By: Senator(s) Cuevas, Gollott, Doxey, Brown To: Public Health and Welfare

SENATE BILL NO. 2326

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO DIRECT THE DIVISION OF MEDICAID TO IMPOSE A CO-PAYMENT
3 REQUIREMENT FOR PATIENT EMERGENCY VISITS TO A HOSPITAL, AND TO
4 LIMIT THE REIMBURSABLE EMERGENCY VISITS TO THREE PER PATIENT PER
5 YEAR; AND FOR RELATED PURPOSES.

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

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

9 43-13-117. Medicaid as authorized by this article shall
10 include payment of part or all of the costs, at the discretion of
11 the division, 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37 subparagraph (c) shall stand repealed on July 1, 2005.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. The division shall
39 impose a Fifty Dollar ($50.00) co-payment requirement per patient
40 per reimbursable emergency room visit, and shall limit such
41 reimbursable visits to three (3) emergency visits per patient per
42 fiscal year. Where the same services are reimbursed as clinic
43 services, the division may revise the rate or methodology of
44 outpatient reimbursement to maintain consistency, efficiency,
45 economy and quality of care.
46 (3) Laboratory and x-ray services.
47 (4) Nursing facility services.
48 (a) The division shall make full payment to
49 nursing facilities for each day, not exceeding fifty-two (52) days
50 per year, that a patient is absent from the facility on home
51 leave. Payment may be made for the following home leave days in
52 addition to the fifty-two-day limitation: Christmas, the day
53 before Christmas, the day after Christmas, Thanksgiving, the day
54 before Thanksgiving and the day after Thanksgiving.
55 (b) From and after July 1, 1997, the division
56 shall implement the integrated case-mix payment and quality
57 monitoring system, which includes the fair rental system for
58 property costs and in which recapture of depreciation is
59 eliminated. The division may reduce the payment for hospital
60 leave and therapeutic home leave days to the lower of the case-mix

61 category as computed for the resident on leave using the
62 assessment being utilized for payment at that point in time, or a
63 case-mix score of 1.000 for nursing facilities, and shall compute
64 case-mix scores of residents so that only services provided at the
65 nursing facility are considered in calculating a facility's per
66 diem.

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

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

92 (e) The division shall develop and implement, not
93 later than January 1, 2001, a case-mix payment add-on determined

94 by time studies and other valid statistical data that will
95 reimburse a nursing facility for the additional cost of caring for
96 a resident who has a diagnosis of Alzheimer's or other related
97 dementia and exhibits symptoms that require special care. Any
98 such case-mix add-on payment shall be supported by a determination
99 of additional cost. The division shall also develop and implement
100 as part of the fair rental reimbursement system for nursing
101 facility beds, an Alzheimer's resident bed depreciation enhanced
102 reimbursement system that will provide an incentive to encourage
103 nursing facilities to convert or construct beds for residents with
104 Alzheimer's or other related dementia.

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

109 The division shall apply for necessary federal waivers to
110 assure that additional services providing alternatives to nursing
111 facility care are made available to applicants for nursing
112 facility care.

113 (5) Periodic screening and diagnostic services for
114 individuals under age twenty-one (21) years as are needed to
115 identify physical and mental defects and to provide health care
116 treatment and other measures designed to correct or ameliorate
117 defects and physical and mental illness and conditions discovered
118 by the screening services, regardless of whether these services
119 are included in the state plan. The division may include in its
120 periodic screening and diagnostic program those discretionary
121 services authorized under the federal regulations adopted to
122 implement Title XIX of the federal Social Security Act, as
123 amended. The division, in obtaining physical therapy services,
124 occupational therapy services, and services for individuals with
125 speech, hearing and language disorders, may enter into a
126 cooperative agreement with the State Department of Education for

127 the provision of those services to handicapped students by public
128 school districts using state funds that are provided from the
129 appropriation to the Department of Education to obtain federal
130 matching funds through the division. The division, in obtaining
131 medical and psychological evaluations for children in the custody
132 of the State Department of Human Services may enter into a
133 cooperative agreement with the State Department of Human Services
134 for the provision of those services using state funds that are
135 provided from the appropriation to the Department of Human
136 Services to obtain federal matching funds through the division.
137 (6) Physician's services. The division shall allow
138 twelve (12) physician visits annually. All fees for physicians'
139 services that are covered only by Medicaid shall be reimbursed at
140 ninety percent (90%) of the rate established on January 1, 1999,
141 and as adjusted each January thereafter, under Medicare (Title
142 XVIII of the federal Social Security Act, as amended), and which
143 shall in no event be less than seventy percent (70%) of the rate
144 established on January 1, 1994.
145 (7) (a) Home health services for eligible persons, not
146 to exceed in cost the prevailing cost of nursing facility
147 services, not to exceed sixty (60) visits per year. All home
148 health visits must be precertified as required by the division.
149 (b) Repealed.
150 (8) Emergency medical transportation services. On
151 January 1, 1994, emergency medical transportation services shall
152 be reimbursed at seventy percent (70%) of the rate established
153 under Medicare (Title XVIII of the federal Social Security Act, as
154 amended). "Emergency medical transportation services" shall mean,
155 but shall not be limited to, the following services by a properly
156 permitted ambulance operated by a properly licensed provider in
157 accordance with the Emergency Medical Services Act of 1974
158 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced

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

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

223 fee or the providers' usual and customary charge to the general
224 public.
225 Payment for nonlegend or over-the-counter drugs covered by
226 the division shall be reimbursed at the lower of the division's
227 estimated shelf price or the providers' usual and customary charge
228 to the general public.
229 The dispensing fee for each new or refill prescription,
230 including nonlegend or over-the-counter drugs covered by the
231 division, shall be not less than Three Dollars and Ninety-one
232 Cents ($3.91), as determined by the division.
233 The division shall not reimburse for single source or
234 innovator multiple source drugs if there are equally effective
235 generic equivalents available and if the generic equivalents are
236 the least expensive.
237 It is the intent of the Legislature that the pharmacists
238 providers be reimbursed for the reasonable costs of filling and
239 dispensing prescriptions for Medicaid beneficiaries.
240 (10) Dental care that is an adjunct to treatment of an
241 acute medical or surgical condition; services of oral surgeons and
242 dentists in connection with surgery related to the jaw or any
243 structure contiguous to the jaw or the reduction of any fracture
244 of the jaw or any facial bone; and emergency dental extractions
245 and treatment related thereto. On July 1, 1999, all fees for
246 dental care and surgery under authority of this paragraph (10)
247 shall be increased to one hundred sixty percent (160%) of the
248 amount of the reimbursement rate that was in effect on June 30,
249 1999. It is the intent of the Legislature to encourage more
250 dentists to participate in the Medicaid program.
251 (11) Eyeglasses for all Medicaid beneficiaries who have
252 (a) had surgery on the eyeball or ocular muscle that results in a
253 vision change for which eyeglasses or a change in eyeglasses is
254 medically indicated within six (6) months of the surgery and is in
255 accordance with policies established by the division, or (b) one

256 (1) pair every five (5) years and in accordance with policies
257 established by the division. In either instance, the eyeglasses
258 must be prescribed by a physician skilled in diseases of the eye
259 or an optometrist, whichever the beneficiary may select.
260 (12) Intermediate care facility services.
261 (a) The division shall make full payment to all
262 intermediate care facilities for the mentally retarded for each
263 day, not exceeding eighty-four (84) days per year, that a patient
264 is absent from the facility on home leave. Payment may be made
265 for the following home leave days in addition to the
266 eighty-four-day limitation: Christmas, the day before Christmas,
267 the day after Christmas, Thanksgiving, the day before Thanksgiving
268 and the day after Thanksgiving.
269 (b) All state-owned intermediate care facilities
270 for the mentally retarded shall be reimbursed on a full reasonable
271 cost basis.
272 (13) Family planning services, including drugs,
273 supplies and devices, when those services are under the
274 supervision of a physician or nurse practitioner.
275 (14) Clinic services. Such diagnostic, preventive,
276 therapeutic, rehabilitative or palliative services furnished to an
277 outpatient by or under the supervision of a physician or dentist
278 in a facility that is not a part of a hospital but that is
279 organized and operated to provide medical care to outpatients.
280 Clinic services shall include any services reimbursed as
281 outpatient hospital services that may be rendered in such a
282 facility, including those that become so after July 1, 1991. On
283 July 1, 1999, all fees for physicians' services reimbursed under
284 authority of this paragraph (14) shall be reimbursed at ninety
285 percent (90%) of the rate established on January 1, 1999, and as
286 adjusted each January thereafter, under Medicare (Title XVIII of
287 the federal Social Security Act, as amended), and which shall in
288 no event be less than seventy percent (70%) of the rate

289 established on January 1, 1994. On July 1, 1999, all fees for
290 dentists' services reimbursed under authority of this paragraph
291 (14) shall be increased to one hundred sixty percent (160%) of the
292 amount of the reimbursement rate that was in effect on June 30,
293 1999.

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

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

322 residential treatment facilities as defined in Section 43-11-1, or
323 by another community mental health service provider meeting the
324 requirements of the Department of Mental Health to be an approved
325 mental health/retardation center if determined necessary by the
326 Department of Mental Health, shall not be included in or provided
327 under any capitated managed care pilot program provided for under
328 paragraph (24) of this section.

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

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

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

355 as the state participates in the Medicare Upper Payment Limits
356 Program. The division shall make additional reimbursement to
357 hospitals and, if the program is established for nursing
358 facilities, shall make additional reimbursement to nursing
359 facilities, for the Medicare Upper Payment Limits, as defined in
360 Section 1902(a)(30) of the federal Social Security Act and any
361 applicable federal regulations. This subparagraph (b) shall stand
362 repealed from and after July 1, 2005.
363 (19) (a) Perinatal risk management services. The
364 division shall promulgate regulations to be effective from and
365 after October 1, 1988, to establish a comprehensive perinatal
366 system for risk assessment of all pregnant and infant Medicaid
367 recipients and for management, education and follow-up for those
368 who are determined to be at risk. Services to be performed
369 include case management, nutrition assessment/counseling,
370 psychosocial assessment/counseling and health education.
371 (b) Early intervention system services. The
372 division shall cooperate with the State Department of Health,
373 acting as lead agency, in the development and implementation of a
374 statewide system of delivery of early intervention services, under
375 Part C of the Individuals with Disabilities Education Act (IDEA).
376 The State Department of Health shall certify annually in writing
377 to the executive director of the division the dollar amount of
378 state early intervention funds available that will be utilized as
379 a certified match for Medicaid matching funds. Those funds then
380 shall be used to provide expanded targeted case management
381 services for Medicaid eligible children with special needs who are
382 eligible for the state's early intervention system.
383 Qualifications for persons providing service coordination shall be
384 determined by the State Department of Health and the Division of
385 Medicaid.
386 (20) Home- and community-based services for physically
387 disabled approved services as allowed by a waiver from the United

388 States Department of Health and Human Services for home- and
389 community-based services for physically disabled people using
390 state funds that are provided from the appropriation to the State
391 Department of Rehabilitation Services and used to match federal
392 funds under a cooperative agreement between the division and the
393 department, provided that funds for these services are
394 specifically appropriated to the Department of Rehabilitation
395 Services.

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

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

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

421 federal regulations. Precertification of inpatient days and
422 residential treatment days must be obtained as required by the
423 division.

424 (24) [Deleted]

425 (25) [Deleted]

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

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

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

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

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

486 division may pay providers a flat fee based on mileage tiers, or
487 in the alternative, may reimburse on actual miles traveled. The
488 division may apply to the Center for Medicare and Medicaid
489 Services (CMS) for a waiver to draw federal matching funds for
490 nonemergency transportation services as a covered service instead
491 of an administrative cost.

492 (37) [Deleted]

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

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

505 (40) [Deleted]

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

516 (42) Notwithstanding any other provision in this
517 article to the contrary, the division may develop a population
518 health management program for women and children health services

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

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

533 (44) Nursing facility services for the severely
534 disabled.

535 (a) Severe disabilities include, but are not
536 limited to, spinal cord injuries, closed head injuries and
537 ventilator dependent patients.

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

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

549 (46) The division shall make application to the federal
550 Centers for Medicare and Medicaid Services (CMS) for a waiver to
551 develop and provide services for children with serious emotional

552 disturbances as defined in Section 43-14-1(1), which may include
553 home- and community-based services, case management services or
554 managed care services through mental health providers certified by
555 the Department of Mental Health. The division may implement and
556 provide services under this waivered program only if funds for
557 these services are specifically appropriated for this purpose by
558 the Legislature, or if funds are voluntarily provided by affected
559 agencies.

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

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

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

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

582 (e) The division shall send written notice to all
583 individuals who participate in the disease management program
584 informing them that they may continue using their local pharmacy

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

618 identification of a usual and customary source of care (a medical
619 home) to aid utilization of disease management tools. This
620 physical examination and utilization of these disease management
621 tools shall be consistent with current United States Preventive
622 Services Task Force or other recognized authority recommendations.
623 For persons who are determined ineligible for Medicaid, the
624 division will provide information and direction for accessing
625 medical care and services in the area of their residence.
626 (52) Notwithstanding any provisions of this article,
627 the division may pay enhanced reimbursement fees related to trauma
628 care, as determined by the division in conjunction with the State
629 Department of Health, using funds appropriated to the State
630 Department of Health for trauma care and services and used to
631 match federal funds under a cooperative agreement between the
632 division and the State Department of Health. The division, in
633 conjunction with the State Department of Health, may use grants,
634 waivers, demonstrations, or other projects as necessary in the
635 development and implementation of this reimbursement program.
636 Notwithstanding any other provision of this article to the
637 contrary, the division shall reduce the rate of reimbursement to
638 providers for any service provided under this section by five
639 percent (5%) of the allowed amount for that service. However, the
640 reduction in the reimbursement rates required by this paragraph
641 shall not apply to inpatient hospital services, nursing facility
642 services, intermediate care facility services, psychiatric
643 residential treatment facility services, pharmacy services
644 provided under paragraph (9) of this section, or any service
645 provided by the University of Mississippi Medical Center or a
646 state agency, a state facility or a public agency that either
647 provides its own state match through intergovernmental transfer or
648 certification of funds to the division, or a service for which the
649 federal government sets the reimbursement methodology and rate.
650 In addition, the reduction in the reimbursement rates required by

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

684 without enabling legislation when the addition of recipients or
685 services is ordered by a court of proper authority. The executive
686 director shall keep the Governor advised on a timely basis of the
687 funds available for expenditure and the projected expenditures.
688 If current or projected expenditures of the division during the
689 first six (6) months of any fiscal year are reasonably anticipated
690 to be not more than twelve percent (12%) above the amount of the
691 appropriated funds that is authorized to be expended during the
692 first allotment period of the fiscal year, the Governor, after
693 consultation with the executive director, may discontinue any or
694 all of the payment of the types of care and services as provided
695 in this section that are deemed to be optional services under
696 Title XIX of the federal Social Security Act, as amended, and when
697 necessary may institute any other cost containment measures on any
698 program or programs authorized under the article to the extent
699 allowed under the federal law governing that program or programs.
700 If current or projected expenditures of the division during the
701 first six (6) months of any fiscal year can be reasonably
702 anticipated to exceed the amount of the appropriated funds that is
703 authorized to be expended during the first allotment period of the
704 fiscal year by more than twelve percent (12%), the Governor, after
705 consultation with the executive director, shall discontinue any or
706 all of the payment of the types of care and services as provided
707 in this section that are deemed to be optional services under
708 Title XIX of the federal Social Security Act, as amended, for any
709 period necessary to ensure that the actual expenditures of the
710 division will not exceed the amount of the appropriated funds that
711 is authorized to be expended during the first allotment period of
712 the fiscal year by more than twelve percent (12%), and when
713 necessary shall institute any other cost containment measures on
714 any program or programs authorized under the article to the extent
715 allowed under the federal law governing that program or programs.
716 If current or projected expenditures of the division during the

717 last six (6) months of any fiscal year can be reasonably
718 anticipated to exceed the amount of the appropriated funds that is
719 authorized to be expended during the second allotment period of
720 the fiscal year, the Governor, after consultation with the
721 executive director, shall discontinue any or all of the payment of
722 the types of care and services as provided in this section that
723 are deemed to be optional services under Title XIX of the federal
724 Social Security Act, as amended, for any period necessary to
725 ensure that the actual expenditures of the division will not
726 exceed the amount of the appropriated funds that is authorized to
727 be expended during the second allotment period of the fiscal year,
728 and when necessary shall institute any other cost containment
729 measures on any program or programs authorized under the article
730 to the extent allowed under the federal law governing that program
731 or programs. It is the intent of the Legislature that the
732 expenditures of the division during any fiscal year shall not
733 exceed the amounts appropriated to the division for that fiscal
734 year.

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

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

747 **SECTION 2.** This act shall take effect and be in force from
748 and after June 30, 2005.