

By: Representative Snowden

To: Medicaid; Appropriations

HOUSE BILL NO. 1083

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,  
2 TO PROVIDE MEDICAID COVERAGE FOR A BREAST PROSTHESIS AND BRASSIERE  
3 FOR MEDICAID-ELIGIBLE WOMEN WHO HAVE UNDERGONE A MASTECTOMY OR  
4 RELATED BREAST RECONSTRUCTION PROCEDURES FOR THE TREATMENT OF  
5 BREAST CANCER.

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 and children under the age of six (6) years if certified  
23 as medically 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.

37 (2) Outpatient hospital services.

38 (a) Emergency services. The division shall allow  
39 six (6) medically necessary emergency room visits per beneficiary  
40 per fiscal year.

41 (b) Other outpatient hospital services. The  
42 division shall allow benefits for other medically necessary  
43 outpatient hospital services (such as chemotherapy, radiation,  
44 surgery and therapy). Where the same services are reimbursed as  
45 clinic services, the division may revise the rate or methodology  
46 of outpatient reimbursement to maintain consistency, efficiency,  
47 economy and quality of care.

48 (3) Laboratory and x-ray services.

49 (4) Nursing facility services.

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

57 (b) From and after July 1, 1997, the division  
58 shall implement the integrated case-mix payment and quality  
59 monitoring system, which includes the fair rental system for  
60 property costs and in which recapture of depreciation is

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

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

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

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

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

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

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

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

139 (6) Physician's services. The division shall allow  
140 twelve (12) physician visits annually. All fees for physicians'  
141 services that are covered only by Medicaid shall be reimbursed at  
142 ninety percent (90%) of the rate established on January 1, 1999,  
143 and as may be adjusted each July thereafter, under Medicare (Title  
144 XVIII of the federal Social Security Act, as amended). The  
145 division may develop and implement a different reimbursement model  
146 or schedule for physician's services provided by physicians based  
147 at an academic health care center and by physicians at rural  
148 health centers that are associated with an academic health care  
149 center.

150 (7) (a) Home health services for eligible persons, not  
151 to exceed in cost the prevailing cost of nursing facility  
152 services, not to exceed twenty-five (25) visits per year. All  
153 home health visits must be precertified as required by the  
154 division.

155 (b) Repealed.

156 (8) Emergency medical transportation services. On  
157 January 1, 1994, emergency medical transportation services shall  
158 be reimbursed at seventy percent (70%) of the rate established  
159 under Medicare (Title XVIII of the federal Social Security Act, as

160 amended). "Emergency medical transportation services" shall mean,  
161 but shall not be limited to, the following services by a properly  
162 permitted ambulance operated by a properly licensed provider in  
163 accordance with the Emergency Medical Services Act of 1974  
164 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced  
165 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,  
166 (vi) disposable supplies, (vii) similar services.

167 (9) (a) Legend and other drugs as may be determined by  
168 the division.

169 The division shall establish a mandatory preferred drug list.  
170 Drugs not on the mandatory preferred drug list shall be made  
171 available by utilizing prior authorization procedures established  
172 by the division.

173 The division may seek to establish relationships with other  
174 states in order to lower acquisition costs of prescription drugs  
175 to include single source and innovator multiple source drugs or  
176 generic drugs. In addition, if allowed by federal law or  
177 regulation, the division may seek to establish relationships with  
178 and negotiate with other countries to facilitate the acquisition  
179 of prescription drugs to include single source and innovator  
180 multiple source drugs or generic drugs, if that will lower the  
181 acquisition costs of those prescription drugs.

182 The division shall allow for a combination of prescriptions  
183 for single source and innovator multiple source drugs and generic  
184 drugs to meet the needs of the beneficiaries, not to exceed five  
185 (5) prescriptions per month for each noninstitutionalized Medicaid  
186 beneficiary, with not more than two (2) of those prescriptions  
187 being for single source or innovator multiple source drugs.

188 The executive director may approve specific maintenance drugs  
189 for beneficiaries with certain medical conditions, which may be  
190 prescribed and dispensed in three-month supply increments. The  
191 executive director may allow a state agency or agencies to be the  
192 sole source purchaser and distributor of hemophilia factor

193 medications, HIV/AIDS medications and other medications as  
194 determined by the executive director as allowed by federal  
195 regulations.

196       Drugs prescribed for a resident of a psychiatric residential  
197 treatment facility must be provided in true unit doses when  
198 available. The division may require that drugs not covered by  
199 Medicare Part D for a resident of a long-term care facility be  
200 provided in true unit doses when available. Those drugs that were  
201 originally billed to the division but are not used by a resident  
202 in any of those facilities shall be returned to the billing  
203 pharmacy for credit to the division, in accordance with the  
204 guidelines of the State Board of Pharmacy and any requirements of  
205 federal law and regulation. Drugs shall be dispensed to a  
206 recipient and only one (1) dispensing fee per month may be  
207 charged. The division shall develop a methodology for reimbursing  
208 for restocked drugs, which shall include a restock fee as  
209 determined by the division not exceeding Seven Dollars and  
210 Eighty-two Cents (\$7.82).

211       The voluntary preferred drug list shall be expanded to  
212 function in the interim in order to have a manageable prior  
213 authorization system, thereby minimizing disruption of service to  
214 beneficiaries.

215       Except for those specific maintenance drugs approved by the  
216 executive director, the division shall not reimburse for any  
217 portion of a prescription that exceeds a thirty-one-day supply of  
218 the drug based on the daily dosage.

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

223       All claims for drugs for dually eligible Medicare/Medicaid  
224 beneficiaries that are paid for by Medicare must be submitted to

225 Medicare for payment before they may be processed by the  
226 division's on-line payment system.

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

232         The division shall develop and implement a method or methods  
233 by which the division will provide on a regular basis to Medicaid  
234 providers who are authorized to prescribe drugs, information about  
235 the costs to the Medicaid program of single source drugs and  
236 innovator multiple source drugs, and information about other drugs  
237 that may be prescribed as alternatives to those single source  
238 drugs and innovator multiple source drugs and the costs to the  
239 Medicaid program of those alternative drugs.

240         Notwithstanding any law or regulation, information obtained  
241 or maintained by the division regarding the prescription drug  
242 program, including trade secrets and manufacturer or labeler  
243 pricing, is confidential and not subject to disclosure except to  
244 other state agencies.

245                 (b) Payment by the division for covered  
246 multisource drugs shall be limited to the lower of the upper  
247 limits established and published by the Centers for Medicare and  
248 Medicaid Services (CMS) plus a dispensing fee, or the estimated  
249 acquisition cost (EAC) as determined by the division, plus a  
250 dispensing fee, or the providers' usual and customary charge to  
251 the general public.

252         Payment for other covered drugs, other than multisource drugs  
253 with CMS upper limits, shall not exceed the lower of the estimated  
254 acquisition cost as determined by the division, plus a dispensing  
255 fee or the providers' usual and customary charge to the general  
256 public.

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

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

265 The division shall not reimburse for single source or  
266 innovator multiple source drugs if there are equally effective  
267 generic equivalents available and if the generic equivalents are  
268 the least expensive.

269 It is the intent of the Legislature that the pharmacists  
270 providers be reimbursed for the reasonable costs of filling and  
271 dispensing prescriptions for Medicaid beneficiaries.

272 (10) Dental care that is an adjunct to treatment of an  
273 acute medical or surgical condition; services of oral surgeons and  
274 dentists in connection with surgery related to the jaw or any  
275 structure contiguous to the jaw or the reduction of any fracture  
276 of the jaw or any facial bone; and emergency dental extractions  
277 and treatment related thereto. On July 1, 1999, all fees for  
278 dental care and surgery under authority of this paragraph (10)  
279 shall be increased to one hundred sixty percent (160%) of the  
280 amount of the reimbursement rate that was in effect on June 30,  
281 1999. It is the intent of the Legislature to encourage more  
282 dentists to participate in the Medicaid program.

283 (11) Eyeglasses for all Medicaid beneficiaries who have  
284 (a) had surgery on the eyeball or ocular muscle that results in a  
285 vision change for which eyeglasses or a change in eyeglasses is  
286 medically indicated within six (6) months of the surgery and is in  
287 accordance with policies established by the division, or (b) one  
288 (1) pair every five (5) years and in accordance with policies  
289 established by the division. In either instance, the eyeglasses

290 must be prescribed by a physician skilled in diseases of the eye  
291 or an optometrist, whichever the beneficiary may select.

292 (12) Intermediate care facility services.

293 (a) The division shall make full payment to all  
294 intermediate care facilities for the mentally retarded for each  
295 day, not exceeding eighty-four (84) days per year, that a patient  
296 is absent from the facility on home leave. Payment may be made  
297 for the following home leave days in addition to the  
298 eighty-four-day limitation: Christmas, the day before Christmas,  
299 the day after Christmas, Thanksgiving, the day before Thanksgiving  
300 and the day after Thanksgiving.

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

304 (13) Family planning services, including drugs,  
305 supplies and devices, when those services are under the  
306 supervision of a physician or nurse practitioner.

307 (14) Clinic services. Such diagnostic, preventive,  
308 therapeutic, rehabilitative or palliative services furnished to an  
309 outpatient by or under the supervision of a physician or dentist  
310 in a facility that is not a part of a hospital but that is  
311 organized and operated to provide medical care to outpatients.  
312 Clinic services shall include any services reimbursed as  
313 outpatient hospital services that may be rendered in such a  
314 facility, including those that become so after July 1, 1991. On  
315 July 1, 1999, all fees for physicians' services reimbursed under  
316 authority of this paragraph (14) shall be reimbursed at ninety  
317 percent (90%) of the rate established on January 1, 1999, and as  
318 may be adjusted each July thereafter, under Medicare (Title XVIII  
319 of the federal Social Security Act, as amended). The division may  
320 develop and implement a different reimbursement model or schedule  
321 for physician's services provided by physicians based at an  
322 academic health care center and by physicians at rural health

323 centers that are associated with an academic health care center.  
324 On July 1, 1999, all fees for dentists' services reimbursed under  
325 authority of this paragraph (14) shall be increased to one hundred  
326 sixty percent (160%) of the amount of the reimbursement rate that  
327 was in effect on June 30, 1999.

328 (15) Home- and community-based services for the elderly  
329 and disabled, as provided under Title XIX of the federal Social  
330 Security Act, as amended, under waivers, subject to the  
331 availability of funds specifically appropriated for that purpose  
332 by the Legislature.

333 (16) Mental health services. Approved therapeutic and  
334 case management services (a) provided by an approved regional  
335 mental health/retardation center established under Sections  
336 41-19-31 through 41-19-39, or by another community mental health  
337 service provider meeting the requirements of the Department of  
338 Mental Health to be an approved mental health/retardation center  
339 if determined necessary by the Department of Mental Health, using  
340 state funds that are provided from the appropriation to the State  
341 Department of Mental Health and/or funds transferred to the  
342 department by a political subdivision or instrumentality of the  
343 state and used to match federal funds under a cooperative  
344 agreement between the division and the department, or (b) provided  
345 by a facility that is certified by the State Department of Mental  
346 Health to provide therapeutic and case management services, to be  
347 reimbursed on a fee for service basis, or (c) provided in the  
348 community by a facility or program operated by the Department of  
349 Mental Health. Any such services provided by a facility described  
350 in subparagraph (b) must have the prior approval of the division  
351 to be reimbursable under this section. After June 30, 1997,  
352 mental health services provided by regional mental  
353 health/retardation centers established under Sections 41-19-31  
354 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)  
355 and/or their subsidiaries and divisions, or by psychiatric

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

363           (17) Durable medical equipment services and medical  
364 supplies. Precertification of durable medical equipment and  
365 medical supplies must be obtained as required by the division.  
366 The Division of Medicaid may require durable medical equipment  
367 providers to obtain a surety bond in the amount and to the  
368 specifications as established by the Balanced Budget Act of 1997.

369           (18) (a) Notwithstanding any other provision of this  
370 section to the contrary, the division shall make additional  
371 reimbursement to hospitals that serve a disproportionate share of  
372 low-income patients and that meet the federal requirements for  
373 those payments as provided in Section 1923 of the federal Social  
374 Security Act and any applicable regulations. However, from and  
375 after January 1, 1999, no public hospital shall participate in the  
376 Medicaid disproportionate share program unless the public hospital  
377 participates in an intergovernmental transfer program as provided  
378 in Section 1903 of the federal Social Security Act and any  
379 applicable regulations.

380           (b) The division shall establish a Medicare Upper  
381 Payment Limits Program, as defined in Section 1902(a)(30) of the  
382 federal Social Security Act and any applicable federal  
383 regulations, for hospitals, and may establish a Medicare Upper  
384 Payments Limits Program for nursing facilities. The division  
385 shall assess each hospital and, if the program is established for  
386 nursing facilities, shall assess each nursing facility, based on  
387 Medicaid utilization or other appropriate method consistent with  
388 federal regulations. The assessment will remain in effect as long

389 as the state participates in the Medicare Upper Payment Limits  
390 Program. The division shall make additional reimbursement to  
391 hospitals and, if the program is established for nursing  
392 facilities, shall make additional reimbursement to nursing  
393 facilities, for the Medicare Upper Payment Limits, as defined in  
394 Section 1902(a)(30) of the federal Social Security Act and any  
395 applicable federal regulations.

396 (19) (a) Perinatal risk management services. The  
397 division shall promulgate regulations to be effective from and  
398 after October 1, 1988, to establish a comprehensive perinatal  
399 system for risk assessment of all pregnant and infant Medicaid  
400 recipients and for management, education and follow-up for those  
401 who are determined to be at risk. Services to be performed  
402 include case management, nutrition assessment/counseling,  
403 psychosocial assessment/counseling and health education.

404 (b) Early intervention system services. The  
405 division shall cooperate with the State Department of Health,  
406 acting as lead agency, in the development and implementation of a  
407 statewide system of delivery of early intervention services, under  
408 Part C of the Individuals with Disabilities Education Act (IDEA).  
409 The State Department of Health shall certify annually in writing  
410 to the executive director of the division the dollar amount of  
411 state early intervention funds available that will be utilized as  
412 a certified match for Medicaid matching funds. Those funds then  
413 shall be used to provide expanded targeted case management  
414 services for Medicaid eligible children with special needs who are  
415 eligible for the state's early intervention system.  
416 Qualifications for persons providing service coordination shall be  
417 determined by the State Department of Health and the Division of  
418 Medicaid.

419 (20) Home- and community-based services for physically  
420 disabled approved services as allowed by a waiver from the United  
421 States Department of Health and Human Services for home- and

422 community-based services for physically disabled people using  
423 state funds that are provided from the appropriation to the State  
424 Department of Rehabilitation Services and used to match federal  
425 funds under a cooperative agreement between the division and the  
426 department, provided that funds for these services are  
427 specifically appropriated to the Department of Rehabilitation  
428 Services.

429           (21) Nurse practitioner services. Services furnished  
430 by a registered nurse who is licensed and certified by the  
431 Mississippi Board of Nursing as a nurse practitioner, including,  
432 but not limited to, nurse anesthetists, nurse midwives, family  
433 nurse practitioners, family planning nurse practitioners,  
434 pediatric nurse practitioners, obstetrics-gynecology nurse  
435 practitioners and neonatal nurse practitioners, under regulations  
436 adopted by the division. Reimbursement for those services shall  
437 not exceed ninety percent (90%) of the reimbursement rate for  
438 comparable services rendered by a physician.

439           (22) Ambulatory services delivered in federally  
440 qualified health centers, rural health centers and clinics of the  
441 local health departments of the State Department of Health for  
442 individuals eligible for Medicaid under this article based on  
443 reasonable costs as determined by the division.

444           (23) Inpatient psychiatric services. Inpatient  
445 psychiatric services to be determined by the division for  
446 recipients under age twenty-one (21) that are provided under the  
447 direction of a physician in an inpatient program in a licensed  
448 acute care psychiatric facility or in a licensed psychiatric  
449 residential treatment facility, before the recipient reaches age  
450 twenty-one (21) or, if the recipient was receiving the services  
451 immediately before he or she reached age twenty-one (21), before  
452 the earlier of the date he or she no longer requires the services  
453 or the date he or she reaches age twenty-two (22), as provided by  
454 federal regulations. Precertification of inpatient days and

455 residential treatment days must be obtained as required by the  
456 division.

457 (24) [Deleted]

458 (25) [Deleted]

459 (26) Hospice care. As used in this paragraph, the term  
460 "hospice care" means a coordinated program of active professional  
461 medical attention within the home and outpatient and inpatient  
462 care that treats the terminally ill patient and family as a unit,  
463 employing a medically directed interdisciplinary team. The  
464 program provides relief of severe pain or other physical symptoms  
465 and supportive care to meet the special needs arising out of  
466 physical, psychological, spiritual, social and economic stresses  
467 that are experienced during the final stages of illness and during  
468 dying and bereavement and meets the Medicare requirements for  
469 participation as a hospice as provided in federal regulations.

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

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

477 (29) The Division of Medicaid may apply for a waiver  
478 from the United States Department of Health and Human Services for  
479 home- and community-based services for developmentally disabled  
480 people using state funds that are provided from the appropriation  
481 to the State Department of Mental Health and/or funds transferred  
482 to the department by a political subdivision or instrumentality of  
483 the state and used to match federal funds under a cooperative  
484 agreement between the division and the department, provided that  
485 funds for these services are specifically appropriated to the  
486 Department of Mental Health and/or transferred to the department  
487 by a political subdivision or instrumentality of the state.

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

490           (31) Targeted case management services for children  
491 with special needs, under waivers from the United States  
492 Department of Health and Human Services, using state funds that  
493 are provided from the appropriation to the Mississippi Department  
494 of Human Services and used to match federal funds under a  
495 cooperative agreement between the division and the department.

496           (32) Care and services provided in Christian Science  
497 Sanatoria listed and certified by the Commission for Accreditation  
498 of Christian Science Nursing Organizations/Facilities, Inc.,  
499 rendered in connection with treatment by prayer or spiritual means  
500 to the extent that those services are subject to reimbursement  
501 under Section 1903 of the federal Social Security Act.

502           (33) Podiatrist services.

503           (34) Assisted living services as provided through home-  
504 and community-based services under Title XIX of the federal Social  
505 Security Act, as amended, subject to the availability of funds  
506 specifically appropriated for that purpose by the Legislature.

507           (35) Services and activities authorized in Sections  
508 43-27-101 and 43-27-103, using state funds that are provided from  
509 the appropriation to the State Department of Human Services and  
510 used to match federal funds under a cooperative agreement between  
511 the division and the department.

512           (36) Nonemergency transportation services for  
513 Medicaid-eligible persons, to be provided by the Division of  
514 Medicaid. The division may contract with additional entities to  
515 administer nonemergency transportation services as it deems  
516 necessary. All providers shall have a valid driver's license,  
517 vehicle inspection sticker, valid vehicle license tags and a  
518 standard liability insurance policy covering the vehicle. The  
519 division may pay providers a flat fee based on mileage tiers, or  
520 in the alternative, may reimburse on actual miles traveled. The

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

525 (37) [Deleted]

526 (38) Chiropractic services. A chiropractor's manual  
527 manipulation of the spine to correct a subluxation, if x-ray  
528 demonstrates that a subluxation exists and if the subluxation has  
529 resulted in a neuromusculoskeletal condition for which  
530 manipulation is appropriate treatment, and related spinal x-rays  
531 performed to document these conditions. Reimbursement for  
532 chiropractic services shall not exceed Seven Hundred Dollars  
533 (\$700.00) per year per beneficiary.

534 (39) Dually eligible Medicare/Medicaid beneficiaries.  
535 The division shall pay the Medicare deductible and coinsurance  
536 amounts for services available under Medicare, as determined by  
537 the division.

538 (40) [Deleted]

539 (41) Services provided by the State Department of  
540 Rehabilitation Services for the care and rehabilitation of persons  
541 with spinal cord injuries or traumatic brain injuries, as allowed  
542 under waivers from the United States Department of Health and  
543 Human Services, using up to seventy-five percent (75%) of the  
544 funds that are appropriated to the Department of Rehabilitation  
545 Services from the Spinal Cord and Head Injury Trust Fund  
546 established under Section 37-33-261 and used to match federal  
547 funds under a cooperative agreement between the division and the  
548 department.

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

554 babies. The division may apply to the federal Centers for  
555 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or  
556 any other waivers that may enhance the program. In order to  
557 effect cost savings, the division may develop a revised payment  
558 methodology that may include at-risk capitated payments, and may  
559 require member participation in accordance with the terms and  
560 conditions of an approved federal waiver.

561 (43) The division shall provide reimbursement,  
562 according to a payment schedule developed by the division, for  
563 smoking cessation medications for pregnant women during their  
564 pregnancy and other Medicaid-eligible women who are of  
565 child-bearing age.

566 (44) Nursing facility services for the severely  
567 disabled.

568 (a) Severe disabilities include, but are not  
569 limited to, spinal cord injuries, closed head injuries and  
570 ventilator dependent patients.

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

575 (45) Physician assistant services. Services furnished  
576 by a physician assistant who is licensed by the State Board of  
577 Medical Licensure and is practicing with physician supervision  
578 under regulations adopted by the board, under regulations adopted  
579 by the division. Reimbursement for those services shall not  
580 exceed ninety percent (90%) of the reimbursement rate for  
581 comparable services rendered by a physician.

582 (46) The division shall make application to the federal  
583 Centers for Medicare and Medicaid Services (CMS) for a waiver to  
584 develop and provide services for children with serious emotional  
585 disturbances as defined in Section 43-14-1(1), which may include  
586 home- and community-based services, case management services or

587 managed care services through mental health providers certified by  
588 the Department of Mental Health. The division may implement and  
589 provide services under this waived program only if funds for  
590 these services are specifically appropriated for this purpose by  
591 the Legislature, or if funds are voluntarily provided by affected  
592 agencies.

593 (47) (a) Notwithstanding any other provision in this  
594 article to the contrary, the division, in conjunction with the  
595 State Department of Health, may develop and implement disease  
596 management programs for individuals with high-cost chronic  
597 diseases and conditions, including the use of grants, waivers,  
598 demonstrations or other projects as necessary.

599 (b) Participation in any disease management  
600 program implemented under this paragraph (47) is optional with the  
601 individual. An individual must affirmatively elect to participate  
602 in the disease management program in order to participate.

603 (c) An individual who participates in the disease  
604 management program has the option of participating in the  
605 prescription drug home delivery component of the program at any  
606 time while participating in the program. An individual must  
607 affirmatively elect to participate in the prescription drug home  
608 delivery component in order to participate.

609 (d) An individual who participates in the disease  
610 management program may elect to discontinue participation in the  
611 program at any time. An individual who participates in the  
612 prescription drug home delivery component may elect to discontinue  
613 participation in the prescription drug home delivery component at  
614 any time.

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

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

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

625 (a) Pediatric long-term acute care hospital  
626 services means services provided to eligible persons under  
627 twenty-one (21) years of age by a freestanding Medicare-certified  
628 hospital that has an average length of inpatient stay greater than  
629 twenty-five (25) days and that is primarily engaged in providing  
630 chronic or long-term medical care to persons under twenty-one (21)  
631 years of age.

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

634 (49) The division shall establish co-payments and/or  
635 coinsurance for all Medicaid services for which co-payments and/or  
636 coinsurance are allowable under federal law or regulation, and  
637 shall set the amount of the co-payment and/or coinsurance for each  
638 of those services at the maximum amount allowable under federal  
639 law or regulation.

640 (50) Services provided by the State Department of  
641 Rehabilitation Services for the care and rehabilitation of persons  
642 who are deaf and blind, as allowed under waivers from the United  
643 States Department of Health and Human Services to provide home-  
644 and community-based services using state funds that are provided  
645 from the appropriation to the State Department of Rehabilitation  
646 Services or if funds are voluntarily provided by another agency.

647 (51) Upon determination of Medicaid eligibility and in  
648 association with annual redetermination of Medicaid eligibility,  
649 beneficiaries shall be encouraged to undertake a physical  
650 examination that will establish a base-line level of health and  
651 identification of a usual and customary source of care (a medical  
652 home) to aid utilization of disease management tools. This

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

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

659 (52) Notwithstanding any provisions of this article,  
660 the division may pay enhanced reimbursement fees related to trauma  
661 care, as determined by the division in conjunction with the State  
662 Department of Health, using funds appropriated to the State  
663 Department of Health for trauma care and services and used to  
664 match federal funds under a cooperative agreement between the  
665 division and the State Department of Health. The division, in  
666 conjunction with the State Department of Health, may use grants,  
667 waivers, demonstrations, or other projects as necessary in the  
668 development and implementation of this reimbursement program.

669 (53) The division shall provide reimbursement,  
670 according to a payment schedule developed by the division, for a  
671 breast prosthesis and brassier for Medicaid-eligible women who  
672 have undergone a mastectomy or related breast reconstruction  
673 procedures for the treatment of breast cancer.

674 (54) Targeted case management services for high-cost  
675 beneficiaries shall be developed by the division for all services  
676 under this section.

677 Notwithstanding any other provision of this article to the  
678 contrary, the division shall reduce the rate of reimbursement to  
679 providers for any service provided under this section by five  
680 percent (5%) of the allowed amount for that service. However, the  
681 reduction in the reimbursement rates required by this paragraph  
682 shall not apply to inpatient hospital services, nursing facility  
683 services, intermediate care facility services, psychiatric  
684 residential treatment facility services, pharmacy services  
685 provided under paragraph (9) of this section, or any service

686 provided by the University of Mississippi Medical Center or a  
687 state agency, a state facility or a public agency that either  
688 provides its own state match through intergovernmental transfer or  
689 certification of funds to the division, or a service for which the  
690 federal government sets the reimbursement methodology and rate.  
691 In addition, the reduction in the reimbursement rates required by  
692 this paragraph shall not apply to case management services and  
693 home-delivered meals provided under the home- and community-based  
694 services program for the elderly and disabled by a planning and  
695 development district (PDD). Planning and development districts  
696 participating in the home- and community-based services program  
697 for the elderly and disabled as case management providers shall be  
698 reimbursed for case management services at the maximum rate  
699 approved by the Centers for Medicare and Medicaid Services (CMS).

700 The division may pay to those providers who participate in  
701 and accept patient referrals from the division's emergency room  
702 redirection program a percentage, as determined by the division,  
703 of savings achieved according to the performance measures and  
704 reduction of costs required of that program. Federally qualified  
705 health centers may participate in the emergency room redirection  
706 program, and the division may pay those centers a percentage of  
707 any savings to the Medicaid program achieved by the centers'  
708 accepting patient referrals through the program, as provided in  
709 this paragraph.

710 Notwithstanding any provision of this article, except as  
711 authorized in the following paragraph and in Section 43-13-139,  
712 neither (a) the limitations on quantity or frequency of use of or  
713 the fees or charges for any of the care or services available to  
714 recipients under this section, nor (b) the payments or rates of  
715 reimbursement to providers rendering care or services authorized  
716 under this section to recipients, may be increased, decreased or  
717 otherwise changed from the levels in effect on July 1, 1999,  
718 unless they are authorized by an amendment to this section by the

719 Legislature. However, the restriction in this paragraph shall not  
720 prevent the division from changing the payments or rates of  
721 reimbursement to providers without an amendment to this section  
722 whenever those changes are required by federal law or regulation,  
723 or whenever those changes are necessary to correct administrative  
724 errors or omissions in calculating those payments or rates of  
725 reimbursement.

726 Notwithstanding any provision of this article, no new groups  
727 or categories of recipients and new types of care and services may  
728 be added without enabling legislation from the Mississippi  
729 Legislature, except that the division may authorize those changes  
730 without enabling legislation when the addition of recipients or  
731 services is ordered by a court of proper authority.

732 The executive director shall keep the Governor advised on a  
733 timely basis of the funds available for expenditure and the  
734 projected expenditures. If current or projected expenditures of  
735 the division are reasonably anticipated to exceed the amount of  
736 funds appropriated to the division for any fiscal year, the  
737 Governor, after consultation with the executive director, shall  
738 discontinue any or all of the payment of the types of care and  
739 services as provided in this section that are deemed to be  
740 optional services under Title XIX of the federal Social Security  
741 Act, as amended, and when necessary, shall institute any other  
742 cost containment measures on any program or programs authorized  
743 under the article to the extent allowed under the federal law  
744 governing that program or programs. However, the Governor shall  
745 not be authorized to discontinue or eliminate any service under  
746 this section that is mandatory under federal law, or to  
747 discontinue or eliminate, or adjust income limits or resource  
748 limits for, any eligibility category or group under Section  
749 43-13-115. It is the intent of the Legislature that the  
750 expenditures of the division during any fiscal year shall not

751 exceed the amounts appropriated to the division for that fiscal  
752 year.

753         Notwithstanding any other provision of this article, it shall  
754 be the duty of each nursing facility, intermediate care facility  
755 for the mentally retarded, psychiatric residential treatment  
756 facility, and nursing facility for the severely disabled that is  
757 participating in the Medicaid program to keep and maintain books,  
758 documents and other records as prescribed by the Division of  
759 Medicaid in substantiation of its cost reports for a period of  
760 three (3) years after the date of submission to the Division of  
761 Medicaid of an original cost report, or three (3) years after the  
762 date of submission to the Division of Medicaid of an amended cost  
763 report.

764         **SECTION 2.** This act shall take effect and be in force from  
765 and after July 1, 2006.