MISSISSIPPI LEGISLATURE REGULAR SESSION 2002

By: Representative McCoy

To: Public Health and Welfare; Appropriations

HOUSE BILL NO. 872

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE THAT MENTAL HEALTH COUNSELING SERVICES PROVIDED BY A
3 LICENSED PROFESSIONAL COUNSELOR (LPC) WILL BE REIMBURSABLE UNDER
4 THE MEDICAID PROGRAM; AND FOR RELATED PURPOSES.

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

6 **SECTION 1.** Section 43-13-117, Mississippi Code of 1972, is
7 amended as follows:

8 43-13-117. Medicaid as authorized by this article shall
9 include payment of part or all of the costs, at the discretion of
10 the division or its successor, with approval of the Governor, of
11 the following types of care and services rendered to eligible
12 applicants who *** * *** have been determined to be eligible for that
13 care and services, within the limits of state appropriations and
14 federal matching funds:

15 (1) Inpatient hospital services.

16 (a) The division shall allow thirty (30) days of
17 inpatient hospital care annually for all Medicaid recipients.
18 Precertification of inpatient days must be obtained as required by
19 the division. The division may allow unlimited days in
20 disproportionate hospitals as defined by the division for eligible
21 infants under the age of six (6) years.

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

28 (c) Hospitals will receive an additional payment
29 for the implantable programmable baclofen drug pump used to treat
30 spasticity which is implanted on an inpatient basis. The payment
31 pursuant to written invoice will be in addition to the facility's
32 per diem reimbursement and will represent a reduction of costs on
33 the facility's annual cost report, and shall not exceed Ten
34 Thousand Dollars ($10,000.00) per year per recipient. This
35 paragraph (c) shall stand repealed on July 1, 2005.
36 (2) Outpatient hospital services. *** * *** Where the same
37 services are reimbursed as clinic services, the division may
38 revise the rate or methodology of outpatient reimbursement to
39 maintain consistency, efficiency, economy and quality of
40 care. *** * ***
41 (3) Laboratory and x-ray services.
42 (4) Nursing facility services.
43 (a) The division shall make full payment to
44 nursing facilities for each day, not exceeding fifty-two (52) days
45 per year, that a patient is absent from the facility on home
46 leave. Payment may be made for the following home leave days in
47 addition to the fifty-two-day limitation: Christmas, the day
48 before Christmas, the day after Christmas, Thanksgiving, the day
49 before Thanksgiving and the day after Thanksgiving.
50 (b) From and after July 1, 1997, the division
51 shall implement the integrated case-mix payment and quality
52 monitoring system, which includes the fair rental system for
53 property costs and in which recapture of depreciation is
54 eliminated. The division may reduce the payment for hospital
55 leave and therapeutic home leave days to the lower of the case-mix
56 category as computed for the resident on leave using the
57 assessment being utilized for payment at that point in time, or a
58 case-mix score of 1.000 for nursing facilities, and shall compute
59 case-mix scores of residents so that only services provided at the

60 nursing facility are considered in calculating a facility's per
61 diem.
62 (c) From and after July 1, 1997, all state-owned
63 nursing facilities shall be reimbursed on a full reasonable cost
64 basis.
65 (d) When a facility of a category that does not
66 require a certificate of need for construction and that could not
67 be eligible for Medicaid reimbursement is constructed to nursing
68 facility specifications for licensure and certification, and the
69 facility is subsequently converted to a nursing facility under a
70 certificate of need that authorizes conversion only and the
71 applicant for the certificate of need was assessed an application
72 review fee based on capital expenditures incurred in constructing
73 the facility, the division shall allow reimbursement for capital
74 expenditures necessary for construction of the facility that were
75 incurred within the twenty-four (24) consecutive calendar months
76 immediately preceding the date that the certificate of need
77 authorizing the conversion was issued, to the same extent that
78 reimbursement would be allowed for construction of a new nursing
79 facility under a certificate of need that authorizes that
80 construction. The reimbursement authorized in this subparagraph
81 (d) may be made only to facilities the construction of which was
82 completed after June 30, 1989. Before the division shall be
83 authorized to make the reimbursement authorized in this
84 subparagraph (d), the division first must have received approval
85 from the Health Care Financing Administration of the United States
86 Department of Health and Human Services of the change in the state
87 Medicaid plan providing for the reimbursement.
88 (e) The division shall develop and implement, not
89 later than January 1, 2001, a case-mix payment add-on determined
90 by time studies and other valid statistical data that will
91 reimburse a nursing facility for the additional cost of caring for
92 a resident who has a diagnosis of Alzheimer's or other related

93 dementia and exhibits symptoms that require special care. Any
94 such case-mix add-on payment shall be supported by a determination
95 of additional cost. The division shall also develop and implement
96 as part of the fair rental reimbursement system for nursing
97 facility beds, an Alzheimer's resident bed depreciation enhanced
98 reimbursement system that will provide an incentive to encourage
99 nursing facilities to convert or construct beds for residents with
100 Alzheimer's or other related dementia.

101 (f) The Division of Medicaid shall develop and
102 implement a referral process for long-term care alternatives for
103 Medicaid beneficiaries and applicants. No Medicaid beneficiary
104 shall be admitted to a Medicaid-certified nursing facility unless
105 a licensed physician certifies that nursing facility care is
106 appropriate for that person on a standardized form to be prepared
107 and provided to nursing facilities by the Division of Medicaid.
108 The physician shall forward a copy of that certification to the
109 Division of Medicaid within twenty-four (24) hours after it is
110 signed by the physician. Any physician who fails to forward the
111 certification to the Division of Medicaid within the time period
112 specified in this paragraph shall be ineligible for Medicaid
113 reimbursement for any physician's services performed for the
114 applicant. The Division of Medicaid shall determine, through an
115 assessment of the applicant conducted within two (2) business days
116 after receipt of the physician's certification, whether the
117 applicant also could live appropriately and cost-effectively at
118 home or in some other community-based setting if home- or
119 community-based services were available to the applicant. The
120 time limitation prescribed in this paragraph shall be waived in
121 cases of emergency. If the Division of Medicaid determines that a
122 home- or other community-based setting is appropriate and
123 cost-effective, the division shall:

124 (i) Advise the applicant or the applicant's
125 legal representative that a home- or other community-based setting
126 is appropriate;
127 (ii) Provide a proposed care plan and inform
128 the applicant or the applicant's legal representative regarding
129 the degree to which the services in the care plan are available in
130 a home- or in other community-based setting rather than nursing
131 facility care; and
132 (iii) Explain that the plan and services are
133 available only if the applicant or the applicant's legal
134 representative chooses a home- or community-based alternative to
135 nursing facility care, and that the applicant is free to choose
136 nursing facility care.
137 The Division of Medicaid may provide the services described
138 in this paragraph (f) directly or through contract with case
139 managers from the local Area Agencies on Aging, and shall
140 coordinate long-term care alternatives to avoid duplication with
141 hospital discharge planning procedures.
142 Placement in a nursing facility may not be denied by the
143 division if home- or community-based services that would be more
144 appropriate than nursing facility care are not actually available,
145 or if the applicant chooses not to receive the appropriate home-
146 or community-based services.
147 The division shall provide an opportunity for a fair hearing
148 under federal regulations to any applicant who is not given the
149 choice of home- or community-based services as an alternative to
150 institutional care.
151 The division shall make full payment for long-term care
152 alternative services.
153 The division shall apply for necessary federal waivers to
154 assure that additional services providing alternatives to nursing
155 facility care are made available to applicants for nursing
156 facility care.

157 (5) Periodic screening and diagnostic services for
158 individuals under age twenty-one (21) years as are needed to
159 identify physical and mental defects and to provide health care
160 treatment and other measures designed to correct or ameliorate
161 defects and physical and mental illness and conditions discovered
162 by the screening services regardless of whether these services are
163 included in the state plan. The division may include in its
164 periodic screening and diagnostic program those discretionary
165 services authorized under the federal regulations adopted to
166 implement Title XIX of the federal Social Security Act, as
167 amended. The division, in obtaining physical therapy services,
168 occupational therapy services, and services for individuals with
169 speech, hearing and language disorders, may enter into a
170 cooperative agreement with the State Department of Education for
171 the provision of those services to handicapped students by public
172 school districts using state funds that are provided from the
173 appropriation to the Department of Education to obtain federal
174 matching funds through the division. The division, in obtaining
175 medical and psychological evaluations for children in the custody
176 of the State Department of Human Services may enter into a
177 cooperative agreement with the State Department of Human Services
178 for the provision of those services using state funds that are
179 provided from the appropriation to the Department of Human
180 Services to obtain federal matching funds through the division.
181 On July 1, 1993, all fees for periodic screening and
182 diagnostic services under this paragraph (5) shall be increased by
183 twenty-five percent (25%) of the reimbursement rate in effect on
184 June 30, 1993.
185 (6) Physician's services. The division shall allow
186 twelve (12) physician visits annually. All fees for physicians'
187 services that are covered only by Medicaid shall be reimbursed at
188 ninety percent (90%) of the rate established on January 1, 1999,
189 and as adjusted each January thereafter, under Medicare (Title

190 XVIII of the Social Security Act, as amended), and which shall in
191 no event be less than seventy percent (70%) of the rate
192 established on January 1, 1994. All fees for physicians' services
193 that are covered by both Medicare and Medicaid shall be reimbursed
194 at ten percent (10%) of the adjusted Medicare payment established
195 on January 1, 1999, and as adjusted each January thereafter, under
196 Medicare (Title XVIII of the Social Security Act, as amended), and
197 which shall in no event be less than seventy percent (70%) of the
198 adjusted Medicare payment established on January 1, 1994.
199 (7) (a) Home health services for eligible persons, not
200 to exceed in cost the prevailing cost of nursing facility
201 services, not to exceed sixty (60) visits per year. All home
202 health visits must be precertified as required by the division.
203 (b) Repealed.
204 (8) Emergency medical transportation services. On
205 January 1, 1994, emergency medical transportation services shall
206 be reimbursed at seventy percent (70%) of the rate established
207 under Medicare (Title XVIII of the Social Security Act, as
208 amended). "Emergency medical transportation services" shall mean,
209 but shall not be limited to, the following services by a properly
210 permitted ambulance operated by a properly licensed provider in
211 accordance with the Emergency Medical Services Act of 1974
212 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
213 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
214 (vi) disposable supplies, (vii) similar services.
215 (9) Legend and other drugs as may be determined by the
216 division. The division may implement a program of prior approval
217 for drugs to the extent permitted by law. Payment by the division
218 for covered multiple source drugs shall be limited to the lower of
219 the upper limits established and published by the <u>Centers for</u>
220 <u>Medicare and Medicaid Services (CMS)</u> plus a dispensing fee of Four
221 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
222 cost (EAC) as determined by the division plus a dispensing fee of

223 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual
224 and customary charge to the general public. The division shall
225 allow ten (10) prescriptions per month for noninstitutionalized
226 Medicaid recipients.

227 Payment for other covered drugs, other than multiple source
228 drugs with CMS upper limits, shall not exceed the lower of the
229 estimated acquisition cost as determined by the division plus a
230 dispensing fee of Four Dollars and Ninety-one Cents ($4.91) or the
231 providers' usual and customary charge to the general public.

232 Payment for nonlegend or over-the-counter drugs covered on
233 the division's formulary shall be reimbursed at the lower of the
234 division's estimated shelf price or the providers' usual and
235 customary charge to the general public. No dispensing fee shall
236 be paid.

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

241 As used in this paragraph (9), "estimated acquisition cost"
242 means the division's best estimate of what price providers
243 generally are paying for a drug in the package size that providers
244 buy most frequently. Product selection shall be made in
245 compliance with existing state law; however, the division may
246 reimburse as if the prescription had been filled under the generic
247 name. The division may provide otherwise in the case of specified
248 drugs when the consensus of competent medical advice is that
249 trademarked drugs are substantially more effective.

250 (10) Dental care that is an adjunct to treatment of an
251 acute medical or surgical condition; services of oral surgeons and
252 dentists in connection with surgery related to the jaw or any
253 structure contiguous to the jaw or the reduction of any fracture
254 of the jaw or any facial bone; and emergency dental extractions
255 and treatment related thereto. On July 1, 1999, all fees for

256 dental care and surgery under authority of this paragraph (10)
257 shall be increased to one hundred sixty percent (160%) of the
258 amount of the reimbursement rate that was in effect on June 30,
259 1999. It is the intent of the Legislature to encourage more
260 dentists to participate in the Medicaid program.
261 (11) Eyeglasses necessitated by reason of eye surgery,
262 and as prescribed by a physician skilled in diseases of the eye or
263 an optometrist, whichever the patient may select, or one (1) pair
264 every three (3) years as prescribed by a physician or an
265 optometrist, whichever the patient may select.
266 (12) Intermediate care facility services.
267 (a) The division shall make full payment to all
268 intermediate care facilities for the mentally retarded for each
269 day, not exceeding eighty-four (84) days per year, that a patient
270 is absent from the facility on home leave. Payment may be made
271 for the following home leave days in addition to the
272 eighty-four-day limitation: Christmas, the day before Christmas,
273 the day after Christmas, Thanksgiving, the day before Thanksgiving
274 and the day after Thanksgiving.
275 (b) All state-owned intermediate care facilities
276 for the mentally retarded shall be reimbursed on a full reasonable
277 cost basis.
278 (13) Family planning services, including drugs,
279 supplies and devices, when those services are under the
280 supervision of a physician.
281 (14) Clinic services. Such diagnostic, preventive,
282 therapeutic, rehabilitative or palliative services furnished to an
283 outpatient by or under the supervision of a physician or dentist
284 in a facility that is not a part of a hospital but that is
285 organized and operated to provide medical care to outpatients.
286 Clinic services shall include any services reimbursed as
287 outpatient hospital services that may be rendered in such a
288 facility, including those that become so after July 1, 1991. On

289 July 1, 1999, all fees for physicians' services reimbursed under
290 authority of this paragraph (14) shall be reimbursed at ninety
291 percent (90%) of the rate established on January 1, 1999, and as
292 adjusted each January thereafter, under Medicare (Title XVIII of
293 the Social Security Act, as amended), and which shall in no event
294 be less than seventy percent (70%) of the rate established on
295 January 1, 1994. All fees for physicians' services that are
296 covered by both Medicare and Medicaid shall be reimbursed at ten
297 percent (10%) of the adjusted Medicare payment established on
298 January 1, 1999, and as adjusted each January thereafter, under
299 Medicare (Title XVIII of the Social Security Act, as amended), and
300 which shall in no event be less than seventy percent (70%) of the
301 adjusted Medicare payment established on January 1, 1994. On July
302 1, 1999, all fees for dentists' services reimbursed under
303 authority of this paragraph (14) shall be increased to one hundred
304 sixty percent (160%) of the amount of the reimbursement rate that
305 was in effect on June 30, 1999.
306 (15) Home- and community-based services, as provided
307 under Title XIX of the federal Social Security Act, as amended,
308 under waivers, subject to the availability of funds specifically
309 appropriated therefor by the Legislature. Payment for <u>those</u>
310 services shall be limited to individuals who would be eligible for
311 and would otherwise require the level of care provided in a
312 nursing facility. The home- and community-based services
313 authorized under this paragraph shall be expanded over a five-year
314 period beginning July 1, 1999. The division shall certify case
315 management agencies to provide case management services and
316 provide for home- and community-based services for eligible
317 individuals under this paragraph. The home- and community-based
318 services under this paragraph and the activities performed by
319 certified case management agencies under this paragraph shall be
320 funded using state funds that are provided from the appropriation
321 to the Division of Medicaid and used to match federal funds.

322 (16) Mental health services. Approved therapeutic and
323 case management services provided by (a) an approved regional
324 mental health/retardation center established under Sections
325 41-19-31 through 41-19-39, or by another community mental health
326 service provider meeting the requirements of the Department of
327 Mental Health to be an approved mental health/retardation center
328 if determined necessary by the Department of Mental Health, using
329 state funds that are provided from the appropriation to the State
330 Department of Mental Health and used to match federal funds under
331 a cooperative agreement between the division and the department,
332 or (b) a facility that is certified by the State Department of
333 Mental Health to provide therapeutic and case management services,
334 to be reimbursed on a fee for service basis. Any such services
335 provided by a facility described in paragraph (b) must have the
336 prior approval of the division to be reimbursable under this
337 section. After June 30, 1997, mental health services provided by
338 regional mental health/retardation centers established under
339 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
340 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
341 psychiatric residential treatment facilities as defined in Section
342 43-11-1, or by another community mental health service provider
343 meeting the requirements of the Department of Mental Health to be
344 an approved mental health/retardation center if determined
345 necessary by the Department of Mental Health, shall not be
346 included in or provided under any capitated managed care pilot
347 program provided for under paragraph (24) of this section.
348 (17) Durable medical equipment services and medical
349 supplies. Precertification of durable medical equipment and
350 medical supplies must be obtained as required by the division.
351 The Division of Medicaid may require durable medical equipment
352 providers to obtain a surety bond in the amount and to the
353 specifications as established by the Balanced Budget Act of 1997.

354 (18) (a) Notwithstanding any other provision of this
355 section to the contrary, the division shall make additional
356 reimbursement to hospitals that serve a disproportionate share of
357 low-income patients and that meet the federal requirements for
358 those payments as provided in Section 1923 of the federal Social
359 Security Act and any applicable regulations. However, from and
360 after January 1, 2000, no public hospital shall participate in the
361 Medicaid disproportionate share program unless the public hospital
362 participates in an intergovernmental transfer program as provided
363 in Section 1903 of the federal Social Security Act and any
364 applicable regulations. Administration and support for
365 participating hospitals shall be provided by the Mississippi
366 Hospital Association.

367 (b) The division shall establish a Medicare Upper
368 Payment Limits Program as defined in Section 1902(a)(30) of the
369 federal Social Security Act and any applicable federal
370 regulations. The division shall assess each hospital for the sole
371 purpose of financing the state portion of the Medicare Upper
372 Payment Limits Program. This assessment shall be based on
373 Medicaid utilization, or other appropriate method consistent with
374 federal regulations, and will remain in effect as long as the
375 state participates in the Medicare Upper Payment Limits Program.
376 The division shall make additional reimbursement to hospitals for
377 the Medicare Upper Payment Limits as defined in Section
378 1902(a)(30) of the federal Social Security Act and any applicable
379 federal regulations. This paragraph (b) shall stand repealed from
380 and after July 1, 2005.

381 (c) The division shall contract with the
382 Mississippi Hospital Association to provide administrative support
383 for the operation of the disproportionate share hospital program
384 and the Medicare Upper Payment Limits Program. This paragraph (c)
385 shall stand repealed from and after July 1, 2005.

386 (19) (a) Perinatal risk management services. The
387 division shall promulgate regulations to be effective from and
388 after October 1, 1988, to establish a comprehensive perinatal
389 system for risk assessment of all pregnant and infant Medicaid
390 recipients and for management, education and follow-up for those
391 who are determined to be at risk. Services to be performed
392 include case management, nutrition assessment/counseling,
393 psychosocial assessment/counseling and health education. The
394 division shall set reimbursement rates for providers in
395 conjunction with the State Department of Health.

396 (b) Early intervention system services. The
397 division shall cooperate with the State Department of Health,
398 acting as lead agency, in the development and implementation of a
399 statewide system of delivery of early intervention services,
400 pursuant to Part H of the Individuals with Disabilities Education
401 Act (IDEA). The State Department of Health shall certify annually
402 in writing to the executive director of the division the dollar
403 amount of state early intervention funds available that will be
404 utilized as a certified match for Medicaid matching funds. Those
405 funds then shall be used to provide expanded targeted case
406 management services for Medicaid eligible children with special
407 needs who are eligible for the state's early intervention system.
408 Qualifications for persons providing service coordination shall be
409 determined by the State Department of Health and the Division of
410 Medicaid.

411 (20) Home- and community-based services for physically
412 disabled approved services as allowed by a waiver from the United
413 States Department of Health and Human Services for home- and
414 community-based services for physically disabled people using
415 state funds that are provided from the appropriation to the State
416 Department of Rehabilitation Services and used to match federal
417 funds under a cooperative agreement between the division and the
418 department, provided that funds for these services are

419 specifically appropriated to the Department of Rehabilitation
420 Services.
421 (21) Nurse practitioner services. Services furnished
422 by a registered nurse who is licensed and certified by the
423 Mississippi Board of Nursing as a nurse practitioner including,
424 but not limited to, nurse anesthetists, nurse midwives, family
425 nurse practitioners, family planning nurse practitioners,
426 pediatric nurse practitioners, obstetrics-gynecology nurse
427 practitioners and neonatal nurse practitioners, under regulations
428 adopted by the division. Reimbursement for those services shall
429 not exceed ninety percent (90%) of the reimbursement rate for
430 comparable services rendered by a physician.
431 (22) Ambulatory services delivered in federally
432 qualified health centers and in clinics of the local health
433 departments of the State Department of Health for individuals
434 eligible for medical assistance under this article based on
435 reasonable costs as determined by the division.
436 (23) Inpatient psychiatric services. Inpatient
437 psychiatric services to be determined by the division for
438 recipients under age twenty-one (21) that are provided under the
439 direction of a physician in an inpatient program in a licensed
440 acute care psychiatric facility or in a licensed psychiatric
441 residential treatment facility, before the recipient reaches age
442 twenty-one (21) or, if the recipient was receiving the services
443 immediately before he reached age twenty-one (21), before the
444 earlier of the date he no longer requires the services or the date
445 he reaches age twenty-two (22), as provided by federal
446 regulations. Precertification of inpatient days and residential
447 treatment days must be obtained as required by the division.
448 (24) Managed care services in a program to be developed
449 by the division by a public or private provider. If managed care
450 services are provided by the division to Medicaid recipients, and
451 those managed care services are operated, managed and controlled

452 by and under the authority of the division, the division shall be
453 responsible for educating the Medicaid recipients who are
454 participants in the managed care program regarding the manner in
455 which the participants should seek health care under the program.
456 Notwithstanding any other provision in this article to the
457 contrary, the division shall establish rates of reimbursement to
458 providers rendering care and services authorized under this
459 paragraph (24), and may revise those rates of reimbursement
460 without amendment to this section by the Legislature for the
461 purpose of achieving effective and accessible health services, and
462 for responsible containment of costs.

463 (25) Birthing center services.

464 (26) Hospice care. As used in this paragraph, the term
465 "hospice care" means a coordinated program of active professional
466 medical attention within the home and outpatient and inpatient
467 care that treats the terminally ill patient and family as a unit,
468 employing a medically directed interdisciplinary team. The
469 program provides relief of severe pain or other physical symptoms
470 and supportive care to meet the special needs arising out of
471 physical, psychological, spiritual, social and economic stresses
472 that are experienced during the final stages of illness and during
473 dying and bereavement and meets the Medicare requirements for
474 participation as a hospice as provided in federal regulations.

475 (27) Group health plan premiums and cost sharing if it
476 is cost effective as defined by the Secretary of Health and Human
477 Services.

478 (28) Other health insurance premiums that are cost
479 effective as defined by the Secretary of Health and Human
480 Services. Medicare eligible must have Medicare Part B before
481 other insurance premiums can be paid.

482 (29) The Division of Medicaid may apply for a waiver
483 from the Department of Health and Human Services for home- and
484 community-based services for developmentally disabled people using

485 state funds that are provided from the appropriation to the State
486 Department of Mental Health and used to match federal funds under
487 a cooperative agreement between the division and the department,
488 provided that funds for these services are specifically
489 appropriated to the Department of Mental Health.
490 (30) Pediatric skilled nursing services for eligible
491 persons under twenty-one (21) years of age.
492 (31) Targeted case management services for children
493 with special needs, under waivers from the United States
494 Department of Health and Human Services, using state funds that
495 are provided from the appropriation to the Mississippi Department
496 of Human Services and used to match federal funds under a
497 cooperative agreement between the division and the department.
498 (32) Care and services provided in Christian Science
499 Sanatoria operated by or listed and certified by The First Church
500 of Christ Scientist, Boston, Massachusetts, rendered in connection
501 with treatment by prayer or spiritual means to the extent that
502 those services are subject to reimbursement under Section 1903 of
503 the Social Security Act.
504 (33) Podiatrist services.
505 (34) The division shall make application to the United
506 States Health Care Financing Administration for a waiver to
507 develop a program of services to personal care and assisted living
508 homes in Mississippi. This waiver shall be completed by December
509 1, 1999.
510 (35) Services and activities authorized in Sections
511 43-27-101 and 43-27-103, using state funds that are provided from
512 the appropriation to the State Department of Human Services and
513 used to match federal funds under a cooperative agreement between
514 the division and the department.
515 (36) Nonemergency transportation services for
516 Medicaid-eligible persons, to be provided by the Division of
517 Medicaid. The division may contract with additional entities to

518 administer nonemergency transportation services as it deems
519 necessary. All providers shall have a valid driver's license,
520 vehicle inspection sticker, valid vehicle license tags and a
521 standard liability insurance policy covering the vehicle.
522 (37) [Deleted]
523 (38) Chiropractic services: a chiropractor's manual
524 manipulation of the spine to correct a subluxation, if x-ray
525 demonstrates that a subluxation exists and if the subluxation has
526 resulted in a neuromusculoskeletal condition for which
527 manipulation is appropriate treatment. Reimbursement for
528 chiropractic services shall not exceed Seven Hundred Dollars
529 ($700.00) per year per recipient.
530 (39) Dually eligible Medicare/Medicaid beneficiaries.
531 The division shall pay the Medicare deductible and ten percent
532 (10%) coinsurance amounts for services available under Medicare
533 for the duration and scope of services otherwise available under
534 the Medicaid program.
535 (40) [Deleted]
536 (41) Services provided by the State Department of
537 Rehabilitation Services for the care and rehabilitation of persons
538 with spinal cord injuries or traumatic brain injuries, as allowed
539 under waivers from the United States Department of Health and
540 Human Services, using up to seventy-five percent (75%) of the
541 funds that are appropriated to the Department of Rehabilitation
542 Services from the Spinal Cord and Head Injury Trust Fund
543 established under Section 37-33-261 and used to match federal
544 funds under a cooperative agreement between the division and the
545 department.
546 (42) Notwithstanding any other provision in this
547 article to the contrary, the division <u>may</u> develop a population
548 health management program for women and children health services
549 through the age of two (2) <u>years</u>. This program is primarily for
550 obstetrical care associated with low birth weight and pre-term

551 babies. In order to effect cost savings, the division may develop
552 a revised payment methodology <u>that</u> may include at-risk capitated
553 payments.
554 (43) The division shall provide reimbursement,
555 according to a payment schedule developed by the division, for
556 smoking cessation medications for pregnant women during their
557 pregnancy and other Medicaid-eligible women who are of
558 child-bearing age.
559 (44) Nursing facility services for the severely
560 disabled.
561 (a) Severe disabilities include, but are not
562 limited to, spinal cord injuries, closed head injuries and
563 ventilator dependent patients.
564 (b) Those services must be provided in a long-term
565 care nursing facility dedicated to the care and treatment of
566 persons with severe disabilities, and shall be reimbursed as a
567 separate category of nursing facilities.
568 (45) Physician assistant services. Services furnished
569 by a physician assistant who is licensed by the State Board of
570 Medical Licensure and is practicing with physician supervision
571 under regulations adopted by the board, under regulations adopted
572 by the division. Reimbursement for those services shall not
573 exceed ninety percent (90%) of the reimbursement rate for
574 comparable services rendered by a physician.
575 (46) The division shall make application to the federal
576 <u>Centers for Medicare and Medicaid Services (CMS)</u> for a waiver to
577 develop and provide services for children with serious emotional
578 disturbances as defined in Section 43-14-1(1), which may include
579 home- and community-based services, case management services or
580 managed care services through mental health providers certified by
581 the Department of Mental Health. The division may implement and
582 provide services under this waivered program only if funds for
583 these services are specifically appropriated for this purpose by

584 the Legislature, or if funds are voluntarily provided by affected
585 agencies.
586 (47) Mental health counseling services provided by a
587 duly licensed professional counselor (LPC). Notwithstanding any
588 provision of this article, except as authorized in the following
589 paragraph and in Section 43-13-139, neither (a) the limitations on
590 quantity or frequency of use of or the fees or charges for any of
591 the care or services available to recipients under this section,
592 nor (b) the payments or rates of reimbursement to providers
593 rendering care or services authorized under this section to
594 recipients, may be increased, decreased or otherwise changed from
595 the levels in effect on July 1, 1999, unless they are authorized
596 by an amendment to this section by the Legislature. However, the
597 restriction in this paragraph shall not prevent the division from
598 changing the payments or rates of reimbursement to providers
599 without an amendment to this section whenever those changes are
600 required by federal law or regulation, or whenever those changes
601 are necessary to correct administrative errors or omissions in
602 calculating those payments or rates of reimbursement.
603 Notwithstanding any provision of this article, no new groups
604 or categories of recipients and new types of care and services may
605 be added without enabling legislation from the Mississippi
606 Legislature, except that the division may authorize those changes
607 without enabling legislation when the addition of recipients or
608 services is ordered by a court of proper authority. The executive
609 director shall keep the Governor advised on a timely basis of the
610 funds available for expenditure and the projected expenditures.
611 If current or projected expenditures of the division can be
612 reasonably anticipated to exceed the amounts appropriated for any
613 fiscal year, the Governor, after consultation with the executive
614 director, shall discontinue any or all of the payment of the types
615 of care and services as provided in this section that are deemed
616 to be optional services under Title XIX of the federal Social

617 Security Act, as amended, for any period necessary to not exceed
618 appropriated funds, and when necessary shall institute any other
619 cost containment measures on any program or programs authorized
620 under the article to the extent allowed under the federal law
621 governing that program or programs, it being the intent of the
622 Legislature that expenditures during any fiscal year shall not
623 exceed the amounts appropriated for that fiscal year.

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

635 **SECTION 2.** This act shall take effect and be in force from
636 and after July 1, 2002.

ST: Medicaid; mental health services provided by licensed professional counselors are reimbursable under.