

By: Representative Watson

To: Medicaid; Appropriations

HOUSE BILL NO. 289

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,  
2 TO EXTEND THE DATE OF THE REPEALER ON THE PROVISION OF LAW THAT  
3 SPECIFIES THE TYPES OF CARE AND SERVICES PAID BY MEDICAID; AND FOR  
4 RELATED PURPOSES.

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

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

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

15 (1) Inpatient hospital services.

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

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

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36 subparagraph (c) shall stand repealed on July 1, 2005.

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

41                   (3) Laboratory and x-ray services.

42                   (4) Nursing facility services.

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

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

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

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

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

95 Department of Health and Human Services of the change in the state  
96 Medicaid plan providing for the reimbursement.

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

110 (f) The division shall develop and implement an  
111 assessment process for long-term care services.

112 The division shall apply for necessary federal waivers to  
113 assure that additional services providing alternatives to nursing  
114 facility care are made available to applicants for nursing  
115 facility care.

116 (5) Periodic screening and diagnostic services for  
117 individuals under age twenty-one (21) years as are needed to  
118 identify physical and mental defects and to provide health care  
119 treatment and other measures designed to correct or ameliorate  
120 defects and physical and mental illness and conditions discovered  
121 by the screening services regardless of whether these services are  
122 included in the state plan. The division may include in its  
123 periodic screening and diagnostic program those discretionary  
124 services authorized under the federal regulations adopted to  
125 implement Title XIX of the federal Social Security Act, as  
126 amended. The division, in obtaining physical therapy services,  
127 occupational therapy services, and services for individuals with

128 speech, hearing and language disorders, may enter into a  
129 cooperative agreement with the State Department of Education for  
130 the provision of those services to handicapped students by public  
131 school districts using state funds that are provided from the  
132 appropriation to the Department of Education to obtain federal  
133 matching funds through the division. The division, in obtaining  
134 medical and psychological evaluations for children in the custody  
135 of the State Department of Human Services may enter into a  
136 cooperative agreement with the State Department of Human Services  
137 for the provision of those services using state funds that are  
138 provided from the appropriation to the Department of Human  
139 Services to obtain federal matching funds through the division.

140 (6) Physician's services. The division shall allow  
141 twelve (12) physician visits annually. All fees for physicians'  
142 services that are covered only by Medicaid shall be reimbursed at  
143 ninety percent (90%) of the rate established on January 1, 1999,  
144 and as adjusted each January thereafter, under Medicare (Title  
145 XVIII of the Social Security Act, as amended), and which shall in  
146 no event be less than seventy percent (70%) of the rate  
147 established on January 1, 1994. All fees for physicians' services  
148 that are covered by both Medicare and Medicaid shall be reimbursed  
149 at ten percent (10%) of the adjusted Medicare payment established  
150 on January 1, 1999, and as adjusted each January thereafter, under  
151 Medicare (Title XVIII of the Social Security Act, as amended), and  
152 which shall in no event be less than seventy percent (70%) of the  
153 adjusted Medicare payment established on January 1, 1994.

154 (7) (a) Home health services for eligible persons, not  
155 to exceed in cost the prevailing cost of nursing facility  
156 services, not to exceed sixty (60) visits per year. All home  
157 health visits must be precertified as required by the division.

158 (b) Repealed.

159 (8) Emergency medical transportation services. On  
160 January 1, 1994, emergency medical transportation services shall

161 be reimbursed at seventy percent (70%) of the rate established  
162 under Medicare (Title XVIII of the Social Security Act, as  
163 amended). "Emergency medical transportation services" shall mean,  
164 but shall not be limited to, the following services by a properly  
165 permitted ambulance operated by a properly licensed provider in  
166 accordance with the Emergency Medical Services Act of 1974  
167 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced  
168 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,  
169 (vi) disposable supplies, (vii) similar services.

170 (9) (a) Legend and other drugs as may be determined by  
171 the division. The division may implement a program of prior  
172 approval for drugs to the extent permitted by law. The division  
173 shall allow seven (7) prescriptions per month for each  
174 noninstitutionalized Medicaid recipient; however, after a  
175 noninstitutionalized or institutionalized recipient has received  
176 five (5) prescriptions in any month, each additional prescription  
177 during that month must have the prior approval of the division.  
178 The division shall not reimburse for any portion of a prescription  
179 that exceeds a thirty-four-day supply of the drug based on the  
180 daily dosage.

181 Provided, however, that until July 1, 2005, any A-typical  
182 antipsychotic drug shall be included in any preferred drug list  
183 developed by the Division of Medicaid and shall not require prior  
184 authorization, and until July 1, 2005, any licensed physician may  
185 prescribe any A-typical antipsychotic drug deemed appropriate for  
186 Medicaid recipients which shall be fully eligible for Medicaid  
187 reimbursement.

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

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

194 Medicare for payment before they may be processed by the  
195 division's on-line payment system.

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

201                 (b) Payment by the division for covered multiple  
202 source drugs shall be limited to the lower of the upper limits  
203 established and published by the Centers for Medicare and Medicaid  
204 Services (CMS) plus a dispensing fee, or the estimated acquisition  
205 cost (EAC) plus a dispensing fee, or the providers' usual and  
206 customary charge to the general public.

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

211         Payment for nonlegend or over-the-counter drugs covered by  
212 the division shall be reimbursed at the lower of the division's  
213 estimated shelf price or the providers' usual and customary charge  
214 to the general public.

215         The dispensing fee for each new or refill prescription,  
216 including nonlegend or over-the-counter drugs covered by the  
217 division, shall be Three Dollars and Ninety-one Cents (\$3.91).

218         The Medicaid provider shall not prescribe, the Medicaid  
219 pharmacy shall not bill, and the division shall not reimburse for  
220 name brand drugs if there are equally effective generic  
221 equivalents available and if the generic equivalents are the least  
222 expensive.

223         As used in this paragraph (9), "estimated acquisition cost"  
224 means twelve percent (12%) less than the average wholesale price  
225 for a drug.

226           (10) Dental care that is an adjunct to treatment of an  
227 acute medical or surgical condition; services of oral surgeons and  
228 dentists in connection with surgery related to the jaw or any  
229 structure contiguous to the jaw or the reduction of any fracture  
230 of the jaw or any facial bone; and emergency dental extractions  
231 and treatment related thereto. On July 1, 1999, all fees for  
232 dental care and surgery under authority of this paragraph (10)  
233 shall be increased to one hundred sixty percent (160%) of the  
234 amount of the reimbursement rate that was in effect on June 30,  
235 1999. It is the intent of the Legislature to encourage more  
236 dentists to participate in the Medicaid program.

237           (11) Eyeglasses for all Medicaid beneficiaries who have  
238 (a) had surgery on the eyeball or ocular muscle that results in a  
239 vision change for which eyeglasses or a change in eyeglasses is  
240 medically indicated within six (6) months of the surgery and is in  
241 accordance with policies established by the division, or (b) one  
242 (1) pair every five (5) years and in accordance with policies  
243 established by the division. In either instance, the eyeglasses  
244 must be prescribed by a physician skilled in diseases of the eye  
245 or an optometrist, whichever the beneficiary may select.

246           (12) Intermediate care facility services.

247           (a) The division shall make full payment to all  
248 intermediate care facilities for the mentally retarded for each  
249 day, not exceeding eighty-four (84) days per year, that a patient  
250 is absent from the facility on home leave. Payment may be made  
251 for the following home leave days in addition to the  
252 eighty-four-day limitation: Christmas, the day before Christmas,  
253 the day after Christmas, Thanksgiving, the day before Thanksgiving  
254 and the day after Thanksgiving.

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



258           (13) Family planning services, including drugs,  
259 supplies and devices, when those services are under the  
260 supervision of a physician.

261           (14) Clinic services. Such diagnostic, preventive,  
262 therapeutic, rehabilitative or palliative services furnished to an  
263 outpatient by or under the supervision of a physician or dentist  
264 in a facility that is not a part of a hospital but that is  
265 organized and operated to provide medical care to outpatients.  
266 Clinic services shall include any services reimbursed as  
267 outpatient hospital services that may be rendered in such a  
268 facility, including those that become so after July 1, 1991. On  
269 July 1, 1999, all fees for physicians' services reimbursed under  
270 authority of this paragraph (14) shall be reimbursed at ninety  
271 percent (90%) of the rate established on January 1, 1999, and as  
272 adjusted each January thereafter, under Medicare (Title XVIII of  
273 the Social Security Act, as amended), and which shall in no event  
274 be less than seventy percent (70%) of the rate established on  
275 January 1, 1994. All fees for physicians' services that are  
276 covered by both Medicare and Medicaid shall be reimbursed at ten  
277 percent (10%) of the adjusted Medicare payment established on  
278 January 1, 1999, and as adjusted each January thereafter, under  
279 Medicare (Title XVIII of the Social Security Act, as amended), and  
280 which shall in no event be less than seventy percent (70%) of the  
281 adjusted Medicare payment established on January 1, 1994. On July  
282 1, 1999, all fees for dentists' services reimbursed under  
283 authority of this paragraph (14) shall be increased to one hundred  
284 sixty percent (160%) of the amount of the reimbursement rate that  
285 was in effect on June 30, 1999.

286           (15) Home- and community-based services for the elderly  
287 and disabled, as provided under Title XIX of the federal Social  
288 Security Act, as amended, under waivers, subject to the  
289 availability of funds specifically appropriated therefor by the  
290 Legislature.

291           (16) Mental health services. Approved therapeutic and  
292 case management services (a) provided by an approved regional  
293 mental health/retardation center established under Sections  
294 41-19-31 through 41-19-39, or by another community mental health  
295 service provider meeting the requirements of the Department of  
296 Mental Health to be an approved mental health/retardation center  
297 if determined necessary by the Department of Mental Health, using  
298 state funds that are provided from the appropriation to the State  
299 Department of Mental Health and/or funds transferred to the  
300 department by a political subdivision or instrumentality of the  
301 state and used to match federal funds under a cooperative  
302 agreement between the division and the department, or (b) provided  
303 by a facility that is certified by the State Department of Mental  
304 Health to provide therapeutic and case management services, to be  
305 reimbursed on a fee for service basis, or (c) provided in the  
306 community by a facility or program operated by the Department of  
307 Mental Health. Any such services provided by a facility described  
308 in subparagraph (b) must have the prior approval of the division  
309 to be reimbursable under this section. After June 30, 1997,  
310 mental health services provided by regional mental  
311 health/retardation centers established under Sections 41-19-31  
312 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)  
313 and/or their subsidiaries and divisions, or by psychiatric  
314 residential treatment facilities as defined in Section 43-11-1, or  
315 by another community mental health service provider meeting the  
316 requirements of the Department of Mental Health to be an approved  
317 mental health/retardation center if determined necessary by the  
318 Department of Mental Health, shall not be included in or provided  
319 under any capitated managed care pilot program provided for under  
320 paragraph (24) of this section.

321           (17) Durable medical equipment services and medical  
322 supplies. Precertification of durable medical equipment and  
323 medical supplies must be obtained as required by the division.

324 The Division of Medicaid may require durable medical equipment  
325 providers to obtain a surety bond in the amount and to the  
326 specifications as established by the Balanced Budget Act of 1997.

327 (18) (a) Notwithstanding any other provision of this  
328 section to the contrary, the division shall make additional  
329 reimbursement to hospitals that serve a disproportionate share of  
330 low-income patients and that meet the federal requirements for  
331 those payments as provided in Section 1923 of the federal Social  
332 Security Act and any applicable regulations. However, from and  
333 after January 1, 1999, no public hospital shall participate in the  
334 Medicaid disproportionate share program unless the public hospital  
335 participates in an intergovernmental transfer program as provided  
336 in Section 1903 of the federal Social Security Act and any  
337 applicable regulations. Administration and support for  
338 participating hospitals shall be provided by the Mississippi  
339 Hospital Association.

340 (b) The division shall establish a Medicare Upper  
341 Payment Limits Program, as defined in Section 1902(a)(30) of the  
342 federal Social Security Act and any applicable federal  
343 regulations, for hospitals, and may establish a Medicare Upper  
344 Payments Limits Program for nursing facilities. The division  
345 shall assess each hospital and, if the program is established for  
346 nursing facilities, shall assess each nursing facility, for the  
347 sole purpose of financing the state portion of the Medicare Upper  
348 Payment Limits Program. This assessment shall be based on  
349 Medicaid utilization, or other appropriate method consistent with  
350 federal regulations, and will remain in effect as long as the  
351 state participates in the Medicare Upper Payment Limits Program.  
352 The division shall make additional reimbursement to hospitals and,  
353 if the program is established for nursing facilities, shall make  
354 additional reimbursement to nursing facilities, for the Medicare  
355 Upper Payment Limits, as defined in Section 1902(a)(30) of the  
356 federal Social Security Act and any applicable federal

357 regulations. This subparagraph (b) shall stand repealed from and  
358 after July 1, 2005.

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

364 (19) (a) Perinatal risk management services. The  
365 division shall promulgate regulations to be effective from and  
366 after October 1, 1988, to establish a comprehensive perinatal  
367 system for risk assessment of all pregnant and infant Medicaid  
368 recipients and for management, education and follow-up for those  
369 who are determined to be at risk. Services to be performed  
370 include case management, nutrition assessment/counseling,  
371 psychosocial assessment/counseling and health education. The  
372 division shall set reimbursement rates for providers in  
373 conjunction with the State Department of Health.

374 (b) Early intervention system services. The  
375 division shall cooperate with the State Department of Health,  
376 acting as lead agency, in the development and implementation of a  
377 statewide system of delivery of early intervention services, under  
378 Part C of the Individuals with Disabilities Education Act (IDEA).  
379 The State Department of Health shall certify annually in writing  
380 to the executive director of the division the dollar amount of  
381 state early intervention funds available that will be utilized as  
382 a certified match for Medicaid matching funds. Those funds then  
383 shall be used to provide expanded targeted case management  
384 services for Medicaid eligible children with special needs who are  
385 eligible for the state's early intervention system.  
386 Qualifications for persons providing service coordination shall be  
387 determined by the State Department of Health and the Division of  
388 Medicaid.

389           (20) Home- and community-based services for physically  
390 disabled approved services as allowed by a waiver from the United  
391 States Department of Health and Human Services for home- and  
392 community-based services for physically disabled people using  
393 state funds that are provided from the appropriation to the State  
394 Department of Rehabilitation Services and used to match federal  
395 funds under a cooperative agreement between the division and the  
396 department, provided that funds for these services are  
397 specifically appropriated to the Department of Rehabilitation  
398 Services.

399           (21) Nurse practitioner services. Services furnished  
400 by a registered nurse who is licensed and certified by the  
401 Mississippi Board of Nursing as a nurse practitioner, including,  
402 but not limited to, nurse anesthetists, nurse midwives, family  
403 nurse practitioners, family planning nurse practitioners,  
404 pediatric nurse practitioners, obstetrics-gynecology nurse  
405 practitioners and neonatal nurse practitioners, under regulations  
406 adopted by the division. Reimbursement for those services shall  
407 not exceed ninety percent (90%) of the reimbursement rate for  
408 comparable services rendered by a physician.

409           (22) Ambulatory services delivered in federally  
410 qualified health centers, rural health centers and clinics of the  
411 local health departments of the State Department of Health for  
412 individuals eligible for Medicaid under this article based on  
413 reasonable costs as determined by the division.

414           (23) Inpatient psychiatric services. Inpatient  
415 psychiatric services to be determined by the division for  
416 recipients under age twenty-one (21) that are provided under the  
417 direction of a physician in an inpatient program in a licensed  
418 acute care psychiatric facility or in a licensed psychiatric  
419 residential treatment facility, before the recipient reaches age  
420 twenty-one (21) or, if the recipient was receiving the services  
421 immediately before he reached age twenty-one (21), before the

422 earlier of the date he no longer requires the services or the date  
423 he reaches age twenty-two (22), as provided by federal  
424 regulations. Precertification of inpatient days and residential  
425 treatment days must be obtained as required by the division.

426 (24) [Deleted]

427 (25) [Deleted]

428 (26) Hospice care. As used in this paragraph, the term  
429 "hospice care" means a coordinated program of active professional  
430 medical attention within the home and outpatient and inpatient  
431 care that treats the terminally ill patient and family as a unit,  
432 employing a medically directed interdisciplinary team. The  
433 program provides relief of severe pain or other physical symptoms  
434 and supportive care to meet the special needs arising out of  
435 physical, psychological, spiritual, social and economic stresses  
436 that are experienced during the final stages of illness and during  
437 dying and bereavement and meets the Medicare requirements for  
438 participation as a hospice as provided in federal regulations.

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

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

446 (29) The Division of Medicaid may apply for a waiver  
447 from the Department of Health and Human Services for home- and  
448 community-based services for developmentally disabled people using  
449 state funds that are provided from the appropriation to the State  
450 Department of Mental Health and/or funds transferred to the  
451 department by a political subdivision or instrumentality of the  
452 state and used to match federal funds under a cooperative  
453 agreement between the division and the department, provided that  
454 funds for these services are specifically appropriated to the

455 Department of Mental Health and/or transferred to the department  
456 by a political subdivision or instrumentality of the state.

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

459 (31) Targeted case management services for children  
460 with special needs, under waivers from the United States  
461 Department of Health and Human Services, using state funds that  
462 are provided from the appropriation to the Mississippi Department  
463 of Human Services and used to match federal funds under a  
464 cooperative agreement between the division and the department.

465 (32) Care and services provided in Christian Science  
466 Sanatoria listed and certified by the Commission for Accreditation  
467 of Christian Science Nursing Organizations/Facilities, Inc.,  
468 rendered in connection with treatment by prayer or spiritual means  
469 to the extent that those services are subject to reimbursement  
470 under Section 1903 of the Social Security Act.

471 (33) Podiatrist services.

472 (34) Assisted living services as provided through home-  
473 and community-based services under Title XIX of the Social  
474 Security Act, as amended, subject to the availability of funds  
475 specifically appropriated therefor by the Legislature.

476 (35) Services and activities authorized in Sections  
477 43-27-101 and 43-27-103, using state funds that are provided from  
478 the appropriation to the State Department of Human Services and  
479 used to match federal funds under a cooperative agreement between  
480 the division and the department.

481 (36) Nonemergency transportation services for  
482 Medicaid-eligible persons, to be provided by the Division of  
483 Medicaid. The division may contract with additional entities to  
484 administer nonemergency transportation services as it deems  
485 necessary. All providers shall have a valid driver's license,  
486 vehicle inspection sticker, valid vehicle license tags and a  
487 standard liability insurance policy covering the vehicle. The

488 division may pay providers a flat fee based on mileage tiers, or  
489 in the alternative, may reimburse on actual miles traveled. The  
490 division may apply to the Center for Medicare and Medicaid  
491 Services (CMS) for a waiver to draw federal matching funds for  
492 nonemergency transportation services as a covered service instead  
493 of an administrative cost.

494 (37) [Deleted]

495 (38) Chiropractic services. A chiropractor's manual  
496 manipulation of the spine to correct a subluxation, if x-ray  
497 demonstrates that a subluxation exists and if the subluxation has  
498 resulted in a neuromusculoskeletal condition for which  
499 manipulation is appropriate treatment, and related spinal x-rays  
500 performed to document these conditions. Reimbursement for  
501 chiropractic services shall not exceed Seven Hundred Dollars  
502 (\$700.00) per year per beneficiary.

503 (39) Dually eligible Medicare/Medicaid beneficiaries.  
504 The division shall pay the Medicare deductible and coinsurance  
505 amounts for services available under Medicare, as determined by  
506 the division.

507 (40) [Deleted]

508 (41) Services provided by the State Department of  
509 Rehabilitation Services for the care and rehabilitation of persons  
510 with spinal cord injuries or traumatic brain injuries, as allowed  
511 under waivers from the United States Department of Health and  
512 Human Services, using up to seventy-five percent (75%) of the  
513 funds that are appropriated to the Department of Rehabilitation  
514 Services from the Spinal Cord and Head Injury Trust Fund  
515 established under Section 37-33-261 and used to match federal  
516 funds under a cooperative agreement between the division and the  
517 department.

518 (42) Notwithstanding any other provision in this  
519 article to the contrary, the division may develop a population  
520 health management program for women and children health services



521 through the age of one (1) year. This program is primarily for  
522 obstetrical care associated with low birth weight and pre-term  
523 babies. The division may apply to the federal Centers for  
524 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or  
525 any other waivers that may enhance the program. In order to  
526 effect cost savings, the division may develop a revised payment  
527 methodology that may include at-risk capitated payments, and may  
528 require member participation in accordance with the terms and  
529 conditions of an approved federal waiver.

530 (43) The division shall provide reimbursement,  
531 according to a payment schedule developed by the division, for  
532 smoking cessation medications for pregnant women during their  
533 pregnancy and other Medicaid-eligible women who are of  
534 child-bearing age.

535 (44) Nursing facility services for the severely  
536 disabled.

537 (a) Severe disabilities include, but are not  
538 limited to, spinal cord injuries, closed head injuries and  
539 ventilator dependent patients.

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

544 (45) Physician assistant services. Services furnished  
545 by a physician assistant who is licensed by the State Board of  
546 Medical Licensure and is practicing with physician supervision  
547 under regulations adopted by the board, under regulations adopted  
548 by the division. Reimbursement for those services shall not  
549 exceed ninety percent (90%) of the reimbursement rate for  
550 comparable services rendered by a physician.

551 (46) The division shall make application to the federal  
552 Centers for Medicare and Medicaid Services (CMS) for a waiver to  
553 develop and provide services for children with serious emotional

554 disturbances as defined in Section 43-14-1(1), which may include  
555 home- and community-based services, case management services or  
556 managed care services through mental health providers certified by  
557 the Department of Mental Health. The division may implement and  
558 provide services under this waived program only if funds for  
559 these services are specifically appropriated for this purpose by  
560 the Legislature, or if funds are voluntarily provided by affected  
561 agencies.

562 (47) (a) Notwithstanding any other provision in this  
563 article to the contrary, the division, in conjunction with the  
564 State Department of Health, shall develop and implement disease  
565 management programs for individuals with asthma, diabetes or  
566 hypertension, including the use of grants, waivers, demonstrations  
567 or other projects as necessary.

568 (b) Participation in any disease management  
569 program implemented under this paragraph (47) is optional with the  
570 individual. An individual must affirmatively elect to participate  
571 in the disease management program in order to participate.

572 (c) An individual who participates in the disease  
573 management program has the option of participating in the  
574 prescription drug home delivery component of the program at any  
575 time while participating in the program. An individual must  
576 affirmatively elect to participate in the prescription drug home  
577 delivery component in order to participate.

578 (d) An individual who participates in the disease  
579 management program may elect to discontinue participation in the  
580 program at any time. An individual who participates in the  
581 prescription drug home delivery component may elect to discontinue  
582 participation in the prescription drug home delivery component at  
583 any time.

584 (e) The division shall send written notice to all  
585 individuals who participate in the disease management program  
586 informing them that they may continue using their local pharmacy

587 or any other pharmacy of their choice to obtain their prescription  
588 drugs while participating in the program.

589 (f) Prescription drugs that are provided to  
590 individuals under the prescription drug home delivery component  
591 shall be limited only to those drugs that are used for the  
592 treatment, management or care of asthma, diabetes or hypertension.

593 (48) Pediatric long-term acute care hospital services.

594 (a) Pediatric long-term acute care hospital  
595 services means services provided to eligible persons under  
596 twenty-one (21) years of age by a freestanding Medicare-certified  
597 hospital that has an average length of inpatient stay greater than  
598 twenty-five (25) days and that is primarily engaged in providing  
599 chronic or long-term medical care to persons under twenty-one (21)  
600 years of age.

601 (b) The services under this paragraph (48) shall  
602 be reimbursed as a separate category of hospital services.

603 (49) The division shall establish copayments for all  
604 Medicaid services for which copayments are allowable under federal  
605 law or regulation, except for nonemergency transportation  
606 services, and shall set the amount of the copayment for each of  
607 those services at the maximum amount allowable under federal law  
608 or regulation.

609 (50) Services provided by the State Department of  
610 Rehabilitation Services for the care and rehabilitation of persons  
611 who are deaf and blind, as allowed under waivers from the United  
612 States Department of Health and Human Services to provide home-  
613 and community-based services using state funds which are provided  
614 from the appropriation to the State Department of Rehabilitation  
615 Services or if funds are voluntarily provided by another agency.

616 Notwithstanding any other provision of this article to the  
617 contrary, the division shall reduce the rate of reimbursement to  
618 providers for any service provided under this section by five  
619 percent (5%) of the allowed amount for that service. However, the

620 reduction in the reimbursement rates required by this paragraph  
621 shall not apply to inpatient hospital services, nursing facility  
622 services, intermediate care facility services, psychiatric  
623 residential treatment facility services, pharmacy services  
624 provided under paragraph (9) of this section, or any service  
625 provided by the University of Mississippi Medical Center or a  
626 state agency, a state facility or a public agency that either  
627 provides its own state match through intergovernmental transfer or  
628 certification of funds to the division, or a service for which the  
629 federal government sets the reimbursement methodology and rate.  
630 In addition, the reduction in the reimbursement rates required by  
631 this paragraph shall not apply to case management services  
632 provided under the home- and community-based services program for  
633 the elderly and disabled by a planning and development district  
634 (PDD). Planning and development districts participating in the  
635 home- and community-based services program for the elderly and  
636 disabled as case management providers shall be reimbursed for case  
637 management services at the maximum rate approved by the Centers  
638 for Medicare and Medicaid Services (CMS). PDDs shall transfer to  
639 the division state match from public funds (not federal) in an  
640 amount equal to the difference between the maximum case management  
641 reimbursement rate approved by CMS and a five percent (5%)  
642 reduction in that rate. The division shall invoice each PDD  
643 fifteen (15) days after the end of each quarter for the  
644 intergovernmental transfer based on payments made for Medicaid  
645 home- and community-based case management services during the  
646 quarter.

647       The division may pay to those providers who participate in  
648 and accept patient referrals from the division's emergency room  
649 redirection program a percentage, as determined by the division,  
650 of savings achieved according to the performance measures and  
651 reduction of costs required of that program.

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, 2006.

701 **SECTION 2.** This act shall take effect and be in force from  
702 and after July 1, 2004.