MISSISSIPPI LEGISLATURE REGULAR SESSION 2005

By: Senator(s) Dearing

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2059

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

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

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

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

16 (1) Inpatient hospital services.

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

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

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37 subparagraph (c) shall stand repealed on July 1, 2005.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

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

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

66 (d) When a facility of a category that does not
67 require a certificate of need for construction and that could not
68 be eligible for Medicaid reimbursement is constructed to nursing
69 facility specifications for licensure and certification, and the
70 facility is subsequently converted to a nursing facility under a
71 certificate of need that authorizes conversion only and the
72 applicant for the certificate of need was assessed an application
73 review fee based on capital expenditures incurred in constructing
74 the facility, the division shall allow reimbursement for capital
75 expenditures necessary for construction of the facility that were
76 incurred within the twenty-four (24) consecutive calendar months
77 immediately preceding the date that the certificate of need
78 authorizing the conversion was issued, to the same extent that
79 reimbursement would be allowed for construction of a new nursing
80 facility under a certificate of need that authorizes that
81 construction. The reimbursement authorized in this subparagraph
82 (d) may be made only to facilities the construction of which was
83 completed after June 30, 1989. Before the division shall be
84 authorized to make the reimbursement authorized in this
85 subparagraph (d), the division first must have received approval
86 from the Centers for Medicare and Medicaid Services (CMS) of the
87 change in the state Medicaid plan providing for the reimbursement.

88 (e) The division shall develop and implement, not
89 later than January 1, 2001, a case-mix payment add-on determined
90 by time studies and other valid statistical data that will
91 reimburse a nursing facility for the additional cost of caring for
92 a resident who has a diagnosis of Alzheimer's or other related
93 dementia and exhibits symptoms that require special care. Any

94 such case-mix add-on payment shall be supported by a determination
95 of additional cost. The division shall also develop and implement
96 as part of the fair rental reimbursement system for nursing
97 facility beds, an Alzheimer's resident bed depreciation enhanced
98 reimbursement system that will provide an incentive to encourage
99 nursing facilities to convert or construct beds for residents with
100 Alzheimer's or other related dementia.
101 (f) The division shall develop and implement an
102 assessment process for long-term care services. The division may
103 provide the assessment and related functions directly or through
104 contract with the area agencies on aging.
105 The division shall apply for necessary federal waivers to
106 assure that additional services providing alternatives to nursing
107 facility care are made available to applicants for nursing
108 facility care.
109 (5) Periodic screening and diagnostic services for
110 individuals under age twenty-one (21) years as are needed to
111 identify physical and mental defects and to provide health care
112 treatment and other measures designed to correct or ameliorate
113 defects and physical and mental illness and conditions discovered
114 by the screening services, regardless of whether these services
115 are included in the state plan. The division shall reimburse
116 early periodic screening and diagnostic treatment (EPSDT) services
117 provided by a licensed professional counselor (LPC). The division
118 may include in its periodic screening and diagnostic program those
119 discretionary services authorized under the federal regulations
120 adopted to implement Title XIX of the federal Social Security Act,
121 as amended. The division, in obtaining physical therapy services,
122 occupational therapy services, and services for individuals with
123 speech, hearing and language disorders, may enter into a
124 cooperative agreement with the State Department of Education for
125 the provision of those services to handicapped students by public
126 school districts using state funds that are provided from the

127 appropriation to the Department of Education to obtain federal
128 matching funds through the division. The division, in obtaining
129 medical and psychological evaluations for children in the custody
130 of the State Department of Human Services may enter into a
131 cooperative agreement with the State Department of Human Services
132 for the provision of those services using state funds that are
133 provided from the appropriation to the Department of Human
134 Services to obtain federal matching funds through the division.

135 (6) Physician's services. The division shall allow
136 twelve (12) physician visits annually. All fees for physicians'
137 services that are covered only by Medicaid shall be reimbursed at
138 ninety percent (90%) of the rate established on January 1, 1999,
139 and as adjusted each January thereafter, under Medicare (Title
140 XVIII of the federal Social Security Act, as amended), and which
141 shall in no event be less than seventy percent (70%) of the rate
142 established on January 1, 1994.

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

147 (b) Repealed.

148 (8) Emergency medical transportation services. On
149 January 1, 1994, emergency medical transportation services shall
150 be reimbursed at seventy percent (70%) of the rate established
151 under Medicare (Title XVIII of the federal Social Security Act, as
152 amended). "Emergency medical transportation services" shall mean,
153 but shall not be limited to, the following services by a properly
154 permitted ambulance operated by a properly licensed provider in
155 accordance with the Emergency Medical Services Act of 1974
156 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
157 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
158 (vi) disposable supplies, (vii) similar services.

159 (9) (a) Legend and other drugs as may be determined by
160 the division. The division shall establish a mandatory preferred
161 drug list. Drugs not on the mandatory preferred drug list shall
162 be made available by utilizing prior authorization procedures
163 established by the division. The division may seek to establish
164 relationships with other states in order to lower acquisition
165 costs of prescription drugs to include single source and innovator
166 multiple source drugs or generic drugs. In addition, if allowed
167 by federal law or regulation, the division may seek to establish
168 relationships with and negotiate with other countries to
169 facilitate the acquisition of prescription drugs to include single
170 source and innovator multiple source drugs or generic drugs, if
171 that will lower the acquisition costs of those prescription drugs.
172 The division shall allow for a combination of prescriptions for
173 single source and innovator multiple source drugs and generic
174 drugs to meet the needs of the beneficiaries, not to exceed four
175 (4) prescriptions for single source or innovator multiple source
176 drugs per month for each noninstitutionalized Medicaid
177 beneficiary. The division shall allow for unlimited prescriptions
178 for generic drugs. The division shall establish a prior
179 authorization process under which the division may allow more than
180 four (4) prescriptions for single source or innovator multiple
181 source drugs per month for those beneficiaries whose conditions
182 require a medical regimen that will not be covered by the
183 combination of prescriptions for single source and innovator
184 multiple source drugs and generic drugs that are otherwise allowed
185 under this paragraph (9). The voluntary preferred drug list shall
186 be expanded to function in the interim in order to have a
187 manageable prior authorization system, thereby minimizing
188 disruption of service to beneficiaries. The division shall not
189 reimburse for any portion of a prescription that exceeds a
190 thirty-four-day supply of the drug based on the daily dosage.

191 The division shall develop and implement a program of payment
192 for additional pharmacist services, with payment to be based on
193 demonstrated savings, but in no case shall the total payment
194 exceed twice the amount of the dispensing fee.
195 All claims for drugs for dually eligible Medicare/Medicaid
196 beneficiaries that are paid for by Medicare must be submitted to
197 Medicare for payment before they may be processed by the
198 division's on-line payment system.
199 The division shall develop a pharmacy policy in which drugs
200 in tamper-resistant packaging that are prescribed for a resident
201 of a nursing facility but are not dispensed to the resident shall
202 be returned to the pharmacy and not billed to Medicaid, in
203 accordance with guidelines of the State Board of Pharmacy.
204 The division shall develop and implement a program that
205 requires Medicaid providers who prescribe drugs to use a
206 counterfeit-proof prescription pad for Medicaid prescriptions for
207 controlled substances; however, this shall not prevent the filling
208 of prescriptions for controlled substances by means of electronic
209 communications between a prescriber and pharmacist as allowed by
210 federal law.
211 (b) Payment by the division for covered
212 multisource drugs shall be limited to the lower of the upper
213 limits established and published by the Centers for Medicare and
214 Medicaid Services (CMS) plus a dispensing fee, or the estimated
215 acquisition cost (EAC) as determined by the division, plus a
216 dispensing fee, or the providers' usual and customary charge to
217 the general public.
218 Payment for other covered drugs, other than multisource drugs
219 with CMS upper limits, shall not exceed the lower of the estimated
220 acquisition cost as determined by the division, plus a dispensing
221 fee or the providers' usual and customary charge to the general
222 public.

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

227 The dispensing fee for each new or refill prescription,
228 including nonlegend or over-the-counter drugs covered by the
229 division, shall be not less than Three Dollars and Ninety-one
230 Cents ($3.91), as determined by the division.

231 The division shall not reimburse for single source or
232 innovator multiple source drugs if there are equally effective
233 generic equivalents available and if the generic equivalents are
234 the least expensive.

235 It is the intent of the Legislature that the pharmacists
236 providers be reimbursed for the reasonable costs of filling and
237 dispensing prescriptions for Medicaid beneficiaries.

238 (10) Dental care that is an adjunct to treatment of an
239 acute medical or surgical condition; services of oral surgeons and
240 dentists in connection with surgery related to the jaw or any
241 structure contiguous to the jaw or the reduction of any fracture
242 of the jaw or any facial bone; and emergency dental extractions
243 and treatment related thereto. On July 1, 1999, all fees for
244 dental care and surgery under authority of this paragraph (10)
245 shall be increased to one hundred sixty percent (160%) of the
246 amount of the reimbursement rate that was in effect on June 30,
247 1999. It is the intent of the Legislature to encourage more
248 dentists to participate in the Medicaid program.

249 (11) Eyeglasses for all Medicaid beneficiaries who have
250 (a) had surgery on the eyeball or ocular muscle that results in a
251 vision change for which eyeglasses or a change in eyeglasses is
252 medically indicated within six (6) months of the surgery and is in
253 accordance with policies established by the division, or (b) one
254 (1) pair every five (5) years and in accordance with policies
255 established by the division. In either instance, the eyeglasses

256 must be prescribed by a physician skilled in diseases of the eye
257 or an optometrist, whichever the beneficiary may select.
258 (12) Intermediate care facility services.
259 (a) The division shall make full payment to all
260 intermediate care facilities for the mentally retarded for each
261 day, not exceeding eighty-four (84) days per year, that a patient
262 is absent from the facility on home leave. Payment may be made
263 for the following home leave days in addition to the
264 eighty-four-day limitation: Christmas, the day before Christmas,
265 the day after Christmas, Thanksgiving, the day before Thanksgiving
266 and the day after Thanksgiving.
267 (b) All state-owned intermediate care facilities
268 for the mentally retarded shall be reimbursed on a full reasonable
269 cost basis.
270 (13) Family planning services, including drugs,
271 supplies and devices, when those services are under the
272 supervision of a physician or nurse practitioner.
273 (14) Clinic services. Such diagnostic, preventive,
274 therapeutic, rehabilitative or palliative services furnished to an
275 outpatient by or under the supervision of a physician or dentist
276 in a facility that is not a part of a hospital but that is
277 organized and operated to provide medical care to outpatients.
278 Clinic services shall include any services reimbursed as
279 outpatient hospital services that may be rendered in such a
280 facility, including those that become so after July 1, 1991. On
281 July 1, 1999, all fees for physicians' services reimbursed under
282 authority of this paragraph (14) shall be reimbursed at ninety
283 percent (90%) of the rate established on January 1, 1999, and as
284 adjusted each January thereafter, under Medicare (Title XVIII of
285 the federal Social Security Act, as amended), and which shall in
286 no event be less than seventy percent (70%) of the rate
287 established on January 1, 1994. On July 1, 1999, all fees for
288 dentists' services reimbursed under authority of this paragraph

289 (14) shall be increased to one hundred sixty percent (160%) of the
290 amount of the reimbursement rate that was in effect on June 30,
291 1999.

292 (15) Home- and community-based services for the elderly
293 and disabled, as provided under Title XIX of the federal Social
294 Security Act, as amended, under waivers, subject to the
295 availability of funds specifically appropriated for that purpose
296 by the Legislature.

297 (16) Mental health services. Approved therapeutic and
298 case management services (a) provided by an approved regional
299 mental health/retardation center established under Sections
300 41-19-31 through 41-19-39, or by another community mental health
301 service provider meeting the requirements of the Department of
302 Mental Health to be an approved mental health/retardation center
303 if determined necessary by the Department of Mental Health, using
304 state funds that are provided from the appropriation to the State
305 Department of Mental Health and/or funds transferred to the
306 department by a political subdivision or instrumentality of the
307 state and used to match federal funds under a cooperative
308 agreement between the division and the department, or (b) provided
309 by a facility that is certified by the State Department of Mental
310 Health to provide therapeutic and case management services, to be
311 reimbursed on a fee for service basis, or (c) provided in the
312 community by a facility or program operated by the Department of
313 Mental Health. Any such services provided by a facility described
314 in subparagraph (b) must have the prior approval of the division
315 to be reimbursable under this section. After June 30, 1997,
316 mental health services provided by regional mental
317 health/retardation centers established under Sections 41-19-31
318 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
319 and/or their subsidiaries and divisions, or by psychiatric
320 residential treatment facilities as defined in Section 43-11-1, or
321 by another community mental health service provider meeting the

322 requirements of the Department of Mental Health to be an approved
323 mental health/retardation center if determined necessary by the
324 Department of Mental Health, shall not be included in or provided
325 under any capitated managed care pilot program provided for under
326 paragraph (24) of this section.

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

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

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

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

361 (19) (a) Perinatal risk management services. The
362 division shall promulgate regulations to be effective from and
363 after October 1, 1988, to establish a comprehensive perinatal
364 system for risk assessment of all pregnant and infant Medicaid
365 recipients and for management, education and follow-up for those
366 who are determined to be at risk. Services to be performed
367 include case management, nutrition assessment/counseling,
368 psychosocial assessment/counseling and health education.

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

384 (20) Home- and community-based services for physically
385 disabled approved services as allowed by a waiver from the United
386 States Department of Health and Human Services for home- and
387 community-based services for physically disabled people using

388 state funds that are provided from the appropriation to the State
389 Department of Rehabilitation Services and used to match federal
390 funds under a cooperative agreement between the division and the
391 department, provided that funds for these services are
392 specifically appropriated to the Department of Rehabilitation
393 Services.

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

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

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

420 residential treatment days must be obtained as required by the
421 division.

422 (24) [Deleted]

423 (25) [Deleted]

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

435 (27) Group health plan premiums and cost sharing if it
436 is cost effective as defined by the United States Secretary of
437 Health and Human Services.

438 (28) Other health insurance premiums that are cost
439 effective as defined by the United States Secretary of Health and
440 Human Services. Medicare eligible must have Medicare Part B
441 before other insurance premiums can be paid.

442 (29) The Division of Medicaid may apply for a waiver
443 from the United States Department of Health and Human Services for
444 home- and community-based services for developmentally disabled
445 people using state funds that are provided from the appropriation
446 to the State Department of Mental Health and/or funds transferred
447 to the department by a political subdivision or instrumentality of
448 the state and used to match federal funds under a cooperative
449 agreement between the division and the department, provided that
450 funds for these services are specifically appropriated to the
451 Department of Mental Health and/or transferred to the department
452 by a political subdivision or instrumentality of the state.

453 (30) Pediatric skilled nursing services for eligible
454 persons under twenty-one (21) years of age.
455 (31) Targeted case management services for children
456 with special needs, under waivers from the United States
457 Department of Health and Human Services, using state funds that
458 are provided from the appropriation to the Mississippi Department
459 of Human Services and used to match federal funds under a
460 cooperative agreement between the division and the department.
461 (32) Care and services provided in Christian Science
462 Sanatoria listed and certified by the Commission for Accreditation
463 of Christian Science Nursing Organizations/Facilities, Inc.,
464 rendered in connection with treatment by prayer or spiritual means
465 to the extent that those services are subject to reimbursement
466 under Section 1903 of the federal Social Security Act.
467 (33) Podiatrist services.
468 (34) Assisted living services as provided through home-
469 and community-based services under Title XIX of the federal Social
470 Security Act, as amended, subject to the availability of funds
471 specifically appropriated for that purpose by the Legislature.
472 (35) Services and activities authorized in Sections
473 43-27-101 and 43-27-103, using state funds that are provided from
474 the appropriation to the State Department of Human Services and
475 used to match federal funds under a cooperative agreement between
476 the division and the department.
477 (36) Nonemergency transportation services for
478 Medicaid-eligible persons, to be provided by the Division of
479 Medicaid. The division may contract with additional entities to
480 administer nonemergency transportation services as it deems
481 necessary. All providers shall have a valid driver's license,
482 vehicle inspection sticker, valid vehicle license tags and a
483 standard liability insurance policy covering the vehicle. The
484 division may pay providers a flat fee based on mileage tiers, or
485 in the alternative, may reimburse on actual miles traveled. The

486 division may apply to the Center for Medicare and Medicaid
487 Services (CMS) for a waiver to draw federal matching funds for
488 nonemergency transportation services as a covered service instead
489 of an administrative cost.

490 (37) [Deleted]

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

499 (39) Dually eligible Medicare/Medicaid beneficiaries.
500 The division shall pay the Medicare deductible and coinsurance
501 amounts for services available under Medicare, as determined by
502 the division.

503 (40) [Deleted]

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

514 (42) Notwithstanding any other provision in this
515 article to the contrary, the division may develop a population
516 health management program for women and children health services
517 through the age of one (1) year. This program is primarily for
518 obstetrical care associated with low birth weight and pre-term

519 babies. The division may apply to the federal Centers for
520 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
521 any other waivers that may enhance the program. In order to
522 effect cost savings, the division may develop a revised payment
523 methodology that may include at-risk capitated payments, and may
524 require member participation in accordance with the terms and
525 conditions of an approved federal waiver.
526 (43) The division shall provide reimbursement,
527 according to a payment schedule developed by the division, for
528 smoking cessation medications for pregnant women during their
529 pregnancy and other Medicaid-eligible women who are of
530 child-bearing age.
531 (44) Nursing facility services for the severely
532 disabled.
533 (a) Severe disabilities include, but are not
534 limited to, spinal cord injuries, closed head injuries and
535 ventilator dependent patients.
536 (b) Those services must be provided in a long-term
537 care nursing facility dedicated to the care and treatment of
538 persons with severe disabilities, and shall be reimbursed as a
539 separate category of nursing facilities.
540 (45) Physician assistant services. Services furnished
541 by a physician assistant who is licensed by the State Board of
542 Medical Licensure and is practicing with physician supervision
543 under regulations adopted by the board, under regulations adopted
544 by the division. Reimbursement for those services shall not
545 exceed ninety percent (90%) of the reimbursement rate for
546 comparable services rendered by a physician.
547 (46) The division shall make application to the federal
548 Centers for Medicare and Medicaid Services (CMS) for a waiver to
549 develop and provide services for children with serious emotional
550 disturbances as defined in Section 43-14-1(1), which may include
551 home- and community-based services, case management services or

552 managed care services through mental health providers certified by
553 the Department of Mental Health. The division may implement and
554 provide services under this waivered program only if funds for
555 these services are specifically appropriated for this purpose by
556 the Legislature, or if funds are voluntarily provided by affected
557 agencies.

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

564 (b) Participation in any disease management
565 program implemented under this paragraph (47) is optional with the
566 individual. An individual must affirmatively elect to participate
567 in the disease management program in order to participate.

568 (c) An individual who participates in the disease
569 management program has the option of participating in the
570 prescription drug home delivery component of the program at any
571 time while participating in the program. An individual must
572 affirmatively elect to participate in the prescription drug home
573 delivery component in order to participate.

574 (d) An individual who participates in the disease
575 management program may elect to discontinue participation in the
576 program at any time. An individual who participates in the
577 prescription drug home delivery component may elect to discontinue
578 participation in the prescription drug home delivery component at
579 any time.

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

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

618 physical examination and utilization of these disease management
619 tools shall be consistent with current United States Preventive
620 Services Task Force or other recognized authority recommendations.

621 For persons who are determined ineligible for Medicaid, the
622 division will provide information and direction for accessing
623 medical care and services in the area of their residence.

624 (52) Notwithstanding any provisions of this article,
625 the division may pay enhanced reimbursement fees related to trauma
626 care, as determined by the division in conjunction with the State
627 Department of Health, using funds appropriated to the State
628 Department of Health for trauma care and services and used to
629 match federal funds under a cooperative agreement between the
630 division and the State Department of Health. The division, in
631 conjunction with the State Department of Health, may use grants,
632 waivers, demonstrations, or other projects as necessary in the
633 development and implementation of this reimbursement program.

634 Notwithstanding any other provision of this article to the
635 contrary, the division shall reduce the rate of reimbursement to
636 providers for any service provided under this section by five
637 percent (5%) of the allowed amount for that service. However, the
638 reduction in the reimbursement rates required by this paragraph
639 shall not apply to inpatient hospital services, nursing facility
640 services, intermediate care facility services, psychiatric
641 residential treatment facility services, pharmacy services
642 provided under paragraph (9) of this section, or any service
643 provided by the University of Mississippi Medical Center or a
644 state agency, a state facility or a public agency that either
645 provides its own state match through intergovernmental transfer or
646 certification of funds to the division, or a service for which the
647 federal government sets the reimbursement methodology and rate.
648 In addition, the reduction in the reimbursement rates required by
649 this paragraph shall not apply to case management services and
650 home-delivered meals provided under the home- and community-based

651 services program for the elderly and disabled by a planning and
652 development district (PDD). Planning and development districts
653 participating in the home- and community-based services program
654 for the elderly and disabled as case management providers shall be
655 reimbursed for case management services at the maximum rate
656 approved by the Centers for Medicare and Medicaid Services (CMS).

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

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

678 Notwithstanding any provision of this article, no new groups
679 or categories of recipients and new types of care and services may
680 be added without enabling legislation from the Mississippi
681 Legislature, except that the division may authorize those changes
682 without enabling legislation when the addition of recipients or
683 services is ordered by a court of proper authority. The executive

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

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

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

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

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

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