

By: Senator(s) Harden

To: Public Health and
Welfare; Appropriations

SENATE BILL NO. 2174

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO ESTABLISH A PROGRAM OF ASSISTANCE PAYMENTS FOR PERSONS WHO
3 RESIDE IN PERSONAL CARE HOMES AND WHO ARE ELIGIBLE FOR AND
4 RECEIVING CERTAIN MEDICAID ASSISTANCE; TO AUTHORIZE THE DIVISION
5 OF MEDICAID TO ADMINISTER THE PROGRAM OF ASSISTANCE PAYMENTS; AND
6 FOR RELATED PURPOSES.

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

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

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

17 (1) Inpatient hospital services.

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

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

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

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38 subparagraph (c) shall stand repealed on July 1, 2005.

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

43 (3) Laboratory and x-ray services.

44 (4) Nursing facility services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

160 (b) Repealed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

248 (12) Intermediate care facility services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

388 Qualifications for persons providing service coordination shall be

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

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

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

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

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

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

428 (24) [Deleted]

429 (25) [Deleted]

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

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

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

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

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

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

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

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

473 (33) Podiatrist services.

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

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

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

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

496 (37) [Deleted]

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

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

509 (40) [Deleted]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

618 (51) As used in this paragraph (51):

619 (a) "Division" means the Division of Medicaid in
620 the Office of the Governor.

621 (b) "Applicant" means a person who applies for
622 personal care home assistance payments under this paragraph.

623 (c) "Recipient" means a person who resides in a
624 personal care home, who is eligible for assistance under the
625 Mississippi Medicaid Law as prescribed in Section 43-13-115,
626 Mississippi Code of 1972, and who is receiving Medicaid assistance
627 for medicine, hospital services and physician's services.

628 (d) "Personal care home" means any building or
629 buildings, residence, private home, boarding home, home for
630 persons eighteen (18) years of age or older, or other place,
631 whether operated for profit or not, which undertakes through its
632 ownership or management to provide, for a period exceeding
633 twenty-four (24) hours, housing, food service, and one or more
634 personal services for four (4) or more adults who are not related
635 to the owner or operator by blood or marriage and who require such
636 services, and which is licensed as a personal care home by the
637 State Department of Health under Section 43-11-1 et seq.,
638 Mississippi Code of 1972.

639 There is established a program of assistance payments for
640 persons who reside in personal care homes, to be administered by
641 the Division of Medicaid. The amount of such assistance payments
642 shall be in the amount of Three Dollars (\$3.00) per bed per day
643 for each eligible recipient, subject to appropriations therefor by
644 the Legislature.

645 Recipients of such personal care home assistance payments
646 shall be applicants who reside in personal care homes, who are
647 certified by the division as persons eligible for Medicaid
648 assistance, and who are receiving Medicaid assistance for
649 medicine, hospital services and physician's services.

650 The division is authorized and empowered to administer the
651 program of personal care home assistance payments established in

652 this act, and to adopt and promulgate reasonable rules,
653 regulations and standards, with the approval of the Governor, as
654 may be necessary for the proper and efficient payment of claims to
655 all qualified recipients.

656 Notwithstanding any other provision of this article to the
657 contrary, the division shall reduce the rate of reimbursement to
658 providers for any service provided under this section by five
659 percent (5%) of the allowed amount for that service. However, the
660 reduction in the reimbursement rates required by this paragraph
661 shall not apply to inpatient hospital services, nursing facility
662 services, intermediate care facility services, psychiatric
663 residential treatment facility services, pharmacy services
664 provided under paragraph (9) of this section, or any service
665 provided by the University of Mississippi Medical Center or a
666 state agency, a state facility or a public agency that either
667 provides its own state match through intergovernmental transfer or
668 certification of funds to the division, or a service for which the
669 federal government sets the reimbursement methodology and rate.
670 In addition, the reduction in the reimbursement rates required by
671 this paragraph shall not apply to case management services
672 provided under the home- and community-based services program for
673 the elderly and disabled by a planning and development district
674 (PDD). Planning and development districts participating in the
675 home- and community-based services program for the elderly and
676 disabled as case management providers shall be reimbursed for case
677 management services at the maximum rate approved by the Centers
678 for Medicare and Medicaid Services (CMS). PDDs shall transfer to
679 the division state match from public funds (not federal) in an
680 amount equal to the difference between the maximum case management
681 reimbursement rate approved by CMS and a five percent (5%)
682 reduction in that rate. The division shall invoice each PDD
683 fifteen (15) days after the end of each quarter for the
684 intergovernmental transfer based on payments made for Medicaid

685 home- and community-based case management services during the
686 quarter.

687 The division may pay to those providers who participate in
688 and accept patient referrals from the division's emergency room
689 redirection program a percentage, as determined by the division,
690 of savings achieved according to the performance measures and
691 reduction of costs required of that program.

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

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

718 fiscal year, the Governor, after consultation with the executive
719 director, shall discontinue any or all of the payment of the types
720 of care and services as provided in this section that are deemed
721 to be optional services under Title XIX of the federal Social
722 Security Act, as amended, for any period necessary to not exceed
723 appropriated funds, and when necessary shall institute any other
724 cost containment measures on any program or programs authorized
725 under the article to the extent allowed under the federal law
726 governing that program or programs, it being the intent of the
727 Legislature that expenditures during any fiscal year shall not
728 exceed the amounts appropriated for that fiscal year.

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

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

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