

By: Representative Hudson

To: Medicaid; Appropriations

HOUSE BILL NO. 1161

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,  
 2 TO REMOVE THE REQUIREMENT THAT THE DIVISION OF MEDICAID DEVELOP  
 3 AND IMPLEMENT DISEASE MANAGEMENT PROGRAMS; TO DIRECT THE DIVISION  
 4 TO REPORT TO THE CHAIRMAN OF THE HOUSE PUBLIC HEALTH AND HUMAN  
 5 SERVICES COMMITTEE AND THE CHAIRMAN OF THE SENATE PUBLIC HEALTH  
 6 AND WELFARE COMMITTEE ON THE DEMONSTRATED AMOUNT OF SAVINGS TO THE  
 7 STATE AS A RESULT OF DISEASE MANAGEMENT PROGRAMS IMPLEMENTED SINCE  
 8 MARCH 6, 2002; TO DELETE THE REPEALER ON THE SECTION; AND FOR  
 9 RELATED PURPOSES.

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

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

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

20 (1) Inpatient hospital services.

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

28 (b) From and after July 1, 1994, the Executive  
 29 Director of the Division of Medicaid shall amend the Mississippi  
 30 Title XIX Inpatient Hospital Reimbursement Plan to remove the

31 occupancy rate penalty from the calculation of the Medicaid  
32 Capital Cost Component utilized to determine total hospital costs  
33 allocated to the Medicaid program.

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

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

46 (3) Laboratory and x-ray services.

47 (4) Nursing facility services.

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

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

64 case-mix scores of residents so that only services provided at the  
65 nursing facility are considered in calculating a facility's per  
66 diem.

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

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

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

97 authorized to make the reimbursement authorized in this  
98 subparagraph (d), the division first must have received approval  
99 from the Health Care Financing Administration of the United States  
100 Department of Health and Human Services of the change in the state  
101 Medicaid plan providing for the reimbursement.

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

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

117 The division shall apply for necessary federal waivers to  
118 assure that additional services providing alternatives to nursing  
119 facility care are made available to applicants for nursing  
120 facility care.

121 (5) Periodic screening and diagnostic services for  
122 individuals under age twenty-one (21) years as are needed to  
123 identify physical and mental defects and to provide health care  
124 treatment and other measures designed to correct or ameliorate  
125 defects and physical and mental illness and conditions discovered  
126 by the screening services regardless of whether these services are  
127 included in the state plan. The division may include in its  
128 periodic screening and diagnostic program those discretionary  
129 services authorized under the federal regulations adopted to

130 implement Title XIX of the federal Social Security Act, as  
131 amended. The division, in obtaining physical therapy services,  
132 occupational therapy services, and services for individuals with  
133 speech, hearing and language disorders, may enter into a  
134 cooperative agreement with the State Department of Education for  
135 the provision of those services to handicapped students by public  
136 school districts using state funds that are provided from the  
137 appropriation to the Department of Education to obtain federal  
138 matching funds through the division. The division, in obtaining  
139 medical and psychological evaluations for children in the custody  
140 of the State Department of Human Services may enter into a  
141 cooperative agreement with the State Department of Human Services  
142 for the provision of those services using state funds that are  
143 provided from the appropriation to the Department of Human  
144 Services to obtain federal matching funds through the division.

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

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

163 (b) Repealed.

164 (8) Emergency medical transportation services. On  
165 January 1, 1994, emergency medical transportation services shall  
166 be reimbursed at seventy percent (70%) of the rate established  
167 under Medicare (Title XVIII of the Social Security Act, as  
168 amended). "Emergency medical transportation services" shall mean,  
169 but shall not be limited to, the following services by a properly  
170 permitted ambulance operated by a properly licensed provider in  
171 accordance with the Emergency Medical Services Act of 1974  
172 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced  
173 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,  
174 (vi) disposable supplies, (vii) similar services.

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

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

193 The division shall develop and implement a program of payment  
194 for additional pharmacist services, with payment to be based on

195 demonstrated savings, but in no case shall the total payment  
196 exceed twice the amount of the dispensing fee.

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

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

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

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

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

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

223 The Medicaid provider shall not prescribe, the Medicaid  
224 pharmacy shall not bill, and the division shall not reimburse for  
225 name brand drugs if there are equally effective generic  
226 equivalents available and if the generic equivalents are the least  
227 expensive.

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

231           (10) Dental care that is an adjunct to treatment of an  
232 acute medical or surgical condition; services of oral surgeons and  
233 dentists in connection with surgery related to the jaw or any  
234 structure contiguous to the jaw or the reduction of any fracture  
235 of the jaw or any facial bone; and emergency dental extractions  
236 and treatment related thereto. On July 1, 1999, all fees for  
237 dental care and surgery under authority of this paragraph (10)  
238 shall be increased to one hundred sixty percent (160%) of the  
239 amount of the reimbursement rate that was in effect on June 30,  
240 1999. It is the intent of the Legislature to encourage more  
241 dentists to participate in the Medicaid program.

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

251           (12) Intermediate care facility services.

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



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

263 (13) Family planning services, including drugs,  
264 supplies and devices, when those services are under the  
265 supervision of a physician.

266 (14) Clinic services. Such diagnostic, preventive,  
267 therapeutic, rehabilitative or palliative services furnished to an  
268 outpatient by or under the supervision of a physician or dentist  
269 in a facility that is not a part of a hospital but that is  
270 organized and operated to provide medical care to outpatients.  
271 Clinic services shall include any services reimbursed as  
272 outpatient hospital services that may be rendered in such a  
273 facility, including those that become so after July 1, 1991. On  
274 July 1, 1999, all fees for physicians' services reimbursed under  
275 authority of this paragraph (14) shall be reimbursed at ninety  
276 percent (90%) of the rate established on January 1, 1999, and as  
277 adjusted each January thereafter, under Medicare (Title XVIII of  
278 the Social Security Act, as amended), and which shall in no event  
279 be less than seventy percent (70%) of the rate established on  
280 January 1, 1994. All fees for physicians' services that are  
281 covered by both Medicare and Medicaid shall be reimbursed at ten  
282 percent (10%) of the adjusted Medicare payment established on  
283 January 1, 1999, and as adjusted each January thereafter, under  
284 Medicare (Title XVIII of the Social Security Act, as amended), and  
285 which shall in no event be less than seventy percent (70%) of the  
286 adjusted Medicare payment established on January 1, 1994. On July  
287 1, 1999, all fees for dentists' services reimbursed under  
288 authority of this paragraph (14) shall be increased to one hundred  
289 sixty percent (160%) of the amount of the reimbursement rate that  
290 was in effect on June 30, 1999.

291 (15) Home- and community-based services for the elderly  
292 and disabled, as provided under Title XIX of the federal Social

293 Security Act, as amended, under waivers, subject to the  
294 availability of funds specifically appropriated therefor by the  
295 Legislature.

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

326           (17) Durable medical equipment services and medical  
327 supplies. Precertification of durable medical equipment and  
328 medical supplies must be obtained as required by the division.  
329 The Division of Medicaid may require durable medical equipment  
330 providers to obtain a surety bond in the amount and to the  
331 specifications as established by the Balanced Budget Act of 1997.

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

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

359 additional reimbursement to nursing facilities, for the Medicare  
360 Upper Payment Limits, as defined in Section 1902(a)(30) of the  
361 federal Social Security Act and any applicable federal  
362 regulations. This subparagraph (b) shall stand repealed from and  
363 after July 1, 2005.

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

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

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

391 Qualifications for persons providing service coordination shall be

392 determined by the State Department of Health and the Division of  
393 Medicaid.

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

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

414 (22) Ambulatory services delivered in federally  
415 qualified health centers, rural health centers and clinics of the  
416 local health departments of the State Department of Health for  
417 individuals eligible for Medicaid under this article based on  
418 reasonable costs as determined by the division.

419 (23) Inpatient psychiatric services. Inpatient  
420 psychiatric services to be determined by the division for  
421 recipients under age twenty-one (21) that are provided under the  
422 direction of a physician in an inpatient program in a licensed  
423 acute care psychiatric facility or in a licensed psychiatric  
424 residential treatment facility, before the recipient reaches age

425 twenty-one (21) or, if the recipient was receiving the services  
426 immediately before he reached age twenty-one (21), before the  
427 earlier of the date he no longer requires the services or the date  
428 he reaches age twenty-two (22), as provided by federal  
429 regulations. Precertification of inpatient days and residential  
430 treatment days must be obtained as required by the division.

431 (24) [Deleted]

432 (25) [Deleted]

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

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

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

451 (29) The Division of Medicaid may apply for a waiver  
452 from the Department of Health and Human Services for home- and  
453 community-based services for developmentally disabled people using  
454 state funds that are provided from the appropriation to the State  
455 Department of Mental Health and/or funds transferred to the  
456 department by a political subdivision or instrumentality of the  
457 state and used to match federal funds under a cooperative

458 agreement between the division and the department, provided that  
459 funds for these services are specifically appropriated to the  
460 Department of Mental Health and/or transferred to the department  
461 by a political subdivision or instrumentality of the state.

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

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

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

476 (33) Podiatrist services.

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

481 (35) Services and activities authorized in Sections  
482 43-27-101 and 43-27-103, using state funds that are provided from  
483 the appropriation to the State Department of Human Services and  
484 used to match federal funds under a cooperative agreement between  
485 the division and the department.

486 (36) Nonemergency transportation services for  
487 Medicaid-eligible persons, to be provided by the Division of  
488 Medicaid. The division may contract with additional entities to  
489 administer nonemergency transportation services as it deems  
490 necessary. All providers shall have a valid driver's license,

491 vehicle inspection sticker, valid vehicle license tags and a  
492 standard liability insurance policy covering the vehicle. The  
493 division may pay providers a flat fee based on mileage tiers, or  
494 in the alternative, may reimburse on actual miles traveled. The  
495 division may apply to the Center for Medicare and Medicaid  
496 Services (CMS) for a waiver to draw federal matching funds for  
497 nonemergency transportation services as a covered service instead  
498 of an administrative cost.

499 (37) [Deleted]

500 (38) Chiropractic services. A chiropractor's manual  
501 manipulation of the spine to correct a subluxation, if x-ray  
502 demonstrates that a subluxation exists and if the subluxation has  
503 resulted in a neuromusculoskeletal condition for which  
504 manipulation is appropriate treatment, and related spinal x-rays  
505 performed to document these conditions. Reimbursement for  
506 chiropractic services shall not exceed Seven Hundred Dollars  
507 (\$700.00) per year per beneficiary.

508 (39) Dually eligible Medicare/Medicaid beneficiaries.  
509 The division shall pay the Medicare deductible and coinsurance  
510 amounts for services available under Medicare, as determined by  
511 the division.

512 (40) [Deleted]

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



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

535           (43) The division shall provide reimbursement,  
536 according to a payment schedule developed by the division, for  
537 smoking cessation medications for pregnant women during their  
538 pregnancy and other Medicaid-eligible women who are of  
539 child-bearing age.

540           (44) Nursing facility services for the severely  
541 disabled.

542                   (a) Severe disabilities include, but are not  
543 limited to, spinal cord injuries, closed head injuries and  
544 ventilator dependent patients.

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

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

556           (46) The division shall make application to the federal  
557 Centers for Medicare and Medicaid Services (CMS) for a waiver to  
558 develop and provide services for children with serious emotional  
559 disturbances as defined in Section 43-14-1(1), which may include  
560 home- and community-based services, case management services or  
561 managed care services through mental health providers certified by  
562 the Department of Mental Health. The division may implement and  
563 provide services under this waived program only if funds for  
564 these services are specifically appropriated for this purpose by  
565 the Legislature, or if funds are voluntarily provided by affected  
566 agencies.

567           (47) (a) Notwithstanding any other provision in this  
568 article to the contrary, the division, in conjunction with the  
569 State Department of Health, may develop and implement disease  
570 management programs for individuals with asthma, diabetes or  
571 hypertension, including the use of grants, waivers, demonstrations  
572 or other projects as necessary. Not later than September 1, 2004,  
573 the division shall report to the Chairman of the Public Health and  
574 Human Services Committee of the House of Representatives and the  
575 Chairman of the Public Health and Welfare Committee of the Senate  
576 on the demonstrated amount of savings to the State of Mississippi  
577 as a result of disease management programs implemented by the  
578 division since March 6, 2002.

579           (b) Participation in any disease management  
580 program implemented under this paragraph (47) is optional with the  
581 individual. An individual must affirmatively elect to participate  
582 in the disease management program in order to participate.

583           (c) An individual who participates in the disease  
584 management program has the option of participating in the  
585 prescription drug home delivery component of the program at any  
586 time while participating in the program. An individual must  
587 affirmatively elect to participate in the prescription drug home  
588 delivery component in order to participate.

589                   (d) An individual who participates in the disease  
590 management program may elect to discontinue participation in the  
591 program at any time. An individual who participates in the  
592 prescription drug home delivery component may elect to discontinue  
593 participation in the prescription drug home delivery component at  
594 any time.

595                   (e) The division shall send written notice to all  
596 individuals who participate in the disease management program  
597 informing them that they may continue using their local pharmacy  
598 or any other pharmacy of their choice to obtain their prescription  
599 drugs while participating in the program.

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

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

605                   (a) Pediatric long-term acute care hospital  
606 services means services provided to eligible persons under  
607 twenty-one (21) years of age by a freestanding Medicare-certified  
608 hospital that has an average length of inpatient stay greater than  
609 twenty-five (25) days and that is primarily engaged in providing  
610 chronic or long-term medical care to persons under twenty-one (21)  
611 years of age.

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

614                   (49) The division shall establish copayments for all  
615 Medicaid services for which copayments are allowable under federal  
616 law or regulation, except for nonemergency transportation  
617 services, and shall set the amount of the copayment for each of  
618 those services at the maximum amount allowable under federal law  
619 or regulation.

620                   (50) Services provided by the State Department of  
621 Rehabilitation Services for the care and rehabilitation of persons

622 who are deaf and blind, as allowed under waivers from the United  
623 States Department of Health and Human Services to provide home-  
624 and community-based services using state funds which are provided  
625 from the appropriation to the State Department of Rehabilitation  
626 Services or if funds are voluntarily provided by another agency.

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

655 intergovernmental transfer based on payments made for Medicaid  
656 home- and community-based case management services during the  
657 quarter.

658         The division may pay to those providers who participate in  
659 and accept patient referrals from the division's emergency room  
660 redirection program a percentage, as determined by the division,  
661 of savings achieved according to the performance measures and  
662 reduction of costs required of that program.

663         Notwithstanding any provision of this article, except as  
664 authorized in the following paragraph and in Section 43-13-139,  
665 neither (a) the limitations on quantity or frequency of use of or  
666 the fees or charges for any of the care or services available to  
667 recipients under this section, nor (b) the payments or rates of  
668 reimbursement to providers rendering care or services authorized  
669 under this section to recipients, may be increased, decreased or  
670 otherwise changed from the levels in effect on July 1, 1999,  
671 unless they are authorized by an amendment to this section by the  
672 Legislature. However, the restriction in this paragraph shall not  
673 prevent the division from changing the payments or rates of  
674 reimbursement to providers without an amendment to this section  
675 whenever those changes are required by federal law or regulation,  
676 or whenever those changes are necessary to correct administrative  
677 errors or omissions in calculating those payments or rates of  
678 reimbursement.

679         Notwithstanding any provision of this article, no new groups  
680 or categories of recipients and new types of care and services may  
681 be added without enabling legislation from the Mississippi  
682 Legislature, except that the division may authorize those changes  
683 without enabling legislation when the addition of recipients or  
684 services is ordered by a court of proper authority. The executive  
685 director shall keep the Governor advised on a timely basis of the  
686 funds available for expenditure and the projected expenditures.  
687 If current or projected expenditures of the division can be

688 reasonably anticipated to exceed the amounts appropriated for any  
689 fiscal year, the Governor, after consultation with the executive  
690 director, shall discontinue any or all of the payment of the types  
691 of care and services as provided in this section that are deemed  
692 to be optional services under Title XIX of the federal Social  
693 Security Act, as amended, for any period necessary to not exceed  
694 appropriated funds, and when necessary shall institute any other  
695 cost containment measures on any program or programs authorized  
696 under the article to the extent allowed under the federal law  
697 governing that program or programs, it being the intent of the  
698 Legislature that expenditures during any fiscal year shall not  
699 exceed the amounts appropriated for that fiscal year.

700 Notwithstanding any other provision of this article, it shall  
701 be the duty of each nursing facility, intermediate care facility  
702 for the mentally retarded, psychiatric residential treatment  
703 facility, and nursing facility for the severely disabled that is  
704 participating in the Medicaid program to keep and maintain books,  
705 documents and other records as prescribed by the Division of  
706 Medicaid in substantiation of its cost reports for a period of  
707 three (3) years after the date of submission to the Division of  
708 Medicaid of an original cost report, or three (3) years after the  
709 date of submission to the Division of Medicaid of an amended cost  
710 report.

711 \* \* \*

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