MISSISSIPPI LEGISLATURE REGULAR SESSION 2002

By: Senator(s) Gollott

To: Insurance; Public Health and Welfare

SENATE BILL NO. 3063

1 AN ACT TO AMEND SECTIONS 83-9-6 AND 25-15-9, MISSISSIPPI CODE
2 OF 1972, TO PROHIBIT HEALTH INSURANCE PLANS, EMPLOYEE BENEFIT
3 PLANS, THE STATE PUBLIC EMPLOYEE AND SCHOOL DISTRICT EMPLOYEE
4 HEALTH INSURANCE PLAN AND HEALTH MAINTENANCE ORGANIZATIONS FROM
5 REIMBURSING FOR DRUGS OR PHARMACY SERVICES AT A RATE THAT IS MORE
6 COSTLY THAN THAT CHARGED FOR SUCH DRUG OR SERVICE IN ANY OTHER
7 STATE, TO REQUIRE THE PHARMACY PROVIDER TO AGREE TO PROVIDE DRUGS
8 OR PHARMACY SERVICES UNDER SUCH PLAN AT A RATE THAT IS NO MORE
9 COSTLY THAN THAT CHARGED FOR SUCH DRUG OR SERVICE IN ANY OTHER
10 STATE, AND TO PROHIBIT ANY PHARMACY PROVIDER FROM IMPOSING ANY
11 PAYMENT OR CONDITION RELATING TO PURCHASING PHARMACY SERVICES THAT
12 IS MORE COSTLY OR RESTRICTIVE THAN THAT WHICH IS IMPOSED UPON THE
13 BENEFICIARY OF SUCH PLAN OR POLICY IN ANY OTHER STATE; TO AMEND
14 SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT THE
15 DIVISION OF MEDICAID SHALL NOT REIMBURSE PHARMACIES FOR DRUGS OR
16 PHARMACY SERVICES OR IMPOSE ANY PAYMENT OR CONDITION ON RECIPIENTS
17 RELATING TO PURCHASING PHARMACY SERVICES THAT IS MORE COSTLY OR
18 RESTRICTIVE THAN THAT RATE WHICH IS PAID OR IMPOSED BY THE
19 MEDICAID PROGRAM IN ANY OTHER STATE; AND FOR RELATED PURPOSES.

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

21 **SECTION 1.** Section 83-9-6, Mississippi Code of 1972, is
22 amended as follows:

23 83-9-6. (1) This section shall apply to all health benefit
24 plans providing pharmaceutical services benefits, including
25 prescription drugs, to any resident of Mississippi. This section
26 shall also apply to insurance companies and health maintenance
27 organizations that provide or administer coverages and benefits
28 for prescription drugs. This section shall not apply to any
29 entity that has its own facility, employs or contracts with
30 physicians, pharmacists, nurses and other health care personnel,
31 and that dispenses prescription drugs from its own pharmacy to its
32 employees and dependents enrolled in its health benefit plan; but
33 this section shall apply to an entity otherwise excluded that
34 contracts with an outside pharmacy or group of pharmacies to
35 provide prescription drugs and services.

36 (2) As used in this section:
37 (a) "Copayment" means a type of cost sharing whereby
38 insured or covered persons pay a specified predetermined amount
39 per unit of service with their insurer paying the remainder of the
40 charge. The copayment is incurred at the time the service is
41 used. The copayment may be a fixed or variable amount.
42 (b) "Contract provider" means a pharmacy granted the
43 right to provide prescription drugs and pharmacy services
44 according to the terms of the insurer.
45 (c) "Health benefit plan" means any entity or program
46 that provides reimbursement for pharmaceutical services.
47 (d) "Insurer" means any entity that provides or offers
48 a health benefit plan.
49 (e) "Pharmacist" means a pharmacist licensed by the
50 Mississippi State Board of Pharmacy.
51 (f) "Pharmacy" means a place licensed by the
52 Mississippi State Board of Pharmacy.
53 (3) A health insurance plan, policy, employee benefit plan
54 or health maintenance organization may not:
55 (a) Prohibit or limit any person who is a participant
56 or beneficiary of the policy or plan from selecting a pharmacy or
57 pharmacist of his choice who has agreed to participate in the plan
58 according to the terms offered by the insurer;
59 (b) Deny a pharmacy or pharmacist the right to
60 participate as a contract provider under the policy or plan if the
61 pharmacy or pharmacist agrees to provide pharmacy services,
62 including but not limited to prescription drugs, that meet the
63 terms and requirements set forth by the insurer under the policy
64 or plan and agrees to the terms of reimbursement set forth by the
65 insurer;
66 (c) Impose upon a beneficiary of pharmacy services
67 under a health benefit plan any copayment, fee or condition that
68 is not equally imposed upon all beneficiaries in the same benefit

69 category, class or copayment level under the health benefit plan
70 when receiving services from a contract provider;
71 (d) Impose a monetary advantage or penalty under a
72 health benefit plan that would affect a beneficiary's choice among
73 those pharmacies or pharmacists who have agreed to participate in
74 the plan according to the terms offered by the insurer. Monetary
75 advantage or penalty includes higher copayment, a reduction in
76 reimbursement for services, or promotion of one participating
77 pharmacy over another by these methods;
78 (e) Reduce allowable reimbursement for pharmacy
79 services to a beneficiary under a health benefit plan because the
80 beneficiary selects a pharmacy of his or her choice, so long as
81 that pharmacy has enrolled with the health benefit plan under the
82 terms offered to all pharmacies in the plan coverage area;
83 (f) Require a beneficiary, as a condition of payment or
84 reimbursement, to purchase pharmacy services, including
85 prescription drugs, exclusively through a mail-order pharmacy; or
86 (g) Impose upon a beneficiary any copayment, amount of
87 reimbursement, number of days of a drug supply for which
88 reimbursement will be allowed, or any other payment or condition
89 relating to purchasing pharmacy services from any pharmacy,
90 including prescription drugs, that is more costly or more
91 restrictive than that which would be imposed upon the beneficiary
92 if such services were purchased from a mail-order pharmacy or any
93 other pharmacy that is willing to provide the same services or
94 products for the same cost and copayment as any mail order
95 service; or
96 (h) Reimburse for drugs or pharmacy services under such
97 plan at a rate that is more costly than that which would be
98 imposed upon the beneficiary if such drug or services were
99 purchased from a pharmacy willing to provide the same services or
100 products in another state, or impose upon a beneficiary any
101 copayment, amount of reimbursement, number of days for a drug

102 supply for which reimbursement will be allowed, or any other
103 payment or condition relating to purchasing pharmacy services that
104 is more costly or more restrictive than that which would be
105 imposed upon the beneficiary if such services were purchased in
106 another state. A carrier that is subject to this paragraph (h)
107 shall sign a contract with the pharmacy provider agreeing to
108 provide prescription drug benefits and pharmacy services to
109 beneficiaries throughout the period of the insurance contract
110 agreeing not to charge more for drugs or pharmacy services covered
111 by the plan than that charged for the same drug or service in any
112 other state, and agreeing not to alter the copayments or other
113 restrictions throughout the period of the insurance contract as
114 required herein. Said contract shall be developed and issued by
115 the Commissioner of Insurance and include provision for a
116 performance review of the requirements of this paragraph (h), and
117 the pharmacy and the carrier shall submit a detailed quarterly
118 financial accounting of reimbursements under the plan as required
119 by the commissioner, including the identification of all revenue
120 and cost items.
121 (4) A pharmacy, by or through a pharmacist acting on its
122 behalf as its employee, agent or owner, may not waive, discount,
123 rebate or distort a copayment of any insurer, policy or plan or a
124 beneficiary's coinsurance portion of a prescription drug coverage
125 or reimbursement and if a pharmacy, by or through a pharmacist's
126 acting on its behalf as its employee, agent or owner, provides a
127 pharmacy service to an enrollee of a health benefit plan that
128 meets the terms and requirements of the insurer under a health
129 benefit plan, the pharmacy shall provide its pharmacy services to
130 all enrollees of that health benefit plan on the same terms and
131 requirements of the insurer. A violation of this subsection shall
132 be a violation of the Pharmacy Practice Act subjecting the
133 pharmacist as a licensee to disciplinary authority of the State
134 Board of Pharmacy.

135 (5) If a health benefit plan providing reimbursement to
136 Mississippi residents for prescription drugs restricts pharmacy
137 participation, the entity providing the health benefit plan shall
138 notify, in writing, all pharmacies within the geographical
139 coverage area of the health benefit plan, and offer to the
140 pharmacies the opportunity to participate in the health benefit
141 plan at least sixty (60) days before the effective date of the
142 plan or before July 1, 1995, whichever comes first. All
143 pharmacies in the geographical coverage area of the plan shall be
144 eligible to participate under identical reimbursement terms for
145 providing pharmacy services, including prescription drugs. The
146 entity providing the health benefit plan shall, through reasonable
147 means, on a timely basis and on regular intervals, inform the
148 beneficiaries of the plan of the names and locations of pharmacies
149 that are participating in the plan as providers of pharmacy
150 services and prescription drugs. Additionally, participating
151 pharmacies shall be entitled to announce their participation to
152 their customers through a means acceptable to the pharmacy and the
153 entity providing the health benefit plans. The pharmacy
154 notification provisions of this section shall not apply when an
155 individual or group is enrolled, but when the plan enters a
156 particular county of the state.
157 (6) A violation of this section creates a civil cause of
158 action for injunctive relief in favor of any person or pharmacy
159 aggrieved by the violation.
160 (7) The Commissioner of Insurance shall not approve any
161 health benefit plan providing pharmaceutical services which does
162 not conform to this section.
163 (8) Any provision in a health benefit plan which is
164 executed, delivered or renewed, or otherwise contracted for in
165 this state that is contrary to this section shall, to the extent
166 of the conflict, be void.

167 (9) It is a violation of this section for any insurer or any
168 person to provide any health benefit plan providing for
169 pharmaceutical services to residents of this state that does not
170 conform to this section.

171 **SECTION 2.** Section 25-15-9, Mississippi Code of 1972, is
172 amended as follows:

173 25-15-9. (1) (a) The board shall design a plan of health
174 insurance for state employees which provides benefits for
175 semiprivate rooms in addition to other incidental coverages which
176 the board deems necessary. The amount of the coverages shall be
177 in such reasonable amount as may be determined by the board to be
178 adequate, after due consideration of current health costs in
179 Mississippi. The plan shall also include major medical benefits
180 in such amounts as the board shall determine. The board is also
181 authorized to accept bids for such alternate coverage and optional
182 benefits as the board shall deem proper. Any contract for
183 alternative coverage and optional benefits shall be awarded by the
184 board after it has carefully studied and evaluated the bids and
185 selected the best and most cost-effective bid. The board may
186 reject all such bids; however, the board shall notify all bidders
187 of the rejection and shall actively solicit new bids if all bids
188 are rejected. The board may employ or contract for such
189 consulting or actuarial services as may be necessary to formulate
190 the plan, and to assist the board in the preparation of
191 specifications and in the process of advertising for the bids for
192 the plan. Such contracts shall be solicited and entered into in
193 accordance with Section 25-15-5. The board shall keep a record of
194 all persons, agents and corporations who contract with or assist
195 the board in preparing and developing the plan. The board in a
196 timely manner shall provide copies of this record to the members
197 of the advisory council created in this section and those
198 legislators, or their designees, who may attend meetings of the
199 advisory council. The board shall provide copies of this record

200 in the solicitation of bids for the administration or servicing of
201 the self-insured program. Each person, agent or corporation
202 which, during the previous fiscal year, has assisted in the
203 development of the plan or employed or compensated any person who
204 assisted in the development of the plan, and which bids on the
205 administration or servicing of the plan, shall submit to the board
206 a statement accompanying the bid explaining in detail its
207 participation with the development of the plan. This statement
208 shall include the amount of compensation paid by the bidder to any
209 such employee during the previous fiscal year. The board shall
210 make all such information available to the members of the advisory
211 council and those legislators, or their designees, who may attend
212 meetings of the advisory council before any action is taken by the
213 board on the bids submitted. The failure of any bidder to fully
214 and accurately comply with this paragraph shall result in the
215 rejection of any bid submitted by that bidder or the cancellation
216 of any contract executed when the failure is discovered after the
217 acceptance of that bid. The board is authorized to promulgate
218 rules and regulations to implement the provisions of this
219 subsection.
220 The board shall develop plans for the insurance plan
221 authorized by this section in accordance with the provisions of
222 Section 25-15-5.
223 Any corporation, association, company or individual that
224 contracts with the board for the third-party claims administration
225 of the self-insured plan shall prepare and keep on file an
226 explanation of benefits for each claim processed. The explanation
227 of benefits shall contain such information relative to each
228 processed claim which the board deems necessary, and, at a
229 minimum, each explanation shall provide the claimant's name, claim
230 number, provider number, provider name, service dates, type of
231 services, amount of charges, amount allowed to the claimant and
232 reason codes. The information contained in the explanation of

233 benefits shall be available for inspection upon request by the
234 board. The board shall have access to all claims information
235 utilized in the issuance of payments to employees and providers.
236 (b) There is created an advisory council to advise the
237 board in the formulation of the State and School Employees Health
238 Insurance Plan. The council shall be composed of the State
239 Insurance Commissioner or his designee, an employee-representative
240 of the institutions of higher learning appointed by the board of
241 trustees thereof, an employee-representative of the Department of
242 Transportation appointed by the director thereof, an
243 employee-representative of the State Tax Commission appointed by
244 the Commissioner of Revenue, an employee-representative of the
245 Mississippi Department of Health appointed by the State Health
246 Officer, an employee-representative of the Mississippi Department
247 of Corrections appointed by the Commissioner of Corrections, and
248 an employee-representative of the Department of Human Services
249 appointed by the Executive Director of Human Services, two (2)
250 certificated public school administrators appointed by the State
251 Board of Education, two (2) certificated classroom teachers
252 appointed by the State Board of Education, a noncertificated
253 school employee appointed by the State Board of Education and a
254 community/junior college employee appointed by the State Board for
255 Community and Junior Colleges.
256 The Lieutenant Governor may designate the Secretary of the
257 Senate, the Chairman of the Senate Appropriations Committee, the
258 Chairman of the Senate Education Committee and the Chairman of the
259 Senate Insurance Committee, and the Speaker of the House of
260 Representatives may designate the Clerk of the House, the Chairman
261 of the House Appropriations Committee, the Chairman of the House
262 Education Committee and the Chairman of the House Insurance
263 Committee, to attend any meeting of the State and School Employees
264 Insurance Advisory Council. The appointing authorities may
265 designate an alternate member from their respective houses to

266 serve when the regular designee is unable to attend such meetings
267 of the council. Such designees shall have no jurisdiction or vote
268 on any matter within the jurisdiction of the council. For
269 attending meetings of the council, such legislators shall receive
270 per diem and expenses which shall be paid from the contingent
271 expense funds of their respective houses in the same amounts as
272 provided for committee meetings when the Legislature is not in
273 session; however, no per diem and expenses for attending meetings
274 of the council will be paid while the Legislature is in session.
275 No per diem and expenses will be paid except for attending
276 meetings of the council without prior approval of the proper
277 committee in their respective houses.

278 (c) No change in the terms of the State and School
279 Employees Health Insurance Plan may be made effective unless the
280 board, or its designee, has provided notice to the State and
281 School Employees Health Insurance Advisory Council and has called
282 a meeting of the council at least fifteen (15) days before the
283 effective date of such change. In the event that the State and
284 School Employees Health Insurance Advisory Council does not meet
285 to advise the board on the proposed changes, the changes to the
286 plan shall become effective at such time as the board has informed
287 the council that the changes shall become effective.

288 (d) **Medical benefits for retired employees and**
289 **dependents under age sixty-five (65) years and not eligible for**
290 **Medicare benefits**. The same health insurance coverage as for all
291 other active employees and their dependents shall be available to
292 retired employees and all dependents under age sixty-five (65)
293 years who are not eligible for Medicare benefits, the level of
294 benefits to be the same level as for all other active
295 participants. This section will apply to those employees who
296 retire due to one hundred percent (100%) medical disability as
297 well as those employees electing early retirement.

298 (e) **Medical benefits for retired employees and**
299 **dependents over age sixty-five (65) years or otherwise eligible**
300 **for Medicare benefits.** The health insurance coverage available to
301 retired employees over age sixty-five (65) years or otherwise
302 eligible for Medicare benefits, and all dependents over age
303 sixty-five (65) years or otherwise eligible for Medicare benefits,
304 shall be the major medical coverage with the lifetime maximum of
305 One Million Dollars ($1,000,000.00). Benefits shall be reduced by
306 Medicare benefits as though such Medicare benefits were the base
307 plan.
308 All covered individuals shall be assumed to have full
309 Medicare coverage, Parts A and B; and any Medicare payments under
310 both Parts A and B shall be computed to reduce benefits payable
311 under this plan.
312 (2) Nonduplication of benefits--reduction of benefits by
313 Title XIX benefits: When benefits would be payable under more
314 than one (1) group plan, benefits under those plans will be
315 coordinated to the extent that the total benefits under all plans
316 will not exceed the total expenses incurred.
317 Benefits for hospital or surgical or medical benefits shall
318 be reduced by any similar benefits payable in accordance with
319 Title XIX of the Social Security Act or under any amendments
320 thereto, or any implementing legislation.
321 Benefits for hospital or surgical or medical benefits shall
322 be reduced by any similar benefits payable by workers'
323 compensation.
324 (3) (a) Schedule of life insurance benefits--group term:
325 The amount of term life insurance for each active employee of a
326 department, agency or institution of the state government shall
327 not be in excess of One Hundred Thousand Dollars ($100,000.00), or
328 twice the amount of the employee's annual wage to the next highest
329 One Thousand Dollars ($1,000.00), whichever may be less, but in no
330 case less than Thirty Thousand Dollars ($30,000.00), with a like

331 amount for accidental death and dismemberment on a
332 twenty-four-hour basis. The plan will further contain a premium
333 waiver provision if a covered employee becomes totally and
334 permanently disabled prior to age sixty-five (65) years.
335 Employees retiring after June 30, 1999, shall be eligible to
336 continue life insurance coverage in an amount of Five Thousand
337 Dollars ($5,000.00), Ten Thousand Dollars ($10,000.00) or Twenty
338 Thousand Dollars ($20,000.00) into retirement.
339 (b) Effective October 1, 1999, schedule of life
340 insurance benefits--group term: The amount of term life insurance
341 for each active employee of any school district, community/junior
342 college, public library or university-based program authorized
343 under Section 37-23-31 for deaf, aphasic and emotionally disturbed
344 children or any regular nonstudent bus driver shall not be in
345 excess of One Hundred Thousand Dollars ($100,000.00), or twice the
346 amount of the employee's annual wage to the next highest One
347 Thousand Dollars ($1,000.00), whichever may be less, but in no
348 case less than Thirty Thousand Dollars ($30,000.00), with a like
349 amount for accidental death and dismemberment on a
350 twenty-four-hour basis. The plan will further contain a premium
351 waiver provision if a covered employee of any school district,
352 community/junior college, public library or university-based
353 program authorized under Section 37-23-31 for deaf, aphasic and
354 emotionally disturbed children or any regular nonstudent bus
355 driver becomes totally and permanently disabled prior to age
356 sixty-five (65) years. Employees of any school district,
357 community/junior college, public library or university-based
358 program authorized under Section 37-23-31 for deaf, aphasic and
359 emotionally disturbed children or any regular nonstudent bus
360 driver retiring after September 30, 1999, shall be eligible to
361 continue life insurance coverage in an amount of Five Thousand
362 Dollars ($5,000.00), Ten Thousand Dollars ($10,000.00) or Twenty
363 Thousand Dollars ($20,000.00) into retirement.

364 (4) Any eligible employee who on March 1, 1971, was
365 participating in a group life insurance program which has
366 provisions different from those included herein and for which the
367 State of Mississippi was paying a part of the premium may, at his
368 discretion, continue to participate in such plan. Such employee
369 shall pay in full all additional costs, if any, above the minimum
370 program established by this article. Under no circumstances shall
371 any individual who begins employment with the state after March 1,
372 1971, be eligible for the provisions of this paragraph.
373 (5) The board may offer medical savings accounts as defined
374 in Section 71-9-3 as a plan option.
375 (6) Any premium differentials, differences in coverages,
376 discounts determined by risk or by any other factors shall be
377 uniformly applied to all active employees participating in the
378 insurance plan. It is the intent of the Legislature that the
379 state contribution to the plan be the same for each employee
380 throughout the state.
381 (7) On October 1, 1999, any school district,
382 community/junior college district or public library may elect to
383 remain with an existing policy or policies of group life insurance
384 with an insurance company approved by the State and School
385 Employees Health Insurance Management Board, in lieu of
386 participation in the State and School Life Insurance Plan. The
387 state's contribution of up to fifty percent (50%) of the active
388 employee's premium under the State and School Life Insurance Plan
389 may be applied toward the cost of coverage for full-time employees
390 participating in the approved life insurance company group plan.
391 For purposes of this subsection (7), "life insurance company group
392 plan" means a plan administered or sold by a private insurance
393 company. After October 1, 1999, the board may assess charges in
394 addition to the existing State and School Life Insurance Plan
395 rates to such employees as a condition of enrollment in the State
396 and School Life Insurance Plan. In order for any life insurance

397 company group plan existing as of October 1, 1999, to be approved
398 by the State and School Employees Health Insurance Management
399 Board under this subsection (7), it shall meet the following
400 criteria:
401 (a) The insurance company offering the group life
402 insurance plan shall be rated "A-" or better by A.M. Best state
403 insurance rating service and be licensed as an admitted carrier in
404 the State of Mississippi by the Mississippi Department of
405 Insurance.
406 (b) The insurance company group life insurance plan
407 shall provide the same life insurance, accidental death and
408 dismemberment insurance and waiver of premium benefits as provided
409 in the State and School Life Insurance Plan.
410 (c) The insurance company group life insurance plan
411 shall be fully insured, and no form of self-funding life insurance
412 by such company shall be approved.
413 (d) The insurance company group life insurance plan
414 shall have one (1) composite rate per One Thousand Dollars
415 ($1,000.00) of coverage for active employees regardless of age and
416 one (1) composite rate per One Thousand Dollars ($1,000.00) of
417 coverage for all retirees regardless of age or type of retiree.
418 (e) The insurance company and its group life insurance
419 plan shall comply with any administrative requirements of the
420 State and School Employees Health Insurance Management Board. In
421 the event any insurance company providing group life insurance
422 benefits to employees under this subsection (7) fails to comply
423 with any requirements specified herein or any administrative
424 requirements of the board, the state shall discontinue providing
425 funding for the cost of such insurance.
426 (8) The State and School Employees Health Insurance Plan
427 shall not reimburse for drugs or pharmacy services under the plan
428 at a rate that is more costly than that which would be imposed
429 upon the beneficiary if such drug or services were purchased from

430 a pharmacy willing to provide the same services or products in
431 another state, and shall not allow the plan to impose upon a
432 beneficiary any copayment, amount or reimbursement, number of days
433 for a drug supply for which reimbursement will be allowed, or
434 impose any other payment or condition relating to purchasing
435 pharmacy services that is more costly or more restrictive than
436 that which would be imposed upon the beneficiary if such services
437 were purchased in another state. The board shall sign a contract
438 with any pharmacy provider agreeing to provide prescription drug
439 benefits and pharmacy services to beneficiaries under the plan
440 agreeing not to charge more for drugs or pharmacy services covered
441 by the plan than that charged for the same drug or service in
442 another state, and agreeing not to alter the copayments or other
443 restrictions as required herein. Said contract shall be developed
444 and issued by the Mississippi Commissioner of Insurance and
445 include provision for a performance review of the requirements of
446 this paragraph (h), and the pharmacy shall submit a detailed
447 quarterly financial accounting of reimbursements under the plan as
448 required by the commissioner, including the identification of all
449 revenue and cost items.
450 **SECTION 3.** Section 43-13-117, Mississippi Code of 1972, is
451 amended as follows:
452 43-13-117. Medical assistance as authorized by this article
453 shall include payment of part or all of the costs, at the
454 discretion of the division or its successor, with approval of the
455 Governor, of the following types of care and services rendered to
456 eligible applicants who shall have been determined to be eligible
457 for such care and services, within the limits of state
458 appropriations and federal matching funds:
459 (1) Inpatient hospital services.
460 (a) The division shall allow thirty (30) days of
461 inpatient hospital care annually for all Medicaid recipients.
462 Precertification of inpatient days must be obtained as required by

463 the division. The division shall be authorized to allow unlimited
464 days in disproportionate hospitals as defined by the division for
465 eligible infants under the age of six (6) years.

466 (b) From and after July 1, 1994, the Executive
467 Director of the Division of Medicaid shall amend the Mississippi
468 Title XIX Inpatient Hospital Reimbursement Plan to remove the
469 occupancy rate penalty from the calculation of the Medicaid
470 Capital Cost Component utilized to determine total hospital costs
471 allocated to the Medicaid program.

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

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

492 (3) Laboratory and x-ray services.

493 (4) Nursing facility services.

494 (a) The division shall make full payment to
495 nursing facilities for each day, not exceeding fifty-two (52) days

496 per year, that a patient is absent from the facility on home
497 leave. Payment may be made for the following home leave days in
498 addition to the fifty-two-day limitation: Christmas, the day
499 before Christmas, the day after Christmas, Thanksgiving, the day
500 before Thanksgiving and the day after Thanksgiving.
501 (b) From and after July 1, 1997, the division
502 shall implement the integrated case-mix payment and quality
503 monitoring system, which includes the fair rental system for
504 property costs and in which recapture of depreciation is
505 eliminated. The division may reduce the payment for hospital
506 leave and therapeutic home leave days to the lower of the case-mix
507 category as computed for the resident on leave using the
508 assessment being utilized for payment at that point in time, or a
509 case-mix score of 1.000 for nursing facilities, and shall compute
510 case-mix scores of residents so that only services provided at the
511 nursing facility are considered in calculating a facility's per
512 diem.
513 (c) From and after July 1, 1997, all state-owned
514 nursing facilities shall be reimbursed on a full reasonable cost
515 basis.
516 (d) When a facility of a category that does not
517 require a certificate of need for construction and that could not
518 be eligible for Medicaid reimbursement is constructed to nursing
519 facility specifications for licensure and certification, and the
520 facility is subsequently converted to a nursing facility pursuant
521 to a certificate of need that authorizes conversion only and the
522 applicant for the certificate of need was assessed an application
523 review fee based on capital expenditures incurred in constructing
524 the facility, the division shall allow reimbursement for capital
525 expenditures necessary for construction of the facility that were
526 incurred within the twenty-four (24) consecutive calendar months
527 immediately preceding the date that the certificate of need
528 authorizing such conversion was issued, to the same extent that

529 reimbursement would be allowed for construction of a new nursing
530 facility pursuant to a certificate of need that authorizes such
531 construction. The reimbursement authorized in this subparagraph
532 (d) may be made only to facilities the construction of which was
533 completed after June 30, 1989. Before the division shall be
534 authorized to make the reimbursement authorized in this
535 subparagraph (d), the division first must have received approval
536 from the Health Care Financing Administration of the United States
537 Department of Health and Human Services of the change in the state
538 Medicaid plan providing for such reimbursement.
539 (e) The division shall develop and implement, not
540 later than January 1, 2001, a case-mix payment add-on determined
541 by time studies and other valid statistical data which will
542 reimburse a nursing facility for the additional cost of caring for
543 a resident who has a diagnosis of Alzheimer's or other related
544 dementia and exhibits symptoms that require special care. Any
545 such case-mix add-on payment shall be supported by a determination
546 of additional cost. The division shall also develop and implement
547 as part of the fair rental reimbursement system for nursing
548 facility beds, an Alzheimer's resident bed depreciation enhanced
549 reimbursement system which will provide an incentive to encourage
550 nursing facilities to convert or construct beds for residents with
551 Alzheimer's or other related dementia.
552 (f) The Division of Medicaid shall develop and
553 implement a referral process for long-term care alternatives for
554 Medicaid beneficiaries and applicants. No Medicaid beneficiary
555 shall be admitted to a Medicaid-certified nursing facility unless
556 a licensed physician certifies that nursing facility care is
557 appropriate for that person on a standardized form to be prepared
558 and provided to nursing facilities by the Division of Medicaid.
559 The physician shall forward a copy of that certification to the
560 Division of Medicaid within twenty-four (24) hours after it is
561 signed by the physician. Any physician who fails to forward the

562 certification to the Division of Medicaid within the time period
563 specified in this paragraph shall be ineligible for Medicaid
564 reimbursement for any physician's services performed for the
565 applicant. The Division of Medicaid shall determine, through an
566 assessment of the applicant conducted within two (2) business days
567 after receipt of the physician's certification, whether the
568 applicant also could live appropriately and cost-effectively at
569 home or in some other community-based setting if home- or
570 community-based services were available to the applicant. The
571 time limitation prescribed in this paragraph shall be waived in
572 cases of emergency. If the Division of Medicaid determines that a
573 home- or other community-based setting is appropriate and
574 cost-effective, the division shall:
575 (i) Advise the applicant or the applicant's
576 legal representative that a home- or other community-based setting
577 is appropriate;
578 (ii) Provide a proposed care plan and inform
579 the applicant or the applicant's legal representative regarding
580 the degree to which the services in the care plan are available in
581 a home- or in other community-based setting rather than nursing
582 facility care; and
583 (iii) Explain that such plan and services are
584 available only if the applicant or the applicant's legal
585 representative chooses a home- or community-based alternative to
586 nursing facility care, and that the applicant is free to choose
587 nursing facility care.
588 The Division of Medicaid may provide the services described
589 in this paragraph (f) directly or through contract with case
590 managers from the local Area Agencies on Aging, and shall
591 coordinate long-term care alternatives to avoid duplication with
592 hospital discharge planning procedures.
593 Placement in a nursing facility may not be denied by the
594 division if home- or community-based services that would be more

595 appropriate than nursing facility care are not actually available,
596 or if the applicant chooses not to receive the appropriate home-
597 or community-based services.

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

602 The division shall make full payment for long-term care
603 alternative services.

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

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

628 cooperative agreement with the State Department of Human Services
629 for the provision of such services using state funds which are
630 provided from the appropriation to the Department of Human
631 Services to obtain federal matching funds through the division.
632 On July 1, 1993, all fees for periodic screening and
633 diagnostic services under this paragraph (5) shall be increased by
634 twenty-five percent (25%) of the reimbursement rate in effect on
635 June 30, 1993.
636 (6) Physician's services. The division shall allow
637 twelve (12) physician visits annually. All fees for physicians'
638 services that are covered only by Medicaid shall be reimbursed at
639 ninety percent (90%) of the rate established on January 1, 1999,
640 and as adjusted each January thereafter, under Medicare (Title
641 XVIII of the Social Security Act, as amended), and which shall in
642 no event be less than seventy percent (70%) of the rate
643 established on January 1, 1994. All fees for physicians' services
644 that are covered by both Medicare and Medicaid shall be reimbursed
645 at ten percent (10%) of the adjusted Medicare payment established
646 on January 1, 1999, and as adjusted each January thereafter, under
647 Medicare (Title XVIII of the Social Security Act, as amended), and
648 which shall in no event be less than seventy percent (70%) of the
649 adjusted Medicare payment established on January 1, 1994.
650 (7) (a) Home health services for eligible persons, not
651 to exceed in cost the prevailing cost of nursing facility
652 services, not to exceed sixty (60) visits per year. All home
653 health visits must be precertified as required by the division.
654 (b) Repealed.
655 (8) Emergency medical transportation services. On
656 January 1, 1994, emergency medical transportation services shall
657 be reimbursed at seventy percent (70%) of the rate established
658 under Medicare (Title XVIII of the Social Security Act, as
659 amended). "Emergency medical transportation services" shall mean,
660 but shall not be limited to, the following services by a properly

661 permitted ambulance operated by a properly licensed provider in
662 accordance with the Emergency Medical Services Act of 1974
663 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
664 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
665 (vi) disposable supplies, (vii) similar services.

666 (9) Legend and other drugs as may be determined by the
667 division. The division may implement a program of prior approval
668 for drugs to the extent permitted by law. Payment by the division
669 for covered multiple source drugs shall be limited to the lower of
670 the upper limits established and published by the Health Care
671 Financing Administration (HCFA) plus a dispensing fee of Four
672 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
673 cost (EAC) as determined by the division plus a dispensing fee of
674 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual
675 and customary charge to the general public. The division shall
676 allow ten (10) prescriptions per month for noninstitutionalized
677 Medicaid recipients.

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

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

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

692 As used in this paragraph (9), "estimated acquisition cost"
693 means the division's best estimate of what price providers

694 generally are paying for a drug in the package size that providers
695 buy most frequently. Product selection shall be made in
696 compliance with existing state law; however, the division may
697 reimburse as if the prescription had been filled under the generic
698 name. The division may provide otherwise in the case of specified
699 drugs when the consensus of competent medical advice is that
700 trademarked drugs are substantially more effective.

701 From and after July 1, 2002, the division shall not reimburse
702 for drugs or pharmacy services under the program at a rate that is
703 more costly than that which would be imposed upon the recipient if
704 such drug or services were purchased from a pharmacy willing to
705 provide the same services or products under the Medicaid program
706 in another state, or impose upon a recipient any copayment, amount
707 of reimbursement, number of days for a drug supply for which
708 reimbursement will be allowed, or any other payment or condition
709 relating to purchasing pharmacy services that is more costly or
710 more restrictive than that which would be imposed upon the
711 recipient if such services were purchased in another state. The
712 division shall sign a contract with the pharmacy provider agreeing
713 to provide prescription drug benefits and pharmacy services to
714 recipients under the Medicaid program not charging more for the
715 drugs or pharmacy services covered by the program than that
716 charged for the same drug or service in any other state, and
717 agreeing not to alter the copayments or other restrictions under
718 the program as required herein. Said contract shall be developed
719 and issued by the Mississippi Commissioner of Insurance and
720 include provision for a performance review of the requirements of
721 this paragraph, and the pharmacy shall submit a detailed quarterly
722 financial accounting of reimbursements under the program as
723 required by the division, including the identification of all
724 revenue and cost items.

725 (10) Dental care that is an adjunct to treatment of an
726 acute medical or surgical condition; services of oral surgeons and

727 dentists in connection with surgery related to the jaw or any
728 structure contiguous to the jaw or the reduction of any fracture
729 of the jaw or any facial bone; and emergency dental extractions
730 and treatment related thereto. On July 1, 1999, all fees for
731 dental care and surgery under authority of this paragraph (10)
732 shall be increased to one hundred sixty percent (160%) of the
733 amount of the reimbursement rate that was in effect on June 30,
734 1999. It is the intent of the Legislature to encourage more
735 dentists to participate in the Medicaid program.

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

741 (12) Intermediate care facility services.

742 (a) The division shall make full payment to all
743 intermediate care facilities for the mentally retarded for each
744 day, not exceeding eighty-four (84) days per year, that a patient
745 is absent from the facility on home leave. Payment may be made
746 for the following home leave days in addition to the
747 eighty-four-day limitation: Christmas, the day before Christmas,
748 the day after Christmas, Thanksgiving, the day before Thanksgiving
749 and the day after Thanksgiving.

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

753 (13) Family planning services, including drugs,
754 supplies and devices, when such services are under the supervision
755 of a physician.

756 (14) Clinic services. Such diagnostic, preventive,
757 therapeutic, rehabilitative or palliative services furnished to an
758 outpatient by or under the supervision of a physician or dentist
759 in a facility which is not a part of a hospital but which is

760 organized and operated to provide medical care to outpatients.
761 Clinic services shall include any services reimbursed as
762 outpatient hospital services which may be rendered in such a
763 facility, including those that become so after July 1, 1991. On
764 July 1, 1999, all fees for physicians' services reimbursed under
765 authority of this paragraph (14) shall be reimbursed at ninety
766 percent (90%) of the rate established on January 1, 1999, and as
767 adjusted each January thereafter, under Medicare (Title XVIII of
768 the Social Security Act, as amended), and which shall in no event
769 be less than seventy percent (70%) of the rate established on
770 January 1, 1994. All fees for physicians' services that are
771 covered by both Medicare and Medicaid shall be reimbursed at ten
772 percent (10%) of the adjusted Medicare payment established on
773 January 1, 1999, and as adjusted each January thereafter, under
774 Medicare (Title XVIII of the Social Security Act, as amended), and
775 which shall in no event be less than seventy percent (70%) of the
776 adjusted Medicare payment established on January 1, 1994. On July
777 1, 1999, all fees for dentists' services reimbursed under
778 authority of this paragraph (14) shall be increased to one hundred
779 sixty percent (160%) of the amount of the reimbursement rate that
780 was in effect on June 30, 1999.
781 (15) Home- and community-based services, as provided
782 under Title XIX of the federal Social Security Act, as amended,
783 under waivers, subject to the availability of funds specifically
784 appropriated therefor by the Legislature. Payment for such
785 services shall be limited to individuals who would be eligible for
786 and would otherwise require the level of care provided in a
787 nursing facility. The home- and community-based services
788 authorized under this paragraph shall be expanded over a five-year
789 period beginning July 1, 1999. The division shall certify case
790 management agencies to provide case management services and
791 provide for home- and community-based services for eligible
792 individuals under this paragraph. The home- and community-based

793 services under this paragraph and the activities performed by
794 certified case management agencies under this paragraph shall be
795 funded using state funds that are provided from the appropriation
796 to the Division of Medicaid and used to match federal funds.

797 (16) Mental health services. Approved therapeutic and
798 case management services provided by (a) an approved regional
799 mental health/retardation center established under Sections
800 41-19-31 through 41-19-39, or by another community mental health
801 service provider meeting the requirements of the Department of
802 Mental Health to be an approved mental health/retardation center
803 if determined necessary by the Department of Mental Health, using
804 state funds which are provided from the appropriation to the State
805 Department of Mental Health and used to match federal funds under
806 a cooperative agreement between the division and the department,
807 or (b) a facility which is certified by the State Department of
808 Mental Health to provide therapeutic and case management services,
809 to be reimbursed on a fee for service basis. Any such services
810 provided by a facility described in paragraph (b) must have the
811 prior approval of the division to be reimbursable under this
812 section. After June 30, 1997, mental health services provided by
813 regional mental health/retardation centers established under
814 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
815 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
816 psychiatric residential treatment facilities as defined in Section
817 43-11-1, or by another community mental health service provider
818 meeting the requirements of the Department of Mental Health to be
819 an approved mental health/retardation center if determined
820 necessary by the Department of Mental Health, shall not be
821 included in or provided under any capitated managed care pilot
822 program provided for under paragraph (24) of this section.

823 (17) Durable medical equipment services and medical
824 supplies. Precertification of durable medical equipment and
825 medical supplies must be obtained as required by the division.

826 The Division of Medicaid may require durable medical equipment
827 providers to obtain a surety bond in the amount and to the
828 specifications as established by the Balanced Budget Act of 1997.
829 (18) (a) Notwithstanding any other provision of this
830 section to the contrary, the division shall make additional
831 reimbursement to hospitals which serve a disproportionate share of
832 low-income patients and which meet the federal requirements for
833 such payments as provided in Section 1923 of the federal Social
834 Security Act and any applicable regulations. However, from and
835 after January 1, 2000, no public hospital shall participate in the
836 Medicaid disproportionate share program unless the public hospital
837 participates in an intergovernmental transfer program as provided
838 in Section 1903 of the federal Social Security Act and any
839 applicable regulations. Administration and support for
840 participating hospitals shall be provided by the Mississippi
841 Hospital Association.
842 (b) The division shall establish a Medicare Upper
843 Payment Limits Program as defined in Section 1902 (a) (30) of the
844 federal Social Security Act and any applicable federal
845 regulations. The division shall assess each hospital for the sole
846 purpose of financing the state portion of the Medicare Upper
847 Payment Limits Program. This assessment shall be based on
848 Medicaid utilization, or other appropriate method consistent with
849 federal regulations, and will remain in effect as long as the
850 state participates in the Medicare Upper Payment Limits Program.
851 The division shall make additional reimbursement to hospitals for
852 the Medicare Upper Payment Limits as defined in Section 1902 (a)
853 (30) of the federal Social Security Act and any applicable federal
854 regulations. This paragraph (b) shall stand repealed from and
855 after July 1, 2005.
856 (c) The division shall contract with the
857 Mississippi Hospital Association to provide administrative support
858 for the operation of the disproportionate share hospital program

859 and the Medicare Upper Payment Limits Program. This paragraph (c)
860 shall stand repealed from and after July 1, 2005.
861 (19) (a) Perinatal risk management services. The
862 division shall promulgate regulations to be effective from and
863 after October 1, 1988, to establish a comprehensive perinatal
864 system for risk assessment of all pregnant and infant Medicaid
865 recipients and for management, education and follow-up for those
866 who are determined to be at risk. Services to be performed
867 include case management, nutrition assessment/counseling,
868 psychosocial assessment/counseling and health education. The
869 division shall set reimbursement rates for providers in
870 conjunction with the State Department of Health.
871 (b) Early intervention system services. The
872 division shall cooperate with the State Department of Health,
873 acting as lead agency, in the development and implementation of a
874 statewide system of delivery of early intervention services,
875 pursuant to Part H of the Individuals with Disabilities Education
876 Act (IDEA). The State Department of Health shall certify annually
877 in writing to the director of the division the dollar amount of
878 state early intervention funds available which shall be utilized
879 as a certified match for Medicaid matching funds. Those funds
880 then shall be used to provide expanded targeted case management
881 services for Medicaid eligible children with special needs who are
882 eligible for the state's early intervention system.
883 Qualifications for persons providing service coordination shall be
884 determined by the State Department of Health and the Division of
885 Medicaid.
886 (20) Home- and community-based services for physically
887 disabled approved services as allowed by a waiver from the United
888 States Department of Health and Human Services for home- and
889 community-based services for physically disabled people using
890 state funds which are provided from the appropriation to the State
891 Department of Rehabilitation Services and used to match federal

892 funds under a cooperative agreement between the division and the
893 department, provided that funds for these services are
894 specifically appropriated to the Department of Rehabilitation
895 Services.

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

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

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

923 (24) Managed care services in a program to be developed
924 by the division by a public or private provider. If managed care

925 services are provided by the division to Medicaid recipients, and
926 those managed care services are operated, managed and controlled
927 by and under the authority of the division, the division shall be
928 responsible for educating the Medicaid recipients who are
929 participants in the managed care program regarding the manner in
930 which the participants should seek health care under the program.
931 Notwithstanding any other provision in this article to the
932 contrary, the division shall establish rates of reimbursement to
933 providers rendering care and services authorized under this
934 paragraph (24), and may revise such rates of reimbursement without
935 amendment to this section by the Legislature for the purpose of
936 achieving effective and accessible health services, and for
937 responsible containment of costs.

938 (25) Birthing center services.

939 (26) Hospice care. As used in this paragraph, the term
940 "hospice care" means a coordinated program of active professional
941 medical attention within the home and outpatient and inpatient
942 care which treats the terminally ill patient and family as a unit,
943 employing a medically directed interdisciplinary team. The
944 program provides relief of severe pain or other physical symptoms
945 and supportive care to meet the special needs arising out of
946 physical, psychological, spiritual, social and economic stresses
947 which are experienced during the final stages of illness and
948 during dying and bereavement and meets the Medicare requirements
949 for participation as a hospice as provided in federal regulations.

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

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

957 (29) The Division of Medicaid may apply for a waiver
958 from the Department of Health and Human Services for home- and
959 community-based services for developmentally disabled people using
960 state funds which are provided from the appropriation to the State
961 Department of Mental Health and used to match federal funds under
962 a cooperative agreement between the division and the department,
963 provided that funds for these services are specifically
964 appropriated to the Department of Mental Health.
965 (30) Pediatric skilled nursing services for eligible
966 persons under twenty-one (21) years of age.
967 (31) Targeted case management services for children
968 with special needs, under waivers from the United States
969 Department of Health and Human Services, using state funds that
970 are provided from the appropriation to the Mississippi Department
971 of Human Services and used to match federal funds under a
972 cooperative agreement between the division and the department.
973 (32) Care and services provided in Christian Science
974 Sanatoria operated by or listed and certified by The First Church
975 of Christ Scientist, Boston, Massachusetts, rendered in connection
976 with treatment by prayer or spiritual means to the extent that
977 such services are subject to reimbursement under Section 1903 of
978 the Social Security Act.
979 (33) Podiatrist services.
980 (34) The division shall make application to the United
981 States Health Care Financing Administration for a waiver to
982 develop a program of services to personal care and assisted living
983 homes in Mississippi. This waiver shall be completed by December
984 1, 1999.
985 (35) Services and activities authorized in Sections
986 43-27-101 and 43-27-103, using state funds that are provided from
987 the appropriation to the State Department of Human Services and
988 used to match federal funds under a cooperative agreement between
989 the division and the department.

990 (36) Nonemergency transportation services for
991 Medicaid-eligible persons, to be provided by the Division of
992 Medicaid. The division may contract with additional entities to
993 administer nonemergency transportation services as it deems
994 necessary. All providers shall have a valid driver's license,
995 vehicle inspection sticker, valid vehicle license tags and a
996 standard liability insurance policy covering the vehicle.
997 (37) [Deleted]
998 (38) Chiropractic services: a chiropractor's manual
999 manipulation of the spine to correct a subluxation, if x-ray
1000 demonstrates that a subluxation exists and if the subluxation has
1001 resulted in a neuromusculoskeletal condition for which
1002 manipulation is appropriate treatment. Reimbursement for
1003 chiropractic services shall not exceed Seven Hundred Dollars
1004 ($700.00) per year per recipient.
1005 (39) Dually eligible Medicare/Medicaid beneficiaries.
1006 The division shall pay the Medicare deductible and ten percent
1007 (10%) coinsurance amounts for services available under Medicare
1008 for the duration and scope of services otherwise available under
1009 the Medicaid program.
1010 (40) [Deleted]
1011 (41) Services provided by the State Department of
1012 Rehabilitation Services for the care and rehabilitation of persons
1013 with spinal cord injuries or traumatic brain injuries, as allowed
1014 under waivers from the United States Department of Health and
1015 Human Services, using up to seventy-five percent (75%) of the
1016 funds that are appropriated to the Department of Rehabilitation
1017 Services from the Spinal Cord and Head Injury Trust Fund
1018 established under Section 37-33-261 and used to match federal
1019 funds under a cooperative agreement between the division and the
1020 department.
1021 (42) Notwithstanding any other provision in this
1022 article to the contrary, the division is hereby authorized to

1023 develop a population health management program for women and
1024 children health services through the age of two (2). This program
1025 is primarily for obstetrical care associated with low birth weight
1026 and pre-term babies. In order to effect cost savings, the
1027 division may develop a revised payment methodology which may
1028 include at-risk capitated payments.

1029 (43) The division shall provide reimbursement,
1030 according to a payment schedule developed by the division, for
1031 smoking cessation medications for pregnant women during their
1032 pregnancy and other Medicaid-eligible women who are of
1033 child-bearing age.

1034 (44) Nursing facility services for the severely
1035 disabled.

1036 (a) Severe disabilities include, but are not
1037 limited to, spinal cord injuries, closed head injuries and
1038 ventilator dependent patients.

1039 (b) Those services must be provided in a long-term
1040 care nursing facility dedicated to the care and treatment of
1041 persons with severe disabilities, and shall be reimbursed as a
1042 separate category of nursing facilities.

1043 (45) Physician assistant services. Services furnished
1044 by a physician assistant who is licensed by the State Board of
1045 Medical Licensure and is practicing with physician supervision
1046 under regulations adopted by the board, under regulations adopted
1047 by the division. Reimbursement for those services shall not
1048 exceed ninety percent (90%) of the reimbursement rate for
1049 comparable services rendered by a physician.

1050 (46) The division shall make application to the federal
1051 Health Care Financing Administration for a waiver to develop and
1052 provide services for children with serious emotional disturbances
1053 as defined in Section 43-14-1(1), which may include home- and
1054 community-based services, case management services or managed care
1055 services through mental health providers certified by the

1056 Department of Mental Health. The division may implement and
1057 provide services under this waivered program only if funds for
1058 these services are specifically appropriated for this purpose by
1059 the Legislature, or if funds are voluntarily provided by affected
1060 agencies.

1061 Notwithstanding any provision of this article, except as
1062 authorized in the following paragraph and in Section 43-13-139,
1063 neither (a) the limitations on quantity or frequency of use of or
1064 the fees or charges for any of the care or services available to
1065 recipients under this section, nor (b) the payments or rates of
1066 reimbursement to providers rendering care or services authorized
1067 under this section to recipients, may be increased, decreased or
1068 otherwise changed from the levels in effect on July 1, 1999,
1069 unless such is authorized by an amendment to this section by the
1070 Legislature. However, the restriction in this paragraph shall not
1071 prevent the division from changing the payments or rates of
1072 reimbursement to providers without an amendment to this section
1073 whenever such changes are required by federal law or regulation,
1074 or whenever such changes are necessary to correct administrative
1075 errors or omissions in calculating such payments or rates of
1076 reimbursement.

1077 Notwithstanding any provision of this article, no new groups
1078 or categories of recipients and new types of care and services may
1079 be added without enabling legislation from the Mississippi
1080 Legislature, except that the division may authorize such changes
1081 without enabling legislation when such addition of recipients or
1082 services is ordered by a court of proper authority. The director
1083 shall keep the Governor advised on a timely basis of the funds
1084 available for expenditure and the projected expenditures. In the
1085 event current or projected expenditures can be reasonably
1086 anticipated to exceed the amounts appropriated for any fiscal
1087 year, the Governor, after consultation with the director, shall
1088 discontinue any or all of the payment of the types of care and

1089 services as provided herein which are deemed to be optional
1090 services under Title XIX of the federal Social Security Act, as
1091 amended, for any period necessary to not exceed appropriated
1092 funds, and when necessary shall institute any other cost
1093 containment measures on any program or programs authorized under
1094 the article to the extent allowed under the federal law governing
1095 such program or programs, it being the intent of the Legislature
1096 that expenditures during any fiscal year shall not exceed the
1097 amounts appropriated for such fiscal year.

1098 Notwithstanding any other provision of this article, it shall
1099 be the duty of each nursing facility, intermediate care facility
1100 for the mentally retarded, psychiatric residential treatment
1101 facility, and nursing facility for the severely disabled that is
1102 participating in the medical assistance program to keep and
1103 maintain books, documents, and other records as prescribed by the
1104 Division of Medicaid in substantiation of its cost reports for a
1105 period of three (3) years after the date of submission to the
1106 Division of Medicaid of an original cost report, or three (3)
1107 years after the date of submission to the Division of Medicaid of
1108 an amended cost report.

1109 **SECTION 4.** This act shall take effect and be in force from
1110 and after July 1, 2002.

ST: Pharmacies shall not charge more for drugs than any other state; require for Medicaid and state health plan.