By: Senator(s) Robertson

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2893

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO INCREASE THE MEDICAID BASE REIMBURSEMENT RATE FOR EMERGENCY
3 MEDICAL TRANSPORTATION SERVICES; AND FOR RELATED PURPOSES.

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

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

7 43-13-117. Medical assistance as authorized by this article
8 shall include payment of part or all of the costs, at the
9 discretion of the division or its successor, with approval of the
10 Governor, of the following types of care and services rendered to
11 eligible applicants who shall have been determined to be eligible
12 for such care and services, within the limits of state
13 appropriations and federal matching funds:

14 (1) Inpatient hospital services.

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

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

27 (c) Hospitals will receive an additional payment
28 for the implantable programmable baclofen drug pump used to treat
29 spasticity which is implanted on an inpatient basis. The payment
30 pursuant to written invoice will be in addition to the facility's
31 per diem reimbursement and will represent a reduction of costs on
32 the facility's annual cost report, and shall not exceed Ten
33 Thousand Dollars ($10,000.00) per year per recipient. This
34 paragraph (c) shall stand repealed on July 1, 2005.
35 (2) Outpatient hospital services. Provided that where
36 the same services are reimbursed as clinic services, the division
37 may revise the rate or methodology of outpatient reimbursement to
38 maintain consistency, efficiency, economy and quality of care.
39 The division shall develop a Medicaid-specific cost-to-charge
40 ratio calculation from data provided by hospitals to determine an
41 allowable rate payment for outpatient hospital services, and shall
42 submit a report thereon to the Medical Advisory Committee on or
43 before December 1, 1999. The committee shall make a
44 recommendation on the specific cost-to-charge reimbursement method
45 for outpatient hospital services to the 2000 Regular Session of
46 the Legislature.
47 (3) Laboratory and x-ray services.
48 (4) Nursing facility services.
49 (a) The division shall make full payment to
50 nursing facilities for each day, not exceeding fifty-two (52) days
51 per year, that a patient is absent from the facility on home
52 leave. Payment may be made for the following home leave days in
53 addition to the fifty-two-day limitation: Christmas, the day
54 before Christmas, the day after Christmas, Thanksgiving, the day
55 before Thanksgiving and the day after Thanksgiving.
56 (b) From and after July 1, 1997, the division
57 shall implement the integrated case-mix payment and quality
58 monitoring system, which includes the fair rental system for
59 property costs and in which recapture of depreciation is

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

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

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

92 Department of Health and Human Services of the change in the state
93 Medicaid plan providing for such reimbursement.
94 (e) The division shall develop and implement, not
95 later than January 1, 2001, a case-mix payment add-on determined
96 by time studies and other valid statistical data which will
97 reimburse a nursing facility for the additional cost of caring for
98 a resident who has a diagnosis of Alzheimer's or other related
99 dementia and exhibits symptoms that require special care. Any
100 such case-mix add-on payment shall be supported by a determination
101 of additional cost. The division shall also develop and implement
102 as part of the fair rental reimbursement system for nursing
103 facility beds, an Alzheimer's resident bed depreciation enhanced
104 reimbursement system which will provide an incentive to encourage
105 nursing facilities to convert or construct beds for residents with
106 Alzheimer's or other related dementia.
107 (f) The Division of Medicaid shall develop and
108 implement a referral process for long-term care alternatives for
109 Medicaid beneficiaries and applicants. No Medicaid beneficiary
110 shall be admitted to a Medicaid-certified nursing facility unless
111 a licensed physician certifies that nursing facility care is
112 appropriate for that person on a standardized form to be prepared
113 and provided to nursing facilities by the Division of Medicaid.
114 The physician shall forward a copy of that certification to the
115 Division of Medicaid within twenty-four (24) hours after it is
116 signed by the physician. Any physician who fails to forward the
117 certification to the Division of Medicaid within the time period
118 specified in this paragraph shall be ineligible for Medicaid
119 reimbursement for any physician's services performed for the
120 applicant. The Division of Medicaid shall determine, through an
121 assessment of the applicant conducted within two (2) business days
122 after receipt of the physician's certification, whether the
123 applicant also could live appropriately and cost-effectively at
124 home or in some other community-based setting if home- or

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

157 The division shall make full payment for long-term care
158 alternative services.
159 The division shall apply for necessary federal waivers to
160 assure that additional services providing alternatives to nursing
161 facility care are made available to applicants for nursing
162 facility care.
163 (5) Periodic screening and diagnostic services for
164 individuals under age twenty-one (21) years as are needed to
165 identify physical and mental defects and to provide health care
166 treatment and other measures designed to correct or ameliorate
167 defects and physical and mental illness and conditions discovered
168 by the screening services regardless of whether these services are
169 included in the state plan. The division may include in its
170 periodic screening and diagnostic program those discretionary
171 services authorized under the federal regulations adopted to
172 implement Title XIX of the federal Social Security Act, as
173 amended. The division, in obtaining physical therapy services,
174 occupational therapy services, and services for individuals with
175 speech, hearing and language disorders, may enter into a
176 cooperative agreement with the State Department of Education for
177 the provision of such services to handicapped students by public
178 school districts using state funds which are provided from the
179 appropriation to the Department of Education to obtain federal
180 matching funds through the division. The division, in obtaining
181 medical and psychological evaluations for children in the custody
182 of the State Department of Human Services may enter into a
183 cooperative agreement with the State Department of Human Services
184 for the provision of such services using state funds which are
185 provided from the appropriation to the Department of Human
186 Services to obtain federal matching funds through the division.
187 On July 1, 1993, all fees for periodic screening and
188 diagnostic services under this paragraph (5) shall be increased by

189 twenty-five percent (25%) of the reimbursement rate in effect on
190 June 30, 1993.
191 (6) Physician's services. The division shall allow
192 twelve (12) physician visits annually. All fees for physicians'
193 services that are covered only by Medicaid shall be reimbursed at
194 ninety percent (90%) of the rate established on January 1, 1999,
195 and as adjusted each January thereafter, under Medicare (Title
196 XVIII of the Social Security Act, as amended), and which shall in
197 no event be less than seventy percent (70%) of the rate
198 established on January 1, 1994. All fees for physicians' services
199 that are covered by both Medicare and Medicaid shall be reimbursed
200 at ten percent (10%) of the adjusted Medicare payment established
201 on January 1, 1999, and as adjusted each January thereafter, under
202 Medicare (Title XVIII of the Social Security Act, as amended), and
203 which shall in no event be less than seventy percent (70%) of the
204 adjusted Medicare payment established on January 1, 1994.
205 (7) (a) Home health services for eligible persons, not
206 to exceed in cost the prevailing cost of nursing facility
207 services, not to exceed sixty (60) visits per year. All home
208 health visits must be precertified as required by the division.
209 (b) Repealed.
210 (8) Emergency medical transportation services. On
211 January 1, 1994, emergency medical transportation services shall
212 be reimbursed at seventy percent (70%) of the rate established
213 under Medicare (Title XVIII of the Social Security Act, as
214 amended). Beginning July 1, 2002, the nonemergency base
215 reimbursement rate per transport shall be One Hundred Fifty-two
216 Dollars and Seventy-two Cents ($152.75) and the emergency base
217 reimbursement rate per transport shall be Three Hundred Forty-six
218 Dollars and Forty-five Cents ($346.45). "Emergency medical
219 transportation services" shall mean, but shall not be limited to,
220 the following services by a properly permitted ambulance operated
221 by a properly licensed provider in accordance with the Emergency

222 Medical Services Act of 1974 (Section 41-59-1 et seq.): (i) basic
223 life support, (ii) advanced life support, (iii) mileage, (iv)
224 oxygen, (v) intravenous fluids, (vi) disposable supplies, (vii)
225 similar services.

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

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

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

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

252 As used in this paragraph (9), "estimated acquisition cost"
253 means the division's best estimate of what price providers
254 generally are paying for a drug in the package size that providers

255 buy most frequently. Product selection shall be made in
256 compliance with existing state law; however, the division may
257 reimburse as if the prescription had been filled under the generic
258 name. The division may provide otherwise in the case of specified
259 drugs when the consensus of competent medical advice is that
260 trademarked drugs are substantially more effective.

261 (10) Dental care that is an adjunct to treatment of an
262 acute medical or surgical condition; services of oral surgeons and
263 dentists in connection with surgery related to the jaw or any
264 structure contiguous to the jaw or the reduction of any fracture
265 of the jaw or any facial bone; and emergency dental extractions
266 and treatment related thereto. On July 1, 1999, all fees for
267 dental care and surgery under authority of this paragraph (10)
268 shall be increased to one hundred sixty percent (160%) of the
269 amount of the reimbursement rate that was in effect on June 30,
270 1999. It is the intent of the Legislature to encourage more
271 dentists to participate in the Medicaid program.

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

277 (12) Intermediate care facility services.

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

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

319 under waivers, subject to the availability of funds specifically
320 appropriated therefor by the Legislature. Payment for such
321 services shall be limited to individuals who would be eligible for
322 and would otherwise require the level of care provided in a
323 nursing facility. The home- and community-based services
324 authorized under this paragraph shall be expanded over a five-year
325 period beginning July 1, 1999. The division shall certify case
326 management agencies to provide case management services and
327 provide for home- and community-based services for eligible
328 individuals under this paragraph. The home- and community-based
329 services under this paragraph and the activities performed by
330 certified case management agencies under this paragraph shall be
331 funded using state funds that are provided from the appropriation
332 to the Division of Medicaid and used to match federal funds.
333 (16) Mental health services. Approved therapeutic and
334 case management services provided by (a) an approved regional
335 mental health/retardation center established under Sections
336 41-19-31 through 41-19-39, or by another community mental health
337 service provider meeting the requirements of the Department of
338 Mental Health to be an approved mental health/retardation center
339 if determined necessary by the Department of Mental Health, using
340 state funds which are provided from the appropriation to the State
341 Department of Mental Health and used to match federal funds under
342 a cooperative agreement between the division and the department,
343 or (b) a facility which is certified by the State Department of
344 Mental Health to provide therapeutic and case management services,
345 to be reimbursed on a fee for service basis. Any such services
346 provided by a facility described in paragraph (b) must have the
347 prior approval of the division to be reimbursable under this
348 section. After June 30, 1997, mental health services provided by
349 regional mental health/retardation centers established under
350 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
351 Section 41-9-3(a) and/or their subsidiaries and divisions, or by

352 psychiatric residential treatment facilities as defined in Section
353 43-11-1, or by another community mental health service provider
354 meeting the requirements of the Department of Mental Health to be
355 an approved mental health/retardation center if determined
356 necessary by the Department of Mental Health, shall not be
357 included in or provided under any capitated managed care pilot
358 program provided for under paragraph (24) of this section.

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

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

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

385 federal regulations, and will remain in effect as long as the
386 state participates in the Medicare Upper Payment Limits Program.
387 The division shall make additional reimbursement to hospitals for
388 the Medicare Upper Payment Limits as defined in Section 1902 (a)
389 (30) of the federal Social Security Act and any applicable federal
390 regulations. This paragraph (b) shall stand repealed from and
391 after July 1, 2005.
392 (c) The division shall contract with the
393 Mississippi Hospital Association to provide administrative support
394 for the operation of the disproportionate share hospital program
395 and the Medicare Upper Payment Limits Program. This paragraph (c)
396 shall stand repealed from and after July 1, 2005.
397 (19) (a) Perinatal risk management services. The
398 division shall promulgate regulations to be effective from and
399 after October 1, 1988, to establish a comprehensive perinatal
400 system for risk assessment of all pregnant and infant Medicaid
401 recipients and for management, education and follow-up for those
402 who are determined to be at risk. Services to be performed
403 include case management, nutrition assessment/counseling,
404 psychosocial assessment/counseling and health education. The
405 division shall set reimbursement rates for providers in
406 conjunction with the State Department of Health.
407 (b) Early intervention system services. The
408 division shall cooperate with the State Department of Health,
409 acting as lead agency, in the development and implementation of a
410 statewide system of delivery of early intervention services,
411 pursuant to Part H of the Individuals with Disabilities Education
412 Act (IDEA). The State Department of Health shall certify annually
413 in writing to the director of the division the dollar amount of
414 state early intervention funds available which shall be utilized
415 as a certified match for Medicaid matching funds. Those funds
416 then shall be used to provide expanded targeted case management
417 services for Medicaid eligible children with special needs who are

418 eligible for the state's early intervention system.
419 Qualifications for persons providing service coordination shall be
420 determined by the State Department of Health and the Division of
421 Medicaid.

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

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

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

447 (23) Inpatient psychiatric services. Inpatient
448 psychiatric services to be determined by the division for
449 recipients under age twenty-one (21) which are provided under the
450 direction of a physician in an inpatient program in a licensed

451 acute care psychiatric facility or in a licensed psychiatric
452 residential treatment facility, before the recipient reaches age
453 twenty-one (21) or, if the recipient was receiving the services
454 immediately before he reached age twenty-one (21), before the
455 earlier of the date he no longer requires the services or the date
456 he reaches age twenty-two (22), as provided by federal
457 regulations. Precertification of inpatient days and residential
458 treatment days must be obtained as required by the division.
459 (24) Managed care services in a program to be developed
460 by the division by a public or private provider. If managed care
461 services are provided by the division to Medicaid recipients, and
462 those managed care services are operated, managed and controlled
463 by and under the authority of the division, the division shall be
464 responsible for educating the Medicaid recipients who are
465 participants in the managed care program regarding the manner in
466 which the participants should seek health care under the program.
467 Notwithstanding any other provision in this article to the
468 contrary, the division shall establish rates of reimbursement to
469 providers rendering care and services authorized under this
470 paragraph (24), and may revise such rates of reimbursement without
471 amendment to this section by the Legislature for the purpose of
472 achieving effective and accessible health services, and for
473 responsible containment of costs.
474 (25) Birthing center services.
475 (26) Hospice care. As used in this paragraph, the term
476 "hospice care" means a coordinated program of active professional
477 medical attention within the home and outpatient and inpatient
478 care which treats the terminally ill patient and family as a unit,
479 employing a medically directed interdisciplinary team. The
480 program provides relief of severe pain or other physical symptoms
481 and supportive care to meet the special needs arising out of
482 physical, psychological, spiritual, social and economic stresses
483 which are experienced during the final stages of illness and

484 during dying and bereavement and meets the Medicare requirements
485 for participation as a hospice as provided in federal regulations.
486 (27) Group health plan premiums and cost sharing if it
487 is cost effective as defined by the Secretary of Health and Human
488 Services.
489 (28) Other health insurance premiums which are cost
490 effective as defined by the Secretary of Health and Human
491 Services. Medicare eligible must have Medicare Part B before
492 other insurance premiums can be paid.
493 (29) The Division of Medicaid may apply for a waiver
494 from the Department of Health and Human Services for home- and
495 community-based services for developmentally disabled people using
496 state funds which are provided from the appropriation to the State
497 Department of Mental Health and used to match federal funds under
498 a cooperative agreement between the division and the department,
499 provided that funds for these services are specifically
500 appropriated to the Department of Mental Health.
501 (30) Pediatric skilled nursing services for eligible
502 persons under twenty-one (21) years of age.
503 (31) Targeted case management services for children
504 with special needs, under waivers from the United States
505 Department of Health and Human Services, using state funds that
506 are provided from the appropriation to the Mississippi Department
507 of Human Services and used to match federal funds under a
508 cooperative agreement between the division and the department.
509 (32) Care and services provided in Christian Science
510 Sanatoria operated by or listed and certified by The First Church
511 of Christ Scientist, Boston, Massachusetts, rendered in connection
512 with treatment by prayer or spiritual means to the extent that
513 such services are subject to reimbursement under Section 1903 of
514 the Social Security Act.
515 (33) Podiatrist services.

516 (34) The division shall make application to the United
517 States Health Care Financing Administration for a waiver to
518 develop a program of services to personal care and assisted living
519 homes in Mississippi. This waiver shall be completed by December
520 1, 1999.
521 (35) Services and activities authorized in Sections
522 43-27-101 and 43-27-103, using state funds that are provided from
523 the appropriation to the State Department of Human Services and
524 used to match federal funds under a cooperative agreement between
525 the division and the department.
526 (36) Nonemergency transportation services for
527 Medicaid-eligible persons, to be provided by the Division of
528 Medicaid. The division may contract with additional entities to
529 administer nonemergency transportation services as it deems
530 necessary. All providers shall have a valid driver's license,
531 vehicle inspection sticker, valid vehicle license tags and a
532 standard liability insurance policy covering the vehicle.
533 (37) [Deleted]
534 (38) Chiropractic services: a chiropractor's manual
535 manipulation of the spine to correct a subluxation, if x-ray
536 demonstrates that a subluxation exists and if the subluxation has
537 resulted in a neuromusculoskeletal condition for which
538 manipulation is appropriate treatment. Reimbursement for
539 chiropractic services shall not exceed Seven Hundred Dollars
540 ($700.00) per year per recipient.
541 (39) Dually eligible Medicare/Medicaid beneficiaries.
542 The division shall pay the Medicare deductible and ten percent
543 (10%) coinsurance amounts for services available under Medicare
544 for the duration and scope of services otherwise available under
545 the Medicaid program.
546 (40) [Deleted]
547 (41) Services provided by the State Department of
548 Rehabilitation Services for the care and rehabilitation of persons

549 with spinal cord injuries or traumatic brain injuries, as allowed
550 under waivers from the United States Department of Health and
551 Human Services, using up to seventy-five percent (75%) of the
552 funds that are appropriated to the Department of Rehabilitation
553 Services from the Spinal Cord and Head Injury Trust Fund
554 established under Section 37-33-261 and used to match federal
555 funds under a cooperative agreement between the division and the
556 department.

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

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

570 (44) Nursing facility services for the severely
571 disabled.

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

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

579 (45) Physician assistant services. Services furnished
580 by a physician assistant who is licensed by the State Board of
581 Medical Licensure and is practicing with physician supervision

582 under regulations adopted by the board, under regulations adopted
583 by the division. Reimbursement for those services shall not
584 exceed ninety percent (90%) of the reimbursement rate for
585 comparable services rendered by a physician.

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

597 Notwithstanding any provision of this article, except as
598 authorized in the following paragraph and in Section 43-13-139,
599 neither (a) the limitations on quantity or frequency of use of or
600 the fees or charges for any of the care or services available to
601 recipients under this section, nor (b) the payments or rates of
602 reimbursement to providers rendering care or services authorized
603 under this section to recipients, may be increased, decreased or
604 otherwise changed from the levels in effect on July 1, 1999,
605 unless such is authorized by an amendment to this section by the
606 Legislature. However, the restriction in this paragraph shall not
607 prevent the division from changing the payments or rates of
608 reimbursement to providers without an amendment to this section
609 whenever such changes are required by federal law or regulation,
610 or whenever such changes are necessary to correct administrative
611 errors or omissions in calculating such payments or rates of
612 reimbursement.

613 Notwithstanding any provision of this article, no new groups
614 or categories of recipients and new types of care and services may

615 be added without enabling legislation from the Mississippi
616 Legislature, except that the division may authorize such changes
617 without enabling legislation when such addition of recipients or
618 services is ordered by a court of proper authority. The director
619 shall keep the Governor advised on a timely basis of the funds
620 available for expenditure and the projected expenditures. In the
621 event current or projected expenditures can be reasonably
622 anticipated to exceed the amounts appropriated for any fiscal
623 year, the Governor, after consultation with the director, shall
624 discontinue any or all of the payment of the types of care and
625 services as provided herein which are deemed to be optional
626 services under Title XIX of the federal Social Security Act, as
627 amended, for any period necessary to not exceed appropriated
628 funds, and when necessary shall institute any other cost
629 containment measures on any program or programs authorized under
630 the article to the extent allowed under the federal law governing
631 such program or programs, it being the intent of the Legislature
632 that expenditures during any fiscal year shall not exceed the
633 amounts appropriated for such fiscal year.

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

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

ST: Emergency medical transportation services Medicaid reimbursement; increase base rate.