MISSISSIPPI LEGISLATURE REGULAR SESSION 2002

By: Senator(s) Huggins

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 3060

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO ADD "DONATED FUNDS" TO THE MEDICAID LAW AUTHORIZING COMMUNITY
3 MENTAL HEALTH CENTER FUNDS TO BE USED AS MEDICAID MATCH FOR
4 REIMBURSEMENT OF MENTAL HEALTH SERVICES OR HOME- AND COMMUNITY-
5 BASED SERVICES; AND 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36 paragraph (c) shall stand repealed on July 1, 2005.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 <u>and/or funds contributed</u>
318 <u>or transferred to a state agency by a political subdivision or</u>
319 <u>instrumentality of the state</u>. Payment for <u>those</u> services shall be
320 limited to individuals who would be eligible for and would
321 otherwise require the level of care provided in a nursing

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

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

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

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

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

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

421 eligible for the state's early intervention system.
422 Qualifications for persons providing service coordination shall be
423 determined by the State Department of Health and the Division of
424 Medicaid.
425 (20) Home- and community-based services for physically
426 disabled approved services as allowed by a waiver from the United
427 States Department of Health and Human Services for home- and
428 community-based services for physically disabled people using
429 state funds which are provided from the appropriation to the State
430 Department of Rehabilitation Services and used to match federal
431 funds under a cooperative agreement between the division and the
432 department, provided that funds for these services are
433 specifically appropriated to the Department of Rehabilitation
434 Services.
435 (21) Nurse practitioner services. Services furnished
436 by a registered nurse who is licensed and certified by the
437 Mississippi Board of Nursing as a nurse practitioner including,
438 but not limited to, nurse anesthetists, nurse midwives, family
439 nurse practitioners, family planning nurse practitioners,
440 pediatric nurse practitioners, obstetrics-gynecology nurse
441 practitioners and neonatal nurse practitioners, under regulations
442 adopted by the division. Reimbursement for such services shall
443 not exceed ninety percent (90%) of the reimbursement rate for
444 comparable services rendered by a physician.
445 (22) Ambulatory services delivered in federally
446 qualified health centers and in clinics of the local health
447 departments of the State Department of Health for individuals
448 eligible for medical assistance under this article based on
449 reasonable costs as determined by the division.
450 (23) Inpatient psychiatric services. Inpatient
451 psychiatric services to be determined by the division for
452 recipients under age twenty-one (21) which are provided under the
453 direction of a physician in an inpatient program in a licensed

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

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

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

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

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

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

573 (44) Nursing facility services for the severely
574 disabled.

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

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

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

585 under regulations adopted by the board, under regulations adopted
586 by the division. Reimbursement for those services shall not
587 exceed ninety percent (90%) of the reimbursement rate for
588 comparable services rendered by a physician.
589 (46) The division shall make application to the federal
590 Health Care Financing Administration for a waiver to develop and
591 provide services for children with serious emotional disturbances
592 as defined in Section 43-14-1(1), which may include home- and
593 community-based services, case management services or managed care
594 services through mental health providers certified by the
595 Department of Mental Health. The division may implement and
596 provide services under this waivered program only if funds for
597 these services are specifically appropriated for this purpose by
598 the Legislature, or if funds are voluntarily provided by affected
599 agencies.
600 Notwithstanding any provision of this article, except as
601 authorized in the following paragraph and in Section 43-13-139,
602 neither (a) the limitations on quantity or frequency of use of or
603 the fees or charges for any of the care or services available to
604 recipients under this section, nor (b) the payments or rates of
605 reimbursement to providers rendering care or services authorized
606 under this section to recipients, may be increased, decreased or
607 otherwise changed from the levels in effect on July 1, 1999,
608 unless such is authorized by an amendment to this section by the
609 Legislature. However, the restriction in this paragraph shall not
610 prevent the division from changing the payments or rates of
611 reimbursement to providers without an amendment to this section
612 whenever such changes are required by federal law or regulation,
613 or whenever such changes are necessary to correct administrative
614 errors or omissions in calculating such payments or rates of
615 reimbursement.
616 Notwithstanding any provision of this article, no new groups
617 or categories of recipients and new types of care and services may

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

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

648 **SECTION 2.** Any contribution or transfer of funds to a state
649 agency by a political subdivision or instrumentality of the state
650 before the effective date of House Bill No. 3060, 2002 Regular

651 Session, which funds were used to match federal funds to provide
652 services under paragraph (15) or (16) of Section 43-13-117, is
653 ratified, approved and confirmed.

654 **SECTION 3**. This act shall take effect and be in force from
655 and after its passage.

ST: Community mental health center donated funds may be used for Medicaid match for mental health or home/community services; authorize.