AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
TO ESTABLISH A PROGRAM OF ASSISTANCE PAYMENTS FOR PERSONS WHO
RESIDE IN PERSONAL CARE HOMES AND WHO ARE ELIGIBLE FOR AND
RECEIVING CERTAIN MEDICAID ASSISTANCE; TO AUTHORIZE THE DIVISION
OF MEDICAID TO ADMINISTER THE PROGRAM OF ASSISTANCE PAYMENTS; AND
FOR RELATED PURPOSES.

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

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

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

(1) Inpatient hospital services.

(a) The division shall allow thirty (30) days of
inpatient hospital care annually for all Medicaid recipients.

Precertification of inpatient days must be obtained as required by
the division. The division shall be authorized to allow unlimited
days in disproportionate hospitals as defined by the division for
eligible infants under the age of six (6) years.

(b) From and after July 1, 1994, the Executive
Director of the Division of Medicaid shall amend the Mississippi
Title XIX Inpatient Hospital Reimbursement Plan to remove the
occupancy rate penalty from the calculation of the Medicaid
Capital Cost Component utilized to determine total hospital costs
allocated to the Medicaid program.
(c) Hospitals will receive an additional payment for the implantable programmable baclofen drug pump used to treat spasticity which is implanted on an inpatient basis. The payment pursuant to written invoice will be in addition to the facility's per diem reimbursement and will represent a reduction of costs on the facility's annual cost report, and shall not exceed Ten Thousand Dollars ($10,000.00) per year per recipient. This paragraph (c) shall stand repealed on July 1, 2005.

(2) Outpatient hospital services. Provided that where the same services are reimbursed as clinic services, the division may revise the rate or methodology of outpatient reimbursement to maintain consistency, efficiency, economy and quality of care. The division shall develop a Medicaid-specific cost-to-charge ratio calculation from data provided by hospitals to determine an allowable rate payment for outpatient hospital services, and shall submit a report thereon to the Medical Advisory Committee on or before December 1, 1999. The committee shall make a recommendation on the specific cost-to-charge reimbursement method for outpatient hospital services to the 2000 Regular Session of the Legislature.

(3) Laboratory and x-ray services.

(4) Nursing facility services.

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

(b) From and after July 1, 1997, the division shall implement the integrated case-mix payment and quality monitoring system, which includes the fair rental system for property costs and in which recapture of depreciation is
eliminated. The division may reduce the payment for hospital
leave and therapeutic home leave days to the lower of the case-mix
category as computed for the resident on leave using the
assessment being utilized for payment at that point in time, or a
case-mix score of 1.000 for nursing facilities, and shall compute
case-mix scores of residents so that only services provided at the
nursing facility are considered in calculating a facility's per
diem.

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

(d) When a facility of a category that does not
require a certificate of need for construction and that could not
be eligible for Medicaid reimbursement is constructed to nursing
facility specifications for licensure and certification, and the
facility is subsequently converted to a nursing facility pursuant
to a certificate of need that authorizes conversion only and the
applicant for the certificate of need was assessed an application
review fee based on capital expenditures incurred in constructing
the facility, the division shall allow reimbursement for capital
expenditures necessary for construction of the facility that were
incurred within the twenty-four (24) consecutive calendar months
immediately preceding the date that the certificate of need
authorizing such conversion was issued, to the same extent that
reimbursement would be allowed for construction of a new nursing
facility pursuant to a certificate of need that authorizes such
construction. The reimbursement authorized in this subparagraph
(d) may be made only to facilities the construction of which was
completed after June 30, 1989. Before the division shall be
authorized to make the reimbursement authorized in this
subparagraph (d), the division first must have received approval
from the Health Care Financing Administration of the United States
Department of Health and Human Services of the change in the state Medicaid plan providing for such reimbursement.

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

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

(i) Advise the applicant or the applicant's
legal representative that a home- or other community-based setting
is appropriate;

(ii) Provide a proposed care plan and inform
the applicant or the applicant's legal representative regarding
the degree to which the services in the care plan are available in
a home- or in other community-based setting rather than nursing
facility care; and

(iii) Explain that such plan and services are
available only if the applicant or the applicant's legal
representative chooses a home- or community-based alternative to
nursing facility care, and that the applicant is free to choose
nursing facility care.

The Division of Medicaid may provide the services described
in this paragraph (f) directly or through contract with case
managers from the local Area Agencies on Aging, and shall
coordinate long-term care alternatives to avoid duplication with
hospital discharge planning procedures.

Placement in a nursing facility may not be denied by the
division if home- or community-based services that would be more
appropriate than nursing facility care are not actually available,
or if the applicant chooses not to receive the appropriate home-
or community-based services.

The division shall provide an opportunity for a fair hearing
under federal regulations to any applicant who is not given the
choice of home- or community-based services as an alternative to
institutional care.
The division shall make full payment for long-term care alternative services.

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

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

On July 1, 1993, all fees for periodic screening and diagnostic services under this paragraph (5) shall be increased by
twenty-five percent (25%) of the reimbursement rate in effect on June 30, 1993.

(6) Physician's services. The division shall allow twelve (12) physician visits annually. All fees for physicians' services that are covered only by Medicaid shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act, as amended), and which shall in no event be less than seventy percent (70%) of the rate established on January 1, 1994. All fees for physicians' services that are covered by both Medicare and Medicaid shall be reimbursed at ten percent (10%) of the adjusted Medicare payment established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act, as amended), and which shall in no event be less than seventy percent (70%) of the adjusted Medicare payment established on January 1, 1994.

(7) (a) Home health services for eligible persons, not to exceed in cost the prevailing cost of nursing facility services, not to exceed sixty (60) visits per year. All home health visits must be precertified as required by the division.

(b) Repealed.

(8) Emergency medical transportation services. On January 1, 1994, emergency medical transportation services shall be reimbursed at seventy percent (70%) of the rate established under Medicare (Title XVIII of the Social Security Act, as amended). "Emergency medical transportation services" shall mean, but shall not be limited to, the following services by a properly permitted ambulance operated by a properly licensed provider in accordance with the Emergency Medical Services Act of 1974 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi) disposable supplies, (vii) similar services.
(9) Legend and other drugs as may be determined by the division. The division may implement a program of prior approval for drugs to the extent permitted by law. Payment by the division for covered multiple source drugs shall be limited to the lower of the upper limits established and published by the Health Care Financing Administration (HCFA) plus a dispensing fee of Four Dollars and Ninety-one Cents ($4.91), or the estimated acquisition cost (EAC) as determined by the division plus a dispensing fee of Four Dollars and Ninety-one Cents ($4.91), or the providers' usual and customary charge to the general public. The division shall allow ten (10) prescriptions per month for noninstitutionalized Medicaid recipients.

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

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

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

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

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

(11) Eyeglasses necessitated by reason of eye surgery,
and as prescribed by a physician skilled in diseases of the eye or
an optometrist, whichever the patient may select, or one (1) pair
every three (3) years as prescribed by a physician or an
optometrist, whichever the patient may select.

(12) Intermediate care facility services.
   (a) The division shall make full payment to all
intermediate care facilities for the mentally retarded for each
day, not exceeding eighty-four (84) days per year, that a patient
is absent from the facility on home leave. Payment may be made
for the following home leave days in addition to the
eighty-four-day limitation: Christmas, the day before Christmas,
the day after Christmas, Thanksgiving, the day before Thanksgiving
and the day after Thanksgiving.
   (b) All state-owned intermediate care facilities
for the mentally retarded shall be reimbursed on a full reasonable
cost basis.

(13) Family planning services, including drugs,
supplies and devices, when such services are under the supervision
of a physician.
(14) Clinic services. Such diagnostic, preventive, therapeutic, rehabilitative or palliative services furnished to an outpatient by or under the supervision of a physician or dentist in a facility which is not a part of a hospital but which is organized and operated to provide medical care to outpatients. Clinic services shall include any services reimbursed as outpatient hospital services which may be rendered in such a facility, including those that become so after July 1, 1991. On July 1, 1999, all fees for physicians' services reimbursed under authority of this paragraph (14) shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act, as amended), and which shall in no event be less than seventy percent (70%) of the rate established on January 1, 1994. All fees for physicians' services that are covered by both Medicare and Medicaid shall be reimbursed at ten percent (10%) of the adjusted Medicare payment established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act, as amended), and which shall in no event be less than seventy percent (70%) of the adjusted Medicare payment established on January 1, 1994. On July 1, 1999, all fees for dentists' services reimbursed under authority of this paragraph (14) shall be increased to one hundred sixty percent (160%) of the amount of the reimbursement rate that was in effect on June 30, 1999.

(15) Home- and community-based services, as provided under Title XIX of the federal Social Security Act, as amended, under waivers, subject to the availability of funds specifically appropriated therefor by the Legislature. Payment for such services shall be limited to individuals who would be eligible for and would otherwise require the level of care provided in a nursing facility. The home- and community-based services authorized under this paragraph shall be expanded over a five-year
period beginning July 1, 1999. The division shall certify case
management agencies to provide case management services and
provide for home- and community-based services for eligible
individuals under this paragraph. The home- and community-based
services under this paragraph and the activities performed by
certified case management agencies under this paragraph shall be
funded using state funds that are provided from the appropriation
to the Division of Medicaid and used to match federal funds.

(16) Mental health services. Approved therapeutic and
case management services provided by (a) an approved regional
mental health/retardation center established under Sections
41-19-31 through 41-19-39, or by another community mental health
service provider meeting the requirements of the Department of
Mental Health to be an approved mental health/retardation center
if determined necessary by the Department of Mental Health, using
state funds which are provided from the appropriation to the State
Department of Mental Health and used to match federal funds under
a cooperative agreement between the division and the department,
or (b) a facility which is certified by the State Department of
Mental Health to provide therapeutic and case management services,
to be reimbursed on a fee for service basis. Any such services
provided by a facility described in paragraph (b) must have the
prior approval of the division to be reimbursable under this
section. After June 30, 1997, mental health services provided by
regional mental health/retardation centers established under
Sections 41-19-31 through 41-19-39, or by hospitals as defined in
Section 41-9-3(a) and/or their subsidiaries and divisions, or by
psychiatric residential treatment facilities as defined in Section
43-11-1, or by another community mental health service provider
meeting the requirements of the Department of Mental Health to be
an approved mental health/retardation center if determined
necessary by the Department of Mental Health, shall not be
included in or provided under any capitated managed care pilot
program provided for under paragraph (24) of this section.

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

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

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

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

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

(b) Early intervention system services. The division shall cooperate with the State Department of Health, acting as lead agency, in the development and implementation of a statewide system of delivery of early intervention services, pursuant to Part H of the Individuals with Disabilities Education Act (IDEA). The State Department of Health shall certify annually in writing to the director of the division the dollar amount of state early intervention funds available which shall be utilized as a certified match for Medicaid matching funds. Those funds then shall be used to provide expanded targeted case management services for Medicaid eligible children with special needs who are eligible for the state's early intervention system. Qualifications for persons providing service coordination shall be determined by the State Department of Health and the Division of Medicaid.
(20) Home- and community-based services for physically disabled approved services as allowed by a waiver from the United States Department of Health and Human Services for home- and community-based services for physically disabled people using state funds which are provided from the appropriation to the State Department of Rehabilitation Services and used to match federal funds under a cooperative agreement between the division and the department, provided that funds for these services are specifically appropriated to the Department of Rehabilitation Services.

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

(22) Ambulatory services delivered in federally qualified health centers and in clinics of the local health departments of the State Department of Health for individuals eligible for medical assistance under this article based on reasonable costs as determined by the division.

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

(24) Managed care services in a program to be developed
by the division by a public or private provider. If managed care
services are provided by the division to Medicaid recipients, and
those managed care services are operated, managed and controlled
by and under the authority of the division, the division shall be
responsible for educating the Medicaid recipients who are
participants in the managed care program regarding the manner in
which the participants should seek health care under the program.
Notwithstanding any other provision in this article to the
contrary, the division shall establish rates of reimbursement to
providers rendering care and services authorized under this
paragraph (24), and may revise such rates of reimbursement without
amendment to this section by the Legislature for the purpose of
achieving effective and accessible health services, and for
responsible containment of costs.

(25) Birthing center services.

(26) Hospice care. As used in this paragraph, the term
"hospice care" means a coordinated program of active professional
medical attention within the home and outpatient and inpatient
care which treats the terminally ill patient and family as a unit,
employing a medically directed interdisciplinary team. The
program provides relief of severe pain or other physical symptoms
and supportive care to meet the special needs arising out of
physical, psychological, spiritual, social and economic stresses
which are experienced during the final stages of illness and
during dying and bereavement and meets the Medicare requirements
for participation as a hospice as provided in federal regulations.
(27) Group health plan premiums and cost sharing if it is cost effective as defined by the Secretary of Health and Human Services.

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

(29) The Division of Medicaid may apply for a waiver from the Department of Health and Human Services for home- and community-based services for developmentally disabled people using state funds which are provided from the appropriation to the State Department of Mental Health and used to match federal funds under a cooperative agreement between the division and the department, provided that funds for these services are specifically appropriated to the Department of Mental Health.

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

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

(32) Care and services provided in Christian Science Sanatoria operated by or listed and certified by The First Church of Christ Scientist, Boston, Massachusetts, rendered in connection with treatment by prayer or spiritual means to the extent that such services are subject to reimbursement under Section 1903 of the Social Security Act.

(33) Podiatrist services.

(34) The division shall make application to the United States Health Care Financing Administration for a waiver to develop a program of services to personal care and assisted living.
homes in Mississippi. This waiver shall be completed by December 1, 1999.

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

(36) Nonemergency transportation services for Medicaid-eligible persons, to be provided by the Division of Medicaid. The division may contract with additional entities to administer nonemergency transportation services as it deems necessary. All providers shall have a valid driver's license, vehicle inspection sticker, valid vehicle license tags and a standard liability insurance policy covering the vehicle.

(37) [Deleted]

(38) Chiropractic services: a chiropractor's manual manipulation of the spine to correct a subluxation, if x-ray demonstrates that a subluxation exists and if the subluxation has resulted in a neuromusculoskeletal condition for which manipulation is appropriate treatment. Reimbursement for chiropractic services shall not exceed Seven Hundred Dollars ($700.00) per year per recipient.

(39) Dually eligible Medicare/Medicaid beneficiaries. The division shall pay the Medicare deductible and ten percent (10%) coinsurance amounts for services available under Medicare for the duration and scope of services otherwise available under the Medicaid program.

(40) [Deleted]

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

(42) Notwithstanding any other provision in this article to the contrary, the division is hereby authorized to develop a population health management program for women and children health services through the age of two (2). This program is primarily for obstetrical care associated with low birth weight and pre-term babies. In order to effect cost savings, the division may develop a revised payment methodology which may include at-risk capitated payments.

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

(44) Nursing facility services for the severely disabled.

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

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

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

(46) The division shall make application to the federal Health Care Financing Administration for a waiver to develop and provide services for children with serious emotional disturbances as defined in Section 43-14-1(1), which may include home- and community-based services, case management services or managed care services through mental health providers certified by the Department of Mental Health. The division may implement and provide services under this waivered program only if funds for these services are specifically appropriated for this purpose by the Legislature, or if funds are voluntarily provided by affected agencies.

(47) As used in this paragraph (47):

(a) "Division" means the Division of Medicaid in the Office of the Governor.

(b) "Applicant" means a person who applies for personal care home assistance payments under this paragraph.

(c) "Recipient" means a person who resides in a personal care home, who is eligible for assistance under the Mississippi Medicaid Law as prescribed in Section 43-13-115, Mississippi Code of 1972, and who is receiving Medicaid assistance for medicine, hospital services and physician's services.

(d) "Personal care home" means any building or buildings, residence, private home, boarding home, home for persons eighteen (18) years of age or older, or other place, whether operated for profit or not, which undertakes through its ownership or management to provide, for a period exceeding twenty-four (24) hours, housing, food service, and one or more personal services for four (4) or more adults who are not related to the owner or operator by blood or marriage and who require such services, and which is licensed as a personal care home by the
State Department of Health under Section 43-11-1 et seq.,

There is established a program of assistance payments for
persons who reside in personal care homes, to be administered by
the Division of Medicaid. The amount of such assistance payments
shall be in the amount of Three Dollars ($3.00) per bed per day
for each eligible recipient, subject to appropriations therefor by
the Legislature.

Recipients of such personal care home assistance payments
shall be applicants who reside in personal care homes, who are
certified by the division as persons eligible for Medicaid
assistance, and who are receiving Medicaid assistance for
medicine, hospital services and physician's services.

The division is authorized and empowered to administer the
program of personal care home assistance payments established in
this act, and to adopt and promulgate reasonable rules,
regulations and standards, with the approval of the Governor, as
may be necessary for the proper and efficient payment of claims to
all qualified recipients.

Notwithstanding any provision of this article, except as
authorized in the following paragraph and in Section 43-13-139,
neither (a) the limitations on quantity or frequency of use of or
the fees or charges for any of the care or services available to
recipients under this section, nor (b) the payments or rates of
reimbursement to providers rendering care or services authorized
under this section to recipients, may be increased, decreased or
otherwise changed from the levels in effect on July 1, 1999,
unless such is authorized by an amendment to this section by the
Legislature. However, the restriction in this paragraph shall not
prevent the division from changing the payments or rates of
reimbursement to providers without an amendment to this section
whenever such changes are required by federal law or regulation,
or whenever such changes are necessary to correct administrative
Notwithstanding any provision of this article, no new groups or categories of recipients and new types of care and services may be added without enabling legislation from the Mississippi Legislature, except that the division may authorize such changes without enabling legislation when such addition of recipients or services is ordered by a court of proper authority. The director shall keep the Governor advised on a timely basis of the funds available for expenditure and the projected expenditures. In the event current or projected expenditures can be reasonably anticipated to exceed the amounts appropriated for any fiscal year, the Governor, after consultation with the director, shall discontinue any or all of the payment of the types of care and services as provided herein which are deemed to be optional services under Title XIX of the federal Social Security Act, as amended, for any period necessary to not exceed appropriated funds, and when necessary shall institute any other cost containment measures on any program or programs authorized under the article to the extent allowed under the federal law governing such program or programs, it being the intent of the Legislature that expenditures during any fiscal year shall not exceed the amounts appropriated for such fiscal year.

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

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