MISSISSIPPI LEGISLATURE REGULAR SESSION 2003

By: Senator(s) Burton

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2343

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO DELETE THE REQUIREMENT THAT LOCAL PLANNING AND DEVELOPMENT
3 DISTRICTS TRANSFER TO THE DIVISION OF MEDICAID FUNDS EQUAL TO A 5%
4 REDUCTION IN MEDICAID REIMBURSEMENT FOR CASE MANAGEMENT SERVICES
5 AND HOME-DELIVERED MEALS PROVIDED UNDER THE HOME- AND
6 COMMUNITY-BASED SERVICES PROGRAM; AND FOR RELATED PURPOSES.

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

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

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

17 (1) Inpatient hospital services.

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

25 (b) From and after July 1, 1994, the Executive
26 Director of the Division of Medicaid shall amend the Mississippi
27 Title XIX Inpatient Hospital Reimbursement Plan to remove the
28 occupancy rate penalty from the calculation of the Medicaid

29 Capital Cost Component utilized to determine total hospital costs
30 allocated to the Medicaid program.

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38 subparagraph (c) shall stand repealed on July 1, 2005.

39 (2) Outpatient hospital services. Where the same
40 services are reimbursed as clinic services, the division may
41 revise the rate or methodology of outpatient reimbursement to
42 maintain consistency, efficiency, economy and quality of care.

43 (3) Laboratory and x-ray services.

44 (4) Nursing facility services.

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

52 (b) From and after July 1, 1997, the division
53 shall implement the integrated case-mix payment and quality
54 monitoring system, which includes the fair rental system for
55 property costs and in which recapture of depreciation is
56 eliminated. The division may reduce the payment for hospital
57 leave and therapeutic home leave days to the lower of the case-mix
58 category as computed for the resident on leave using the
59 assessment being utilized for payment at that point in time, or a
60 case-mix score of 1.000 for nursing facilities, and shall compute
61 case-mix scores of residents so that only services provided at the

62 nursing facility are considered in calculating a facility's per
63 diem.

64 During the period between May 1, 2002, and December 1, 2002,
65 the Chairmen of the Public Health and Welfare Committees of the
66 Senate and the House of Representatives may appoint a joint study
67 committee to consider the issue of setting uniform reimbursement
68 rates for nursing facilities. The study committee will consist of
69 the Chairmen of the Public Health and Welfare Committees, three
70 (3) members of the Senate and three (3) members of the House. The
71 study committee shall complete its work in not more than three (3)
72 meetings.

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

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

95 subparagraph (d), the division first must have received approval
96 from the Health Care Financing Administration of the United States
97 Department of Health and Human Services of the change in the state
98 Medicaid plan providing for the reimbursement.

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

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

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

160 choice of home- or community-based services as an alternative to
161 institutional care.

162 The division shall make full payment for long-term care
163 alternative services.

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

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

192 (6) Physician's services. The division shall allow
193 twelve (12) physician visits annually. All fees for physicians'
194 services that are covered only by Medicaid shall be reimbursed at
195 ninety percent (90%) of the rate established on January 1, 1999,
196 and as adjusted each January thereafter, under Medicare (Title
197 XVIII of the Social Security Act, as amended), and which shall in
198 no event be less than seventy percent (70%) of the rate
199 established on January 1, 1994. All fees for physicians' services
200 that are covered by both Medicare and Medicaid shall be reimbursed
201 at ten percent (10%) of the adjusted Medicare payment established
202 on January 1, 1999, and as adjusted each January thereafter, under
203 Medicare (Title XVIII of the Social Security Act, as amended), and
204 which shall in no event be less than seventy percent (70%) of the
205 adjusted Medicare payment established on January 1, 1994.
206 (7) (a) Home health services for eligible persons, not
207 to exceed in cost the prevailing cost of nursing facility
208 services, not to exceed sixty (60) visits per year. All home
209 health visits must be precertified as required by the division.
210 (b) Repealed.
211 (8) Emergency medical transportation services. On
212 January 1, 1994, emergency medical transportation services shall
213 be reimbursed at seventy percent (70%) of the rate established
214 under Medicare (Title XVIII of the Social Security Act, as
215 amended). "Emergency medical transportation services" shall mean,
216 but shall not be limited to, the following services by a properly
217 permitted ambulance operated by a properly licensed provider in
218 accordance with the Emergency Medical Services Act of 1974
219 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
220 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
221 (vi) disposable supplies, (vii) similar services.
222 (9) (a) Legend and other drugs as may be determined by
223 the division. The division shall opt out of the federal drug
224 rebate program and shall create a closed drug formulary as soon as

225 practicable after April 12, 2002. Drugs included on the formulary
226 will be those with the lowest and best price as determined through
227 a bidding process. The division may implement a program of prior
228 approval for drugs to the extent permitted by law. The division
229 shall allow seven (7) prescriptions per month for each
230 noninstitutionalized Medicaid recipient; however, after a
231 noninstitutionalized or institutionalized recipient has received
232 five (5) prescriptions in any month, each additional prescription
233 during that month must have the prior approval of the division.
234 The division shall not reimburse for any portion of a prescription
235 that exceeds a thirty-four-day supply of the drug based on the
236 daily dosage.

237 The dispensing fee for each new or refill prescription shall
238 be Three Dollars and Ninety-one Cents ($3.91).

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

243 All claims for drugs for dually eligible Medicare/Medicaid
244 beneficiaries that are paid for by Medicare must be submitted to
245 Medicare for payment before they may be processed by the
246 division's on-line payment system.

247 The division shall develop a pharmacy policy in which drugs
248 in tamper-resistant packaging that are prescribed for a resident
249 of a nursing facility but are not dispensed to the resident shall
250 be returned to the pharmacy and not billed to Medicaid, in
251 accordance with guidelines of the State Board of Pharmacy.

252 (b) Legend and other drugs as may be determined by
253 the division. The division may implement a program of prior
254 approval for drugs to the extent permitted by law. Payment by the
255 division for covered multiple source drugs shall be limited to the
256 lower of the upper limits established and published by the Centers
257 for Medicare and Medicaid Services (CMS) plus a dispensing fee, or

258 the estimated acquisition cost (EAC) plus a dispensing fee, or the
259 providers' usual and customary charge to the general public. The
260 division shall allow seven (7) prescriptions per month for each
261 noninstitutionalized Medicaid recipient; however, after a
262 noninstitutionalized or institutionalized recipient has received
263 five (5) prescriptions in any month, each additional prescription
264 during that month must have the prior approval of the division.
265 The division shall not reimburse for any portion of a prescription
266 that exceeds a thirty-four-day supply of the drug based on the
267 daily dosage.

268 Payment for other covered drugs, other than multiple source
269 drugs with CMS upper limits, shall not exceed the lower of the
270 estimated acquisition cost plus a dispensing fee or the providers'
271 usual and customary charge to the general public.

272 Payment for nonlegend or over-the-counter drugs covered on
273 the division's formulary shall be reimbursed at the lower of the
274 division's estimated shelf price or the providers' usual and
275 customary charge to the general public. No dispensing fee shall
276 be paid.

277 The dispensing fee for each new or refill prescription shall
278 be Three Dollars and Ninety-one Cents ($3.91).

279 The Medicaid provider shall not prescribe, the Medicaid
280 pharmacy shall not bill, and the division shall not reimburse for
281 name brand drugs if there are equally effective generic
282 equivalents available and if the generic equivalents are the least
283 expensive.

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

288 All claims for drugs for dually eligible Medicare/Medicaid
289 beneficiaries that are paid for by Medicare must be submitted to

290 Medicare for payment before they may be processed by the
291 division's on-line payment system.
292 The division shall develop a pharmacy policy in which drugs
293 in tamper-resistant packaging that are prescribed for a resident
294 of a nursing facility but are not dispensed to the resident shall
295 be returned to the pharmacy and not billed to Medicaid, in
296 accordance with guidelines of the State Board of Pharmacy.
297 As used in this paragraph (9), "estimated acquisition cost"
298 means twelve percent (12%) less than the average wholesale price
299 for a drug.
300 (c) The division may operate the drug program
301 under the provisions of subparagraph (b) until the closed drug
302 formulary required by subparagraph (a) is established and
303 implemented. Subparagraph (a) of this paragraph (9) shall stand
304 repealed on July 1, 2003.
305 (10) Dental care that is an adjunct to treatment of an
306 acute medical or surgical condition; services of oral surgeons and
307 dentists in connection with surgery related to the jaw or any
308 structure contiguous to the jaw or the reduction of any fracture
309 of the jaw or any facial bone; and emergency dental extractions
310 and treatment related thereto. On July 1, 1999, all fees for
311 dental care and surgery under authority of this paragraph (10)
312 shall be increased to one hundred sixty percent (160%) of the
313 amount of the reimbursement rate that was in effect on June 30,
314 1999. It is the intent of the Legislature to encourage more
315 dentists to participate in the Medicaid program.
316 (11) Eyeglasses for all Medicaid beneficiaries who have
317 (a) had surgery on the eyeball or ocular muscle that results in a
318 vision change for which eyeglasses or a change in eyeglasses is
319 medically indicated within six (6) months of the surgery and is in
320 accordance with policies established by the division, or (b) one
321 (1) pair every five (5) years and in accordance with policies
322 established by the division. In either instance, the eyeglasses

323 must be prescribed by a physician skilled in diseases of the eye
324 or an optometrist, whichever the beneficiary may select.
325 (12) Intermediate care facility services.
326 (a) The division shall make full payment to all
327 intermediate care facilities for the mentally retarded for each
328 day, not exceeding eighty-four (84) days per year, that a patient
329 is absent from the facility on home leave. Payment may be made
330 for the following home leave days in addition to the
331 eighty-four-day limitation: Christmas, the day before Christmas,
332 the day after Christmas, Thanksgiving, the day before Thanksgiving
333 and the day after Thanksgiving.
334 (b) All state-owned intermediate care facilities
335 for the mentally retarded shall be reimbursed on a full reasonable
336 cost basis.
337 (13) Family planning services, including drugs,
338 supplies and devices, when those services are under the
339 supervision of a physician.
340 (14) Clinic services. Such diagnostic, preventive,
341 therapeutic, rehabilitative or palliative services furnished to an
342 outpatient by or under the supervision of a physician or dentist
343 in a facility that is not a part of a hospital but that is
344 organized and operated to provide medical care to outpatients.
345 Clinic services shall include any services reimbursed as
346 outpatient hospital services that may be rendered in such a
347 facility, including those that become so after July 1, 1991. On
348 July 1, 1999, all fees for physicians' services reimbursed under
349 authority of this paragraph (14) shall be reimbursed at ninety
350 percent (90%) of the rate established on January 1, 1999, and as
351 adjusted each January thereafter, under Medicare (Title XVIII of
352 the Social Security Act, as amended), and which shall in no event
353 be less than seventy percent (70%) of the rate established on
354 January 1, 1994. All fees for physicians' services that are
355 covered by both Medicare and Medicaid shall be reimbursed at ten

356 percent (10%) of the adjusted Medicare payment established on
357 January 1, 1999, and as adjusted each January thereafter, under
358 Medicare (Title XVIII of the Social Security Act, as amended), and
359 which shall in no event be less than seventy percent (70%) of the
360 adjusted Medicare payment established on January 1, 1994. On July
361 1, 1999, all fees for dentists' services reimbursed under
362 authority of this paragraph (14) shall be increased to one hundred
363 sixty percent (160%) of the amount of the reimbursement rate that
364 was in effect on June 30, 1999.
365 (15) Home- and community-based services, as provided
366 under Title XIX of the federal Social Security Act, as amended,
367 under waivers, subject to the availability of funds specifically
368 appropriated therefor by the Legislature. Payment for those
369 services shall be limited to individuals who would be eligible for
370 and would otherwise require the level of care provided in a
371 nursing facility. The home- and community-based services
372 authorized under this paragraph shall be expanded over a five-year
373 period beginning July 1, 1999. The division shall certify case
374 management agencies to provide case management services and
375 provide for home- and community-based services for eligible
376 individuals under this paragraph. The home- and community-based
377 services under this paragraph and the activities performed by
378 certified case management agencies under this paragraph shall be
379 funded using state funds that are provided from the appropriation
380 to the Division of Medicaid and used to match federal funds.
381 (16) Mental health services. Approved therapeutic and
382 case management services (a) provided by an approved regional
383 mental health/retardation center established under Sections
384 41-19-31 through 41-19-39, or by another community mental health
385 service provider meeting the requirements of the Department of
386 Mental Health to be an approved mental health/retardation center
387 if determined necessary by the Department of Mental Health, using
388 state funds that are provided from the appropriation to the State

389 Department of Mental Health and/or funds transferred to the
390 department by a political subdivision or instrumentality of the
391 state and used to match federal funds under a cooperative
392 agreement between the division and the department, or (b) provided
393 by a facility that is certified by the State Department of Mental
394 Health to provide therapeutic and case management services, to be
395 reimbursed on a fee for service basis, or (c) provided in the
396 community by a facility or program operated by the Department of
397 Mental Health. Any such services provided by a facility described
398 in subparagraph (b) must have the prior approval of the division
399 to be reimbursable under this section. After June 30, 1997,
400 mental health services provided by regional mental
401 health/retardation centers established under Sections 41-19-31
402 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
403 and/or their subsidiaries and divisions, or by psychiatric
404 residential treatment facilities as defined in Section 43-11-1, or
405 by another community mental health service provider meeting the
406 requirements of the Department of Mental Health to be an approved
407 mental health/retardation center if determined necessary by the
408 Department of Mental Health, shall not be included in or provided
409 under any capitated managed care pilot program provided for under
410 paragraph (24) of this section.
411 (17) Durable medical equipment services and medical
412 supplies. Precertification of durable medical equipment and
413 medical supplies must be obtained as required by the division.
414 The Division of Medicaid may require durable medical equipment
415 providers to obtain a surety bond in the amount and to the
416 specifications as established by the Balanced Budget Act of 1997.
417 (18) (a) Notwithstanding any other provision of this
418 section to the contrary, the division shall make additional
419 reimbursement to hospitals that serve a disproportionate share of
420 low-income patients and that meet the federal requirements for
421 those payments as provided in Section 1923 of the federal Social

422 Security Act and any applicable regulations. However, from and
423 after January 1, 1999, no public hospital shall participate in the
424 Medicaid disproportionate share program unless the public hospital
425 participates in an intergovernmental transfer program as provided
426 in Section 1903 of the federal Social Security Act and any
427 applicable regulations. Administration and support for
428 participating hospitals shall be provided by the Mississippi
429 Hospital Association.

430 (b) The division shall establish a Medicare Upper
431 Payment Limits Program, as defined in Section 1902(a)(30) of the
432 federal Social Security Act and any applicable federal
433 regulations, for hospitals, and may establish a Medicare Upper
434 Payments Limits Program for nursing facilities. The division
435 shall assess each hospital and, if the program is established for
436 nursing facilities, shall assess each nursing facility, for the
437 sole purpose of financing the state portion of the Medicare Upper
438 Payment Limits Program. This assessment shall be based on
439 Medicaid utilization, or other appropriate method consistent with
440 federal regulations, and will remain in effect as long as the
441 state participates in the Medicare Upper Payment Limits Program.
442 The division shall make additional reimbursement to hospitals and,
443 if the program is established for nursing facilities, shall make
444 additional reimbursement to nursing facilities, for the Medicare
445 Upper Payment Limits, as defined in Section 1902(a)(30) of the
446 federal Social Security Act and any applicable federal
447 regulations. This subparagraph (b) shall stand repealed from and
448 after July 1, 2005.

449 (c) The division shall contract with the
450 Mississippi Hospital Association to provide administrative support
451 for the operation of the disproportionate share hospital program
452 and the Medicare Upper Payment Limits Program. This subparagraph
453 (c) shall stand repealed from and after July 1, 2005.

454 (19) (a) Perinatal risk management services. The
455 division shall promulgate regulations to be effective from and
456 after October 1, 1988, to establish a comprehensive perinatal
457 system for risk assessment of all pregnant and infant Medicaid
458 recipients and for management, education and follow-up for those
459 who are determined to be at risk. Services to be performed
460 include case management, nutrition assessment/counseling,
461 psychosocial assessment/counseling and health education. The
462 division shall set reimbursement rates for providers in
463 conjunction with the State Department of Health.

464 (b) Early intervention system services. The
465 division shall cooperate with the State Department of Health,
466 acting as lead agency, in the development and implementation of a
467 statewide system of delivery of early intervention services, under
468 Part C of the Individuals with Disabilities Education Act (IDEA).
469 The State Department of Health shall certify annually in writing
470 to the executive director of the division the dollar amount of
471 state early intervention funds available that will be utilized as
472 a certified match for Medicaid matching funds. Those funds then
473 shall be used to provide expanded targeted case management
474 services for Medicaid eligible children with special needs who are
475 eligible for the state's early intervention system.
476 Qualifications for persons providing service coordination shall be
477 determined by the State Department of Health and the Division of
478 Medicaid.

479 (20) Home- and community-based services for physically
480 disabled approved services as allowed by a waiver from the United
481 States Department of Health and Human Services for home- and
482 community-based services for physically disabled people using
483 state funds that are provided from the appropriation to the State
484 Department of Rehabilitation Services and used to match federal
485 funds under a cooperative agreement between the division and the
486 department, provided that funds for these services are

487 specifically appropriated to the Department of Rehabilitation
488 Services.
489 (21) Nurse practitioner services. Services furnished
490 by a registered nurse who is licensed and certified by the
491 Mississippi Board of Nursing as a nurse practitioner, including,
492 but not limited to, nurse anesthetists, nurse midwives, family
493 nurse practitioners, family planning nurse practitioners,
494 pediatric nurse practitioners, obstetrics-gynecology nurse
495 practitioners and neonatal nurse practitioners, under regulations
496 adopted by the division. Reimbursement for those services shall
497 not exceed ninety percent (90%) of the reimbursement rate for
498 comparable services rendered by a physician.
499 (22) Ambulatory services delivered in federally
500 qualified health centers, rural health centers and clinics of the
501 local health departments of the State Department of Health for
502 individuals eligible for Medicaid under this article based on
503 reasonable costs as determined by the division.
504 (23) Inpatient psychiatric services. Inpatient
505 psychiatric services to be determined by the division for
506 recipients under age twenty-one (21) that are provided under the
507 direction of a physician in an inpatient program in a licensed
508 acute care psychiatric facility or in a licensed psychiatric
509 residential treatment facility, before the recipient reaches age
510 twenty-one (21) or, if the recipient was receiving the services
511 immediately before he reached age twenty-one (21), before the
512 earlier of the date he no longer requires the services or the date
513 he reaches age twenty-two (22), as provided by federal
514 regulations. Precertification of inpatient days and residential
515 treatment days must be obtained as required by the division.
516 (24) [Deleted]
517 (25) Birthing center services.
518 (26) Hospice care. As used in this paragraph, the term
519 "hospice care" means a coordinated program of active professional

520 medical attention within the home and outpatient and inpatient
521 care that treats the terminally ill patient and family as a unit,
522 employing a medically directed interdisciplinary team. The
523 program provides relief of severe pain or other physical symptoms
524 and supportive care to meet the special needs arising out of
525 physical, psychological, spiritual, social and economic stresses
526 that are experienced during the final stages of illness and during
527 dying and bereavement and meets the Medicare requirements for
528 participation as a hospice as provided in federal regulations.

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

532 (28) Other health insurance premiums that are cost
533 effective as defined by the Secretary of Health and Human
534 Services. Medicare eligible must have Medicare Part B before
535 other insurance premiums can be paid.

536 (29) The Division of Medicaid may apply for a waiver
537 from the Department of Health and Human Services for home- and
538 community-based services for developmentally disabled people using
539 state funds that are provided from the appropriation to the State
540 Department of Mental Health and/or funds transferred to the
541 department by a political subdivision or instrumentality of the
542 state and used to match federal funds under a cooperative
543 agreement between the division and the department, provided that
544 funds for these services are specifically appropriated to the
545 Department of Mental Health and/or transferred to the department
546 by a political subdivision or instrumentality of the state.

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

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

553 of Human Services and used to match federal funds under a
554 cooperative agreement between the division and the department.
555 (32) Care and services provided in Christian Science
556 Sanatoria listed and certified by the Commission for Accreditation
557 of Christian Science Nursing Organizations/Facilities, Inc.,
558 rendered in connection with treatment by prayer or spiritual means
559 to the extent that those services are subject to reimbursement
560 under Section 1903 of the Social Security Act.
561 (33) Podiatrist services.
562 (34) The division shall make application to the United
563 States Health Care Financing Administration for a waiver to
564 develop a program of services to personal care and assisted living
565 homes in Mississippi. This waiver shall be completed by December
566 1, 1999.
567 (35) Services and activities authorized in Sections
568 43-27-101 and 43-27-103, using state funds that are provided from
569 the appropriation to the State Department of Human Services and
570 used to match federal funds under a cooperative agreement between
571 the division and the department.
572 (36) Nonemergency transportation services for
573 Medicaid-eligible persons, to be provided by the Division of
574 Medicaid. The division may contract with additional entities to
575 administer nonemergency transportation services as it deems
576 necessary. All providers shall have a valid driver's license,
577 vehicle inspection sticker, valid vehicle license tags and a
578 standard liability insurance policy covering the vehicle.
579 (37) [Deleted]
580 (38) Chiropractic services. A chiropractor's manual
581 manipulation of the spine to correct a subluxation, if x-ray
582 demonstrates that a subluxation exists and if the subluxation has
583 resulted in a neuromusculoskeletal condition for which
584 manipulation is appropriate treatment, and related spinal x-rays
585 performed to document these conditions. Reimbursement for

586 chiropractic services shall not exceed Seven Hundred Dollars
587 ($700.00) per year per beneficiary.
588 (39) Dually eligible Medicare/Medicaid beneficiaries.
589 The division shall pay the Medicare deductible and ten percent
590 (10%) coinsurance amounts for services available under Medicare
591 for the duration and scope of services otherwise available under
592 the Medicaid program.
593 (40) [Deleted]
594 (41) Services provided by the State Department of
595 Rehabilitation Services for the care and rehabilitation of persons
596 with spinal cord injuries or traumatic brain injuries, as allowed
597 under waivers from the United States Department of Health and
598 Human Services, using up to seventy-five percent (75%) of the
599 funds that are appropriated to the Department of Rehabilitation
600 Services from the Spinal Cord and Head Injury Trust Fund
601 established under Section 37-33-261 and used to match federal
602 funds under a cooperative agreement between the division and the
603 department.
604 (42) Notwithstanding any other provision in this
605 article to the contrary, the division may develop a population
606 health management program for women and children health services
607 through the age of two (2) years. This program is primarily for
608 obstetrical care associated with low birth weight and pre-term
609 babies. The division may apply to the federal Centers for
610 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
611 any other waivers that may enhance the program. In order to
612 effect cost savings, the division may develop a revised payment
613 methodology that may include at-risk capitated payments, and may
614 require member participation in accordance with the terms and
615 conditions of an approved federal waiver.
616 (43) The division shall provide reimbursement,
617 according to a payment schedule developed by the division, for
618 smoking cessation medications for pregnant women during their

619 pregnancy and other Medicaid-eligible women who are of
620 child-bearing age.
621 (44) Nursing facility services for the severely
622 disabled.
623 (a) Severe disabilities include, but are not
624 limited to, spinal cord injuries, closed head injuries and
625 ventilator dependent patients.
626 (b) Those services must be provided in a long-term
627 care nursing facility dedicated to the care and treatment of
628 persons with severe disabilities, and shall be reimbursed as a
629 separate category of nursing facilities.
630 (45) Physician assistant services. Services furnished
631 by a physician assistant who is licensed by the State Board of
632 Medical Licensure and is practicing with physician supervision
633 under regulations adopted by the board, under regulations adopted
634 by the division. Reimbursement for those services shall not
635 exceed ninety percent (90%) of the reimbursement rate for
636 comparable services rendered by a physician.
637 (46) The division shall make application to the federal
638 Centers for Medicare and Medicaid Services (CMS) for a waiver to
639 develop and provide services for children with serious emotional
640 disturbances as defined in Section 43-14-1(1), which may include
641 home- and community-based services, case management services or
642 managed care services through mental health providers certified by
643 the Department of Mental Health. The division may implement and
644 provide services under this waivered program only if funds for
645 these services are specifically appropriated for this purpose by
646 the Legislature, or if funds are voluntarily provided by affected
647 agencies.
648 (47) Notwithstanding any other provision in this
649 article to the contrary, the division, in conjunction with the
650 State Department of Health, shall develop and implement disease
651 management programs statewide for individuals with asthma,

652 diabetes or hypertension, including the use of grants, waivers,
653 demonstrations or other projects as necessary.
654 (48) Pediatric long-term acute care hospital services.
655 (a) Pediatric long-term acute care hospital
656 services means services provided to eligible persons under
657 twenty-one (21) years of age by a freestanding Medicare-certified
658 hospital that has an average length of inpatient stay greater than
659 twenty-five (25) days and that is primarily engaged in providing
660 chronic or long-term medical care to persons under twenty-one (21)
661 years of age.
662 (b) The services under this paragraph (48) shall
663 be reimbursed as a separate category of hospital services.
664 (49) The division shall establish copayments for all
665 Medicaid services for which copayments are allowable under federal
666 law or regulation, except for nonemergency transportation
667 services, and shall set the amount of the copayment for each of
668 those services at the maximum amount allowable under federal law
669 or regulation.
670 Notwithstanding any other provision of this article to the
671 contrary, the division shall reduce the rate of reimbursement to
672 providers for any service provided under this section by five
673 percent (5%) of the allowed amount for that service. However, the
674 reduction in the reimbursement rates required by this paragraph
675 shall not apply to inpatient hospital services, nursing facility
676 services, intermediate care facility services, psychiatric
677 residential treatment facility services, pharmacy services
678 provided under paragraph (9) of this section, or any service
679 provided by the University of Mississippi Medical Center or a
680 state agency, a state facility or a public agency that either
681 provides its own state match through intergovernmental transfer or
682 certification of funds to the division, or a service for which the
683 federal government sets the reimbursement methodology and rate.
684 In addition, the reduction in the reimbursement rates required by

685 this paragraph shall not apply to case management services and
686 home delivered meal services provided under the home- and
687 community-based services program for the elderly and disabled by a
688 planning and development district *** * ***.

689 Notwithstanding any provision of this article, except as
690 authorized in the following paragraph and in Section 43-13-139,
691 neither (a) the limitations on quantity or frequency of use of or
692 the fees or charges for any of the care or services available to
693 recipients under this section, nor (b) the payments or rates of
694 reimbursement to providers rendering care or services authorized
695 under this section to recipients, may be increased, decreased or
696 otherwise changed from the levels in effect on July 1, 1999,
697 unless they are authorized by an amendment to this section by the
698 Legislature. However, the restriction in this paragraph shall not
699 prevent the division from changing the payments or rates of
700 reimbursement to providers without an amendment to this section
701 whenever those changes are required by federal law or regulation,
702 or whenever those changes are necessary to correct administrative
703 errors or omissions in calculating those payments or rates of
704 reimbursement.

705 Notwithstanding any provision of this article, no new groups
706 or categories of recipients and new types of care and services may
707 be added without enabling legislation from the Mississippi
708 Legislature, except that the division may authorize those changes
709 without enabling legislation when the addition of recipients or
710 services is ordered by a court of proper authority. The executive
711 director shall keep the Governor advised on a timely basis of the
712 funds available for expenditure and the projected expenditures.
713 If current or projected expenditures of the division can be
714 reasonably anticipated to exceed the amounts appropriated for any
715 fiscal year, the Governor, after consultation with the executive
716 director, shall discontinue any or all of the payment of the types
717 of care and services as provided in this section that are deemed

718 to be optional services under Title XIX of the federal Social
719 Security Act, as amended, for any period necessary to not exceed
720 appropriated funds, and when necessary shall institute any other
721 cost containment measures on any program or programs authorized
722 under the article to the extent allowed under the federal law
723 governing that program or programs, it being the intent of the
724 Legislature that expenditures during any fiscal year shall not
725 exceed the amounts appropriated for that fiscal year.

726 Notwithstanding any other provision of this article, it shall
727 be the duty of each nursing facility, intermediate care facility
728 for the mentally retarded, psychiatric residential treatment
729 facility, and nursing facility for the severely disabled that is
730 participating in the Medicaid program to keep and maintain books,
731 documents and other records as prescribed by the Division of
732 Medicaid in substantiation of its cost reports for a period of
733 three (3) years after the date of submission to the Division of
734 Medicaid of an original cost report, or three (3) years after the
735 date of submission to the Division of Medicaid of an amended cost
736 report.

737 This section shall stand repealed on July 1, 2004.

738 **SECTION 2**. This act shall take effect and be in force from
739 and after its passage.

ST: Medicaid reimbursement for case management services and home-delivered meals; delete certain requirements.