

By: Senator(s) Burton

To: Public Health and  
Welfare; Appropriations

SENATE BILL NO. 2609

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,  
2 TO PROVIDE FOR A RURAL HOSPITAL PRESERVATION PROGRAM WITHIN THE  
3 DIVISION OF MEDICAID, TO PROVIDE FOR CERTAIN MEDICAID  
4 REIMBURSEMENTS TO RURAL HOSPITALS UNDER CERTAIN CONDITIONS; AND  
5 FOR RELATED PURPOSES.

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

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

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

16 (1) Inpatient hospital services.

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

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



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36 paragraph (c) shall stand repealed on July 1, 2005.

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

49                   (3) Laboratory and x-ray services.

50                   (4) Nursing facility services.

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

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



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

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

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



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

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

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



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

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

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

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

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

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

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



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

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

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

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



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

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

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

211 (b) Repealed.

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



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

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

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

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

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



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

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

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

274           (12) Intermediate care facility services.

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

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

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



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

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



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

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



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

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

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

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



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

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

394 (d) The division shall establish a Rural Hospital  
395 Preservation Program under the provisions of this paragraph (d).

396 (i) The Legislature finds that:

397 1. Small rural hospitals provide most of  
398 the health care services required by a substantial number of low  
399 income rural residents living in the state and therefore  
400 constitute an invaluable part of the health care delivery system  
401 of the state.

402 2. Residents living in rural areas of  
403 the state are in poorer health than residents living in the urban  
404 areas of the state and lack adequate public transportation.

405 3. Small rural hospitals are in poor  
406 financial condition as a result of payment reductions in the  
407 Medicare and Medicaid programs and lack of a substantial private  
408 payor base to offset those reductions.

409 4. Small rural hospitals have a  
410 difficult time attracting physicians to practice in their service  
411 areas, thereby resulting in a continued shortage of primary health  
412 care in the state's rural areas.

413 5. Absent intervention, continued  
414 reductions in the Medicare and Medicaid programs, as well as  
415 changes in health care reimbursement methodologies, have caused  
416 and will continue to cause the closure of many of the state's  
417 small rural hospitals, thereby jeopardizing the very existence of  
418 a vital link in the health care delivery system for residents  
419 residing in rural areas of the state.



420 6. Rural hospitals constitute, in many  
421 instances, the largest single employer of residents in areas  
422 served by them and thus constitute a vital economic component of  
423 many rural county economies.

424 (ii) The Legislature hereby declares that  
425 absent the enactment of the following provisions, the very  
426 existence of Mississippi's small rural hospital is imperiled. The  
427 Legislature hereby declares that the purpose of this act is to  
428 assure the continued viability of rural hospitals.

429 (iii) As used in this subparagraph (iii):

430 1. "Division" means the Mississippi  
431 Division of Medicaid, or its successor, in the role of designated  
432 state agency under Title XIX of the Social Security Act or any  
433 successor act, including, but not limited to, block grants or  
434 other funding for medical care of the poor.

435 2. "Emergency medical condition" means  
436 acute symptoms of sufficient severity such that the absence of  
437 immediate medical attention could reasonably be expected to result  
438 in any one or more of the following:

439 a. Placing the health of the  
440 individual in serious jeopardy, including the health of the unborn  
441 child in the case of a pregnant woman.

442 b. Serious impairment to any bodily  
443 function.

444 c. Serious dysfunction of any  
445 bodily part.

446 3. a. "Rural hospital" means a hospital  
447 licensed by the State Department of Health which meets one (1) of  
448 the following criteria: A. has no more than ninety (90) acute  
449 care hospital beds as of July 1, 2001; and (aa) is located in a  
450 county with a population of less than forty thousand (40,000); or  
451 (bb) is located in a municipality with a population of less than  
452 fifteen thousand (15,000).



453 b. "Rural hospital" does not mean a  
454 long-term care hospital, a rehabilitation hospital or a  
455 free-standing psychiatric hospital.

456 4. "State plan for medical assistance"  
457 means the plan promulgated by the division in accordance with its  
458 role as designated state agency under Title XIX of the Social  
459 Security Act, or its successor plan, including, but not limited  
460 to, any plan adopted pursuant to any federal law creating block  
461 grants or other funding for medical care of the poor.

462 5. The division shall adopt rules and  
463 regulations in accordance with the Administrative Procedure Act  
464 that provide the following:

465 a. Allow a rural hospital to  
466 certify as a contributing public agency, public funds as  
467 representing expenditures eligible for federal financial  
468 participation in the Medicaid program to the extent authorized by  
469 federal law. The expenditure of such funds shall be in accordance  
470 with rules promulgated by the division.

471 b. Maximize funding for services  
472 provided by rural hospitals to the extent allowed by federal law  
473 and in amounts as may be appropriated by the Legislature.

474 6. a. With respect to reimbursement for  
475 services furnished in another state, the division shall insure  
476 that reimbursement for such services shall be the lesser of the  
477 payment for such services by the state wherein such hospital is  
478 located or the division's payment made to like in-state providers.  
479 The division shall provide coverage for such services to the same  
480 extent that it would pay for services furnished within the  
481 boundaries of this state, only if any of the following conditions  
482 are met: A. medical services are needed because of a medical  
483 emergency; B. medical services are needed and the recipient's  
484 health would be endangered if he were required to travel to his  
485 state or residence; C. the state determines, on the basis of



486 medical advice, that the needed medical services are necessary  
487 supplementary resources, and more readily available in the other  
488 state; and D. it is general practice for recipients in a  
489 particular locality to use medical resources in another state.

490 b. In the event federal  
491 requirements for the state plan for medical assistance permit the  
492 division to impose further restrictions on payment for and  
493 coverage of medical services to Mississippi Medicaid patients  
494 rendered by out-of-state providers, the division shall promulgate  
495 regulations restricting payment for and coverage of such services  
496 to the fullest extent permitted by law.

497 7. The rules and regulations promulgated  
498 pursuant to subparagraph (i) of this item shall be promulgated no  
499 later than one hundred twenty (120) days after the effective date  
500 of this act. No later than one hundred twenty (120) days after  
501 the effective date of this act, the division shall also submit to  
502 the Secretary of the United States Department of Health and Human  
503 Services those amendments to the state plan for medical assistance  
504 necessary to conform the state plan for medical assistance with  
505 the provisions of subparagraph (i) of this item.

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

516 (b) Early intervention system services. The  
517 division shall cooperate with the State Department of Health,  
518 acting as lead agency, in the development and implementation of a



519 statewide system of delivery of early intervention services,  
520 pursuant to Part H of the Individuals with Disabilities Education  
521 Act (IDEA). The State Department of Health shall certify annually  
522 in writing to the director of the division the dollar amount of  
523 state early intervention funds available which shall be utilized  
524 as a certified match for Medicaid matching funds. Those funds  
525 then shall be used to provide expanded targeted case management  
526 services for Medicaid eligible children with special needs who are  
527 eligible for the state's early intervention system.  
528 Qualifications for persons providing service coordination shall be  
529 determined by the State Department of Health and the Division of  
530 Medicaid.

531 (20) Home- and community-based services for physically  
532 disabled approved services as allowed by a waiver from the United  
533 States Department of Health and Human Services for home- and  
534 community-based services for physically disabled people using  
535 state funds which are provided from the appropriation to the State  
536 Department of Rehabilitation Services and used to match federal  
537 funds under a cooperative agreement between the division and the  
538 department, provided that funds for these services are  
539 specifically appropriated to the Department of Rehabilitation  
540 Services.

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



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

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

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

583           (25) Birthing center services.



584           (26) Hospice care. As used in this paragraph, the term  
585 "hospice care" means a coordinated program of active professional  
586 medical attention within the home and outpatient and inpatient  
587 care which treats the terminally ill patient and family as a unit,  
588 employing a medically directed interdisciplinary team. The  
589 program provides relief of severe pain or other physical symptoms  
590 and supportive care to meet the special needs arising out of  
591 physical, psychological, spiritual, social and economic stresses  
592 which are experienced during the final stages of illness and  
593 during dying and bereavement and meets the Medicare requirements  
594 for participation as a hospice as provided in federal regulations.

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

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

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

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

612           (31) Targeted case management services for children  
613 with special needs, under waivers from the United States  
614 Department of Health and Human Services, using state funds that  
615 are provided from the appropriation to the Mississippi Department



616 of Human Services and used to match federal funds under a  
617 cooperative agreement between the division and the department.

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

624 (33) Podiatrist services.

625 (34) The division shall make application to the United  
626 States Health Care Financing Administration for a waiver to  
627 develop a program of services to personal care and assisted living  
628 homes in Mississippi. This waiver shall be completed by December  
629 1, 1999.

630 (35) Services and activities authorized in Sections  
631 43-27-101 and 43-27-103, using state funds that are provided from  
632 the appropriation to the State Department of Human Services and  
633 used to match federal funds under a cooperative agreement between  
634 the division and the department.

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

642 (37) [Deleted]

643 (38) Chiropractic services: a chiropractor's manual  
644 manipulation of the spine to correct a subluxation, if x-ray  
645 demonstrates that a subluxation exists and if the subluxation has  
646 resulted in a neuromusculoskeletal condition for which  
647 manipulation is appropriate treatment. Reimbursement for



648 chiropractic services shall not exceed Seven Hundred Dollars  
649 (\$700.00) per year per recipient.

650 (39) Dually eligible Medicare/Medicaid beneficiaries.  
651 The division shall pay the Medicare deductible and ten percent  
652 (10%) coinsurance amounts for services available under Medicare  
653 for the duration and scope of services otherwise available under  
654 the Medicaid program.

655 (40) [Deleted]

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

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

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

679 (44) Nursing facility services for the severely  
680 disabled.



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

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

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

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

706 Notwithstanding any provision of this article, except as  
707 authorized in the following paragraph and in Section 43-13-139,  
708 neither (a) the limitations on quantity or frequency of use of or  
709 the fees or charges for any of the care or services available to  
710 recipients under this section, nor (b) the payments or rates of  
711 reimbursement to providers rendering care or services authorized  
712 under this section to recipients, may be increased, decreased or  
713 otherwise changed from the levels in effect on July 1, 1999,



714 unless such is authorized by an amendment to this section by the  
715 Legislature. However, the restriction in this paragraph shall not  
716 prevent the division from changing the payments or rates of  
717 reimbursement to providers without an amendment to this section  
718 whenever such changes are required by federal law or regulation,  
719 or whenever such changes are necessary to correct administrative  
720 errors or omissions in calculating such payments or rates of  
721 reimbursement.

722 Notwithstanding any provision of this article, no new groups  
723 or categories of recipients and new types of care and services may  
724 be added without enabling legislation from the Mississippi  
725 Legislature, except that the division may authorize such changes  
726 without enabling legislation when such addition of recipients or  
727 services is ordered by a court of proper authority. The director  
728 shall keep the Governor advised on a timely basis of the funds  
729 available for expenditure and the projected expenditures. In the  
730 event current or projected expenditures can be reasonably  
731 anticipated to exceed the amounts appropriated for any fiscal  
732 year, the Governor, after consultation with the director, shall  
733 discontinue any or all of the payment of the types of care and  
734 services as provided herein which are deemed to be optional  
735 services under Title XIX of the federal Social Security Act, as  
736 amended, for any period necessary to not exceed appropriated  
737 funds, and when necessary shall institute any other cost  
738 containment measures on any program or programs authorized under  
739 the article to the extent allowed under the federal law governing  
740 such program or programs, it being the intent of the Legislature  
741 that expenditures during any fiscal year shall not exceed the  
742 amounts appropriated for such fiscal year.

743 Notwithstanding any other provision of this article, it shall  
744 be the duty of each nursing facility, intermediate care facility  
745 for the mentally retarded, psychiatric residential treatment  
746 facility, and nursing facility for the severely disabled that is



747 participating in the medical assistance program to keep and  
748 maintain books, documents, and other records as prescribed by the  
749 Division of Medicaid in substantiation of its cost reports for a  
750 period of three (3) years after the date of submission to the  
751 Division of Medicaid of an original cost report, or three (3)  
752 years after the date of submission to the Division of Medicaid of  
753 an amended cost report.

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

