Adopted

AMENDMENT No. 1 PROPOSED TO

House Bill NO. 1200

By Senator(s) Committee

Amend by striking all after the enacting clause and inserting in lieu thereof the following:

48 **SECTION 1.** Section 43-13-117, Mississippi Code of 1972, is
49 amended as follows:
50 43-13-117. Medicaid as authorized by this article shall
51 include payment of part or all of the costs, at the discretion of
52 the division or its successor, with approval of the Governor, of
53 the following types of care and services rendered to eligible
54 applicants who *** have been determined to be eligible for that
55 care and services, within the limits of state appropriations and
56 federal matching funds:
57 (1) Inpatient hospital services.
58 (a) The division shall allow thirty (30) days of
59 inpatient hospital care annually for all Medicaid recipients.
60 Precertification of inpatient days must be obtained as required by
61 the division. The division may allow unlimited days in
62 disproportionate hospitals as defined by the division for eligible
63 infants under the age of six (6) years.
64 (b) From and after July 1, 1994, the Executive
65 Director of the Division of Medicaid shall amend the Mississippi
66 Title XIX Inpatient Hospital Reimbursement Plan to remove the
67 occupancy rate penalty from the calculation of the Medicaid

68 Capital Cost Component utilized to determine total hospital costs
69 allocated to the Medicaid program.
70 (c) Hospitals will receive an additional payment
71 for the implantable programmable baclofen drug pump used to treat
72 spasticity which is implanted on an inpatient basis. The payment
73 pursuant to written invoice will be in addition to the facility's
74 per diem reimbursement and will represent a reduction of costs on
75 the facility's annual cost report, and shall not exceed Ten
76 Thousand Dollars ($10,000.00) per year per recipient. This
77 paragraph (c) shall stand repealed on July 1, 2005.
78 (2) Outpatient hospital services. *** * *** Where the same
79 services are reimbursed as clinic services, the division may
80 revise the rate or methodology of outpatient reimbursement to
81 maintain consistency, efficiency, economy and quality of
82 care. *** * ***
83 (3) Laboratory and x-ray services.
84 (4) Nursing facility services.
85 (a) The division shall make full payment to
86 nursing facilities for each day, not exceeding fifty-two (52) days
87 per year, that a patient is absent from the facility on home
88 leave. Payment may be made for the following home leave days in
89 addition to the fifty-two-day limitation: Christmas, the day
90 before Christmas, the day after Christmas, Thanksgiving, the day
91 before Thanksgiving and the day after Thanksgiving.
92 (b) From and after July 1, 1997, the division
93 shall implement the integrated case-mix payment and quality
94 monitoring system, which includes the fair rental system for
95 property costs and in which recapture of depreciation is
96 eliminated. The division may reduce the payment for hospital
97 leave and therapeutic home leave days to the lower of the case-mix
98 category as computed for the resident on leave using the
99 assessment being utilized for payment at that point in time, or a
100 case-mix score of 1.000 for nursing facilities, and shall compute
101 case-mix scores of residents so that only services provided at the
102 nursing facility are considered in calculating a facility's per

103 diem.

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

107 (d) When a facility of a category that does not
108 require a certificate of need for construction and that could not
109 be eligible for Medicaid reimbursement is constructed to nursing
110 facility specifications for licensure and certification, and the
111 facility is subsequently converted to a nursing facility under a
112 certificate of need that authorizes conversion only and the
113 applicant for the certificate of need was assessed an application
114 review fee based on capital expenditures incurred in constructing
115 the facility, the division shall allow reimbursement for capital
116 expenditures necessary for construction of the facility that were
117 incurred within the twenty-four (24) consecutive calendar months
118 immediately preceding the date that the certificate of need
119 authorizing the conversion was issued, to the same extent that
120 reimbursement would be allowed for construction of a new nursing
121 facility under a certificate of need that authorizes that
122 construction. The reimbursement authorized in this subparagraph
123 (d) may be made only to facilities the construction of which was
124 completed after June 30, 1989. Before the division shall be
125 authorized to make the reimbursement authorized in this
126 subparagraph (d), the division first must have received approval
127 from the Health Care Financing Administration of the United States
128 Department of Health and Human Services of the change in the state
129 Medicaid plan providing for the reimbursement.

130 (e) The division shall develop and implement, not
131 later than January 1, 2001, a case-mix payment add-on determined
132 by time studies and other valid statistical data that will
133 reimburse a nursing facility for the additional cost of caring for
134 a resident who has a diagnosis of Alzheimer's or other related
135 dementia and exhibits symptoms that require special care. Any
136 such case-mix add-on payment shall be supported by a determination
137 of additional cost. The division shall also develop and implement

138 as part of the fair rental reimbursement system for nursing
139 facility beds, an Alzheimer's resident bed depreciation enhanced
140 reimbursement system that will provide an incentive to encourage
141 nursing facilities to convert or construct beds for residents with
142 Alzheimer's or other related dementia.

143 (f) The Division of Medicaid shall develop and
144 implement a referral process for long-term care alternatives for
145 Medicaid beneficiaries and applicants. No Medicaid beneficiary
146 shall be admitted to a Medicaid-certified nursing facility unless
147 a licensed physician certifies that nursing facility care is
148 appropriate for that person on a standardized form to be prepared
149 and provided to nursing facilities by the Division of Medicaid.
150 The physician shall forward a copy of that certification to the
151 Division of Medicaid within twenty-four (24) hours after it is
152 signed by the physician. Any physician who fails to forward the
153 certification to the Division of Medicaid within the time period
154 specified in this paragraph shall be ineligible for Medicaid
155 reimbursement for any physician's services performed for the
156 applicant. The Division of Medicaid shall determine, through an
157 assessment of the applicant conducted within two (2) business days
158 after receipt of the physician's certification, whether the
159 applicant also could live appropriately and cost-effectively at
160 home or in some other community-based setting if home- or
161 community-based services were available to the applicant. The
162 time limitation prescribed in this paragraph shall be waived in
163 cases of emergency. If the Division of Medicaid determines that a
164 home- or other community-based setting is appropriate and
165 cost-effective, the division shall:

166 (i) Advise the applicant or the applicant's
167 legal representative that a home- or other community-based setting
168 is appropriate;

169 (ii) Provide a proposed care plan and inform
170 the applicant or the applicant's legal representative regarding
171 the degree to which the services in the care plan are available in
172 a home- or in other community-based setting rather than nursing

173 facility care; and

174 (iii) Explain that <u>the</u> plan and services are
175 available only if the applicant or the applicant's legal
176 representative chooses a home- or community-based alternative to
177 nursing facility care, and that the applicant is free to choose
178 nursing facility care.

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

184 Placement in a nursing facility may not be denied by the
185 division if home- or community-based services that would be more
186 appropriate than nursing facility care are not actually available,
187 or if the applicant chooses not to receive the appropriate home-
188 or community-based services.

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

193 The division shall make full payment for long-term care
194 alternative services.

195 The division shall apply for necessary federal waivers to
196 assure that additional services providing alternatives to nursing
197 facility care are made available to applicants for nursing
198 facility care.

199 (5) Periodic screening and diagnostic services for
200 individuals under age twenty-one (21) years as are needed to
201 identify physical and mental defects and to provide health care
202 treatment and other measures designed to correct or ameliorate
203 defects and physical and mental illness and conditions discovered
204 by the screening services regardless of whether these services are
205 included in the state plan. The division may include in its
206 periodic screening and diagnostic program those discretionary
207 services authorized under the federal regulations adopted to

208 implement Title XIX of the federal Social Security Act, as
209 amended. The division, in obtaining physical therapy services,
210 occupational therapy services, and services for individuals with
211 speech, hearing and language disorders, may enter into a
212 cooperative agreement with the State Department of Education for
213 the provision of <u>those</u> services to handicapped students by public
214 school districts using state funds <u>that</u> are provided from the
215 appropriation to the Department of Education to obtain federal
216 matching funds through the division. The division, in obtaining
217 medical and psychological evaluations for children in the custody
218 of the State Department of Human Services may enter into a
219 cooperative agreement with the State Department of Human Services
220 for the provision of <u>those</u> services using state funds <u>that</u> are
221 provided from the appropriation to the Department of Human
222 Services to obtain federal matching funds through the division.
223 On July 1, 1993, all fees for periodic screening and
224 diagnostic services under this paragraph (5) shall be increased by
225 twenty-five percent (25%) of the reimbursement rate in effect on
226 June 30, 1993.
227 (6) Physician's services. The division shall allow
228 twelve (12) physician visits annually. All fees for physicians'
229 services that are covered only by Medicaid shall be reimbursed at
230 ninety percent (90%) of the rate established on January 1, 1999,
231 and as adjusted each January thereafter, under Medicare (Title
232 XVIII of the Social Security Act, as amended), and which shall in
233 no event be less than seventy percent (70%) of the rate
234 established on January 1, 1994. All fees for physicians' services
235 that are covered by both Medicare and Medicaid shall be reimbursed
236 at ten percent (10%) of the adjusted Medicare payment established
237 on January 1, 1999, and as adjusted each January thereafter, under
238 Medicare (Title XVIII of the Social Security Act, as amended), and
239 which shall in no event be less than seventy percent (70%) of the
240 adjusted Medicare payment established on January 1, 1994.
241 (7) (a) Home health services for eligible persons, not
242 to exceed in cost the prevailing cost of nursing facility

243 services, not to exceed sixty (60) visits per year. All home
244 health visits must be precertified as required by the division.
245 (b) Repealed.
246 (8) Emergency medical transportation services. On
247 January 1, 1994, emergency medical transportation services shall
248 be reimbursed at seventy percent (70%) of the rate established
249 under Medicare (Title XVIII of the Social Security Act, as
250 amended). "Emergency medical transportation services" shall mean,
251 but shall not be limited to, the following services by a properly
252 permitted ambulance operated by a properly licensed provider in
253 accordance with the Emergency Medical Services Act of 1974
254 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
255 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
256 (vi) disposable supplies, (vii) similar services.
257 (9) Legend and other drugs as may be determined by the
258 division. The division may implement a program of prior approval
259 for drugs to the extent permitted by law. Payment by the division
260 for covered multiple source drugs shall be limited to the lower of
261 the upper limits established and published by the <u>Centers for</u>
262 <u>Medicare and Medicaid Services (CMS)</u> plus a dispensing fee *** * ***,
263 or the estimated acquisition cost (EAC) *** * *** plus a dispensing
264 fee *** * ***, or the providers' usual and customary charge to the
265 general public. The division shall allow <u>seven (7)</u> prescriptions
266 per month for <u>each</u> Medicaid <u>recipient; however, after a recipient</u>
267 <u>has received five (5) prescriptions in any month, each additional</u>
268 <u>prescription during that month must have the prior approval of the</u>
269 <u>division. The division shall not reimburse for any portion of a</u>
270 <u>prescription that exceeds a thirty-four-day supply of the drug</u>
271 <u>based on the daily dosage. Provided, however, that if additional</u>
272 <u>prescriptions per month are necessary to sustain the life of the</u>
273 <u>recipient, as certified to the division by a licensed physician,</u>
274 <u>the division shall allow prescriptions in excess of the seven (7)</u>
275 <u>prescription monthly limit.</u>
276 Payment for other covered drugs, other than multiple source
277 drugs with <u>CMS</u> upper limits, shall not exceed the lower of the

278 estimated acquisition cost * * * plus a dispensing fee * * * or
279 the providers' usual and customary charge to the general public.
280 Payment for nonlegend or over-the-counter drugs covered on
281 the division's formulary shall be reimbursed at the lower of the
282 division's estimated shelf price or the providers' usual and
283 customary charge to the general public. No dispensing fee shall
284 be paid.
285 The dispensing fee for each new or refill prescription shall
286 be Three Dollars and Ninety-one Cents ($3.91).
287 The Medicaid provider shall not prescribe, the Medicaid
288 pharmacy shall not bill, and the division shall not reimburse for
289 name brand drugs if there are equally effective generic
290 equivalents available.
291 The division shall develop and implement a program of payment
292 for additional pharmacist services, with payment to be based on
293 demonstrated savings, but in no case shall the total payment
294 exceed twice the amount of the dispensing fee.
295 All claims for drugs for dually eligible Medicare/Medicaid
296 beneficiaries that are paid for by Medicare must be submitted to
297 Medicare for payment before they may be processed by the
298 division's on-line payment system.
299 The division shall develop pharmacy policy in which drugs in
300 tamper-resistant packaging that are prescribed for a resident of a
301 nursing facility but are not dispensed to the resident shall be
302 returned to the pharmacy and not billed to Medicaid, in accordance
303 with guidelines of the State Board of Pharmacy.
304 As used in this paragraph (9), "estimated acquisition cost"
305 means ten percent (10%) less than the average wholesale price for
306 a drug * * *.
307 (10) Dental care that is an adjunct to treatment of an
308 acute medical or surgical condition; services of oral surgeons and
309 dentists in connection with surgery related to the jaw or any
310 structure contiguous to the jaw or the reduction of any fracture
311 of the jaw or any facial bone; and emergency dental extractions
312 and treatment related thereto. On July 1, 1999, all fees for

313 dental care and surgery under authority of this paragraph (10)
314 shall be increased to one hundred sixty percent (160%) of the
315 amount of the reimbursement rate that was in effect on June 30,
316 1999. It is the intent of the Legislature to encourage more
317 dentists to participate in the Medicaid program.

318 (11) Eyeglasses necessitated by reason of eye surgery,
319 and as prescribed by a physician skilled in diseases of the eye or
320 an optometrist, whichever the patient may select, or one (1) pair
321 every <u>five (5)</u> years as prescribed by a physician or an
322 optometrist, whichever the patient may select.

323 (12) Intermediate care facility services.

324 (a) The division shall make full payment to all
325 intermediate care facilities for the mentally retarded for each
326 day, not exceeding eighty-four (84) days per year, that a patient
327 is absent from the facility on home leave. Payment may be made
328 for the following home leave days in addition to the
329 eighty-four-day limitation: Christmas, the day before Christmas,
330 the day after Christmas, Thanksgiving, the day before Thanksgiving
331 and the day after Thanksgiving.

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

335 (13) Family planning services, including drugs,
336 supplies and devices, when <u>those</u> services are under the
337 supervision of a physician.

338 (14) Clinic services. Such diagnostic, preventive,
339 therapeutic, rehabilitative or palliative services furnished to an
340 outpatient by or under the supervision of a physician or dentist
341 in a facility <u>that</u> is not a part of a hospital but <u>that</u> is
342 organized and operated to provide medical care to outpatients.
343 Clinic services shall include any services reimbursed as
344 outpatient hospital services <u>that</u> may be rendered in such a
345 facility, including those that become so after July 1, 1991. On
346 July 1, 1999, all fees for physicians' services reimbursed under
347 authority of this paragraph (14) shall be reimbursed at ninety

348 percent (90%) of the rate established on January 1, 1999, and as
349 adjusted each January thereafter, under Medicare (Title XVIII of
350 the Social Security Act, as amended), and which shall in no event
351 be less than seventy percent (70%) of the rate established on
352 January 1, 1994. All fees for physicians' services that are
353 covered by both Medicare and Medicaid shall be reimbursed at ten
354 percent (10%) of the adjusted Medicare payment established on
355 January 1, 1999, and as adjusted each January thereafter, under
356 Medicare (Title XVIII of the Social Security Act, as amended), and
357 which shall in no event be less than seventy percent (70%) of the
358 adjusted Medicare payment established on January 1, 1994. On July
359 1, 1999, all fees for dentists' services reimbursed under
360 authority of this paragraph (14) shall be increased to one hundred
361 sixty percent (160%) of the amount of the reimbursement rate that
362 was in effect on June 30, 1999.
363 (15) Home- and community-based services, as provided
364 under Title XIX of the federal Social Security Act, as amended,
365 under waivers, subject to the availability of funds specifically
366 appropriated therefor by the Legislature. Payment for <u>those</u>
367 services shall be limited to individuals who would be eligible for
368 and would otherwise require the level of care provided in a
369 nursing facility. The home- and community-based services
370 authorized under this paragraph shall be expanded over a five-year
371 period beginning July 1, 1999. The division shall certify case
372 management agencies to provide case management services and
373 provide for home- and community-based services for eligible
374 individuals under this paragraph. The home- and community-based
375 services under this paragraph and the activities performed by
376 certified case management agencies under this paragraph shall be
377 funded using state funds that are provided from the appropriation
378 to the Division of Medicaid and used to match federal funds.
379 (16) Mental health services. Approved therapeutic and
380 case management services provided by (a) an approved regional
381 mental health/retardation center established under Sections
382 41-19-31 through 41-19-39, or by another community mental health

383 service provider meeting the requirements of the Department of
384 Mental Health to be an approved mental health/retardation center
385 if determined necessary by the Department of Mental Health, using
386 state funds that are provided from the appropriation to the State
387 Department of Mental Health and used to match federal funds under
388 a cooperative agreement between the division and the department,
389 or (b) a facility that is certified by the State Department of
390 Mental Health to provide therapeutic and case management services,
391 to be reimbursed on a fee for service basis. Any such services
392 provided by a facility described in paragraph (b) must have the
393 prior approval of the division to be reimbursable under this
394 section. After June 30, 1997, mental health services provided by
395 regional mental health/retardation centers established under
396 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
397 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
398 psychiatric residential treatment facilities as defined in Section
399 43-11-1, or by another community mental health service provider
400 meeting the requirements of the Department of Mental Health to be
401 an approved mental health/retardation center if determined
402 necessary by the Department of Mental Health, shall not be
403 included in or provided under any capitated managed care pilot
404 program provided for under paragraph (24) of this section.
405 (17) Durable medical equipment services and medical
406 supplies. Precertification of durable medical equipment and
407 medical supplies must be obtained as required by the division.
408 The Division of Medicaid may require durable medical equipment
409 providers to obtain a surety bond in the amount and to the
410 specifications as established by the Balanced Budget Act of 1997.
411 (18) (a) Notwithstanding any other provision of this
412 section to the contrary, the division shall make additional
413 reimbursement to hospitals that serve a disproportionate share of
414 low-income patients and that meet the federal requirements for
415 such payments as provided in Section 1923 of the federal Social
416 Security Act and any applicable regulations. However, from and
417 after January 1, 2000, no public hospital shall participate in the

418 Medicaid disproportionate share program unless the public hospital
419 participates in an intergovernmental transfer program as provided
420 in Section 1903 of the federal Social Security Act and any
421 applicable regulations. Administration and support for
422 participating hospitals shall be provided by the Mississippi
423 Hospital Association.
424 (b) The division shall establish a Medicare Upper
425 Payment Limits Program as defined in Section 1902(a)(30) of the
426 federal Social Security Act and any applicable federal
427 regulations. The division shall assess each hospital for the sole
428 purpose of financing the state portion of the Medicare Upper
429 Payment Limits Program. This assessment shall be based on
430 Medicaid utilization, or other appropriate method consistent with
431 federal regulations, and will remain in effect as long as the
432 state participates in the Medicare Upper Payment Limits Program.
433 The division shall make additional reimbursement to hospitals for
434 the Medicare Upper Payment Limits as defined in Section
435 1902(a)(30) of the federal Social Security Act and any applicable
436 federal regulations. This paragraph (b) shall stand repealed from
437 and after July 1, 2005.
438 (c) The division shall contract with the
439 Mississippi Hospital Association to provide administrative support
440 for the operation of the disproportionate share hospital program
441 and the Medicare Upper Payment Limits Program. This paragraph (c)
442 shall stand repealed from and after July 1, 2005.
443 (19) (a) Perinatal risk management services. The
444 division shall promulgate regulations to be effective from and
445 after October 1, 1988, to establish a comprehensive perinatal
446 system for risk assessment of all pregnant and infant Medicaid
447 recipients and for management, education and follow-up for those
448 who are determined to be at risk. Services to be performed
449 include case management, nutrition assessment/counseling,
450 psychosocial assessment/counseling and health education. The
451 division shall set reimbursement rates for providers in
452 conjunction with the State Department of Health.

453 (b) Early intervention system services. The
454 division shall cooperate with the State Department of Health,
455 acting as lead agency, in the development and implementation of a
456 statewide system of delivery of early intervention services,
457 pursuant to Part H of the Individuals with Disabilities Education
458 Act (IDEA). The State Department of Health shall certify annually
459 in writing to the <u>executive</u> director of the division the dollar
460 amount of state early intervention funds available <u>that will</u> be
461 utilized as a certified match for Medicaid matching funds. Those
462 funds then shall be used to provide expanded targeted case
463 management services for Medicaid eligible children with special
464 needs who are eligible for the state's early intervention system.
465 Qualifications for persons providing service coordination shall
466 be determined by the State Department of Health and the Division
467 of Medicaid.

468 (20) Home- and community-based services for physically
469 disabled approved services as allowed by a waiver from the United
470 States Department of Health and Human Services for home- and
471 community-based services for physically disabled people using
472 state funds <u>that</u> are provided from the appropriation to the State
473 Department of Rehabilitation Services and used to match federal
474 funds under a cooperative agreement between the division and the
475 department, provided that funds for these services are
476 specifically appropriated to the Department of Rehabilitation
477 Services.

478 (21) Nurse practitioner services. Services furnished
479 by a registered nurse who is licensed and certified by the
480 Mississippi Board of Nursing as a nurse practitioner including,
481 but not limited to, nurse anesthetists, nurse midwives, family
482 nurse practitioners, family planning nurse practitioners,
483 pediatric nurse practitioners, obstetrics-gynecology nurse
484 practitioners and neonatal nurse practitioners, under regulations
485 adopted by the division. Reimbursement for <u>those</u> services shall
486 not exceed ninety percent (90%) of the reimbursement rate for
487 comparable services rendered by a physician.

488 (22) Ambulatory services delivered in federally
489 qualified health centers and in clinics of the local health
490 departments of the State Department of Health for individuals
491 eligible for medical assistance under this article based on
492 reasonable costs as determined by the division.
493 (23) Inpatient psychiatric services. Inpatient
494 psychiatric services to be determined by the division for
495 recipients under age twenty-one (21) that are provided under the
496 direction of a physician in an inpatient program in a licensed
497 acute care psychiatric facility or in a licensed psychiatric
498 residential treatment facility, before the recipient reaches age
499 twenty-one (21) or, if the recipient was receiving the services
500 immediately before he reached age twenty-one (21), before the
501 earlier of the date he no longer requires the services or the date
502 he reaches age twenty-two (22), as provided by federal
503 regulations. Precertification of inpatient days and residential
504 treatment days must be obtained as required by the division.
505 (24) * * *
506 (25) Birthing center services.
507 (26) Hospice care. As used in this paragraph, the term
508 "hospice care" means a coordinated program of active professional
509 medical attention within the home and outpatient and inpatient
510 care that treats the terminally ill patient and family as a unit,
511 employing a medically directed interdisciplinary team. The
512 program provides relief of severe pain or other physical symptoms
513 and supportive care to meet the special needs arising out of
514 physical, psychological, spiritual, social and economic stresses
515 that are experienced during the final stages of illness and during
516 dying and bereavement and meets the Medicare requirements for
517 participation as a hospice as provided in federal regulations.
518 (27) Group health plan premiums and cost sharing if it
519 is cost effective as defined by the Secretary of Health and Human
520 Services.
521 (28) Other health insurance premiums that are cost
522 effective as defined by the Secretary of Health and Human

523 Services. Medicare eligible must have Medicare Part B before
524 other insurance premiums can be paid.
525 (29) The Division of Medicaid may apply for a waiver
526 from the Department of Health and Human Services for home- and
527 community-based services for developmentally disabled people using
528 state funds that are provided from the appropriation to the State
529 Department of Mental Health and used to match federal funds under
530 a cooperative agreement between the division and the department,
531 provided that funds for these services are specifically
532 appropriated to the Department of Mental Health.
533 (30) Pediatric skilled nursing services for eligible
534 persons under twenty-one (21) years of age.
535 (31) Targeted case management services for children
536 with special needs, under waivers from the United States
537 Department of Health and Human Services, using state funds that
538 are provided from the appropriation to the Mississippi Department
539 of Human Services and used to match federal funds under a
540 cooperative agreement between the division and the department.
541 (32) Care and services provided in Christian Science
542 Sanatoria operated by or listed and certified by The First Church
543 of Christ Scientist, Boston, Massachusetts, rendered in connection
544 with treatment by prayer or spiritual means to the extent that
545 those services are subject to reimbursement under Section 1903 of
546 the Social Security Act.
547 (33) Podiatrist services.
548 (34) The division shall make application to the United
549 States Health Care Financing Administration for a waiver to
550 develop a program of services to personal care and assisted living
551 homes in Mississippi. This waiver shall be completed by December
552 1, 1999.
553 (35) Services and activities authorized in Sections
554 43-27-101 and 43-27-103, using state funds that are provided from
555 the appropriation to the State Department of Human Services and
556 used to match federal funds under a cooperative agreement between
557 the division and the department.

558 (36) Nonemergency transportation services for
559 Medicaid-eligible persons, to be provided by the Division of
560 Medicaid. The division may contract with additional entities to
561 administer nonemergency transportation services as it deems
562 necessary. All providers shall have a valid driver's license,
563 vehicle inspection sticker, valid vehicle license tags and a
564 standard liability insurance policy covering the vehicle.
565 (37) [Deleted]
566 (38) Chiropractic services: a chiropractor's manual
567 manipulation of the spine to correct a subluxation, if x-ray
568 demonstrates that a subluxation exists and if the subluxation has
569 resulted in a neuromusculoskeletal condition for which
570 manipulation is appropriate treatment. Reimbursement for
571 chiropractic services shall not exceed Seven Hundred Dollars
572 ($700.00) per year per recipient.
573 (39) Dually eligible Medicare/Medicaid beneficiaries.
574 The division shall pay the Medicare deductible and ten percent
575 (10%) coinsurance amounts for services available under Medicare
576 for the duration and scope of services otherwise available under
577 the Medicaid program.
578 (40) [Deleted]
579 (41) Services provided by the State Department of
580 Rehabilitation Services for the care and rehabilitation of persons
581 with spinal cord injuries or traumatic brain injuries, as allowed
582 under waivers from the United States Department of Health and
583 Human Services, using up to seventy-five percent (75%) of the
584 funds that are appropriated to the Department of Rehabilitation
585 Services from the Spinal Cord and Head Injury Trust Fund
586 established under Section 37-33-261 and used to match federal
587 funds under a cooperative agreement between the division and the
588 department.
589 (42) Notwithstanding any other provision in this
590 article to the contrary, the division <u>may</u> develop a population
591 health management program for women and children health services
592 through the age of two (2) <u>years</u>. This program is primarily for

593 obstetrical care associated with low birth weight and pre-term
594 babies. In order to effect cost savings, the division may develop
595 a revised payment methodology that may include at-risk capitated
596 payments.
597 (43) The division shall provide reimbursement,
598 according to a payment schedule developed by the division, for
599 smoking cessation medications for pregnant women during their
600 pregnancy and other Medicaid-eligible women who are of
601 child-bearing age.
602 (44) Nursing facility services for the severely
603 disabled.
604 (a) Severe disabilities include, but are not
605 limited to, spinal cord injuries, closed head injuries and
606 ventilator dependent patients.
607 (b) Those services must be provided in a long-term
608 care nursing facility dedicated to the care and treatment of
609 persons with severe disabilities, and shall be reimbursed as a
610 separate category of nursing facilities.
611 (45) Physician assistant services. Services furnished
612 by a physician assistant who is licensed by the State Board of
613 Medical Licensure and is practicing with physician supervision
614 under regulations adopted by the board, under regulations adopted
615 by the division. Reimbursement for those services shall not
616 exceed ninety percent (90%) of the reimbursement rate for
617 comparable services rendered by a physician.
618 (46) The division shall make application to the federal
619 Centers for Medicare and Medicaid Services (CMS) for a waiver to
620 develop and provide services for children with serious emotional
621 disturbances as defined in Section 43-14-1(1), which may include
622 home- and community-based services, case management services or
623 managed care services through mental health providers certified by
624 the Department of Mental Health. The division may implement and
625 provide services under this waivered program only if funds for
626 these services are specifically appropriated for this purpose by
627 the Legislature, or if funds are voluntarily provided by affected

628 agencies.

629 (47) Notwithstanding any other provision in this
630 article to the contrary, the division, in conjunction with the
631 State Department of Health, shall develop and implement disease
632 management programs statewide for individuals with asthma,
633 diabetes or hypertension, including the use of grants, waivers,
634 demonstrations or other projects as necessary.

635 (48) The division shall establish copayments for all
636 Medicaid services for which copayments are allowable under federal
637 law or regulation, and shall set the amount of the copayment for
638 each of those services at the maximum amount allowable under
639 federal law or regulation.

640 Notwithstanding any other provision of this article to the
641 contrary, the division shall reduce the rate of reimbursement to
642 providers for any service provided under this section by five
643 percent (5%) of the allowed amount for that service. However, the
644 reduction in the reimbursement rates required by this paragraph
645 shall not apply to any service provided under paragraph (9) of
646 this section or any service provided by a state agency, a state
647 facility, a public agency, or the University of Mississippi
648 Medical Center that either provides its own state match through
649 inter-governmental transfer or certification of funds to the
650 division, or a service for which the federal government sets the
651 reimbursement methodology and rate.

652 Notwithstanding any provision of this article, except as
653 authorized in the following paragraph and in Section 43-13-139,
654 neither (a) the limitations on quantity or frequency of use of or
655 the fees or charges for any of the care or services available to
656 recipients under this section, nor (b) the payments or rates of
657 reimbursement to providers rendering care or services authorized
658 under this section to recipients, may be increased, decreased or
659 otherwise changed from the levels in effect on July 1, 1999,
660 unless they are authorized by an amendment to this section by the
661 Legislature. However, the restriction in this paragraph shall not
662 prevent the division from changing the payments or rates of

663 reimbursement to providers without an amendment to this section
664 whenever those changes are required by federal law or regulation,
665 or whenever those changes are necessary to correct administrative
666 errors or omissions in calculating those payments or rates of
667 reimbursement.
668 Notwithstanding any provision of this article, no new groups
669 or categories of recipients and new types of care and services may
670 be added without enabling legislation from the Mississippi
671 Legislature, except that the division may authorize those changes
672 without enabling legislation when the addition of recipients or
673 services is ordered by a court of proper authority. The executive
674 director shall keep the Governor advised on a timely basis of the
675 funds available for expenditure and the projected expenditures.
676 If current or projected expenditures of the division can be
677 reasonably anticipated to exceed the amounts appropriated for any
678 fiscal year, the Governor, after consultation with the executive
679 director, shall discontinue any or all of the payment of the types
680 of care and services as provided in this section that are deemed
681 to be optional services under Title XIX of the federal Social
682 Security Act, as amended, for any period necessary to not exceed
683 appropriated funds, and when necessary shall institute any other
684 cost containment measures on any program or programs authorized
685 under the article to the extent allowed under the federal law
686 governing that program or programs, it being the intent of the
687 Legislature that expenditures during any fiscal year shall not
688 exceed the amounts appropriated for that fiscal year.
689 Notwithstanding any other provision of this article, it shall
690 be the duty of each nursing facility, intermediate care facility
691 for the mentally retarded, psychiatric residential treatment
692 facility, and nursing facility for the severely disabled that is
693 participating in the Medicaid program to keep and maintain books,
694 documents, and other records as prescribed by the Division of
695 Medicaid in substantiation of its cost reports for a period of
696 three (3) years after the date of submission to the Division of
697 Medicaid of an original cost report, or three (3) years after the

698 date of submission to the Division of Medicaid of an amended cost
699 report.
700 This section shall stand repealed on July 1, 2004.
701 **SECTION 2.** Section 43-13-407, Mississippi Code of 1972, is
702 amended as follows:
703 43-13-407. (1) In accordance with the purposes of this
704 article, there is established in the State Treasury the Health
705 Care Expendable Fund, into which shall be transferred from the
706 Health Care Trust Fund the following sums:
707 (a) In fiscal year 2000, Fifty Million Dollars
708 ($50,000,000.00);
709 (b) In fiscal year 2001, Fifty-five Million Dollars
710 ($55,000,000.00);
711 (c) In fiscal year 2002, Sixty Million Five Hundred
712 Thousand Dollars ($60,500,000.00);
713 (d) In fiscal year 2003, Sixty-six Million Five Hundred
714 Fifty Thousand Dollars ($66,550,000.00);
715 (e) In fiscal year 2004 and each subsequent fiscal
716 year, a sum equal to the average annual amount of the income from
717 the investment of the funds in the Health Care Trust Fund since
718 July 1, 1999.
719 (2) In any fiscal year in which interest and dividends from
720 the investment of the funds in the Health Care Trust Fund are not
721 sufficient to fund the full amount of the annual transfer into the
722 Health Care Expendable Fund as required in subsection (1) of this
723 section, the State Treasurer shall transfer from tobacco
724 settlement installment payments an amount that is sufficient to
725 fully fund the amount of the annual transfer.
726 (3) (a) On the effective date of House Bill No. 1200, 2002
727 Regular Session, the State Treasurer shall transfer the sum of
728 Eighty-seven Million Dollars ($87,000,000.00) from the Health Care
729 Trust Fund into the Health Care Expendable Fund. In addition, at
730 the time the State of Mississippi receives the 2002 calendar year
731 tobacco settlement installment payment, the State Treasurer shall
732 deposit the full amount of that installment payment into the

733 Health Care Expendable Fund.

734 (b) If during any fiscal year after the effective date
735 of House Bill No. 1200, 2002 Regular Session, the general fund
736 revenues received by the state exceed the general fund revenues
737 received during the previous fiscal year by more than five percent
738 (5%), the Legislature shall repay to the Health Care Trust Fund
739 one-third (1/3) of the amount of the general fund revenues that
740 exceed the five percent (5%) growth in general fund revenues. The
741 repayment required by this paragraph shall continue in each fiscal
742 year in which there is more than five percent (5%) growth in
743 general fund revenues, until the full amount of the funds that
744 were transferred and deposited into the Health Care Expendable
745 Fund under the provisions of paragraph (a) of this subsection have
746 been repaid to the Health Care Trust Fund.

747 (4) All income from the investment of the funds in the
748 Health Care Expendable Fund shall be credited to the account of
749 the Health Care Expendable Fund. Any funds in the Health Care
750 Expendable Fund at the end of a fiscal year shall not lapse into
751 the State General Fund.

752 (5) The funds in the Health Care Expendable Fund shall be
753 available for expenditure under specific appropriation by the
754 Legislature beginning in fiscal year 2000, and shall be expended
755 exclusively for health care purposes.

756 (6) Subsections (1), (2), (4) and (5) of this section shall
757 stand repealed on July 1, 2004.

758 **SECTION 3.** Section 43-13-405, Mississippi Code of 1972, is
759 amended as follows:

760 43-13-405. (1) In accordance with the purposes of this
761 article, there is established in the State Treasury the Health
762 Care Trust Fund, into which shall be deposited Two Hundred Eighty
763 Million Dollars ($280,000,000.00) of the funds received by the
764 State of Mississippi as a result of the tobacco settlement as of
765 the end of fiscal year 1999, and all tobacco settlement
766 installment payments made in subsequent years for which the use or
767 purpose for expenditure is not restricted by the terms of the

768 settlement, except as otherwise provided in Section 43-13-407(2)
769 and (3). All income from the investment of the funds in the
770 Health Care Trust Fund shall be credited to the account of the
771 Health Care Trust Fund. The funds in the Health Care Trust Fund
772 at the end of a fiscal year shall not lapse into the State General
773 Fund.

774 (2) The Health Care Trust Fund shall remain inviolate and
775 shall never be expended, except as provided in this article. The
776 Legislature shall appropriate from the Health Care Trust Fund such
777 sums as are necessary to recoup any funds lost as a result of any
778 of the following actions:

779 (a) The federal Centers for Medicare and Medicaid
780 Services, or other agency of the federal government, is successful
781 in recouping tobacco settlement funds from the State of
782 Mississippi;

783 (b) The federal share of funds for the support of the
784 Mississippi Medicaid Program is reduced directly or indirectly as
785 a result of the tobacco settlement;

786 (c) Federal funding for any other program is reduced as
787 a result of the tobacco settlement; or

788 (d) Tobacco cessation programs are mandated by the
789 federal government or court order.

790 (3) This section shall stand repealed on July 1, 2004.

791 **SECTION 4.** This act shall take effect and be in force from
792 and after its passage.

Further, amend by striking the title in its entirety and inserting in lieu thereof the following:

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO REDUCE THE MONTHLY NUMBER OF PRESCRIPTIONS FOR ALL MEDICAID
3 RECIPIENTS AND REQUIRE PRIOR APPROVAL FOR PRESCRIPTIONS ABOVE A
4 CERTAIN NUMBER; TO PROVIDE AN EXCEPTION TO THE MONTHLY LIMIT IF A
5 PHYSICIAN DETERMINES IT IS NECESSARY TO SUSTAIN THE LIFE OF THE
6 RECIPIENT; TO PROVIDE THAT THE DIVISION OF MEDICAID WILL NOT
7 REIMBURSE FOR ANY PORTION OF A PRESCRIPTION THAT EXCEEDS A
8 THIRTY-FOUR DAY SUPPLY OF THE DRUG; TO REDUCE THE PHARMACY
9 DISPENSING FEE FOR PRESCRIPTIONS; TO PROVIDE THAT IF A GENERIC
10 DRUG IS AVAILABLE FOR A PRESCRIPTION, THE PROVIDER SHALL NOT
11 PRESCRIBE AND THE DIVISION SHALL NOT REIMBURSE FOR NAME BRAND
12 DRUGS; TO PROVIDE THAT CLAIMS FOR DRUGS FOR DUALLY ELIGIBLE
13 MEDICARE/MEDICAID BENEFICIARIES THAT ARE PAID FOR BY MEDICARE MUST

14 BE SUBMITTED TO MEDICARE FOR PAYMENT BEFORE THEY MAY BE PROCESSED
15 BY MEDICAID'S ON-LINE PAYMENT SYSTEM; TO PROVIDE THAT CERTAIN
16 DRUGS PRESCRIBED FOR RESIDENTS OF NURSING FACILITIES THAT WERE
17 ORIGINALLY BILLED TO MEDICAID BUT ARE NOT USED BY THE RESIDENTS
18 SHALL BE RETURNED TO THE BILLING PHARMACY FOR CREDIT TO MEDICAID;
19 TO PROVIDE THAT THE ESTIMATED ACQUISITION COST OF A DRUG THAT IS
20 USED FOR REIMBURSEMENT PURPOSES SHALL BE TEN PERCENT LESS THAN THE
21 AVERAGE WHOLESALE PRICE FOR THE DRUG; TO ALLOW MEDICAID RECIPIENTS
22 ONE PAIR OF EYEGLASSES EVERY FIVE YEARS INSTEAD OF EVERY THREE
23 YEARS; TO DELETE THE AUTHORITY FOR THE DIVISION TO PROVIDE MANAGED
24 CARE SERVICES; TO DIRECT THE DIVISION TO DEVELOP AND IMPLEMENT
25 DISEASE MANAGEMENT PROGRAMS STATEWIDE FOR INDIVIDUALS WITH ASTHMA,
26 DIABETES OR HYPERTENSION; TO DIRECT THE DIVISION TO ESTABLISH
27 COPAYMENTS FOR ALL MEDICAID SERVICES FOR WHICH COPAYMENTS ARE
28 ALLOWABLE UNDER FEDERAL LAW OR REGULATION, AND TO SET THE AMOUNT
29 OF THE COPAYMENT FOR EACH OF THOSE SERVICES AT THE MAXIMUM AMOUNT
30 ALLOWABLE UNDER FEDERAL LAW OR REGULATION; TO DIRECT THE DIVISION
31 TO REDUCE THE RATE OF REIMBURSEMENT TO PROVIDERS FOR MEDICAID
32 SERVICES BY FIVE PERCENT OF THE REIMBURSEMENT RATE ON JANUARY 1,
33 2002; TO AMEND SECTION 43-13-407, MISSISSIPPI CODE OF 1972, TO
34 DIRECT THE STATE TREASURER TO TRANSFER $87,000,000.00 FROM THE
35 HEALTH CARE TRUST FUND INTO THE HEALTH CARE EXPENDABLE FUND; TO
36 DIRECT THE TREASURER TO DEPOSIT THE FULL AMOUNT OF THE 2002
37 TOBACCO SETTLEMENT INSTALLMENT PAYMENT RECEIVED BY THE STATE INTO
38 THE HEALTH CARE EXPENDABLE FUND; TO PROVIDE THAT IF DURING ANY
39 FISCAL YEAR AFTER THE EFFECTIVE DATE OF THIS ACT, THE GENERAL FUND
40 REVENUES RECEIVED BY THE STATE EXCEED THE GENERAL FUND REVENUES
41 RECEIVED DURING THE PREVIOUS FISCAL YEAR BY FIVE PERCENT OR MORE,
42 THE LEGISLATURE SHALL REPAY TO THE HEALTH CARE TRUST FUND
43 ONE-THIRD OF THE AMOUNT OF THE GENERAL FUND REVENUES THAT EXCEED
44 THE FIVE PERCENT GROWTH; TO AMEND SECTION 43-13-405, MISSISSIPPI
45 CODE OF 1972, TO CONFORM TO THE PRECEDING PROVISION; AND FOR
46 RELATED PURPOSES.