

By: Senator(s) Harden

To: Public Health and
Welfare; Appropriations

SENATE BILL NO. 2240

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

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

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

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

17 (1) Inpatient hospital services.

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

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



30 (c) Hospitals will receive an additional payment
31 for the implantable programmable baclofen drug pump used to treat
32 spasticity which is implanted on an inpatient basis. The payment
33 pursuant to written invoice will be in addition to the facility's
34 per diem reimbursement and will represent a reduction of costs on
35 the facility's annual cost report, and shall not exceed Ten
36 Thousand Dollars (\$10,000.00) per year per recipient. This
37 paragraph (c) shall stand repealed on July 1, 2005.

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

50 (3) Laboratory and x-ray services.

51 (4) Nursing facility services.

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

59 (b) From and after July 1, 1997, the division
60 shall implement the integrated case-mix payment and quality
61 monitoring system, which includes the fair rental system for
62 property costs and in which recapture of depreciation is



63 eliminated. The division may reduce the payment for hospital
64 leave and therapeutic home leave days to the lower of the case-mix
65 category as computed for the resident on leave using the
66 assessment being utilized for payment at that point in time, or a
67 case-mix score of 1.000 for nursing facilities, and shall compute
68 case-mix scores of residents so that only services provided at the
69 nursing facility are considered in calculating a facility's per
70 diem.

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

74 (d) When a facility of a category that does not
75 require a certificate of need for construction and that could not
76 be eligible for Medicaid reimbursement is constructed to nursing
77 facility specifications for licensure and certification, and the
78 facility is subsequently converted to a nursing facility pursuant
79 to a certificate of need that authorizes conversion only and the
80 applicant for the certificate of need was assessed an application
81 review fee based on capital expenditures incurred in constructing
82 the facility, the division shall allow reimbursement for capital
83 expenditures necessary for construction of the facility that were
84 incurred within the twenty-four (24) consecutive calendar months
85 immediately preceding the date that the certificate of need
86 authorizing such conversion was issued, to the same extent that
87 reimbursement would be allowed for construction of a new nursing
88 facility pursuant to a certificate of need that authorizes such
89 construction. The reimbursement authorized in this subparagraph
90 (d) may be made only to facilities the construction of which was
91 completed after June 30, 1989. Before the division shall be
92 authorized to make the reimbursement authorized in this
93 subparagraph (d), the division first must have received approval
94 from the Health Care Financing Administration of the United States



95 Department of Health and Human Services of the change in the state
96 Medicaid plan providing for such reimbursement.

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

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



128 community-based services were available to the applicant. The
129 time limitation prescribed in this paragraph shall be waived in
130 cases of emergency. If the Division of Medicaid determines that a
131 home- or other community-based setting is appropriate and
132 cost-effective, the division shall:

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

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

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

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

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

156 The division shall provide an opportunity for a fair hearing
157 under federal regulations to any applicant who is not given the
158 choice of home- or community-based services as an alternative to
159 institutional care.



160 The division shall make full payment for long-term care
161 alternative services.

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

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

190 On July 1, 1993, all fees for periodic screening and
191 diagnostic services under this paragraph (5) shall be increased by



192 twenty-five percent (25%) of the reimbursement rate in effect on
193 June 30, 1993.

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

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

212 (b) Repealed.

213 (8) Emergency medical transportation services. On
214 January 1, 1994, emergency medical transportation services shall
215 be reimbursed at seventy percent (70%) of the rate established
216 under Medicare (Title XVIII of the Social Security Act, as
217 amended). "Emergency medical transportation services" shall mean,
218 but shall not be limited to, the following services by a properly
219 permitted ambulance operated by a properly licensed provider in
220 accordance with the Emergency Medical Services Act of 1974
221 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
222 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
223 (vi) disposable supplies, (vii) similar services.



224 (9) Legend and other drugs as may be determined by the
225 division. The division may implement a program of prior approval
226 for drugs to the extent permitted by law. Payment by the division
227 for covered multiple source drugs shall be limited to the lower of
228 the upper limits established and published by the Health Care
229 Financing Administration (HCFA) plus a dispensing fee of Four
230 Dollars and Ninety-one Cents (\$4.91), or the estimated acquisition
231 cost (EAC) as determined by the division plus a dispensing fee of
232 Four Dollars and Ninety-one Cents (\$4.91), or the providers' usual
233 and customary charge to the general public. The division shall
234 allow ten (10) prescriptions per month for noninstitutionalized
235 Medicaid recipients.

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

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

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

250 As used in this paragraph (9), "estimated acquisition cost"
251 means the division's best estimate of what price providers
252 generally are paying for a drug in the package size that providers
253 buy most frequently. Product selection shall be made in
254 compliance with existing state law; however, the division may
255 reimburse as if the prescription had been filled under the generic
256 name. The division may provide otherwise in the case of specified



257 drugs when the consensus of competent medical advice is that
258 trademarked drugs are substantially more effective.

259 (10) Dental care that is an adjunct to treatment of an
260 acute medical or surgical condition; services of oral surgeons and
261 dentists in connection with surgery related to the jaw or any
262 structure contiguous to the jaw or the reduction of any fracture
263 of the jaw or any facial bone; and emergency dental extractions
264 and treatment related thereto. On July 1, 1999, all fees for
265 dental care and surgery under authority of this paragraph (10)
266 shall be increased to one hundred sixty percent (160%) of the
267 amount of the reimbursement rate that was in effect on June 30,
268 1999. It is the intent of the Legislature to encourage more
269 dentists to participate in the Medicaid program.

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

275 (12) Intermediate care facility services.

276 (a) The division shall make full payment to all
277 intermediate care facilities for the mentally retarded for each
278 day, not exceeding eighty-four (84) days per year, that a patient
279 is absent from the facility on home leave. Payment may be made
280 for the following home leave days in addition to the
281 eighty-four-day limitation: Christmas, the day before Christmas,
282 the day after Christmas, Thanksgiving, the day before Thanksgiving
283 and the day after Thanksgiving.

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

287 (13) Family planning services, including drugs,
288 supplies and devices, when such services are under the supervision
289 of a physician.



290 (14) Clinic services. Such diagnostic, preventive,
291 therapeutic, rehabilitative or palliative services furnished to an
292 outpatient by or under the supervision of a physician or dentist
293 in a facility which is not a part of a hospital but which is
294 organized and operated to provide medical care to outpatients.
295 Clinic services shall include any services reimbursed as
296 outpatient hospital services which may be rendered in such a
297 facility, including those that become so after July 1, 1991. On
298 July 1, 1999, all fees for physicians' services reimbursed under
299 authority of this paragraph (14) shall be reimbursed at ninety
300 percent (90%) of the rate established on January 1, 1999, and as
301 adjusted each January thereafter, under Medicare (Title XVIII of
302 the Social Security Act, as amended), and which shall in no event
303 be less than seventy percent (70%) of the rate established on
304 January 1, 1994. All fees for physicians' services that are
305 covered by both Medicare and Medicaid shall be reimbursed at ten
306 percent (10%) of the adjusted Medicare payment established on
307 January 1, 1999, and as adjusted each January thereafter, under
308 Medicare (Title XVIII of the Social Security Act, as amended), and
309 which shall in no event be less than seventy percent (70%) of the
310 adjusted Medicare payment established on January 1, 1994. On July
311 1, 1999, all fees for dentists' services reimbursed under
312 authority of this paragraph (14) shall be increased to one hundred
313 sixty percent (160%) of the amount of the reimbursement rate that
314 was in effect on June 30, 1999.

315 (15) Home- and community-based services, as provided
316 under Title XIX of the federal Social Security Act, as amended,
317 under waivers, subject to the availability of funds specifically
318 appropriated therefor by the Legislature. Payment for such
319 services shall be limited to individuals who would be eligible for
320 and would otherwise require the level of care provided in a
321 nursing facility. The home- and community-based services
322 authorized under this paragraph shall be expanded over a five-year



323 period beginning July 1, 1999. The division shall certify case
324 management agencies to provide case management services and
325 provide for home- and community-based services for eligible
326 individuals under this paragraph. The home- and community-based
327 services under this paragraph and the activities performed by
328 certified case management agencies under this paragraph shall be
329 funded using state funds that are provided from the appropriation
330 to the Division of Medicaid and used to match federal funds.

331 (16) Mental health services. Approved therapeutic and
332 case management services provided by (a) an approved regional
333 mental health/retardation center established under Sections
334 41-19-31 through 41-19-39, or by another community mental health
335 service provider meeting the requirements of the Department of
336 Mental Health to be an approved mental health/retardation center
337 if determined necessary by the Department of Mental Health, using
338 state funds which are provided from the appropriation to the State
339 Department of Mental Health and used to match federal funds under
340 a cooperative agreement between the division and the department,
341 or (b) a facility which is certified by the State Department of
342 Mental Health to provide therapeutic and case management services,
343 to be reimbursed on a fee for service basis. Any such services
344 provided by a facility described in paragraph (b) must have the
345 prior approval of the division to be reimbursable under this
346 section. After June 30, 1997, mental health services provided by
347 regional mental health/retardation centers established under
348 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
349 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
350 psychiatric residential treatment facilities as defined in Section
351 43-11-1, or by another community mental health service provider
352 meeting the requirements of the Department of Mental Health to be
353 an approved mental health/retardation center if determined
354 necessary by the Department of Mental Health, shall not be



355 included in or provided under any capitated managed care pilot
356 program provided for under paragraph (24) of this section.

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

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

376 (b) The division shall establish a Medicare Upper
377 Payment Limits Program as defined in Section 1902 (a) (30) of the
378 federal Social Security Act and any applicable federal
379 regulations. The division shall assess each hospital for the sole
380 purpose of financing the state portion of the Medicare Upper
381 Payment Limits Program. This assessment shall be based on
382 Medicaid utilization, or other appropriate method consistent with
383 federal regulations, and will remain in effect as long as the
384 state participates in the Medicare Upper Payment Limits Program.
385 The division shall make additional reimbursement to hospitals for
386 the Medicare Upper Payment Limits as defined in Section 1902 (a)
387 (30) of the federal Social Security Act and any applicable federal



388 regulations. This paragraph (b) shall stand repealed from and
389 after July 1, 2005.

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

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

405 (b) Early intervention system services. The
406 division shall cooperate with the State Department of Health,
407 acting as lead agency, in the development and implementation of a
408 statewide system of delivery of early intervention services,
409 pursuant to Part H of the Individuals with Disabilities Education
410 Act (IDEA). The State Department of Health shall certify annually
411 in writing to the director of the division the dollar amount of
412 state early intervention funds available which shall be utilized
413 as a certified match for Medicaid matching funds. Those funds
414 then shall be used to provide expanded targeted case management
415 services for Medicaid eligible children with special needs who are
416 eligible for the state's early intervention system.
417 Qualifications for persons providing service coordination shall be
418 determined by the State Department of Health and the Division of
419 Medicaid.



420 (20) Home- and community-based services for physically
421 disabled approved services as allowed by a waiver from the United
422 States Department of Health and Human Services for home- and
423 community-based services for physically disabled people using
424 state funds which are provided from the appropriation to the State
425 Department of Rehabilitation Services and used to match federal
426 funds under a cooperative agreement between the division and the
427 department, provided that funds for these services are
428 specifically appropriated to the Department of Rehabilitation
429 Services.

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

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

445 (23) Inpatient psychiatric services. Inpatient
446 psychiatric services to be determined by the division for
447 recipients under age twenty-one (21) which are provided under the
448 direction of a physician in an inpatient program in a licensed
449 acute care psychiatric facility or in a licensed psychiatric
450 residential treatment facility, before the recipient reaches age
451 twenty-one (21) or, if the recipient was receiving the services
452 immediately before he reached age twenty-one (21), before the



453 earlier of the date he no longer requires the services or the date
454 he reaches age twenty-two (22), as provided by federal
455 regulations. Precertification of inpatient days and residential
456 treatment days must be obtained as required by the division.

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

472 (25) Birthing center services.

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



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

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

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

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

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

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

513 (33) Podiatrist services.

514 (34) The division shall make application to the United
515 States Health Care Financing Administration for a waiver to
516 develop a program of services to personal care and assisted living



517 homes in Mississippi. This waiver shall be completed by December
518 1, 1999.

519 (35) Services and activities authorized in Sections
520 43-27-101 and 43-27-103, using state funds that are provided from
521 the appropriation to the State Department of Human Services and
522 used to match federal funds under a cooperative agreement between
523 the division and the department.

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

531 (37) [Deleted]

532 (38) Chiropractic services: a chiropractor's manual
533 manipulation of the spine to correct a subluxation, if x-ray
534 demonstrates that a subluxation exists and if the subluxation has
535 resulted in a neuromusculoskeletal condition for which
536 manipulation is appropriate treatment. Reimbursement for
537 chiropractic services shall not exceed Seven Hundred Dollars
538 (\$700.00) per year per recipient.

539 (39) Dually eligible Medicare/Medicaid beneficiaries.
540 The division shall pay the Medicare deductible and ten percent
541 (10%) coinsurance amounts for services available under Medicare
542 for the duration and scope of services otherwise available under
543 the Medicaid program.

544 (40) [Deleted]

545 (41) Services provided by the State Department of
546 Rehabilitation Services for the care and rehabilitation of persons
547 with spinal cord injuries or traumatic brain injuries, as allowed
548 under waivers from the United States Department of Health and
549 Human Services, using up to seventy-five percent (75%) of the



550 funds that are appropriated to the Department of Rehabilitation
551 Services from the Spinal Cord and Head Injury Trust Fund
552 established under Section 37-33-261 and used to match federal
553 funds under a cooperative agreement between the division and the
554 department.

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

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

568 (44) Nursing facility services for the severely
569 disabled.

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

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

577 (45) Physician assistant services. Services furnished
578 by a physician assistant who is licensed by the State Board of
579 Medical Licensure and is practicing with physician supervision
580 under regulations adopted by the board, under regulations adopted
581 by the division. Reimbursement for those services shall not



582 exceed ninety percent (90%) of the reimbursement rate for
583 comparable services rendered by a physician.

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

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

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

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

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

605 (d) "Personal care home" means any building or
606 buildings, residence, private home, boarding home, home for
607 persons eighteen (18) years of age or older, or other place,
608 whether operated for profit or not, which undertakes through its
609 ownership or management to provide, for a period exceeding
610 twenty-four (24) hours, housing, food service, and one or more
611 personal services for four (4) or more adults who are not related
612 to the owner or operator by blood or marriage and who require such
613 services, and which is licensed as a personal care home by the



614 State Department of Health under Section 43-11-1 et seq.,
615 Mississippi Code of 1972.

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

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

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

633 Notwithstanding any provision of this article, except as
634 authorized in the following paragraph and in Section 43-13-139,
635 neither (a) the limitations on quantity or frequency of use of or
636 the fees or charges for any of the care or services available to
637 recipients under this section, nor (b) the payments or rates of
638 reimbursement to providers rendering care or services authorized
639 under this section to recipients, may be increased, decreased or
640 otherwise changed from the levels in effect on July 1, 1999,
641 unless such is authorized by an amendment to this section by the
642 Legislature. However, the restriction in this paragraph shall not
643 prevent the division from changing the payments or rates of
644 reimbursement to providers without an amendment to this section
645 whenever such changes are required by federal law or regulation,
646 or whenever such changes are necessary to correct administrative



647 errors or omissions in calculating such payments or rates of
648 reimbursement.

649 Notwithstanding any provision of this article, no new groups
650 or categories of recipients and new types of care and services may
651 be added without enabling legislation from the Mississippi
652 Legislature, except that the division may authorize such changes
653 without enabling legislation when such addition of recipients or
654 services is ordered by a court of proper authority. The director
655 shall keep the Governor advised on a timely basis of the funds
656 available for expenditure and the projected expenditures. In the
657 event current or projected expenditures can be reasonably
658 anticipated to exceed the amounts appropriated for any fiscal
659 year, the Governor, after consultation with the director, shall
660 discontinue any or all of the payment of the types of care and
661 services as provided herein which are deemed to be optional
662 services under Title XIX of the federal Social Security Act, as
663 amended, for any period necessary to not exceed appropriated
664 funds, and when necessary shall institute any other cost
665 containment measures on any program or programs authorized under
666 the article to the extent allowed under the federal law governing
667 such program or programs, it being the intent of the Legislature
668 that expenditures during any fiscal year shall not exceed the
669 amounts appropriated for such fiscal year.

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



679 years after the date of submission to the Division of Medicaid of
680 an amended cost report.

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

