

By: Senator(s) Harden

To: Public Health and  
Welfare; Appropriations

## SENATE BILL NO. 2230

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

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

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

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

17 (1) Inpatient hospital services.

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

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

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

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

38 (2) Outpatient hospital services.

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

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

49 (3) Laboratory and x-ray services.

50 (4) Nursing facility services.

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

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

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

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

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

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

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

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

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

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

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

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

(b) Repealed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

(12) Intermediate care facility services.

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

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

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

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

centers that are associated with an academic health care center.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(24) [Deleted]

(25) [Deleted]

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

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

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

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

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

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

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

(33) Podiatrist services.

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

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

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



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

526 (37) [Deleted]

527 (38) Chiropractic services. A chiropractor's manual  
528 manipulation of the spine to correct a subluxation, if x-ray  
529 demonstrates that a subluxation exists and if the subluxation has  
530 resulted in a neuromusculoskeletal condition for which  
531 manipulation is appropriate treatment, and related spinal x-rays  
532 performed to document these conditions. Reimbursement for  
533 chiropractic services shall not exceed Seven Hundred Dollars  
534 (\$700.00) per year per beneficiary.

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

539 (40) [Deleted]

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

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

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

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

(44) Nursing facility services for the severely disabled.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(54) As used in this paragraph (54):

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

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

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

(d) "Personal care home" means any building or buildings, residence, private home, boarding home, home for persons eighteen (18) years of age or older, or other place, whether operated for profit or not, which undertakes through its

687 ownership or management to provide, for a period exceeding  
688 twenty-four (24) hours, housing, food service, and one or more  
689 personal services for four (4) or more adults who are not related  
690 to the owner or operator by blood or marriage and who require such  
691 services, and which is licensed as a personal care home by the  
692 State Department of Health under Section 43-11-1 et seq.,  
693 Mississippi Code of 1972.

694 There is established a program of assistance payments for  
695 persons who reside in personal care homes, to be administered by  
696 the Division of Medicaid. The amount of such assistance payments  
697 shall be in the amount of Three Dollars (\$3.00) per bed per day  
698 for each eligible recipient, subject to appropriations therefor by  
699 the Legislature.

700 Recipients of such personal care home assistance payments  
701 shall be applicants who reside in personal care homes, who are  
702 certified by the division as persons eligible for Medicaid  
703 assistance, and who are receiving Medicaid assistance for  
704 medicine, hospital services and physician's services.

705 The division is authorized and empowered to administer the  
706 program of personal care home assistance payments established in  
707 this act, and to adopt and promulgate reasonable rules,  
708 regulations and standards, with the approval of the Governor, as  
709 may be necessary for the proper and efficient payment of claims to  
710 all qualified recipients.

711 Notwithstanding any other provision of this article to the  
712 contrary, the division shall reduce the rate of reimbursement to  
713 providers for any service provided under this section by five  
714 percent (5%) of the allowed amount for that service. However, the  
715 reduction in the reimbursement rates required by this paragraph  
716 shall not apply to inpatient hospital services, nursing facility  
717 services, intermediate care facility services, psychiatric  
718 residential treatment facility services, pharmacy services  
719 provided under paragraph (9) of this section, or any service

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

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

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

753 Legislature. However, the restriction in this paragraph shall not  
754 prevent the division from changing the payments or rates of  
755 reimbursement to providers without an amendment to this section  
756 whenever those changes are required by federal law or regulation,  
757 or whenever those changes are necessary to correct administrative  
758 errors or omissions in calculating those payments or rates of  
759 reimbursement.

760         Notwithstanding any provision of this article, no new groups  
761 or categories of recipients and new types of care and services may  
762 be added without enabling legislation from the Mississippi  
763 Legislature, except that the division may authorize those changes  
764 without enabling legislation when the addition of recipients or  
765 services is ordered by a court of proper authority.

766         The executive director shall keep the Governor advised on a  
767 timely basis of the funds available for expenditure and the  
768 projected expenditures. If current or projected expenditures of  
769 the division are reasonably anticipated to exceed the amount of  
770 funds appropriated to the division for any fiscal year, the  
771 Governor, after consultation with the executive director, shall  
772 discontinue any or all of the payment of the types of care and  
773 services as provided in this section that are deemed to be  
774 optional services under Title XIX of the federal Social Security  
775 Act, as amended, and when necessary, shall institute any other  
776 cost containment measures on any program or programs authorized  
777 under the article to the extent allowed under the federal law  
778 governing that program or programs. However, the Governor shall  
779 not be authorized to discontinue or eliminate any service under  
780 this section that is mandatory under federal law, or to  
781 discontinue or eliminate, or adjust income limits or resource  
782 limits for, any eligibility category or group under Section  
783 43-13-115. It is the intent of the Legislature that the  
784 expenditures of the division during any fiscal year shall not



785 exceed the amounts appropriated to the division for that fiscal  
786 year.

787       Notwithstanding any other provision of this article, it shall  
788 be the duty of each nursing facility, intermediate care facility  
789 for the mentally retarded, psychiatric residential treatment  
790 facility, and nursing facility for the severely disabled that is  
791 participating in the Medicaid program to keep and maintain books,  
792 documents and other records as prescribed by the Division of  
793 Medicaid in substantiation of its cost reports for a period of  
794 three (3) years after the date of submission to the Division of  
795 Medicaid of an original cost report, or three (3) years after the  
796 date of submission to the Division of Medicaid of an amended cost  
797 report.

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