

By: Senator(s) Nunnelee

To: Public Health and
Welfare; Appropriations

SENATE BILL NO. 2455

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO AUTHORIZE MEDICAID REIMBURSEMENT FOR ASSISTED LIVING SERVICES
3 PROVIDED TO DEVELOPMENTALLY DISABLED ADULTS RESIDING IN A PERSONAL
4 CARE FACILITY IN MADISON COUNTY; AND FOR RELATED PURPOSES.

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

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

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

15 (1) Inpatient hospital services.

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

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

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

36 (2) Outpatient hospital services.

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

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

47 (3) Laboratory and x-ray services.

48 (4) Nursing facility services.

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

56 (b) From and after July 1, 1997, the division
57 shall implement the integrated case-mix payment and quality
58 monitoring system, which includes the fair rental system for
59 property costs and in which recapture of depreciation is
60 eliminated. The division may reduce the payment for hospital
61 leave and therapeutic home leave days to the lower of the case-mix

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

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

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

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

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

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

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

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

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

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

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

154 (b) Repealed.

155 (8) Emergency medical transportation services. On
156 January 1, 1994, emergency medical transportation services shall
157 be reimbursed at seventy percent (70%) of the rate established
158 under Medicare (Title XVIII of the federal Social Security Act, as
159 amended). "Emergency medical transportation services" shall mean,
160 but shall not be limited to, the following services by a properly

161 permitted ambulance operated by a properly licensed provider in
162 accordance with the Emergency Medical Services Act of 1974
163 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
164 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
165 (vi) disposable supplies, (vii) similar services.

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

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

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

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

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

193 determined by the executive director as allowed by federal
194 regulations.

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

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

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

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

222 All claims for drugs for dually eligible Medicare/Medicaid
223 beneficiaries that are paid for by Medicare must be submitted to
224 Medicare for payment before they may be processed by the
225 division's on-line payment system.

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

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

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

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

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

256 Payment for nonlegend or over-the-counter drugs covered by
257 the division shall be reimbursed at the lower of the division's

258 estimated shelf price or the providers' usual and customary charge
259 to the general public.

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

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

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

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

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

291 (12) Intermediate care facility services.

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

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

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

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

324 authority of this paragraph (14) shall be increased to one hundred
325 sixty percent (160%) of the amount of the reimbursement rate that
326 was in effect on June 30, 1999.

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

332 (16) Mental health services. Approved therapeutic and
333 case management services (a) provided by an approved regional
334 mental health/retardation center established under Sections
335 41-19-31 through 41-19-39, or by another community mental health
336 service provider meeting the requirements of the Department of
337 Mental Health to be an approved mental health/retardation center
338 if determined necessary by the Department of Mental Health, using
339 state funds that are provided from the appropriation to the State
340 Department of Mental Health and/or funds transferred to the
341 department by a political subdivision or instrumentality of the
342 state and used to match federal funds under a cooperative
343 agreement between the division and the department, or (b) provided
344 by a facility that is certified by the State Department of Mental
345 Health to provide therapeutic and case management services, to be
346 reimbursed on a fee for service basis, or (c) provided in the
347 community by a facility or program operated by the Department of
348 Mental Health. Any such services provided by a facility described
349 in subparagraph (b) must have the prior approval of the division
350 to be reimbursable under this section. After June 30, 1997,
351 mental health services provided by regional mental
352 health/retardation centers established under Sections 41-19-31
353 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
354 and/or their subsidiaries and divisions, or by psychiatric
355 residential treatment facilities as defined in Section 43-11-1, or
356 by another community mental health service provider meeting the

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

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

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

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

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

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

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

415 Qualifications for persons providing service coordination shall be
416 determined by the State Department of Health and the Division of
417 Medicaid.

418 (20) Home- and community-based services for physically
419 disabled approved services as allowed by a waiver from the United
420 States Department of Health and Human Services for home- and
421 community-based services for physically disabled people using
422 state funds that are provided from the appropriation to the State

423 Department of Rehabilitation Services and used to match federal
424 funds under a cooperative agreement between the division and the
425 department, provided that funds for these services are
426 specifically appropriated to the Department of Rehabilitation
427 Services.

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

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

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

456 (24) [Deleted]

457 (25) [Deleted]

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

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

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

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

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

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

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

501 (33) Podiatrist services.

502 (34) Assisted living services as provided through home-
503 and community-based services under Title XIX of the federal Social
504 Security Act, as amended, subject to the availability of funds
505 specifically appropriated for that purpose by the Legislature.
506 The division shall apply for necessary waivers under this
507 paragraph (34) to provide assisted living services to
508 developmentally disabled adults residing in a personal care
509 facility located in Madison County.

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

515 (36) Nonemergency transportation services for
516 Medicaid-eligible persons, to be provided by the Division of
517 Medicaid. The division may contract with additional entities to
518 administer nonemergency transportation services as it deems
519 necessary. All providers shall have a valid driver's license,
520 vehicle inspection sticker, valid vehicle license tags and a
521 standard liability insurance policy covering the vehicle. The

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

528 (37) [Deleted]

529 (38) Chiropractic services. A chiropractor's manual
530 manipulation of the spine to correct a subluxation, if x-ray
531 demonstrates that a subluxation exists and if the subluxation has
532 resulted in a neuromusculoskeletal condition for which
533 manipulation is appropriate treatment, and related spinal x-rays
534 performed to document these conditions. Reimbursement for
535 chiropractic services shall not exceed Seven Hundred Dollars
536 (\$700.00) per year per beneficiary.

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

541 (40) [Deleted]

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

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

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

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

569 (44) Nursing facility services for the severely
570 disabled.

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

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

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

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

588 disturbances as defined in Section 43-14-1(1), which may include
589 home- and community-based services, case management services or
590 managed care services through mental health providers certified by
591 the Department of Mental Health. The division may implement and
592 provide services under this waived program only if funds for
593 these services are specifically appropriated for this purpose by
594 the Legislature, or if funds are voluntarily provided by affected
595 agencies.

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

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

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

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

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

621 or any other pharmacy of their choice to obtain their prescription
622 drugs while participating in the program.

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

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

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

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

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

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

650 (51) Upon determination of Medicaid eligibility and in
651 association with annual redetermination of Medicaid eligibility,
652 beneficiaries shall be encouraged to undertake a physical
653 examination that will establish a base-line level of health and

654 identification of a usual and customary source of care (a medical
655 home) to aid utilization of disease management tools. This
656 physical examination and utilization of these disease management
657 tools shall be consistent with current United States Preventive
658 Services Task Force or other recognized authority recommendations.

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

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

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

675 Notwithstanding any other provision of this article to the
676 contrary, the division shall reduce the rate of reimbursement to
677 providers for any service provided under this section by five
678 percent (5%) of the allowed amount for that service. However, the
679 reduction in the reimbursement rates required by this paragraph
680 shall not apply to inpatient hospital services, nursing facility
681 services, intermediate care facility services, psychiatric
682 residential treatment facility services, pharmacy services
683 provided under paragraph (9) of this section, or any service
684 provided by the University of Mississippi Medical Center or a
685 state agency, a state facility or a public agency that either
686 provides its own state match through intergovernmental transfer or

687 certification of funds to the division, or a service for which the
688 federal government sets the reimbursement methodology and rate.
689 In addition, the reduction in the reimbursement rates required by
690 this paragraph shall not apply to case management services and
691 home-delivered meals provided under the home- and community-based
692 services program for the elderly and disabled by a planning and
693 development district (PDD). Planning and development districts
694 participating in the home- and community-based services program
695 for the elderly and disabled as case management providers shall be
696 reimbursed for case management services at the maximum rate
697 approved by the Centers for Medicare and Medicaid Services (CMS).

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

708 Notwithstanding any provision of this article, except as
709 authorized in the following paragraph and in Section 43-13-139,
710 neither (a) the limitations on quantity or frequency of use of or
711 the fees or charges for any of the care or services available to
712 recipients under this section, nor (b) the payments or rates of
713 reimbursement to providers rendering care or services authorized
714 under this section to recipients, may be increased, decreased or
715 otherwise changed from the levels in effect on July 1, 1999,
716 unless they are authorized by an amendment to this section by the
717 Legislature. However, the restriction in this paragraph shall not
718 prevent the division from changing the payments or rates of
719 reimbursement to providers without an amendment to this section

720 whenever those changes are required by federal law or regulation,
721 or whenever those changes are necessary to correct administrative
722 errors or omissions in calculating those payments or rates of
723 reimbursement.

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

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

751 Notwithstanding any other provision of this article, it shall
752 be the duty of each nursing facility, intermediate care facility

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

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