional
1154 disturbances as defined in Section 43-14-1(1), which may include
1155 home- and community-based services, case management services or
1156 managed care services through mental health providers certified by
1157 the Department of Mental Health. The division may implement and
1158 provide services under this waivered program only if funds for
1159 these services are specifically appropriated for this purpose by

1160 the Legislature, or if funds are voluntarily provided by affected
1161 agencies.
1162 (47) (a) Notwithstanding any other provision in this
1163 article to the contrary, the division, in conjunction with the
1164 State Department of Health, shall develop and implement disease
1165 management programs for individuals with asthma, diabetes or
1166 hypertension, including the use of grants, waivers, demonstrations
1167 or other projects as necessary.
1168 (b) Participation in any disease management
1169 program implemented under this paragraph (47) is optional with the
1170 individual. An individual must affirmatively elect to participate
1171 in the disease management program in order to participate.
1172 (c) An individual who participates in the disease
1173 management program has the option of participating in the
1174 prescription drug home delivery component of the program at any
1175 time while participating in the program. An individual must
1176 affirmatively elect to participate in the prescription drug home
1177 delivery component in order to participate.
1178 (d) An individual who participates in the disease
1179 management program may elect to discontinue participation in the
1180 program at any time. An individual who participates in the
1181 prescription drug home delivery component may elect to discontinue
1182 participation in the prescription drug home delivery component at
1183 any time.
1184 (e) The division shall send written notice to all
1185 individuals who participate in the disease management program
1186 informing them that they may continue using their local pharmacy
1187 or any other pharmacy of their choice to obtain their prescription
1188 drugs while participating in the program.
1189 (f) Prescription drugs that are provided to
1190 individuals under the prescription drug home delivery component
1191 shall be limited only to those drugs that are used for the
1192 treatment, management or care of asthma, diabetes or hypertension.

1193 (48) Pediatric long-term acute care hospital services.
1194 (a) Pediatric long-term acute care hospital
1195 services means services provided to eligible persons under
1196 twenty-one (21) years of age by a freestanding Medicare-certified
1197 hospital that has an average length of inpatient stay greater than
1198 twenty-five (25) days and that is primarily engaged in providing
1199 chronic or long-term medical care to persons under twenty-one (21)
1200 years of age.
1201 (b) The services under this paragraph (48) shall
1202 be reimbursed as a separate category of hospital services.
1203 (49) The division shall establish co-payments and/or
1204 coinsurance for all Medicaid services for which co-payments and/or
1205 coinsurance are allowable under federal law or regulation, *** * ***
1206 and shall set the amount of the co-payment and/or coinsurance for
1207 each of those services at the maximum amount allowable under
1208 federal law or regulation.
1209 (50) Services provided by the State Department of
1210 Rehabilitation Services for the care and rehabilitation of persons
1211 who are deaf and blind, as allowed under waivers from the United
1212 States Department of Health and Human Services to provide home-
1213 and community-based services using state funds that are provided
1214 from the appropriation to the State Department of Rehabilitation
1215 Services or if funds are voluntarily provided by another agency.
1216 (51) Upon determination of Medicaid eligibility and in
1217 association with annual redetermination of Medicaid eligibility,
1218 beneficiaries shall be encouraged to undertake a physical
1219 examination that will establish a base-line level of health and
1220 identification of a usual and customary source of care (a medical
1221 home) to aid utilization of disease management tools. This
1222 physical examination and utilization of these disease management
1223 tools shall be consistent with current United States Preventive
1224 Services Task Force or other recognized authority recommendations.

1225 For persons who are determined ineligible for Medicaid, the
1226 division will provide information and direction for accessing
1227 medical care and services in the area of their residence.
1228 (52) Notwithstanding any provisions of this article,
1229 the division may pay enhanced reimbursement fees related to trauma
1230 care, as determined by the division in conjunction with the State
1231 Department of Health, using funds appropriated to the State
1232 Department of Health for trauma care and services and used to
1233 match federal funds under a cooperative agreement between the
1234 division and the State Department of Health. The division, in
1235 conjunction with the State Department of Health, may use grants,
1236 waivers, demonstrations, or other projects as necessary in the
1237 development and implementation of this reimbursement program.
1238 Notwithstanding any other provision of this article to the
1239 contrary, the division shall reduce the rate of reimbursement to
1240 providers for any service provided under this section by five
1241 percent (5%) of the allowed amount for that service. However, the
1242 reduction in the reimbursement rates required by this paragraph
1243 shall not apply to inpatient hospital services, nursing facility
1244 services, intermediate care facility services, psychiatric
1245 residential treatment facility services, pharmacy services
1246 provided under paragraph (9) of this section, or any service
1247 provided by the University of Mississippi Medical Center or a
1248 state agency, a state facility or a public agency that either
1249 provides its own state match through intergovernmental transfer or
1250 certification of funds to the division, or a service for which the
1251 federal government sets the reimbursement methodology and rate.
1252 In addition, the reduction in the reimbursement rates required by
1253 this paragraph shall not apply to case management services and
1254 home-delivered meals provided under the home- and community-based
1255 services program for the elderly and disabled by a planning and
1256 development district (PDD). Planning and development districts
1257 participating in the home- and community-based services program

1258 for the elderly and disabled as case management providers shall be
1259 reimbursed for case management services at the maximum rate
1260 approved by the Centers for Medicare and Medicaid Services
1261 (CMS). ***
1262 The division may pay to those providers who participate in
1263 and accept patient referrals from the division's emergency room
1264 redirection program a percentage, as determined by the division,
1265 of savings achieved according to the performance measures and
1266 reduction of costs required of that program.
1267 Notwithstanding any provision of this article, except as
1268 authorized in the following paragraph and in Section 43-13-139,
1269 neither (a) the limitations on quantity or frequency of use of or
1270 the fees or charges for any of the care or services available to
1271 recipients under this section, nor (b) the payments or rates of
1272 reimbursement to providers rendering care or services authorized
1273 under this section to recipients, may be increased, decreased or
1274 otherwise changed from the levels in effect on July 1, 1999,
1275 unless they are authorized by an amendment to this section by the
1276 Legislature. However, the restriction in this paragraph shall not
1277 prevent the division from changing the payments or rates of
1278 reimbursement to providers without an amendment to this section
1279 whenever those changes are required by federal law or regulation,
1280 or whenever those changes are necessary to correct administrative
1281 errors or omissions in calculating those payments or rates of
1282 reimbursement.
1283 Notwithstanding any provision of this article, no new groups
1284 or categories of recipients and new types of care and services may
1285 be added without enabling legislation from the Mississippi
1286 Legislature, except that the division may authorize those changes
1287 without enabling legislation when the addition of recipients or
1288 services is ordered by a court of proper authority. The executive
1289 director shall keep the Governor advised on a timely basis of the
1290 funds available for expenditure and the projected expenditures.

1291 If current or projected expenditures of the division during the
1292 first six (6) months of any fiscal year are reasonably anticipated
1293 to be not more than twelve percent (12%) above the amount of the
1294 appropriated funds that is authorized to be expended during the
1295 first allotment period of the fiscal year, the Governor, after
1296 consultation with the executive director, may discontinue any or
1297 all of the payment of the types of care and services as provided
1298 in this section that are deemed to be optional services under
1299 Title XIX of the federal Social Security Act, as amended, and when
1300 necessary may institute any other cost containment measures on any
1301 program or programs authorized under the article to the extent
1302 allowed under the federal law governing that program or programs.
1303 If current or projected expenditures of the division during the
1304 first six (6) months of any fiscal year can be reasonably
1305 anticipated to exceed the amount of the appropriated funds that is
1306 authorized to be expended during the first allotment period of the
1307 fiscal year by more than twelve percent (12%), the Governor, after
1308 consultation with the executive director, shall discontinue any or
1309 all of the payment of the types of care and services as provided
1310 in this section that are deemed to be optional services under
1311 Title XIX of the federal Social Security Act, as amended, for any
1312 period necessary to ensure that the actual expenditures of the
1313 division will not exceed the amount of the appropriated funds that
1314 is authorized to be expended during the first allotment period of
1315 the fiscal year by more than twelve percent (12%), and when
1316 necessary shall institute any other cost containment measures on
1317 any program or programs authorized under the article to the extent
1318 allowed under the federal law governing that program or programs.
1319 If current or projected expenditures of the division during the
1320 last six (6) months of any fiscal year can be reasonably
1321 anticipated to exceed the amount of the appropriated funds that is
1322 authorized to be expended during the second allotment period of
1323 the fiscal year, the Governor, after consultation with the

1324 executive director, shall discontinue any or all of the payment of
1325 the types of care and services as provided in this section that
1326 are deemed to be optional services under Title XIX of the federal
1327 Social Security Act, as amended, for any period necessary to
1328 ensure that the actual expenditures of the division will not
1329 exceed the amount of the appropriated funds that is authorized to
1330 be expended during the second allotment period of the fiscal year,
1331 and when necessary shall institute any other cost containment
1332 measures on any program or programs authorized under the article
1333 to the extent allowed under the federal law governing that program
1334 or programs. It is the intent of the Legislature that the
1335 expenditures of the division during any fiscal year shall not
1336 exceed the amounts appropriated to the division for that fiscal
1337 year.

1338 Notwithstanding any other provision of this article, it shall
1339 be the duty of each nursing facility, intermediate care facility
1340 for the mentally retarded, psychiatric residential treatment
1341 facility, and nursing facility for the severely disabled that is
1342 participating in the Medicaid program to keep and maintain books,
1343 documents and other records as prescribed by the Division of
1344 Medicaid in substantiation of its cost reports for a period of
1345 three (3) years after the date of submission to the Division of
1346 Medicaid of an original cost report, or three (3) years after the
1347 date of submission to the Division of Medicaid of an amended cost
1348 report.

1349 This section shall stand repealed on July 1, 2007.

1350 **SECTION 4.** Section 43-13-121, Mississippi Code of 1972, is
1351 amended as follows:

1352 43-13-121. (1) The division shall administer the Medicaid
1353 program under the provisions of this article, and may do the
1354 following:

1355 (a) Adopt and promulgate reasonable rules, regulations
1356 and standards, with approval of the Governor, and in accordance
1357 with the Administrative Procedures Law, Section 25-43-1 et seq.:
1358 (i) Establishing methods and procedures as may be
1359 necessary for the proper and efficient administration of this
1360 article;
1361 (ii) Providing Medicaid to all qualified
1362 recipients under the provisions of this article as the division
1363 may determine and within the limits of appropriated funds;
1364 (iii) Establishing reasonable fees, charges and
1365 rates for medical services and drugs; in doing so, the division
1366 shall fix all of those fees, charges and rates at the minimum
1367 levels absolutely necessary to provide the medical assistance
1368 authorized by this article, and shall not change any of those
1369 fees, charges or rates except as may be authorized in Section
1370 43-13-117;
1371 (iv) Providing for fair and impartial hearings;
1372 (v) Providing safeguards for preserving the
1373 confidentiality of records; and
1374 (vi) For detecting and processing fraudulent
1375 practices and abuses of the program;
1376 (b) Receive and expend state, federal and other funds
1377 in accordance with court judgments or settlements and agreements
1378 between the State of Mississippi and the federal government, the
1379 rules and regulations promulgated by the division, with the
1380 approval of the Governor, and within the limitations and
1381 restrictions of this article and within the limits of funds
1382 available for that purpose;
1383 (c) Subject to the limits imposed by this article, to
1384 submit a Medicaid plan to the United States Department of Health
1385 and Human Services for approval under the provisions of the
1386 federal Social Security Act, to act for the state in making
1387 negotiations relative to the submission and approval of that plan,

1388 to make such arrangements, not inconsistent with the law, as may
1389 be required by or under federal law to obtain and retain that
1390 approval and to secure for the state the benefits of the
1391 provisions of that law.

1392 No agreements, specifically including the general plan for
1393 the operation of the Medicaid program in this state, shall be made
1394 by and between the division and the United States Department of
1395 Health and Human Services unless the Attorney General of the State
1396 of Mississippi has reviewed the agreements, specifically including
1397 the operational plan, and has certified in writing to the Governor
1398 and to the executive director of the division that the agreements,
1399 including the plan of operation, have been drawn strictly in
1400 accordance with the terms and requirements of this article;

1401 (d) In accordance with the purposes and intent of this
1402 article and in compliance with its provisions, provide for aged
1403 persons otherwise eligible for the benefits provided under Title
1404 XVIII of the federal Social Security Act by expenditure of funds
1405 available for those purposes;

1406 (e) To make reports to the United States Department of
1407 Health and Human Services as from time to time may be required by
1408 that federal department and to the Mississippi Legislature as
1409 provided in this section;

1410 (f) Define and determine the scope, duration and amount
1411 of Medicaid that may be provided in accordance with this article
1412 and establish priorities therefor in conformity with this article;

1413 (g) Cooperate and contract with other state agencies
1414 for the purpose of coordinating Medicaid provided under this
1415 article and eliminating duplication and inefficiency in the
1416 Medicaid program;

1417 (h) Adopt and use an official seal of the division;

1418 (i) Sue in its own name on behalf of the State of
1419 Mississippi and employ legal counsel on a contingency basis with
1420 the approval of the Attorney General;

1421 (j) To recover any and all payments incorrectly made by
1422 the division * * * to a recipient or provider from the recipient
1423 or provider receiving the payments. To recover those payments,
1424 the division may use the following methods, in addition to any
1425 other methods available to the division:
1426 (i) The division shall report to the State Tax
1427 Commission the name of any current or former Medicaid recipient
1428 who has received medical services rendered during a period of
1429 established Medicaid ineligibility and who has not reimbursed the
1430 division for the related medical service payment(s). The State
1431 Tax Commission shall withhold from the state tax refund of the
1432 individual, and pay to the division, the amount of the payment(s)
1433 for medical services rendered to the ineligible individual that
1434 have not been reimbursed to the division for the related medical
1435 service payment(s).
1436 (ii) The division shall report to the State Tax
1437 Commission the name of any Medicaid provider to whom payments were
1438 incorrectly made that the division has not been able to recover by
1439 other methods available to the division. The State Tax Commission
1440 shall withhold from the state tax refund of the provider, and pay
1441 to the division, the amount of the payments that were incorrectly
1442 made to the provider that have not been recovered by other
1443 available methods;
1444 (k) To recover any and all payments by the
1445 division * * * fraudulently obtained by a recipient or provider.
1446 Additionally, if recovery of any payments fraudulently obtained by
1447 a recipient or provider is made in any court, then, upon motion of
1448 the Governor, the judge of the court may award twice the payments
1449 recovered as damages;
1450 (l) Have full, complete and plenary power and authority
1451 to conduct such investigations as it may deem necessary and
1452 requisite of alleged or suspected violations or abuses of the
1453 provisions of this article or of the regulations adopted under

1454 this article, including, but not limited to, fraudulent or
1455 unlawful act or deed by applicants for Medicaid or other benefits,
1456 or payments made to any person, firm or corporation under the
1457 terms, conditions and authority of this article, to suspend or
1458 disqualify any provider of services, applicant or recipient for
1459 gross abuse, fraudulent or unlawful acts for such periods,
1460 including permanently, and under such conditions as the division
1461 deems proper and just, including the imposition of a legal rate of
1462 interest on the amount improperly or incorrectly paid. Recipients
1463 who are found to have misused or abused Medicaid benefits may be
1464 locked into one (1) physician and/or one (1) pharmacy of the
1465 recipient's choice for a reasonable amount of time in order to
1466 educate and promote appropriate use of medical services, in
1467 accordance with federal regulations. If an administrative hearing
1468 becomes necessary, the division may, if the provider does not
1469 succeed in his <u>or her</u> defense, tax the costs of the administrative
1470 hearing, including the costs of the court reporter or stenographer
1471 and transcript, to the provider. The convictions of a recipient
1472 or a provider in a state or federal court for abuse, fraudulent or
1473 unlawful acts under this chapter shall constitute an automatic
1474 disqualification of the recipient or automatic disqualification of
1475 the provider from participation under the Medicaid program.

1476 A conviction, for the purposes of this chapter, shall include
1477 a judgment entered on a plea of nolo contendere or a
1478 nonadjudicated guilty plea and shall have the same force as a
1479 judgment entered pursuant to a guilty plea or a conviction
1480 following trial. A certified copy of the judgment of the court of
1481 competent jurisdiction of the conviction shall constitute prima
1482 facie evidence of the conviction for disqualification purposes;

1483 (m) Establish and provide such methods of
1484 administration as may be necessary for the proper and efficient
1485 operation of the Medicaid program, fully utilizing computer
1486 equipment as may be necessary to oversee and control all current

1487 expenditures for purposes of this article, and to closely monitor
1488 and supervise all recipient payments and vendors rendering
1489 services under this article;

1490 (n) To cooperate and contract with the federal
1491 government for the purpose of providing Medicaid to Vietnamese and
1492 Cambodian refugees, under the provisions of Public Law 94-23 and
1493 Public Law 94-24, including any amendments to those laws, only to
1494 the extent that the Medicaid assistance and the administrative
1495 cost related thereto are one hundred percent (100%) reimbursable
1496 by the federal government. For the purposes of Section 43-13-117,
1497 persons receiving Medicaid under Public Law 94-23 and Public Law
1498 94-24, including any amendments to those laws, shall not be
1499 considered a new group or category of recipient; and

1500 (o) The division shall impose penalties upon Medicaid
1501 only, Title XIX participating long-term care facilities found to
1502 be in noncompliance with division and certification standards in
1503 accordance with federal and state regulations, including interest
1504 at the same rate calculated by the United States Department of
1505 Health and Human Services and/or the Centers for Medicare and
1506 Medicaid Services (CMS) under federal regulations.

1507 (2) The division also shall exercise such additional powers
1508 and perform such other duties as may be conferred upon the
1509 division by act of the Legislature.

1510 (3) The division, and the State Department of Health as the
1511 agency for licensure of health care facilities and certification
1512 and inspection for the Medicaid and/or Medicare programs, shall
1513 contract for or otherwise provide for the consolidation of on-site
1514 inspections of health care facilities that are necessitated by the
1515 respective programs and functions of the division and the
1516 department.

1517 (4) The division and its hearing officers shall have power
1518 to preserve and enforce order during hearings; to issue subpoenas
1519 for, to administer oaths to and to compel the attendance and

1520 testimony of witnesses, or the production of books, papers,
1521 documents and other evidence, or the taking of depositions before
1522 any designated individual competent to administer oaths; to
1523 examine witnesses; and to do all things conformable to law that
1524 may be necessary to enable them effectively to discharge the
1525 duties of their office. In compelling the attendance and
1526 testimony of witnesses, or the production of books, papers,
1527 documents and other evidence, or the taking of depositions, as
1528 authorized by this section, the division or its hearing officers
1529 may designate an individual employed by the division or some other
1530 suitable person to execute and return that process, whose action
1531 in executing and returning that process shall be as lawful as if
1532 done by the sheriff or some other proper officer authorized to
1533 execute and return process in the county where the witness may
1534 reside. In carrying out the investigatory powers under the
1535 provisions of this article, the executive director or other
1536 designated person or persons may examine, obtain, copy or
1537 reproduce the books, papers, documents, medical charts,
1538 prescriptions and other records relating to medical care and
1539 services furnished by the provider to a recipient or designated
1540 recipients of Medicaid services under investigation. In the
1541 absence of the voluntary submission of the books, papers,
1542 documents, medical charts, prescriptions and other records, the
1543 Governor, the executive director, or other designated person may
1544 issue and serve subpoenas instantly upon the provider, his or her
1545 agent, servant or employee for the production of the books,
1546 papers, documents, medical charts, prescriptions or other records
1547 during an audit or investigation of the provider. If any provider
1548 or his or her agent, servant or employee refuses to produce the
1549 records after being duly subpoenaed, the executive director may
1550 certify those facts and institute contempt proceedings in the
1551 manner, time and place as authorized by law for administrative
1552 proceedings. As an additional remedy, the division may recover

1553 all amounts paid to the provider covering the period of the audit
1554 or investigation, inclusive of a legal rate of interest and a
1555 reasonable attorney's fee and costs of court if suit becomes
1556 necessary. Division staff shall have immediate access to the
1557 provider's physical location, facilities, records, documents,
1558 books, and any other records relating to medical care and services
1559 rendered to recipients during regular business hours.
1560 (5) If any person in proceedings before the division
1561 disobeys or resists any lawful order or process, or misbehaves
1562 during a hearing or so near the place thereof as to obstruct the
1563 hearing, or neglects to produce, after having been ordered to do
1564 so, any pertinent book, paper or document, or refuses to appear
1565 after having been subpoenaed, or upon appearing refuses to take
1566 the oath as a witness, or after having taken the oath refuses to
1567 be examined according to law, the executive director shall certify
1568 the facts to any court having jurisdiction in the place in which
1569 it is sitting, and the court shall thereupon, in a summary manner,
1570 hear the evidence as to the acts complained of, and if the
1571 evidence so warrants, punish that person in the same manner and to
1572 the same extent as for a contempt committed before the court, or
1573 commit that person upon the same condition as if the doing of the
1574 forbidden act had occurred with reference to the process of, or in
1575 the presence of, the court.
1576 (6) In suspending or terminating any provider from
1577 participation in the Medicaid program, the division shall preclude
1578 the provider from submitting claims for payment, either personally
1579 or through any clinic, group, corporation or other association to
1580 the division or its fiscal agents for any services or supplies
1581 provided under the Medicaid program except for those services or
1582 supplies provided before the suspension or termination. No
1583 clinic, group, corporation or other association that is a provider
1584 of services shall submit claims for payment to the division or its
1585 fiscal agents for any services or supplies provided by a person

1586 within that organization who has been suspended or terminated from
1587 participation in the Medicaid program except for those services or
1588 supplies provided before the suspension or termination. When this
1589 provision is violated by a provider of services that is a clinic,
1590 group, corporation or other association, the division may suspend
1591 or terminate that organization from participation. Suspension may
1592 be applied by the division to all known affiliates of a provider,
1593 provided that each decision to include an affiliate is made on a
1594 case-by-case basis after giving due regard to all relevant facts
1595 and circumstances. The violation, failure or inadequacy of
1596 performance may be imputed to a person with whom the provider is
1597 affiliated where that conduct was accomplished within the course
1598 of his or her official duty or was effectuated by him or her with
1599 the knowledge or approval of that person.

1600 (7) The division may deny or revoke enrollment in the
1601 Medicaid program to a provider if any of the following are found
1602 to be applicable to the provider, his or her agent, a managing
1603 employee or any person having an ownership interest equal to five
1604 percent (5%) or greater in the provider:

1605 (a) Failure to truthfully or fully disclose any and all
1606 information required, or the concealment of any and all
1607 information required, on a claim, a provider application or a
1608 provider agreement, or the making of a false or misleading
1609 statement to the division relative to the Medicaid program.

1610 (b) Previous or current exclusion, suspension,
1611 termination from or the involuntary withdrawing from participation
1612 in the Medicaid program, any other state's Medicaid program,
1613 Medicare or any other public or private health or health insurance
1614 program. If the division ascertains that a provider has been
1615 convicted of a felony under federal or state law for an offense
1616 that the division determines is detrimental to the best interest
1617 of the program or of Medicaid beneficiaries, the division may

1618 refuse to enter into an agreement with that provider, or may
1619 terminate or refuse to renew an existing agreement.
1620 (c) Conviction under federal or state law of a criminal
1621 offense relating to the delivery of any goods, services or
1622 supplies, including the performance of management or
1623 administrative services relating to the delivery of the goods,
1624 services or supplies, under the Medicaid program, any other
1625 state's Medicaid program, Medicare or any other public or private
1626 health or health insurance program.
1627 (d) Conviction under federal or state law of a criminal
1628 offense relating to the neglect or abuse of a patient in
1629 connection with the delivery of any goods, services or supplies.
1630 (e) Conviction under federal or state law of a criminal
1631 offense relating to the unlawful manufacture, distribution,
1632 prescription or dispensing of a controlled substance.
1633 (f) Conviction under federal or state law of a criminal
1634 offense relating to fraud, theft, embezzlement, breach of
1635 fiduciary responsibility or other financial misconduct.
1636 (g) Conviction under federal or state law of a criminal
1637 offense punishable by imprisonment of a year or more that involves
1638 moral turpitude, or acts against the elderly, children or infirm.
1639 (h) Conviction under federal or state law of a criminal
1640 offense in connection with the interference or obstruction of any
1641 investigation into any criminal offense listed in paragraphs (c)
1642 through (i) of this subsection.
1643 (i) Sanction for a violation of federal or state laws
1644 or rules relative to the Medicaid program, any other state's
1645 Medicaid program, Medicare or any other public health care or
1646 health insurance program.
1647 (j) Revocation of license or certification.
1648 (k) Failure to pay recovery properly assessed or
1649 pursuant to an approved repayment schedule under the Medicaid
1650 program.

1651 (l) Failure to meet any condition of enrollment.

1652 **SECTION 5.** Section 43-13-125, Mississippi Code of 1972, is
1653 amended as follows:

1654 43-13-125. (1) If Medicaid is provided to a recipient under
1655 this article for injuries, disease or sickness caused under
1656 circumstances creating a cause of action in favor of the recipient
1657 against any person, firm or corporation, then the division shall
1658 be entitled to recover the proceeds that may result from the
1659 exercise of any rights of recovery that the recipient may have
1660 against any such person, firm or corporation to the extent of the
1661 Division of Medicaid's interest on behalf of the recipient. The
1662 recipient shall execute and deliver instruments and papers to do
1663 whatever is necessary to secure those rights and shall do nothing
1664 after Medicaid is provided to prejudice the subrogation rights of
1665 the division. Court orders or agreements for reimbursement of
1666 Medicaid's interest shall direct those payments to the Division of
1667 Medicaid, which shall be authorized to endorse any and all,
1668 including, but not limited to, multi-payee checks, drafts, money
1669 orders, or other negotiable instruments representing Medicaid
1670 payment recoveries that are received. In accordance with Section
1671 43-13-305, endorsement of multi-payee checks, drafts, money orders
1672 or other negotiable instruments by the Division of Medicaid shall
1673 be deemed endorsed by the recipient.

1674 The division, with the approval of the Governor, may
1675 compromise or settle any such claim and execute a release of any
1676 claim it has by virtue of this section.

1677 (2) The acceptance of Medicaid under this article or the
1678 making of a claim under this article shall not affect the right of
1679 a recipient or his or her legal representative to recover
1680 Medicaid's interest as an element of *** * *** damages in any action
1681 at law; however, a copy of the pleadings shall be certified to the
1682 division at the time of the institution of suit, and proof of
1683 that notice shall be filed of record in that action. The division

1684 may, at any time before the trial on the facts, join in that
1685 action or may intervene in that action. Any amount recovered by a
1686 recipient or his or her legal representative shall be applied as
1687 follows:
1688 (a) The reasonable costs of the collection, including
1689 attorney's fees, as approved and allowed by the court in which
1690 that action is pending, or in case of settlement without suit, by
1691 the legal representative of the division;
1692 (b) The amount of Medicaid's interest on behalf of the
1693 recipient; or such pro rata amount as may be arrived at by the
1694 legal representative of the division and the recipient's attorney,
1695 or as set by the court having jurisdiction; and
1696 (c) Any excess shall be awarded to the recipient.
1697 (3) No compromise of any claim by the recipient or his or
1698 her legal representative shall be binding upon or affect the
1699 rights of the division against the third party unless the
1700 division, with the approval of the Governor, has entered into the
1701 compromise. Any compromise effected by the recipient or his or
1702 her legal representative with the third party in the absence of
1703 advance notification to and approved by the division shall
1704 constitute conclusive evidence of the liability of the third
1705 party, and the division, in litigating its claim against the third
1706 party, shall be required only to prove the amount and correctness
1707 of its claim relating to the injury, disease or sickness. If the
1708 recipient or his or her legal representative fails to notify the
1709 division of the institution of legal proceedings against a third
1710 party for which the division has a cause of action, the facts
1711 relating to negligence and the liability of the third party, if
1712 judgment is rendered for the recipient, shall constitute
1713 conclusive evidence of liability in a subsequent action maintained
1714 by the division and only the amount and correctness of the
1715 division's claim relating to injuries, disease or sickness shall
1716 be tried before the court. The division shall be authorized in

1717 bringing that action against the third party and his or her
1718 insurer jointly or against the insurer alone.
1719 (4) Nothing in this section shall be construed to diminish
1720 or otherwise restrict the subrogation rights of the Division of
1721 Medicaid against a third party for Medicaid provided by the
1722 Division of Medicaid to the recipient as a result of injuries,
1723 disease or sickness caused under circumstances creating a cause of
1724 action in favor of the recipient against such a third party.
1725 (5) Any amounts recovered by the division under this section
1726 shall, by the division, be placed to the credit of the funds
1727 appropriated for benefits under this article proportionate to the
1728 amounts provided by the state and federal governments
1729 respectively.
1730 **SECTION 6.** Section 43-13-145, Mississippi Code of 1972, is
1731 amended as follows:
1732 43-13-145. (1) (a) Upon each nursing facility and each
1733 intermediate care facility for the mentally retarded licensed by
1734 the State of Mississippi, there is levied an assessment in the
1735 amount of Six Dollars ($6.00) per day for each licensed and/or
1736 certified bed of the facility. *** * ***
1737 (b) A nursing facility or intermediate care facility
1738 for the mentally retarded is exempt from the assessment levied
1739 under this subsection if the facility is operated under the
1740 direction and control of:
1741 (i) The United States Veterans Administration or
1742 other agency or department of the United States government;
1743 (ii) The State Veterans Affairs Board;
1744 (iii) The University of Mississippi Medical
1745 Center; or
1746 (iv) A state agency or a state facility that
1747 either provides its own state match through intergovernmental
1748 transfer or certification of funds to the division.

1749 (2) (a) Upon each psychiatric residential treatment
1750 facility licensed by the State of Mississippi, there is levied an
1751 assessment in the amount of Six Dollars ($6.00) per day for each
1752 licensed and/or certified bed of the facility.
1753 (b) A psychiatric residential treatment facility is
1754 exempt from the assessment levied under this subsection if the
1755 facility is operated under the direction and control of:
1756 (i) The United States Veterans Administration or
1757 other agency or department of the United States government;
1758 (ii) The University of Mississippi Medical Center;
1759 (iii) A state agency or a state facility that
1760 either provides its own state match through intergovernmental
1761 transfer or certification of funds to the division.
1762 (3) (a) Upon each hospital licensed by the State of
1763 Mississippi, there is levied an assessment in the amount of One
1764 Dollar and Fifty Cents ($1.50) per day for each licensed inpatient
1765 acute care bed of the hospital.
1766 (b) A hospital is exempt from the assessment levied
1767 under this subsection if the hospital is operated under the
1768 direction and control of:
1769 (i) The United States Veterans Administration or
1770 other agency or department of the United States government;
1771 (ii) The University of Mississippi Medical Center;
1772 or
1773 (iii) A state agency or a state facility that
1774 either provides its own state match through intergovernmental
1775 transfer or certification of funds to the division.
1776 (4) Each health care facility that is subject to the
1777 provisions of this section shall keep and preserve such suitable
1778 books and records as may be necessary to determine the amount of
1779 assessment for which it is liable under this section. The books
1780 and records shall be kept and preserved for a period of not less
1781 than five (5) years, and those books and records shall be open for

1782 examination during business hours by the division, the State Tax
1783 Commission, the Office of the Attorney General and the State
1784 Department of Health.
1785 (5) The assessment levied under this section shall be
1786 collected by the division each month beginning on April 12, 2002.
1787 (6) All assessments collected under this section shall be
1788 deposited in the Medical Care Fund created by Section 43-13-143.
1789 (7) The assessment levied under this section shall be in
1790 addition to any other assessments, taxes or fees levied by law,
1791 and the assessment shall constitute a debt due the State of
1792 Mississippi from the time the assessment is due until it is paid.
1793 (8) (a) If a health care facility that is liable for
1794 payment of the assessment levied under this section does not pay
1795 the assessment when it is due, the division shall give written
1796 notice to the health care facility by certified or registered mail
1797 demanding payment of the assessment within ten (10) days from the
1798 date of delivery of the notice. If the health care facility
1799 fails or refuses to pay the assessment after receiving the notice
1800 and demand from the division, the division shall withhold from any
1801 Medicaid reimbursement payments that are due to the health care
1802 facility the amount of the unpaid assessment and a penalty of ten
1803 percent (10%) of the amount of the assessment, plus the legal rate
1804 of interest until the assessment is paid in full. If the health
1805 care facility does not participate in the Medicaid program, the
1806 division shall turn over to the Office of the Attorney General the
1807 collection of the unpaid assessment by civil action. In any such
1808 civil action, the Office of the Attorney General shall collect the
1809 amount of the unpaid assessment and a penalty of ten percent (10%)
1810 of the amount of the assessment, plus the legal rate of interest
1811 until the assessment is paid in full.
1812 (b) As an additional or alternative method for
1813 collecting unpaid assessments under this section, if a health care
1814 facility fails or refuses to pay the assessment after receiving

1815 notice and demand from the division, the division may file a
1816 notice of a tax lien with the circuit clerk of the county in which
1817 the health care facility is located, for the amount of the unpaid
1818 assessment and a penalty of ten percent (10%) of the amount of the
1819 assessment, plus the legal rate of interest until the assessment
1820 is paid in full. Immediately upon receipt of notice of the tax
1821 lien for the assessment, the circuit clerk shall enter the notice
1822 of the tax lien as a judgment upon the judgment roll and show in
1823 the appropriate columns the name of the health care facility as
1824 judgment debtor, the name of the division as judgment creditor,
1825 the amount of the unpaid assessment, and the date and time of
1826 enrollment. The judgment shall be valid as against mortgagees,
1827 pledgees, entrusters, purchasers, judgment creditors and other
1828 persons from the time of filing with the clerk. The amount of the
1829 judgment shall be a debt due the State of Mississippi and remain a
1830 lien upon the tangible property of the health care facility until
1831 the judgment is satisfied. The judgment shall be the equivalent
1832 of any enrolled judgment of a court of record and shall serve as
1833 authority for the issuance of writs of execution, writs of
1834 attachment or other remedial writs.

1835 **SECTION 7.** Section 43-13-317, Mississippi Code of 1972, is
1836 amended as follows:

1837 43-13-317. (1) *** * *** The division shall be noticed as an
1838 identified creditor against the estate of <u>any</u> deceased Medicaid
1839 recipient <u>under</u> Section 91-7-145.

1840 (2) <u>In accordance with applicable federal law and rules and</u>
1841 <u>regulations, including those under Title XIX of the federal Social</u>
1842 <u>Security Act, the division may seek recovery of payments for</u>
1843 <u>nursing facility services, home- and community-based services and</u>
1844 <u>related hospital and prescription drug services from the estate of</u>
1845 <u>a deceased Medicaid recipient who was fifty-five (55) years of age</u>
1846 <u>or older when he or she received the assistance.</u> The claim shall
1847 be waived by the division (a) if there is a surviving spouse; or

1848 (b) if there is a surviving dependent who is under the age of
1849 twenty-one (21) years or who is blind or disabled; or (c) as
1850 provided by federal law and regulation, if it is determined by the
1851 division or by court order that there is undue hardship.

1852 **SECTION 8.** Section 43-13-141, Mississippi Code of 1972,
1853 which provides for an assessment upon certain Medicaid
1854 reimbursement payments to be paid into the Medical Care Assessment
1855 Fund, is repealed.

1856 **SECTION 9.** Sections 9 through 14 of this act shall be known
1857 and may be cited as the "Mississippi Seniors and Indigents Rx
1858 Program."

1859 **SECTION 10.** As used in Sections 9 through 14 of this act,
1860 the following terms shall have the following meanings:

1861 (a) "Department" means the Department of Human
1862 Services.

1863 (b) "Program" means the Mississippi Seniors and
1864 Indigents Rx Program established in Sections 9 through 14 of this
1865 act.

1866 **SECTION 11.** (1) The Legislature finds that many low income
1867 seniors and other indigents are unaware of bona fide assistance
1868 programs that are voluntarily offered by pharmaceutical
1869 manufacturers to the elderly and underprivileged. It is the
1870 intent of the Legislature to take steps necessary to make it more
1871 widely known that such assistance is available and to make it
1872 easier for people to apply for that assistance.

1873 (2) The Mississippi Seniors and Indigents Rx Program is
1874 established in the Department of Human Services to help seniors
1875 and qualified indigents in accessing pharmaceutical manufacturers'
1876 discount cards and pharmaceutical assistance programs and to
1877 provide seniors and qualified indigents with applications for
1878 those programs. The department shall coordinate the operation of
1879 the program with the Division of Medicaid, the Department of
1880 Mental Health, the State Department of Health and the State

1881 Department of Rehabilitation Services to insure that the services
1882 available under the program are maximized and that paperwork and
1883 inconvenience to the seniors and qualified indigents are
1884 minimized. The department may develop, maintain and make
1885 available an Internet-based application form to the general public
1886 and to each of those state agencies so that seniors and qualified
1887 indigents may get applications for pharmaceutical assistance
1888 programs at the local offices of any of those state agencies. The
1889 department may coordinate with pharmaceutical manufacturers to
1890 obtain program applications at no cost to the state.

1891 (3) The Office of Aging and Adult Services of the Department
1892 of Human Services shall play a primary role in administering the
1893 program to seniors in the same way that the office assists in
1894 administering programs of the Centers for Medicare and Medicaid
1895 Services (CMS).

1896 **SECTION 12.** Subject to appropriation for the program, the
1897 department may provide assistance to persons determined to be
1898 eligible for services authorized by Sections 9 through 14 of this
1899 act. The assistance provided by the department may include:

1900 (a) Assisting seniors and qualified indigents in
1901 accessing manufacturers' pharmaceutical assistance program
1902 applications; and

1903 (b) Assisting seniors and qualified indigents in
1904 applying for manufacturers' pharmaceutical assistance programs.

1905 **SECTION 13.** The department may seek and receive voluntary
1906 monies from any sources, including federal funds and gifts, which
1907 shall be expended for the purposes specified in Sections 9 through
1908 14 of this act. The department also may accept voluntary funding
1909 in the form of grants available to build community, public sector
1910 and private sector partnerships. The department shall include
1911 within the development of the program the assistance of
1912 foundations, independent and chain community pharmacists,
1913 volunteers, state agencies, community groups, religious groups,

1914 area agencies on aging, corporations, hospitals, physicians, and
1915 any other entity that can further the intent of the program.
1916 **SECTION 14.** The department shall prepare and submit an
1917 annual report on the program to the Governor, Lieutenant Governor,
1918 Speaker of the House of Representatives, the Chairman of the
1919 Senate Public Health and Welfare Committee and the Chairman of the
1920 House Public Health and Human Services Committee. Those reports
1921 shall include the number of clients served, the number of
1922 prescriptions filled and refilled, and the value of the drugs
1923 provided.
1924 **SECTION 15.** This act shall take effect and be in force from
1925 and after July 1, 2004.