MISSISSIPPI LEGISLATURE REGULAR SESSION 2005

By: Senator(s) Dearing

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2055

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE THAT MENTAL HEALTH COUNSELING SERVICES PROVIDED BY A
3 LICENSED PROFESSIONAL COUNSELOR (LPC) SHALL BE REIMBURSABLE UNDER
4 THE MEDICAID PROGRAM; AND FOR RELATED PURPOSES.

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

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

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

15 (1) Inpatient hospital services.

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

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

29 (c) Hospitals will receive an additional payment
30 for the implantable programmable baclofen drug pump used to treat
31 spasticity that is implanted on an inpatient basis. The payment
32 pursuant to written invoice will be in addition to the facility's
33 per diem reimbursement and will represent a reduction of costs on
34 the facility's annual cost report, and shall not exceed Ten
35 Thousand Dollars ($10,000.00) per year per recipient. This
36 subparagraph (c) shall stand repealed on July 1, 2005.
37 (2) Outpatient hospital services. Where the same
38 services are reimbursed as clinic services, the division may
39 revise the rate or methodology of outpatient reimbursement to
40 maintain consistency, efficiency, economy and quality of care.
41 (3) Laboratory and x-ray services.
42 (4) Nursing facility services.
43 (a) The division shall make full payment to
44 nursing facilities for each day, not exceeding fifty-two (52) days
45 per year, that a patient is absent from the facility on home
46 leave. Payment may be made for the following home leave days in
47 addition to the fifty-two-day limitation: Christmas, the day
48 before Christmas, the day after Christmas, Thanksgiving, the day
49 before Thanksgiving and the day after Thanksgiving.
50 (b) From and after July 1, 1997, the division
51 shall implement the integrated case-mix payment and quality
52 monitoring system, which includes the fair rental system for
53 property costs and in which recapture of depreciation is
54 eliminated. The division may reduce the payment for hospital
55 leave and therapeutic home leave days to the lower of the case-mix
56 category as computed for the resident on leave using the
57 assessment being utilized for payment at that point in time, or a
58 case-mix score of 1.000 for nursing facilities, and shall compute
59 case-mix scores of residents so that only services provided at the
60 nursing facility are considered in calculating a facility's per
61 diem.

62 (c) From and after July 1, 1997, all state-owned
63 nursing facilities shall be reimbursed on a full reasonable cost
64 basis.
65 (d) When a facility of a category that does not
66 require a certificate of need for construction and that could not
67 be eligible for Medicaid reimbursement is constructed to nursing
68 facility specifications for licensure and certification, and the
69 facility is subsequently converted to a nursing facility under a
70 certificate of need that authorizes conversion only and the
71 applicant for the certificate of need was assessed an application
72 review fee based on capital expenditures incurred in constructing
73 the facility, the division shall allow reimbursement for capital
74 expenditures necessary for construction of the facility that were
75 incurred within the twenty-four (24) consecutive calendar months
76 immediately preceding the date that the certificate of need
77 authorizing the conversion was issued, to the same extent that
78 reimbursement would be allowed for construction of a new nursing
79 facility under a certificate of need that authorizes that
80 construction. The reimbursement authorized in this subparagraph
81 (d) may be made only to facilities the construction of which was
82 completed after June 30, 1989. Before the division shall be
83 authorized to make the reimbursement authorized in this
84 subparagraph (d), the division first must have received approval
85 from the Centers for Medicare and Medicaid Services (CMS) of the
86 change in the state Medicaid plan providing for the reimbursement.
87 (e) The division shall develop and implement, not
88 later than January 1, 2001, a case-mix payment add-on determined
89 by time studies and other valid statistical data that will
90 reimburse a nursing facility for the additional cost of caring for
91 a resident who has a diagnosis of Alzheimer's or other related
92 dementia and exhibits symptoms that require special care. Any
93 such case-mix add-on payment shall be supported by a determination
94 of additional cost. The division shall also develop and implement

95 as part of the fair rental reimbursement system for nursing
96 facility beds, an Alzheimer's resident bed depreciation enhanced
97 reimbursement system that will provide an incentive to encourage
98 nursing facilities to convert or construct beds for residents with
99 Alzheimer's or other related dementia.

100 (f) The division shall develop and implement an
101 assessment process for long-term care services. The division may
102 provide the assessment and related functions directly or through
103 contract with the area agencies on aging.

104 The division shall apply for necessary federal waivers to
105 assure that additional services providing alternatives to nursing
106 facility care are made available to applicants for nursing
107 facility care.

108 (5) Periodic screening and diagnostic services for
109 individuals under age twenty-one (21) years as are needed to
110 identify physical and mental defects and to provide health care
111 treatment and other measures designed to correct or ameliorate
112 defects and physical and mental illness and conditions discovered
113 by the screening services, regardless of whether these services
114 are included in the state plan. The division may include in its
115 periodic screening and diagnostic program those discretionary
116 services authorized under the federal regulations adopted to
117 implement Title XIX of the federal Social Security Act, as
118 amended. The division, in obtaining physical therapy services,
119 occupational therapy services, and services for individuals with
120 speech, hearing and language disorders, may enter into a
121 cooperative agreement with the State Department of Education for
122 the provision of those services to handicapped students by public
123 school districts using state funds that are provided from the
124 appropriation to the Department of Education to obtain federal
125 matching funds through the division. The division, in obtaining
126 medical and psychological evaluations for children in the custody
127 of the State Department of Human Services may enter into a

128 cooperative agreement with the State Department of Human Services
129 for the provision of those services using state funds that are
130 provided from the appropriation to the Department of Human
131 Services to obtain federal matching funds through the division.
132 (6) Physician's services. The division shall allow
133 twelve (12) physician visits annually. All fees for physicians'
134 services that are covered only by Medicaid shall be reimbursed at
135 ninety percent (90%) of the rate established on January 1, 1999,
136 and as adjusted each January thereafter, under Medicare (Title
137 XVIII of the federal Social Security Act, as amended), and which
138 shall in no event be less than seventy percent (70%) of the rate
139 established on January 1, 1994.
140 (7) (a) Home health services for eligible persons, not
141 to exceed in cost the prevailing cost of nursing facility
142 services, not to exceed sixty (60) visits per year. All home
143 health visits must be precertified as required by the division.
144 (b) Repealed.
145 (8) Emergency medical transportation services. On
146 January 1, 1994, emergency medical transportation services shall
147 be reimbursed at seventy percent (70%) of the rate established
148 under Medicare (Title XVIII of the federal Social Security Act, as
149 amended). "Emergency medical transportation services" shall mean,
150 but shall not be limited to, the following services by a properly
151 permitted ambulance operated by a properly licensed provider in
152 accordance with the Emergency Medical Services Act of 1974
153 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
154 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
155 (vi) disposable supplies, (vii) similar services.
156 (9) (a) Legend and other drugs as may be determined by
157 the division. The division shall establish a mandatory preferred
158 drug list. Drugs not on the mandatory preferred drug list shall
159 be made available by utilizing prior authorization procedures
160 established by the division. The division may seek to establish

161 relationships with other states in order to lower acquisition
162 costs of prescription drugs to include single source and innovator
163 multiple source drugs or generic drugs. In addition, if allowed
164 by federal law or regulation, the division may seek to establish
165 relationships with and negotiate with other countries to
166 facilitate the acquisition of prescription drugs to include single
167 source and innovator multiple source drugs or generic drugs, if
168 that will lower the acquisition costs of those prescription drugs.
169 The division shall allow for a combination of prescriptions for
170 single source and innovator multiple source drugs and generic
171 drugs to meet the needs of the beneficiaries, not to exceed four
172 (4) prescriptions for single source or innovator multiple source
173 drugs per month for each noninstitutionalized Medicaid
174 beneficiary. The division shall allow for unlimited prescriptions
175 for generic drugs. The division shall establish a prior
176 authorization process under which the division may allow more than
177 four (4) prescriptions for single source or innovator multiple
178 source drugs per month for those beneficiaries whose conditions
179 require a medical regimen that will not be covered by the
180 combination of prescriptions for single source and innovator
181 multiple source drugs and generic drugs that are otherwise allowed
182 under this paragraph (9). The voluntary preferred drug list shall
183 be expanded to function in the interim in order to have a
184 manageable prior authorization system, thereby minimizing
185 disruption of service to beneficiaries. The division shall not
186 reimburse for any portion of a prescription that exceeds a
187 thirty-four-day supply of the drug based on the daily dosage.
188 The division shall develop and implement a program of payment
189 for additional pharmacist services, with payment to be based on
190 demonstrated savings, but in no case shall the total payment
191 exceed twice the amount of the dispensing fee.
192 All claims for drugs for dually eligible Medicare/Medicaid
193 beneficiaries that are paid for by Medicare must be submitted to

194 Medicare for payment before they may be processed by the
195 division's on-line payment system.
196 The division shall develop a pharmacy policy in which drugs
197 in tamper-resistant packaging that are prescribed for a resident
198 of a nursing facility but are not dispensed to the resident shall
199 be returned to the pharmacy and not billed to Medicaid, in
200 accordance with guidelines of the State Board of Pharmacy.
201 The division shall develop and implement a program that
202 requires Medicaid providers who prescribe drugs to use a
203 counterfeit-proof prescription pad for Medicaid prescriptions for
204 controlled substances; however, this shall not prevent the filling
205 of prescriptions for controlled substances by means of electronic
206 communications between a prescriber and pharmacist as allowed by
207 federal law.
208 (b) Payment by the division for covered
209 multisource drugs shall be limited to the lower of the upper
210 limits established and published by the Centers for Medicare and
211 Medicaid Services (CMS) plus a dispensing fee, or the estimated
212 acquisition cost (EAC) as determined by the division, plus a
213 dispensing fee, or the providers' usual and customary charge to
214 the general public.
215 Payment for other covered drugs, other than multisource drugs
216 with CMS upper limits, shall not exceed the lower of the estimated
217 acquisition cost as determined by the division, plus a dispensing
218 fee or the providers' usual and customary charge to the general
219 public.
220 Payment for nonlegend or over-the-counter drugs covered by
221 the division shall be reimbursed at the lower of the division's
222 estimated shelf price or the providers' usual and customary charge
223 to the general public.
224 The dispensing fee for each new or refill prescription,
225 including nonlegend or over-the-counter drugs covered by the

226 division, shall be not less than Three Dollars and Ninety-one
227 Cents ($3.91), as determined by the division.
228 The division shall not reimburse for single source or
229 innovator multiple source drugs if there are equally effective
230 generic equivalents available and if the generic equivalents are
231 the least expensive.
232 It is the intent of the Legislature that the pharmacists
233 providers be reimbursed for the reasonable costs of filling and
234 dispensing prescriptions for Medicaid beneficiaries.
235 (10) Dental care that is an adjunct to treatment of an
236 acute medical or surgical condition; services of oral surgeons and
237 dentists in connection with surgery related to the jaw or any
238 structure contiguous to the jaw or the reduction of any fracture
239 of the jaw or any facial bone; and emergency dental extractions
240 and treatment related thereto. On July 1, 1999, all fees for
241 dental care and surgery under authority of this paragraph (10)
242 shall be increased to one hundred sixty percent (160%) of the
243 amount of the reimbursement rate that was in effect on June 30,
244 1999. It is the intent of the Legislature to encourage more
245 dentists to participate in the Medicaid program.
246 (11) Eyeglasses for all Medicaid beneficiaries who have
247 (a) had surgery on the eyeball or ocular muscle that results in a
248 vision change for which eyeglasses or a change in eyeglasses is
249 medically indicated within six (6) months of the surgery and is in
250 accordance with policies established by the division, or (b) one
251 (1) pair every five (5) years and in accordance with policies
252 established by the division. In either instance, the eyeglasses
253 must be prescribed by a physician skilled in diseases of the eye
254 or an optometrist, whichever the beneficiary may select.
255 (12) Intermediate care facility services.
256 (a) The division shall make full payment to all
257 intermediate care facilities for the mentally retarded for each
258 day, not exceeding eighty-four (84) days per year, that a patient

259 is absent from the facility on home leave. Payment may be made
260 for the following home leave days in addition to the
261 eighty-four-day limitation: Christmas, the day before Christmas,
262 the day after Christmas, Thanksgiving, the day before Thanksgiving
263 and the day after Thanksgiving.
264 (b) All state-owned intermediate care facilities
265 for the mentally retarded shall be reimbursed on a full reasonable
266 cost basis.
267 (13) Family planning services, including drugs,
268 supplies and devices, when those services are under the
269 supervision of a physician or nurse practitioner.
270 (14) Clinic services. Such diagnostic, preventive,
271 therapeutic, rehabilitative or palliative services furnished to an
272 outpatient by or under the supervision of a physician or dentist
273 in a facility that is not a part of a hospital but that is
274 organized and operated to provide medical care to outpatients.
275 Clinic services shall include any services reimbursed as
276 outpatient hospital services that may be rendered in such a
277 facility, including those that become so after July 1, 1991. On
278 July 1, 1999, all fees for physicians' services reimbursed under
279 authority of this paragraph (14) shall be reimbursed at ninety
280 percent (90%) of the rate established on January 1, 1999, and as
281 adjusted each January thereafter, under Medicare (Title XVIII of
282 the federal Social Security Act, as amended), and which shall in
283 no event be less than seventy percent (70%) of the rate
284 established on January 1, 1994. On July 1, 1999, all fees for
285 dentists' services reimbursed under authority of this paragraph
286 (14) shall be increased to one hundred sixty percent (160%) of the
287 amount of the reimbursement rate that was in effect on June 30,
288 1999.
289 (15) Home- and community-based services for the elderly
290 and disabled, as provided under Title XIX of the federal Social
291 Security Act, as amended, under waivers, subject to the

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

324 (17) Durable medical equipment services and medical
325 supplies. Precertification of durable medical equipment and
326 medical supplies must be obtained as required by the division.
327 The Division of Medicaid may require durable medical equipment
328 providers to obtain a surety bond in the amount and to the
329 specifications as established by the Balanced Budget Act of 1997.
330 (18) (a) Notwithstanding any other provision of this
331 section to the contrary, the division shall make additional
332 reimbursement to hospitals that serve a disproportionate share of
333 low-income patients and that meet the federal requirements for
334 those payments as provided in Section 1923 of the federal Social
335 Security Act and any applicable regulations. However, from and
336 after January 1, 1999, no public hospital shall participate in the
337 Medicaid disproportionate share program unless the public hospital
338 participates in an intergovernmental transfer program as provided
339 in Section 1903 of the federal Social Security Act and any
340 applicable regulations.
341 (b) The division shall establish a Medicare Upper
342 Payment Limits Program, as defined in Section 1902(a)(30) of the
343 federal Social Security Act and any applicable federal
344 regulations, for hospitals, and may establish a Medicare Upper
345 Payments Limits Program for nursing facilities. The division
346 shall assess each hospital and, if the program is established for
347 nursing facilities, shall assess each nursing facility, based on
348 Medicaid utilization or other appropriate method consistent with
349 federal regulations. The assessment will remain in effect as long
350 as the state participates in the Medicare Upper Payment Limits
351 Program. The division shall make additional reimbursement to
352 hospitals and, if the program is established for nursing
353 facilities, shall make additional reimbursement to nursing
354 facilities, for the Medicare Upper Payment Limits, as defined in
355 Section 1902(a)(30) of the federal Social Security Act and any

356 applicable federal regulations. This subparagraph (b) shall stand
357 repealed from and after July 1, 2005.
358 (19) (a) Perinatal risk management services. The
359 division shall promulgate regulations to be effective from and
360 after October 1, 1988, to establish a comprehensive perinatal
361 system for risk assessment of all pregnant and infant Medicaid
362 recipients and for management, education and follow-up for those
363 who are determined to be at risk. Services to be performed
364 include case management, nutrition assessment/counseling,
365 psychosocial assessment/counseling and health education.
366 (b) Early intervention system services. The
367 division shall cooperate with the State Department of Health,
368 acting as lead agency, in the development and implementation of a
369 statewide system of delivery of early intervention services, under
370 Part C of the Individuals with Disabilities Education Act (IDEA).
371 The State Department of Health shall certify annually in writing
372 to the executive director of the division the dollar amount of
373 state early intervention funds available that will be utilized as
374 a certified match for Medicaid matching funds. Those funds then
375 shall be used to provide expanded targeted case management
376 services for Medicaid eligible children with special needs who are
377 eligible for the state's early intervention system.
378 Qualifications for persons providing service coordination shall be
379 determined by the State Department of Health and the Division of
380 Medicaid.
381 (20) Home- and community-based services for physically
382 disabled approved services as allowed by a waiver from the United
383 States Department of Health and Human Services for home- and
384 community-based services for physically disabled people using
385 state funds that are provided from the appropriation to the State
386 Department of Rehabilitation Services and used to match federal
387 funds under a cooperative agreement between the division and the
388 department, provided that funds for these services are

389 specifically appropriated to the Department of Rehabilitation
390 Services.

391 (21) Nurse practitioner services. Services furnished
392 by a registered nurse who is licensed and certified by the
393 Mississippi Board of Nursing as a nurse practitioner, including,
394 but not limited to, nurse anesthetists, nurse midwives, family
395 nurse practitioners, family planning nurse practitioners,
396 pediatric nurse practitioners, obstetrics-gynecology nurse
397 practitioners and neonatal nurse practitioners, under regulations
398 adopted by the division. Reimbursement for those services shall
399 not exceed ninety percent (90%) of the reimbursement rate for
400 comparable services rendered by a physician.

401 (22) Ambulatory services delivered in federally
402 qualified health centers, rural health centers and clinics of the
403 local health departments of the State Department of Health for
404 individuals eligible for Medicaid under this article based on
405 reasonable costs as determined by the division.

406 (23) Inpatient psychiatric services. Inpatient
407 psychiatric services to be determined by the division for
408 recipients under age twenty-one (21) that are provided under the
409 direction of a physician in an inpatient program in a licensed
410 acute care psychiatric facility or in a licensed psychiatric
411 residential treatment facility, before the recipient reaches age
412 twenty-one (21) or, if the recipient was receiving the services
413 immediately before he or she reached age twenty-one (21), before
414 the earlier of the date he or she no longer requires the services
415 or the date he or she reaches age twenty-two (22), as provided by
416 federal regulations. Precertification of inpatient days and
417 residential treatment days must be obtained as required by the
418 division.

419 (24) [Deleted]

420 (25) [Deleted]

421 (26) Hospice care. As used in this paragraph, the term
422 "hospice care" means a coordinated program of active professional
423 medical attention within the home and outpatient and inpatient
424 care that treats the terminally ill patient and family as a unit,
425 employing a medically directed interdisciplinary team. The
426 program provides relief of severe pain or other physical symptoms
427 and supportive care to meet the special needs arising out of
428 physical, psychological, spiritual, social and economic stresses
429 that are experienced during the final stages of illness and during
430 dying and bereavement and meets the Medicare requirements for
431 participation as a hospice as provided in federal regulations.
432 (27) Group health plan premiums and cost sharing if it
433 is cost effective as defined by the United States Secretary of
434 Health and Human Services.
435 (28) Other health insurance premiums that are cost
436 effective as defined by the United States Secretary of Health and
437 Human Services. Medicare eligible must have Medicare Part B
438 before other insurance premiums can be paid.
439 (29) The Division of Medicaid may apply for a waiver
440 from the United States Department of Health and Human Services for
441 home- and community-based services for developmentally disabled
442 people using state funds that are provided from the appropriation
443 to the State Department of Mental Health and/or funds transferred
444 to the department by a political subdivision or instrumentality of
445 the state and used to match federal funds under a cooperative
446 agreement between the division and the department, provided that
447 funds for these services are specifically appropriated to the
448 Department of Mental Health and/or transferred to the department
449 by a political subdivision or instrumentality of the state.
450 (30) Pediatric skilled nursing services for eligible
451 persons under twenty-one (21) years of age.
452 (31) Targeted case management services for children
453 with special needs, under waivers from the United States

454 Department of Health and Human Services, using state funds that
455 are provided from the appropriation to the Mississippi Department
456 of Human Services and used to match federal funds under a
457 cooperative agreement between the division and the department.
458 (32) Care and services provided in Christian Science
459 Sanatoria listed and certified by the Commission for Accreditation
460 of Christian Science Nursing Organizations/Facilities, Inc.,
461 rendered in connection with treatment by prayer or spiritual means
462 to the extent that those services are subject to reimbursement
463 under Section 1903 of the federal Social Security Act.
464 (33) Podiatrist services.
465 (34) Assisted living services as provided through home-
466 and community-based services under Title XIX of the federal Social
467 Security Act, as amended, subject to the availability of funds
468 specifically appropriated for that purpose by the Legislature.
469 (35) Services and activities authorized in Sections
470 43-27-101 and 43-27-103, using state funds that are provided from
471 the appropriation to the State Department of Human Services and
472 used to match federal funds under a cooperative agreement between
473 the division and the department.
474 (36) Nonemergency transportation services for
475 Medicaid-eligible persons, to be provided by the Division of
476 Medicaid. The division may contract with additional entities to
477 administer nonemergency transportation services as it deems
478 necessary. All providers shall have a valid driver's license,
479 vehicle inspection sticker, valid vehicle license tags and a
480 standard liability insurance policy covering the vehicle. The
481 division may pay providers a flat fee based on mileage tiers, or
482 in the alternative, may reimburse on actual miles traveled. The
483 division may apply to the Center for Medicare and Medicaid
484 Services (CMS) for a waiver to draw federal matching funds for
485 nonemergency transportation services as a covered service instead
486 of an administrative cost.

487 (37) [Deleted]
488 (38) Chiropractic services. A chiropractor's manual
489 manipulation of the spine to correct a subluxation, if x-ray
490 demonstrates that a subluxation exists and if the subluxation has
491 resulted in a neuromusculoskeletal condition for which
492 manipulation is appropriate treatment, and related spinal x-rays
493 performed to document these conditions. Reimbursement for
494 chiropractic services shall not exceed Seven Hundred Dollars
495 ($700.00) per year per beneficiary.
496 (39) Dually eligible Medicare/Medicaid beneficiaries.
497 The division shall pay the Medicare deductible and coinsurance
498 amounts for services available under Medicare, as determined by
499 the division.
500 (40) [Deleted]
501 (41) Services provided by the State Department of
502 Rehabilitation Services for the care and rehabilitation of persons
503 with spinal cord injuries or traumatic brain injuries, as allowed
504 under waivers from the United States Department of Health and
505 Human Services, using up to seventy-five percent (75%) of the
506 funds that are appropriated to the Department of Rehabilitation
507 Services from the Spinal Cord and Head Injury Trust Fund
508 established under Section 37-33-261 and used to match federal
509 funds under a cooperative agreement between the division and the
510 department.
511 (42) Notwithstanding any other provision in this
512 article to the contrary, the division may develop a population
513 health management program for women and children health services
514 through the age of one (1) year. This program is primarily for
515 obstetrical care associated with low birth weight and pre-term
516 babies. The division may apply to the federal Centers for
517 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
518 any other waivers that may enhance the program. In order to
519 effect cost savings, the division may develop a revised payment

520 methodology that may include at-risk capitated payments, and may
521 require member participation in accordance with the terms and
522 conditions of an approved federal waiver.

523 (43) The division shall provide reimbursement,
524 according to a payment schedule developed by the division, for
525 smoking cessation medications for pregnant women during their
526 pregnancy and other Medicaid-eligible women who are of
527 child-bearing age.

528 (44) Nursing facility services for the severely
529 disabled.

530 (a) Severe disabilities include, but are not
531 limited to, spinal cord injuries, closed head injuries and
532 ventilator dependent patients.

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

537 (45) Physician assistant services. Services furnished
538 by a physician assistant who is licensed by the State Board of
539 Medical Licensure and is practicing with physician supervision
540 under regulations adopted by the board, under regulations adopted
541 by the division. Reimbursement for those services shall not
542 exceed ninety percent (90%) of the reimbursement rate for
543 comparable services rendered by a physician.

544 (46) The division shall make application to the federal
545 Centers for Medicare and Medicaid Services (CMS) for a waiver to
546 develop and provide services for children with serious emotional
547 disturbances as defined in Section 43-14-1(1), which may include
548 home- and community-based services, case management services or
549 managed care services through mental health providers certified by
550 the Department of Mental Health. The division may implement and
551 provide services under this waivered program only if funds for
552 these services are specifically appropriated for this purpose by

553 the Legislature, or if funds are voluntarily provided by affected
554 agencies.
555 (47) (a) Notwithstanding any other provision in this
556 article to the contrary, the division, in conjunction with the
557 State Department of Health, shall develop and implement disease
558 management programs for individuals with asthma, diabetes or
559 hypertension, including the use of grants, waivers, demonstrations
560 or other projects as necessary.
561 (b) Participation in any disease management
562 program implemented under this paragraph (47) is optional with the
563 individual. An individual must affirmatively elect to participate
564 in the disease management program in order to participate.
565 (c) An individual who participates in the disease
566 management program has the option of participating in the
567 prescription drug home delivery component of the program at any
568 time while participating in the program. An individual must
569 affirmatively elect to participate in the prescription drug home
570 delivery component in order to participate.
571 (d) An individual who participates in the disease
572 management program may elect to discontinue participation in the
573 program at any time. An individual who participates in the
574 prescription drug home delivery component may elect to discontinue
575 participation in the prescription drug home delivery component at
576 any time.
577 (e) The division shall send written notice to all
578 individuals who participate in the disease management program
579 informing them that they may continue using their local pharmacy
580 or any other pharmacy of their choice to obtain their prescription
581 drugs while participating in the program.
582 (f) Prescription drugs that are provided to
583 individuals under the prescription drug home delivery component
584 shall be limited only to those drugs that are used for the
585 treatment, management or care of asthma, diabetes or hypertension.

586 (48) Pediatric long-term acute care hospital services.
587 (a) Pediatric long-term acute care hospital
588 services means services provided to eligible persons under
589 twenty-one (21) years of age by a freestanding Medicare-certified
590 hospital that has an average length of inpatient stay greater than
591 twenty-five (25) days and that is primarily engaged in providing
592 chronic or long-term medical care to persons under twenty-one (21)
593 years of age.
594 (b) The services under this paragraph (48) shall
595 be reimbursed as a separate category of hospital services.
596 (49) The division shall establish co-payments and/or
597 coinsurance for all Medicaid services for which co-payments and/or
598 coinsurance are allowable under federal law or regulation, and
599 shall set the amount of the co-payment and/or coinsurance for each
600 of those services at the maximum amount allowable under federal
601 law or regulation.
602 (50) Services provided by the State Department of
603 Rehabilitation Services for the care and rehabilitation of persons
604 who are deaf and blind, as allowed under waivers from the United
605 States Department of Health and Human Services to provide home-
606 and community-based services using state funds that are provided
607 from the appropriation to the State Department of Rehabilitation
608 Services or if funds are voluntarily provided by another agency.
609 (51) Upon determination of Medicaid eligibility and in
610 association with annual redetermination of Medicaid eligibility,
611 beneficiaries shall be encouraged to undertake a physical
612 examination that will establish a base-line level of health and
613 identification of a usual and customary source of care (a medical
614 home) to aid utilization of disease management tools. This
615 physical examination and utilization of these disease management
616 tools shall be consistent with current United States Preventive
617 Services Task Force or other recognized authority recommendations.

618 For persons who are determined ineligible for Medicaid, the
619 division will provide information and direction for accessing
620 medical care and services in the area of their residence.
621 (52) Notwithstanding any provisions of this article,
622 the division may pay enhanced reimbursement fees related to trauma
623 care, as determined by the division in conjunction with the State
624 Department of Health, using funds appropriated to the State
625 Department of Health for trauma care and services and used to
626 match federal funds under a cooperative agreement between the
627 division and the State Department of Health. The division, in
628 conjunction with the State Department of Health, may use grants,
629 waivers, demonstrations, or other projects as necessary in the
630 development and implementation of this reimbursement program.
631 (53) Mental health counseling services provided by a
632 duly licensed professional counselor (LPC).
633 Notwithstanding any other provision of this article to the
634 contrary, the division shall reduce the rate of reimbursement to
635 providers for any service provided under this section by five
636 percent (5%) of the allowed amount for that service. However, the
637 reduction in the reimbursement rates required by this paragraph
638 shall not apply to inpatient hospital services, nursing facility
639 services, intermediate care facility services, psychiatric
640 residential treatment facility services, pharmacy services
641 provided under paragraph (9) of this section, or any service
642 provided by the University of Mississippi Medical Center or a
643 state agency, a state facility or a public agency that either
644 provides its own state match through intergovernmental transfer or
645 certification of funds to the division, or a service for which the
646 federal government sets the reimbursement methodology and rate.
647 In addition, the reduction in the reimbursement rates required by
648 this paragraph shall not apply to case management services and
649 home-delivered meals provided under the home- and community-based
650 services program for the elderly and disabled by a planning and

651 development district (PDD). Planning and development districts
652 participating in the home- and community-based services program
653 for the elderly and disabled as case management providers shall be
654 reimbursed for case management services at the maximum rate
655 approved by the Centers for Medicare and Medicaid Services (CMS).
656 The division may pay to those providers who participate in
657 and accept patient referrals from the division's emergency room
658 redirection program a percentage, as determined by the division,
659 of savings achieved according to the performance measures and
660 reduction of costs required of that program.
661 Notwithstanding any provision of this article, except as
662 authorized in the following paragraph and in Section 43-13-139,
663 neither (a) the limitations on quantity or frequency of use of or
664 the fees or charges for any of the care or services available to
665 recipients under this section, nor (b) the payments or rates of
666 reimbursement to providers rendering care or services authorized
667 under this section to recipients, may be increased, decreased or
668 otherwise changed from the levels in effect on July 1, 1999,
669 unless they are authorized by an amendment to this section by the
670 Legislature. However, the restriction in this paragraph shall not
671 prevent the division from changing the payments or rates of
672 reimbursement to providers without an amendment to this section
673 whenever those changes are required by federal law or regulation,
674 or whenever those changes are necessary to correct administrative
675 errors or omissions in calculating those payments or rates of
676 reimbursement.
677 Notwithstanding any provision of this article, no new groups
678 or categories of recipients and new types of care and services may
679 be added without enabling legislation from the Mississippi
680 Legislature, except that the division may authorize those changes
681 without enabling legislation when the addition of recipients or
682 services is ordered by a court of proper authority. The executive
683 director shall keep the Governor advised on a timely basis of the

684 funds available for expenditure and the projected expenditures.
685 If current or projected expenditures of the division during the
686 first six (6) months of any fiscal year are reasonably anticipated
687 to be not more than twelve percent (12%) above the amount of the
688 appropriated funds that is authorized to be expended during the
689 first allotment period of the fiscal year, the Governor, after
690 consultation with the executive director, may discontinue any or
691 all of the payment of the types of care and services as provided
692 in this section that are deemed to be optional services under
693 Title XIX of the federal Social Security Act, as amended, and when
694 necessary may institute any other cost containment measures on any
695 program or programs authorized under the article to the extent
696 allowed under the federal law governing that program or programs.
697 If current or projected expenditures of the division during the
698 first six (6) months of any fiscal year can be reasonably
699 anticipated to exceed the amount of the appropriated funds that is
700 authorized to be expended during the first allotment period of the
701 fiscal year by more than twelve percent (12%), the Governor, after
702 consultation with the executive director, shall discontinue any or
703 all of the payment of the types of care and services as provided
704 in this section that are deemed to be optional services under
705 Title XIX of the federal Social Security Act, as amended, for any
706 period necessary to ensure that the actual expenditures of the
707 division will not exceed the amount of the appropriated funds that
708 is authorized to be expended during the first allotment period of
709 the fiscal year by more than twelve percent (12%), and when
710 necessary shall institute any other cost containment measures on
711 any program or programs authorized under the article to the extent
712 allowed under the federal law governing that program or programs.
713 If current or projected expenditures of the division during the
714 last six (6) months of any fiscal year can be reasonably
715 anticipated to exceed the amount of the appropriated funds that is
716 authorized to be expended during the second allotment period of

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

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

743 This section shall stand repealed on July 1, 2007.

744 **SECTION 2.** This act shall take effect and be in force from
745 and after July 1, 2005.

ST: Medicaid reimbursable; mental health services provided by licensed professional counselor.