MISSISSIPPI LEGISLATURE REGULAR SESSION 2004

By: Representatives Scott, Coleman (65th), Bailey, Banks, Blackmon, Broomfield, Buck, Burnett, Clark, Clarke, Flaggs, Fleming, Harrison, Hines, Myers, Straughter, Thomas, West, Young

To: Appropriations; Ways and Means

HOUSE BILL NO. 1638

1 AN ACT TO PROVIDE FOR THE REIMBURSEMENT OF RELOCATION
2 EXPENSES FOR LICENSED PHYSICIANS TO MOVE AND PRACTICE FAMILY
3 MEDICINE IN CRITICAL NEEDS AREAS FOR PRIMARY MEDICAL CARE; TO
4 PROVIDE FOR THE PAYMENT OF START-UP EXPENSES AND MEDICAL
5 MALPRACTICE INSURANCE PREMIUMS FOR THOSE PHYSICIANS; TO PROVIDE
6 FOR THE PAYMENT OF ANNUAL INCOME SUBSIDIES FOR THOSE PHYSICIANS;
7 TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO PROVIDE
8 AN ADDITIONAL 10% FEE INCREASE IN MEDICAID REIMBURSEMENT FOR
9 PHYSICIANS WHO PRACTICE IN CRITICAL NEEDS AREAS FOR PRIMARY
10 MEDICAL CARE; TO PROVIDE A CREDIT AGAINST STATE INCOME TAXES FOR
11 PHYSICIANS WHO PRACTICE FULL TIME IN CRITICAL NEEDS AREAS FOR
12 PRIMARY MEDICAL CARE; AND FOR RELATED PURPOSES.

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

14 **SECTION 1.** (1) The Board of Trustees of State Institutions
15 of Higher Learning shall prescribe rules and regulations that,
16 subject to available appropriations, allow for reimbursement to
17 licensed physicians who practice family medicine in a critical
18 needs area for primary medical care as designated under subsection
19 (4) of Section 37-143-6, for the expense of moving when the
20 employment necessitates the relocation of the physician or his
21 family to a different geographical area than that in which the
22 physician resides. If the reimbursement is approved, the board of
23 trustees shall provide funds to reimburse the physician an amount
24 not to exceed One Thousand Dollars ($1,000.00) for the documented
25 actual expenses incurred in the course of relocating, including
26 the expense of any professional moving company or persons employed
27 to assist with the move, rented moving vehicles or equipment,
28 mileage in the amount authorized for state employees under Section
29 25-3-41 if the physician used his personal vehicle for the move,
30 meals and such other expenses associated with the relocation in
31 accordance with the established rules and regulations.

32 (2) The Board of Trustees of State Institutions of Higher
33 Learning shall prescribe rules and regulations that, subject to
34 available appropriations, allow for reimbursement to licensed
35 physicians to practice family medicine in a critical needs area
36 for primary medical care as designated under subsection (4) of
37 Section 37-143-6, for the direct expense associated with starting
38 a full-time medical practice, including the cost of building,
39 lease payments, equipment purchases, furniture, medical supplies
40 and medical malpractice insurance associated with a family
41 practice. If the reimbursement is approved, the board of trustees
42 shall provide funds to reimburse the physician an amount not to
43 exceed Twenty Thousand Dollars ($20,000.00) over a two (2) year
44 period for the documented actual expenses incurred in starting a
45 physician's practice.
46 (3) The Board of Trustees of State Institutions of Higher
47 Learning shall prescribe rules and regulations that, subject to
48 available appropriations, allow income subsidies for licensed
49 physicians who practice family medicine full time in a critical
50 needs area for primary medical care as designated under subsection
51 (4) of Section 37-143-6, to recognize the reduced earning capacity
52 associated with practicing in a rural area. If the income subsidy
53 is approved, the board of trustees shall provide funds to
54 compensate the physician in an amount not to exceed Twenty
55 Thousand Dollars ($20,000.00) annually.
56 **SECTION 2.** Section 43-13-117, Mississippi Code of 1972, is
57 amended as follows:
58 43-13-117. Medicaid as authorized by this article shall
59 include payment of part or all of the costs, at the discretion of
60 the division or its successor, with approval of the Governor, of
61 the following types of care and services rendered to eligible
62 applicants who have been determined to be eligible for that care
63 and services, within the limits of state appropriations and
64 federal matching funds:

65 (1) Inpatient hospital services.
66 (a) The division shall allow thirty (30) days of
67 inpatient hospital care annually for all Medicaid recipients.
68 Precertification of inpatient days must be obtained as required by
69 the division. The division may allow unlimited days in
70 disproportionate hospitals as defined by the division for eligible
71 infants under the age of six (6) years if certified as medically
72 necessary as required by the division.
73 (b) From and after July 1, 1994, the Executive
74 Director of the Division of Medicaid shall amend the Mississippi
75 Title XIX Inpatient Hospital Reimbursement Plan to remove the
76 occupancy rate penalty from the calculation of the Medicaid
77 Capital Cost Component utilized to determine total hospital costs
78 allocated to the Medicaid program.
79 (c) Hospitals will receive an additional payment
80 for the implantable programmable baclofen drug pump used to treat
81 spasticity which is implanted on an inpatient basis. The payment
82 pursuant to written invoice will be in addition to the facility's
83 per diem reimbursement and will represent a reduction of costs on
84 the facility's annual cost report, and shall not exceed Ten
85 Thousand Dollars ($10,000.00) per year per recipient. This
86 subparagraph (c) shall stand repealed on July 1, 2005.
87 (2) Outpatient hospital services. Where the same
88 services are reimbursed as clinic services, the division may
89 revise the rate or methodology of outpatient reimbursement to
90 maintain consistency, efficiency, economy and quality of care.
91 (3) Laboratory and x-ray services.
92 (4) Nursing facility services.
93 (a) The division shall make full payment to
94 nursing facilities for each day, not exceeding fifty-two (52) days
95 per year, that a patient is absent from the facility on home
96 leave. Payment may be made for the following home leave days in
97 addition to the fifty-two-day limitation: Christmas, the day

98 before Christmas, the day after Christmas, Thanksgiving, the day
99 before Thanksgiving and the day after Thanksgiving.
100 (b) From and after July 1, 1997, the division
101 shall implement the integrated case-mix payment and quality
102 monitoring system, which includes the fair rental system for
103 property costs and in which recapture of depreciation is
104 eliminated. The division may reduce the payment for hospital
105 leave and therapeutic home leave days to the lower of the case-mix
106 category as computed for the resident on leave using the
107 assessment being utilized for payment at that point in time, or a
108 case-mix score of 1.000 for nursing facilities, and shall compute
109 case-mix scores of residents so that only services provided at the
110 nursing facility are considered in calculating a facility's per
111 diem.
112 During the period between May 1, 2002, and December 1, 2002,
113 the Chairmen of the Public Health and Welfare Committees of the
114 Senate and the House of Representatives may appoint a joint study
115 committee to consider the issue of setting uniform reimbursement
116 rates for nursing facilities. The study committee will consist of
117 the Chairmen of the Public Health and Welfare Committees, three
118 (3) members of the Senate and three (3) members of the House. The
119 study committee shall complete its work in not more than three (3)
120 meetings.
121 (c) From and after July 1, 1997, all state-owned
122 nursing facilities shall be reimbursed on a full reasonable cost
123 basis.
124 (d) When a facility of a category that does not
125 require a certificate of need for construction and that could not
126 be eligible for Medicaid reimbursement is constructed to nursing
127 facility specifications for licensure and certification, and the
128 facility is subsequently converted to a nursing facility under a
129 certificate of need that authorizes conversion only and the
130 applicant for the certificate of need was assessed an application

131 review fee based on capital expenditures incurred in constructing
132 the facility, the division shall allow reimbursement for capital
133 expenditures necessary for construction of the facility that were
134 incurred within the twenty-four (24) consecutive calendar months
135 immediately preceding the date that the certificate of need
136 authorizing the conversion was issued, to the same extent that
137 reimbursement would be allowed for construction of a new nursing
138 facility under a certificate of need that authorizes that
139 construction. The reimbursement authorized in this subparagraph
140 (d) may be made only to facilities the construction of which was
141 completed after June 30, 1989. Before the division shall be
142 authorized to make the reimbursement authorized in this
143 subparagraph (d), the division first must have received approval
144 from the Health Care Financing Administration of the United States
145 Department of Health and Human Services of the change in the state
146 Medicaid plan providing for the reimbursement.

147 (e) The division shall develop and implement, not
148 later than January 1, 2001, a case-mix payment add-on determined
149 by time studies and other valid statistical data that will
150 reimburse a nursing facility for the additional cost of caring for
151 a resident who has a diagnosis of Alzheimer's or other related
152 dementia and exhibits symptoms that require special care. Any
153 such case-mix add-on payment shall be supported by a determination
154 of additional cost. The division shall also develop and implement
155 as part of the fair rental reimbursement system for nursing
156 facility beds, an Alzheimer's resident bed depreciation enhanced
157 reimbursement system that will provide an incentive to encourage
158 nursing facilities to convert or construct beds for residents with
159 Alzheimer's or other related dementia.

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

162 The division shall apply for necessary federal waivers to
163 assure that additional services providing alternatives to nursing

164 facility care are made available to applicants for nursing
165 facility care.
166 (5) Periodic screening and diagnostic services for
167 individuals under age twenty-one (21) years as are needed to
168 identify physical and mental defects and to provide health care
169 treatment and other measures designed to correct or ameliorate
170 defects and physical and mental illness and conditions discovered
171 by the screening services regardless of whether these services are
172 included in the state plan. The division may include in its
173 periodic screening and diagnostic program those discretionary
174 services authorized under the federal regulations adopted to
175 implement Title XIX of the federal Social Security Act, as
176 amended. The division, in obtaining physical therapy services,
177 occupational therapy services, and services for individuals with
178 speech, hearing and language disorders, may enter into a
179 cooperative agreement with the State Department of Education for
180 the provision of those services to handicapped students by public
181 school districts using state funds that are provided from the
182 appropriation to the Department of Education to obtain federal
183 matching funds through the division. The division, in obtaining
184 medical and psychological evaluations for children in the custody
185 of the State Department of Human Services may enter into a
186 cooperative agreement with the State Department of Human Services
187 for the provision of those services using state funds that are
188 provided from the appropriation to the Department of Human
189 Services to obtain federal matching funds through the division.
190 (6) Physician's services. The division shall allow
191 twelve (12) physician visits annually. All fees for physicians'
192 services that are covered only by Medicaid shall be reimbursed at
193 ninety percent (90%) of the rate established on January 1, 1999,
194 and as adjusted each January thereafter, under Medicare (Title
195 XVIII of the Social Security Act, as amended), and which shall in
196 no event be less than seventy percent (70%) of the rate

197 established on January 1, 1994. All fees for physicians' services
198 that are covered by both Medicare and Medicaid shall be reimbursed
199 at ten percent (10%) of the adjusted Medicare payment established
200 on January 1, 1999, and as adjusted each January thereafter, under
201 Medicare (Title XVIII of the Social Security Act, as amended), and
202 which shall in no event be less than seventy percent (70%) of the
203 adjusted Medicare payment established on January 1, 1994. All
204 fees for physicians' services that are covered by Medicaid shall
205 be reimbursed at one hundred ten percent (110%) of the current
206 rate for licensed physicians who practice family medicine in
207 critical needs areas for primary medical care as designated under
208 subsection (4) of Section 37-143-6.
209 (7) (a) Home health services for eligible persons, not
210 to exceed in cost the prevailing cost of nursing facility
211 services, not to exceed sixty (60) visits per year. All home
212 health visits must be precertified as required by the division.
213 (b) Repealed.
214 (8) Emergency medical transportation services. On
215 January 1, 1994, emergency medical transportation services shall
216 be reimbursed at seventy percent (70%) of the rate established
217 under Medicare (Title XVIII of the Social Security Act, as
218 amended). "Emergency medical transportation services" shall mean,
219 but shall not be limited to, the following services by a properly
220 permitted ambulance operated by a properly licensed provider in
221 accordance with the Emergency Medical Services Act of 1974
222 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
223 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
224 (vi) disposable supplies, (vii) similar services.
225 (9) (a) Legend and other drugs as may be determined by
226 the division. The division may implement a program of prior
227 approval for drugs to the extent permitted by law. The division
228 shall allow seven (7) prescriptions per month for each
229 noninstitutionalized Medicaid recipient; however, after a

230 noninstitutionalized or institutionalized recipient has received
231 five (5) prescriptions in any month, each additional prescription
232 during that month must have the prior approval of the division.
233 The division shall not reimburse for any portion of a prescription
234 that exceeds a thirty-four-day supply of the drug based on the
235 daily dosage.

236 Provided, however, that until July 1, 2005, any A-typical
237 antipsychotic drug shall be included in any preferred drug list
238 developed by the Division of Medicaid and shall not require prior
239 authorization, and until July 1, 2005, any licensed physician may
240 prescribe any A-typical antipsychotic drug deemed appropriate for
241 Medicaid recipients which shall be fully eligible for Medicaid
242 reimbursement.

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

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

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

256 (b) Payment by the division for covered multiple
257 source drugs shall be limited to the lower of the upper limits
258 established and published by the Centers for Medicare and Medicaid
259 Services (CMS) plus a dispensing fee, or the estimated acquisition
260 cost (EAC) plus a dispensing fee, or the providers' usual and
261 customary charge to the general public.

262 Payment for other covered drugs, other than multiple source
263 drugs with CMS upper limits, shall not exceed the lower of the
264 estimated acquisition cost plus a dispensing fee or the providers'
265 usual and customary charge to the general public.
266 Payment for nonlegend or over-the-counter drugs covered by
267 the division shall be reimbursed at the lower of the division's
268 estimated shelf price or the providers' usual and customary charge
269 to the general public.
270 The dispensing fee for each new or refill prescription,
271 including nonlegend or over-the-counter drugs covered by the
272 division, shall be Three Dollars and Ninety-one Cents ($3.91).
273 The Medicaid provider shall not prescribe, the Medicaid
274 pharmacy shall not bill, and the division shall not reimburse for
275 name brand drugs if there are equally effective generic
276 equivalents available and if the generic equivalents are the least
277 expensive.
278 As used in this paragraph (9), "estimated acquisition cost"
279 means twelve percent (12%) less than the average wholesale price
280 for a drug.
281 (10) Dental care that is an adjunct to treatment of an
282 acute medical or surgical condition; services of oral surgeons and
283 dentists in connection with surgery related to the jaw or any
284 structure contiguous to the jaw or the reduction of any fracture
285 of the jaw or any facial bone; and emergency dental extractions
286 and treatment related thereto. On July 1, 1999, all fees for
287 dental care and surgery under authority of this paragraph (10)
288 shall be increased to one hundred sixty percent (160%) of the
289 amount of the reimbursement rate that was in effect on June 30,
290 1999. It is the intent of the Legislature to encourage more
291 dentists to participate in the Medicaid program.
292 (11) Eyeglasses for all Medicaid beneficiaries who have
293 (a) had surgery on the eyeball or ocular muscle that results in a
294 vision change for which eyeglasses or a change in eyeglasses is

295 medically indicated within six (6) months of the surgery and is in
296 accordance with policies established by the division, or (b) one
297 (1) pair every five (5) years and in accordance with policies
298 established by the division. In either instance, the eyeglasses
299 must be prescribed by a physician skilled in diseases of the eye
300 or an optometrist, whichever the beneficiary may select.
301 (12) Intermediate care facility services.
302 (a) The division shall make full payment to all
303 intermediate care facilities for the mentally retarded for each
304 day, not exceeding eighty-four (84) days per year, that a patient
305 is absent from the facility on home leave. Payment may be made
306 for the following home leave days in addition to the
307 eighty-four-day limitation: Christmas, the day before Christmas,
308 the day after Christmas, Thanksgiving, the day before Thanksgiving
309 and the day after Thanksgiving.
310 (b) All state-owned intermediate care facilities
311 for the mentally retarded shall be reimbursed on a full reasonable
312 cost basis.
313 (13) Family planning services, including drugs,
314 supplies and devices, when those services are under the
315 supervision of a physician.
316 (14) Clinic services. Such diagnostic, preventive,
317 therapeutic, rehabilitative or palliative services furnished to an
318 outpatient by or under the supervision of a physician or dentist
319 in a facility that is not a part of a hospital but that is
320 organized and operated to provide medical care to outpatients.
321 Clinic services shall include any services reimbursed as
322 outpatient hospital services that may be rendered in such a
323 facility, including those that become so after July 1, 1991. On
324 July 1, 1999, all fees for physicians' services reimbursed under
325 authority of this paragraph (14) shall be reimbursed at ninety
326 percent (90%) of the rate established on January 1, 1999, and as
327 adjusted each January thereafter, under Medicare (Title XVIII of

328 the Social Security Act, as amended), and which shall in no event
329 be less than seventy percent (70%) of the rate established on
330 January 1, 1994. All fees for physicians' services that are
331 covered by both Medicare and Medicaid shall be reimbursed at ten
332 percent (10%) of the adjusted Medicare payment established on
333 January 1, 1999, and as adjusted each January thereafter, under
334 Medicare (Title XVIII of the Social Security Act, as amended), and
335 which shall in no event be less than seventy percent (70%) of the
336 adjusted Medicare payment established on January 1, 1994. On July
337 1, 1999, all fees for dentists' services reimbursed under
338 authority of this paragraph (14) shall be increased to one hundred
339 sixty percent (160%) of the amount of the reimbursement rate that
340 was in effect on June 30, 1999.

341 (15) Home- and community-based services for the elderly
342 and disabled, as provided under Title XIX of the federal Social
343 Security Act, as amended, under waivers, subject to the
344 availability of funds specifically appropriated therefor by the
345 Legislature.

346 (16) Mental health services. Approved therapeutic and
347 case management services (a) provided by an approved regional
348 mental health/retardation center established under Sections
349 41-19-31 through 41-19-39, or by another community mental health
350 service provider meeting the requirements of the Department of
351 Mental Health to be an approved mental health/retardation center
352 if determined necessary by the Department of Mental Health, using
353 state funds that are provided from the appropriation to the State
354 Department of Mental Health and/or funds transferred to the
355 department by a political subdivision or instrumentality of the
356 state and used to match federal funds under a cooperative
357 agreement between the division and the department, or (b) provided
358 by a facility that is certified by the State Department of Mental
359 Health to provide therapeutic and case management services, to be
360 reimbursed on a fee for service basis, or (c) provided in the

361 community by a facility or program operated by the Department of
362 Mental Health. Any such services provided by a facility described
363 in subparagraph (b) must have the prior approval of the division
364 to be reimbursable under this section. After June 30, 1997,
365 mental health services provided by regional mental
366 health/retardation centers established under Sections 41-19-31
367 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
368 and/or their subsidiaries and divisions, or by psychiatric
369 residential treatment facilities as defined in Section 43-11-1, or
370 by another community mental health service provider meeting the
371 requirements of the Department of Mental Health to be an approved
372 mental health/retardation center if determined necessary by the
373 Department of Mental Health, shall not be included in or provided
374 under any capitated managed care pilot program provided for under
375 paragraph (24) of this section.
376 (17) Durable medical equipment services and medical
377 supplies. Precertification of durable medical equipment and
378 medical supplies must be obtained as required by the division.
379 The Division of Medicaid may require durable medical equipment
380 providers to obtain a surety bond in the amount and to the
381 specifications as established by the Balanced Budget Act of 1997.
382 (18) (a) Notwithstanding any other provision of this
383 section to the contrary, the division shall make additional
384 reimbursement to hospitals that serve a disproportionate share of
385 low-income patients and that meet the federal requirements for
386 those payments as provided in Section 1923 of the federal Social
387 Security Act and any applicable regulations. However, from and
388 after January 1, 1999, no public hospital shall participate in the
389 Medicaid disproportionate share program unless the public hospital
390 participates in an intergovernmental transfer program as provided
391 in Section 1903 of the federal Social Security Act and any
392 applicable regulations. Administration and support for

393 participating hospitals shall be provided by the Mississippi
394 Hospital Association.
395 (b) The division shall establish a Medicare Upper
396 Payment Limits Program, as defined in Section 1902(a)(30) of the
397 federal Social Security Act and any applicable federal
398 regulations, for hospitals, and may establish a Medicare Upper
399 Payments Limits Program for nursing facilities. The division
400 shall assess each hospital and, if the program is established for
401 nursing facilities, shall assess each nursing facility, for the
402 sole purpose of financing the state portion of the Medicare Upper
403 Payment Limits Program. This assessment shall be based on
404 Medicaid utilization, or other appropriate method consistent with
405 federal regulations, and will remain in effect as long as the
406 state participates in the Medicare Upper Payment Limits Program.
407 The division shall make additional reimbursement to hospitals and,
408 if the program is established for nursing facilities, shall make
409 additional reimbursement to nursing facilities, for the Medicare
410 Upper Payment Limits, as defined in Section 1902(a)(30) of the
411 federal Social Security Act and any applicable federal
412 regulations. This subparagraph (b) shall stand repealed from and
413 after July 1, 2005.
414 (c) The division shall contract with the
415 Mississippi Hospital Association to provide administrative support
416 for the operation of the disproportionate share hospital program
417 and the Medicare Upper Payment Limits Program. This subparagraph
418 (c) shall stand repealed from and after July 1, 2005.
419 (19) (a) Perinatal risk management services. The
420 division shall promulgate regulations to be effective from and
421 after October 1, 1988, to establish a comprehensive perinatal
422 system for risk assessment of all pregnant and infant Medicaid
423 recipients and for management, education and follow-up for those
424 who are determined to be at risk. Services to be performed
425 include case management, nutrition assessment/counseling,

426 psychosocial assessment/counseling and health education. The
427 division shall set reimbursement rates for providers in
428 conjunction with the State Department of Health.
429 (b) Early intervention system services. The
430 division shall cooperate with the State Department of Health,
431 acting as lead agency, in the development and implementation of a
432 statewide system of delivery of early intervention services, under
433 Part C of the Individuals with Disabilities Education Act (IDEA).
434 The State Department of Health shall certify annually in writing
435 to the executive director of the division the dollar amount of
436 state early intervention funds available that will be utilized as
437 a certified match for Medicaid matching funds. Those funds then
438 shall be used to provide expanded targeted case management
439 services for Medicaid eligible children with special needs who are
440 eligible for the state's early intervention system.
441 Qualifications for persons providing service coordination shall be
442 determined by the State Department of Health and the Division of
443 Medicaid.
444 (20) Home- and community-based services for physically
445 disabled approved services as allowed by a waiver from the United
446 States Department of Health and Human Services for home- and
447 community-based services for physically disabled people using
448 state funds that are provided from the appropriation to the State
449 Department of Rehabilitation Services and used to match federal
450 funds under a cooperative agreement between the division and the
451 department, provided that funds for these services are
452 specifically appropriated to the Department of Rehabilitation
453 Services.
454 (21) Nurse practitioner services. Services furnished
455 by a registered nurse who is licensed and certified by the
456 Mississippi Board of Nursing as a nurse practitioner, including,
457 but not limited to, nurse anesthetists, nurse midwives, family
458 nurse practitioners, family planning nurse practitioners,

459 pediatric nurse practitioners, obstetrics-gynecology nurse
460 practitioners and neonatal nurse practitioners, under regulations
461 adopted by the division. Reimbursement for those services shall
462 not exceed ninety percent (90%) of the reimbursement rate for
463 comparable services rendered by a physician.
464 (22) Ambulatory services delivered in federally
465 qualified health centers, rural health centers and clinics of the
466 local health departments of the State Department of Health for
467 individuals eligible for Medicaid under this article based on
468 reasonable costs as determined by the division.
469 (23) Inpatient psychiatric services. Inpatient
470 psychiatric services to be determined by the division for
471 recipients under age twenty-one (21) that are provided under the
472 direction of a physician in an inpatient program in a licensed
473 acute care psychiatric facility or in a licensed psychiatric
474 residential treatment facility, before the recipient reaches age
475 twenty-one (21) or, if the recipient was receiving the services
476 immediately before he reached age twenty-one (21), before the
477 earlier of the date he no longer requires the services or the date
478 he reaches age twenty-two (22), as provided by federal
479 regulations. Precertification of inpatient days and residential
480 treatment days must be obtained as required by the division.
481 (24) [Deleted]
482 (25) [Deleted]
483 (26) Hospice care. As used in this paragraph, the term
484 "hospice care" means a coordinated program of active professional
485 medical attention within the home and outpatient and inpatient
486 care that treats the terminally ill patient and family as a unit,
487 employing a medically directed interdisciplinary team. The
488 program provides relief of severe pain or other physical symptoms
489 and supportive care to meet the special needs arising out of
490 physical, psychological, spiritual, social and economic stresses
491 that are experienced during the final stages of illness and during

492 dying and bereavement and meets the Medicare requirements for
493 participation as a hospice as provided in federal regulations.
494 (27) Group health plan premiums and cost sharing if it
495 is cost effective as defined by the Secretary of Health and Human
496 Services.
497 (28) Other health insurance premiums that are cost
498 effective as defined by the Secretary of Health and Human
499 Services. Medicare eligible must have Medicare Part B before
500 other insurance premiums can be paid.
501 (29) The Division of Medicaid may apply for a waiver
502 from the Department of Health and Human Services for home- and
503 community-based services for developmentally disabled people using
504 state funds that are provided from the appropriation to the State
505 Department of Mental Health and/or funds transferred to the
506 department by a political subdivision or instrumentality of the
507 state and used to match federal funds under a cooperative
508 agreement between the division and the department, provided that
509 funds for these services are specifically appropriated to the
510 Department of Mental Health and/or transferred to the department
511 by a political subdivision or instrumentality of the state.
512 (30) Pediatric skilled nursing services for eligible
513 persons under twenty-one (21) years of age.
514 (31) Targeted case management services for children
515 with special needs, under waivers from the United States
516 Department of Health and Human Services, using state funds that
517 are provided from the appropriation to the Mississippi Department
518 of Human Services and used to match federal funds under a
519 cooperative agreement between the division and the department.
520 (32) Care and services provided in Christian Science
521 Sanatoria listed and certified by the Commission for Accreditation
522 of Christian Science Nursing Organizations/Facilities, Inc.,
523 rendered in connection with treatment by prayer or spiritual means

524 to the extent that those services are subject to reimbursement
525 under Section 1903 of the Social Security Act.
526 (33) Podiatrist services.
527 (34) Assisted living services as provided through home-
528 and community-based services under Title XIX of the Social
529 Security Act, as amended, subject to the availability of funds
530 specifically appropriated therefor by the Legislature.
531 (35) Services and activities authorized in Sections
532 43-27-101 and 43-27-103, using state funds that are provided from
533 the appropriation to the State Department of Human Services and
534 used to match federal funds under a cooperative agreement between
535 the division and the department.
536 (36) Nonemergency transportation services for
537 Medicaid-eligible persons, to be provided by the Division of
538 Medicaid. The division may contract with additional entities to
539 administer nonemergency transportation services as it deems
540 necessary. All providers shall have a valid driver's license,
541 vehicle inspection sticker, valid vehicle license tags and a
542 standard liability insurance policy covering the vehicle. The
543 division may pay providers a flat fee based on mileage tiers, or
544 in the alternative, may reimburse on actual miles traveled. The
545 division may apply to the Center for Medicare and Medicaid
546 Services (CMS) for a waiver to draw federal matching funds for
547 nonemergency transportation services as a covered service instead
548 of an administrative cost.
549 (37) [Deleted]
550 (38) Chiropractic services. A chiropractor's manual
551 manipulation of the spine to correct a subluxation, if x-ray
552 demonstrates that a subluxation exists and if the subluxation has
553 resulted in a neuromusculoskeletal condition for which
554 manipulation is appropriate treatment, and related spinal x-rays
555 performed to document these conditions. Reimbursement for

556 chiropractic services shall not exceed Seven Hundred Dollars
557 ($700.00) per year per beneficiary.
558 (39) Dually eligible Medicare/Medicaid beneficiaries.
559 The division shall pay the Medicare deductible and coinsurance
560 amounts for services available under Medicare, as determined by
561 the division.
562 (40) [Deleted]
563 (41) Services provided by the State Department of
564 Rehabilitation Services for the care and rehabilitation of persons
565 with spinal cord injuries or traumatic brain injuries, as allowed
566 under waivers from the United States Department of Health and
567 Human Services, using up to seventy-five percent (75%) of the
568 funds that are appropriated to the Department of Rehabilitation
569 Services from the Spinal Cord and Head Injury Trust Fund
570 established under Section 37-33-261 and used to match federal
571 funds under a cooperative agreement between the division and the
572 department.
573 (42) Notwithstanding any other provision in this
574 article to the contrary, the division may develop a population
575 health management program for women and children health services
576 through the age of one (1) year. This program is primarily for
577 obstetrical care associated with low birth weight and pre-term
578 babies. The division may apply to the federal Centers for
579 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
580 any other waivers that may enhance the program. In order to
581 effect cost savings, the division may develop a revised payment
582 methodology that may include at-risk capitated payments, and may
583 require member participation in accordance with the terms and
584 conditions of an approved federal waiver.
585 (43) The division shall provide reimbursement,
586 according to a payment schedule developed by the division, for
587 smoking cessation medications for pregnant women during their

588 pregnancy and other Medicaid-eligible women who are of
589 child-bearing age.
590 (44) Nursing facility services for the severely
591 disabled.
592 (a) Severe disabilities include, but are not
593 limited to, spinal cord injuries, closed head injuries and
594 ventilator dependent patients.
595 (b) Those services must be provided in a long-term
596 care nursing facility dedicated to the care and treatment of
597 persons with severe disabilities, and shall be reimbursed as a
598 separate category of nursing facilities.
599 (45) Physician assistant services. Services furnished
600 by a physician assistant who is licensed by the State Board of
601 Medical Licensure and is practicing with physician supervision
602 under regulations adopted by the board, under regulations adopted
603 by the division. Reimbursement for those services shall not
604 exceed ninety percent (90%) of the reimbursement rate for
605 comparable services rendered by a physician.
606 (46) The division shall make application to the federal
607 Centers for Medicare and Medicaid Services (CMS) for a waiver to
608 develop and provide services for children with serious emotional
609 disturbances as defined in Section 43-14-1(1), which may include
610 home- and community-based services, case management services or
611 managed care services through mental health providers certified by
612 the Department of Mental Health. The division may implement and
613 provide services under this waivered program only if funds for
614 these services are specifically appropriated for this purpose by
615 the Legislature, or if funds are voluntarily provided by affected
616 agencies.
617 (47) (a) Notwithstanding any other provision in this
618 article to the contrary, the division, in conjunction with the
619 State Department of Health, shall develop and implement disease
620 management programs for individuals with asthma, diabetes or

621 hypertension, including the use of grants, waivers, demonstrations
622 or other projects as necessary.
623 (b) Participation in any disease management
624 program implemented under this paragraph (47) is optional with the
625 individual. An individual must affirmatively elect to participate
626 in the disease management program in order to participate.
627 (c) An individual who participates in the disease
628 management program has the option of participating in the
629 prescription drug home delivery component of the program at any
630 time while participating in the program. An individual must
631 affirmatively elect to participate in the prescription drug home
632 delivery component in order to participate.
633 (d) An individual who participates in the disease
634 management program may elect to discontinue participation in the
635 program at any time. An individual who participates in the
636 prescription drug home delivery component may elect to discontinue
637 participation in the prescription drug home delivery component at
638 any time.
639 (e) The division shall send written notice to all
640 individuals who participate in the disease management program
641 informing them that they may continue using their local pharmacy
642 or any other pharmacy of their choice to obtain their prescription
643 drugs while participating in the program.
644 (f) Prescription drugs that are provided to
645 individuals under the prescription drug home delivery component
646 shall be limited only to those drugs that are used for the
647 treatment, management or care of asthma, diabetes or hypertension.
648 (48) Pediatric long-term acute care hospital services.
649 (a) Pediatric long-term acute care hospital
650 services means services provided to eligible persons under
651 twenty-one (21) years of age by a freestanding Medicare-certified
652 hospital that has an average length of inpatient stay greater than
653 twenty-five (25) days and that is primarily engaged in providing

654 chronic or long-term medical care to persons under twenty-one (21)
655 years of age.
656 (b) The services under this paragraph (48) shall
657 be reimbursed as a separate category of hospital services.
658 (49) The division shall establish copayments for all
659 Medicaid services for which copayments are allowable under federal
660 law or regulation, except for nonemergency transportation
661 services, and shall set the amount of the copayment for each of
662 those services at the maximum amount allowable under federal law
663 or regulation.
664 (50) Services provided by the State Department of
665 Rehabilitation Services for the care and rehabilitation of persons
666 who are deaf and blind, as allowed under waivers from the United
667 States Department of Health and Human Services to provide home-
668 and community-based services using state funds which are provided
669 from the appropriation to the State Department of Rehabilitation
670 Services or if funds are voluntarily provided by another agency.
671 Notwithstanding any other provision of this article to the
672 contrary, the division shall reduce the rate of reimbursement to
673 providers for any service provided under this section by five
674 percent (5%) of the allowed amount for that service. However, the
675 reduction in the reimbursement rates required by this paragraph
676 shall not apply to inpatient hospital services, nursing facility
677 services, intermediate care facility services, psychiatric
678 residential treatment facility services, pharmacy services
679 provided under paragraph (9) of this section, or any service
680 provided by the University of Mississippi Medical Center or a
681 state agency, a state facility or a public agency that either
682 provides its own state match through intergovernmental transfer or
683 certification of funds to the division, or a service for which the
684 federal government sets the reimbursement methodology and rate.
685 In addition, the reduction in the reimbursement rates required by
686 this paragraph shall not apply to case management services

687 provided under the home- and community-based services program for
688 the elderly and disabled by a planning and development district
689 (PDD). Planning and development districts participating in the
690 home- and community-based services program for the elderly and
691 disabled as case management providers shall be reimbursed for case
692 management services at the maximum rate approved by the Centers
693 for Medicare and Medicaid Services (CMS). PDDs shall transfer to
694 the division state match from public funds (not federal) in an
695 amount equal to the difference between the maximum case management
696 reimbursement rate approved by CMS and a five percent (5%)
697 reduction in that rate. The division shall invoice each PDD
698 fifteen (15) days after the end of each quarter for the
699 intergovernmental transfer based on payments made for Medicaid
700 home- and community-based case management services during the
701 quarter.

702 The division may pay to those providers who participate in
703 and accept patient referrals from the division's emergency room
704 redirection program a percentage, as determined by the division,
705 of savings achieved according to the performance measures and
706 reduction of costs required of that program.

707 Notwithstanding any provision of this article, except as
708 authorized in the following paragraph and in Section 43-13-139,
709 neither (a) the limitations on quantity or frequency of use of or
710 the fees or charges for any of the care or services available to
711 recipients under this section, nor (b) the payments or rates of
712 reimbursement to providers rendering care or services authorized
713 under this section to recipients, may be increased, decreased or
714 otherwise changed from the levels in effect on July 1, 1999,
715 unless they are authorized by an amendment to this section by the
716 Legislature. However, the restriction in this paragraph shall not
717 prevent the division from changing the payments or rates of
718 reimbursement to providers without an amendment to this section
719 whenever those changes are required by federal law or regulation,

720 or whenever those changes are necessary to correct administrative
721 errors or omissions in calculating those payments or rates of
722 reimbursement.

723 Notwithstanding any provision of this article, no new groups
724 or categories of recipients and new types of care and services may
725 be added without enabling legislation from the Mississippi
726 Legislature, except that the division may authorize those changes
727 without enabling legislation when the addition of recipients or
728 services is ordered by a court of proper authority. The executive
729 director shall keep the Governor advised on a timely basis of the
730 funds available for expenditure and the projected expenditures.
731 If current or projected expenditures of the division can be
732 reasonably anticipated to exceed the amounts appropriated for any
733 fiscal year, the Governor, after consultation with the executive
734 director, shall discontinue any or all of the payment of the types
735 of care and services as provided in this section that are deemed
736 to be optional services under Title XIX of the federal Social
737 Security Act, as amended, for any period necessary to not exceed
738 appropriated funds, and when necessary shall institute any other
739 cost containment measures on any program or programs authorized
740 under the article to the extent allowed under the federal law
741 governing that program or programs, it being the intent of the
742 Legislature that expenditures during any fiscal year shall not
743 exceed the amounts appropriated for that fiscal year.

744 Notwithstanding any other provision of this article, it shall
745 be the duty of each nursing facility, intermediate care facility
746 for the mentally retarded, psychiatric residential treatment
747 facility, and nursing facility for the severely disabled that is
748 participating in the Medicaid program to keep and maintain books,
749 documents and other records as prescribed by the Division of
750 Medicaid in substantiation of its cost reports for a period of
751 three (3) years after the date of submission to the Division of
752 Medicaid of an original cost report, or three (3) years after the

753 date of submission to the Division of Medicaid of an amended cost
754 report.
755 This section shall stand repealed on July 1, 2006.
756 **SECTION 3.** (1) Any licensed physician who practices full
757 time in any critical needs area for primary medical care as
758 designated under subsection (4) of Section 37-143-6 shall be
759 allowed a credit against the taxes imposed by this chapter in an
760 amount equal to fifty percent (50%) of the physician's income tax
761 liability that results from income derived from his or her
762 practice in any such underserved area. The credit shall be
763 allowed for a maximum of ten (10) years for all practice in any
764 such critical needs areas for primary medical care in which the
765 physician practices during his or her career.
766 (2) Subsection (1) of this section shall be codified as a
767 new section in Article 1, Chapter 7, Title 27, Mississippi Code of
768 1972.
769 **SECTION 4.** This act shall take effect and be in force from
770 and after July 1, 2004; provided that Section 3 of this act shall
771 take effect and be in force from and after January 1, 2004.