

By: Representatives Lott, Chism, Moore

To: Medicaid; Appropriations

HOUSE BILL NO. 1584

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE THAT SURGICAL PROCEDURES TO REVERSE TUBAL LIGATIONS,
3 VASECTOMIES OR OTHER METHODS OF BIRTH CONTROL SHALL NOT BE
4 REIMBURSABLE UNDER MEDICAID; TO EXTEND THE REPEALER ON THAT
5 SECTION; AND FOR RELATED PURPOSES.

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

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

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

16 (1) Inpatient hospital services.

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

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

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

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37 subparagraph (c) shall stand repealed on July 1, 2005.

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

42 (3) Laboratory and x-ray services.

43 (4) Nursing facility services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

159 (b) Repealed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

247 (12) Intermediate care facility services.

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

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

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

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

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

289 Security Act, as amended, under waivers, subject to the
290 availability of funds specifically appropriated therefor by the
291 Legislature.

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

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

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

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

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

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

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

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

388 determined by the State Department of Health and the Division of
389 Medicaid.

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

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

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

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

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

427 (24) [Deleted]

428 (25) [Deleted]

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

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

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

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

454 agreement between the division and the department, provided that
455 funds for these services are specifically appropriated to the
456 Department of Mental Health and/or transferred to the department
457 by a political subdivision or instrumentality of the state.

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

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

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

472 (33) Podiatrist services.

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

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

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

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

495 (37) [Deleted]

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

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

508 (40) [Deleted]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

648 The division may pay to those providers who participate in
649 and accept patient referrals from the division's emergency room

650 redirection program a percentage, as determined by the division,
651 of savings achieved according to the performance measures and
652 reduction of costs required of that program.

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

669 Notwithstanding any provision of this article, no new groups
670 or categories of recipients and new types of care and services may
671 be added without enabling legislation from the Mississippi
672 Legislature, except that the division may authorize those changes
673 without enabling legislation when the addition of recipients or
674 services is ordered by a court of proper authority. The executive
675 director shall keep the Governor advised on a timely basis of the
676 funds available for expenditure and the projected expenditures.
677 If current or projected expenditures of the division can be
678 reasonably anticipated to exceed the amounts appropriated for any
679 fiscal year, the Governor, after consultation with the executive
680 director, shall discontinue any or all of the payment of the types
681 of care and services as provided in this section that are deemed
682 to be optional services under Title XIX of the federal Social

683 Security Act, as amended, for any period necessary to not exceed
684 appropriated funds, and when necessary shall institute any other
685 cost containment measures on any program or programs authorized
686 under the article to the extent allowed under the federal law
687 governing that program or programs, it being the intent of the
688 Legislature that expenditures during any fiscal year shall not
689 exceed the amounts appropriated for that fiscal year.

690 Notwithstanding any other provision of this article, it shall
691 be the duty of each nursing facility, intermediate care facility
692 for the mentally retarded, psychiatric residential treatment
693 facility, and nursing facility for the severely disabled that is
694 participating in the Medicaid program to keep and maintain books,
695 documents and other records as prescribed by the Division of
696 Medicaid in substantiation of its cost reports for a period of
697 three (3) years after the date of submission to the Division of
698 Medicaid of an original cost report, or three (3) years after the
699 date of submission to the Division of Medicaid of an amended cost
700 report.

701 Notwithstanding any provision of this section to the
702 contrary, the division shall not provide reimbursement to any
703 provider for surgical procedures to reverse tubal ligations,
704 vasectomies or other methods of birth control.

705 This section shall stand repealed on July 1, 2005.

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