MISSISSIPPI LEGISLATURE REGULAR SESSION 2007

By: Representatives Holland, Morgan To: Medicaid; Appropriations

HOUSE BILL NO. 1133

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE MEDICAID COVERAGE FOR UNLIMITED INPATIENT HOSPITAL DAYS
3 FOR ELIGIBLE INFANTS AND CHILDREN; AND FOR RELATED PURPOSES.

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

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

7 43-13-117. Medicaid as authorized by this article shall
8 include payment of part or all of the costs, at the discretion of
9 the division, with approval of the Governor, of the following
10 types of care and services rendered to eligible applicants who
11 have been determined to be eligible for that care and services,
12 within the limits of state appropriations and federal matching
13 funds:

14 (1) Inpatient hospital services.

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

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

27 (c) Hospitals will receive an additional payment
28 for the implantable programmable baclofen drug pump used to treat
29 spasticity that is implanted on an inpatient basis. The payment
30 pursuant to written invoice will be in addition to the facility's
31 per diem reimbursement and will represent a reduction of costs on
32 the facility's annual cost report, and shall not exceed Ten
33 Thousand Dollars ($10,000.00) per year per recipient.
34 (2) Outpatient hospital services.
35 (a) Emergency services. The division shall allow
36 six (6) medically necessary emergency room visits per beneficiary
37 per fiscal year.
38 (b) Other outpatient hospital services. The
39 division shall allow benefits for other medically necessary
40 outpatient hospital services (such as chemotherapy, radiation,
41 surgery and therapy). Where the same services are reimbursed as
42 clinic services, the division may revise the rate or methodology
43 of outpatient reimbursement to maintain consistency, efficiency,
44 economy and quality of care.
45 (3) Laboratory and x-ray services.
46 (4) Nursing facility services.
47 (a) The division shall make full payment to
48 nursing facilities for each day, not exceeding fifty-two (52) days
49 per year, that a patient is absent from the facility on home
50 leave. Payment may be made for the following home leave days in
51 addition to the fifty-two-day limitation: Christmas, the day
52 before Christmas, the day after Christmas, Thanksgiving, the day
53 before Thanksgiving and the day after Thanksgiving.
54 (b) From and after July 1, 1997, the division
55 shall implement the integrated case-mix payment and quality
56 monitoring system, which includes the fair rental system for
57 property costs and in which recapture of depreciation is
58 eliminated. The division may reduce the payment for hospital
59 leave and therapeutic home leave days to the lower of the case-mix

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

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

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

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

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

126 the provision of those services to handicapped students by public
127 school districts using state funds that are provided from the
128 appropriation to the Department of Education to obtain federal
129 matching funds through the division. The division, in obtaining
130 medical and psychological evaluations for children in the custody
131 of the State Department of Human Services may enter into a
132 cooperative agreement with the State Department of Human Services
133 for the provision of those services using state funds that are
134 provided from the appropriation to the Department of Human
135 Services to obtain federal matching funds through the division.
136 (6) Physician's services. The division shall allow
137 twelve (12) physician visits annually. All fees for physicians'
138 services that are covered only by Medicaid shall be reimbursed at
139 ninety percent (90%) of the rate established on January 1, 1999,
140 and as may be adjusted each July thereafter, under Medicare (Title
141 XVIII of the federal Social Security Act, as amended). The
142 division may develop and implement a different reimbursement model
143 or schedule for physician's services provided by physicians based
144 at an academic health care center and by physicians at rural
145 health centers that are associated with an academic health care
146 center.
147 (7) (a) Home health services for eligible persons, not
148 to exceed in cost the prevailing cost of nursing facility
149 services, not to exceed twenty-five (25) visits per year. All
150 home health visits must be precertified as required by the
151 division.
152 (b) Repealed.
153 (8) Emergency medical transportation services. On
154 January 1, 1994, emergency medical transportation services shall
155 be reimbursed at seventy percent (70%) of the rate established
156 under Medicare (Title XVIII of the federal Social Security Act, as
157 amended). "Emergency medical transportation services" shall mean,
158 but shall not be limited to, the following services by a properly

159 permitted ambulance operated by a properly licensed provider in
160 accordance with the Emergency Medical Services Act of 1974
161 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
162 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
163 (vi) disposable supplies, (vii) similar services.
164 (9) (a) Legend and other drugs as may be determined by
165 the division.
166 The division shall establish a mandatory preferred drug list.
167 Drugs not on the mandatory preferred drug list shall be made
168 available by utilizing prior authorization procedures established
169 by the division.
170 The division may seek to establish relationships with other
171 states in order to lower acquisition costs of prescription drugs
172 to include single source and innovator multiple source drugs or
173 generic drugs. In addition, if allowed by federal law or
174 regulation, the division may seek to establish relationships with
175 and negotiate with other countries to facilitate the acquisition
176 of prescription drugs to include single source and innovator
177 multiple source drugs or generic drugs, if that will lower the
178 acquisition costs of those prescription drugs.
179 The division shall allow for a combination of prescriptions
180 for single source and innovator multiple source drugs and generic
181 drugs to meet the needs of the beneficiaries, not to exceed five
182 (5) prescriptions per month for each noninstitutionalized Medicaid
183 beneficiary, with not more than two (2) of those prescriptions
184 being for single source or innovator multiple source drugs.
185 The executive director may approve specific maintenance drugs
186 for beneficiaries with certain medical conditions, which may be
187 prescribed and dispensed in three-month supply increments. The
188 executive director may allow a state agency or agencies to be the
189 sole source purchaser and distributor of hemophilia factor
190 medications, HIV/AIDS medications and other medications as

191 determined by the executive director as allowed by federal
192 regulations.

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

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

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

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

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

224 The division shall develop a pharmacy policy in which drugs
225 in tamper-resistant packaging that are prescribed for a resident
226 of a nursing facility but are not dispensed to the resident shall
227 be returned to the pharmacy and not billed to Medicaid, in
228 accordance with guidelines of the State Board of Pharmacy.
229 The division shall develop and implement a method or methods
230 by which the division will provide on a regular basis to Medicaid
231 providers who are authorized to prescribe drugs, information about
232 the costs to the Medicaid program of single source drugs and
233 innovator multiple source drugs, and information about other drugs
234 that may be prescribed as alternatives to those single source
235 drugs and innovator multiple source drugs and the costs to the
236 Medicaid program of those alternative drugs.
237 Notwithstanding any law or regulation, information obtained
238 or maintained by the division regarding the prescription drug
239 program, including trade secrets and manufacturer or labeler
240 pricing, is confidential and not subject to disclosure except to
241 other state agencies.
242 (b) Payment by the division for covered
243 multisource drugs shall be limited to the lower of the upper
244 limits established and published by the Centers for Medicare and
245 Medicaid Services (CMS) plus a dispensing fee, or the estimated
246 acquisition cost (EAC) as determined by the division, plus a
247 dispensing fee, or the providers' usual and customary charge to
248 the general public.
249 Payment for other covered drugs, other than multisource drugs
250 with CMS upper limits, shall not exceed the lower of the estimated
251 acquisition cost as determined by the division, plus a dispensing
252 fee or the providers' usual and customary charge to the general
253 public.
254 Payment for nonlegend or over-the-counter drugs covered by
255 the division shall be reimbursed at the lower of the division's

256 estimated shelf price or the providers' usual and customary charge
257 to the general public.
258 The dispensing fee for each new or refill prescription,
259 including nonlegend or over-the-counter drugs covered by the
260 division, shall be not less than Three Dollars and Ninety-one
261 Cents ($3.91), as determined by the division.
262 The division shall not reimburse for single source or
263 innovator multiple source drugs if there are equally effective
264 generic equivalents available and if the generic equivalents are
265 the least expensive.
266 It is the intent of the Legislature that the pharmacists
267 providers be reimbursed for the reasonable costs of filling and
268 dispensing prescriptions for Medicaid beneficiaries.
269 (10) Dental care that is an adjunct to treatment of an
270 acute medical or surgical condition; services of oral surgeons and
271 dentists in connection with surgery related to the jaw or any
272 structure contiguous to the jaw or the reduction of any fracture
273 of the jaw or any facial bone; and emergency dental extractions
274 and treatment related thereto. On July 1, 1999, all fees for
275 dental care and surgery under authority of this paragraph (10)
276 shall be increased to one hundred sixty percent (160%) of the
277 amount of the reimbursement rate that was in effect on June 30,
278 1999. It is the intent of the Legislature to encourage more
279 dentists to participate in the Medicaid program.
280 (11) Eyeglasses for all Medicaid beneficiaries who have
281 (a) had surgery on the eyeball or ocular muscle that results in a
282 vision change for which eyeglasses or a change in eyeglasses is
283 medically indicated within six (6) months of the surgery and is in
284 accordance with policies established by the division, or (b) one
285 (1) pair every five (5) years and in accordance with policies
286 established by the division. In either instance, the eyeglasses
287 must be prescribed by a physician skilled in diseases of the eye
288 or an optometrist, whichever the beneficiary may select.

289 (12) Intermediate care facility services.
290 (a) The division shall make full payment to all
291 intermediate care facilities for the mentally retarded for each
292 day, not exceeding eighty-four (84) days per year, that a patient
293 is absent from the facility on home leave. Payment may be made
294 for the following home leave days in addition to the
295 eighty-four-day limitation: Christmas, the day before Christmas,
296 the day after Christmas, Thanksgiving, the day before Thanksgiving
297 and the day after Thanksgiving.
298 (b) All state-owned intermediate care facilities
299 for the mentally retarded shall be reimbursed on a full reasonable
300 cost basis.
301 (13) Family planning services, including drugs,
302 supplies and devices, when those services are under the
303 supervision of a physician or nurse practitioner.
304 (14) Clinic services. Such diagnostic, preventive,
305 therapeutic, rehabilitative or palliative services furnished to an
306 outpatient by or under the supervision of a physician or dentist
307 in a facility that is not a part of a hospital but that is
308 organized and operated to provide medical care to outpatients.
309 Clinic services shall include any services reimbursed as
310 outpatient hospital services that may be rendered in such a
311 facility, including those that become so after July 1, 1991. On
312 July 1, 1999, all fees for physicians' services reimbursed under
313 authority of this paragraph (14) shall be reimbursed at ninety
314 percent (90%) of the rate established on January 1, 1999, and as
315 may be adjusted each July thereafter, under Medicare (Title XVIII
316 of the federal Social Security Act, as amended). The division may
317 develop and implement a different reimbursement model or schedule
318 for physician's services provided by physicians based at an
319 academic health care center and by physicians at rural health
320 centers that are associated with an academic health care center.
321 On July 1, 1999, all fees for dentists' services reimbursed under

322 authority of this paragraph (14) shall be increased to one hundred
323 sixty percent (160%) of the amount of the reimbursement rate that
324 was in effect on June 30, 1999.
325 (15) Home- and community-based services for the elderly
326 and disabled, as provided under Title XIX of the federal Social
327 Security Act, as amended, under waivers, subject to the
328 availability of funds specifically appropriated for that purpose
329 by the Legislature.
330 (16) Mental health services. Approved therapeutic and
331 case management services (a) provided by an approved regional
332 mental health/retardation center established under Sections
333 41-19-31 through 41-19-39, or by another community mental health
334 service provider meeting the requirements of the Department of
335 Mental Health to be an approved mental health/retardation center
336 if determined necessary by the Department of Mental Health, using
337 state funds that are provided from the appropriation to the State
338 Department of Mental Health and/or funds transferred to the
339 department by a political subdivision or instrumentality of the
340 state and used to match federal funds under a cooperative
341 agreement between the division and the department, or (b) provided
342 by a facility that is certified by the State Department of Mental
343 Health to provide therapeutic and case management services, to be
344 reimbursed on a fee for service basis, or (c) provided in the
345 community by a facility or program operated by the Department of
346 Mental Health. Any such services provided by a facility described
347 in subparagraph (b) must have the prior approval of the division
348 to be reimbursable under this section. After June 30, 1997,
349 mental health services provided by regional mental
350 health/retardation centers established under Sections 41-19-31
351 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
352 and/or their subsidiaries and divisions, or by psychiatric
353 residential treatment facilities as defined in Section 43-11-1, or
354 by another community mental health service provider meeting the

355 requirements of the Department of Mental Health to be an approved
356 mental health/retardation center if determined necessary by the
357 Department of Mental Health, shall not be included in or provided
358 under any capitated managed care pilot program provided for under
359 paragraph (24) of this section.
360 (17) Durable medical equipment services and medical
361 supplies. Precertification of durable medical equipment and
362 medical supplies must be obtained as required by the division.
363 The Division of Medicaid may require durable medical equipment
364 providers to obtain a surety bond in the amount and to the
365 specifications as established by the Balanced Budget Act of 1997.
366 (18) (a) Notwithstanding any other provision of this
367 section to the contrary, the division shall make additional
368 reimbursement to hospitals that serve a disproportionate share of
369 low-income patients and that meet the federal requirements for
370 those payments as provided in Section 1923 of the federal Social
371 Security Act and any applicable regulations. However, from and
372 after January 1, 1999, no public hospital shall participate in the
373 Medicaid disproportionate share program unless the public hospital
374 participates in an intergovernmental transfer program as provided
375 in Section 1903 of the federal Social Security Act and any
376 applicable regulations.
377 (b) The division shall establish a Medicare Upper
378 Payment Limits Program, as defined in Section 1902(a)(30) of the
379 federal Social Security Act and any applicable federal
380 regulations, for hospitals, and may establish a Medicare Upper
381 Payments Limits Program for nursing facilities. The division
382 shall assess each hospital and, if the program is established for
383 nursing facilities, shall assess each nursing facility, based on
384 Medicaid utilization or other appropriate method consistent with
385 federal regulations. The assessment will remain in effect as long
386 as the state participates in the Medicare Upper Payment Limits
387 Program. The division shall make additional reimbursement to

388 hospitals and, if the program is established for nursing
389 facilities, shall make additional reimbursement to nursing
390 facilities, for the Medicare Upper Payment Limits, as defined in
391 Section 1902(a)(30) of the federal Social Security Act and any
392 applicable federal regulations.
393 (19) (a) Perinatal risk management services. The
394 division shall promulgate regulations to be effective from and
395 after October 1, 1988, to establish a comprehensive perinatal
396 system for risk assessment of all pregnant and infant Medicaid
397 recipients and for management, education and follow-up for those
398 who are determined to be at risk. Services to be performed
399 include case management, nutrition assessment/counseling,
400 psychosocial assessment/counseling and health education.
401 (b) Early intervention system services. The
402 division shall cooperate with the State Department of Health,
403 acting as lead agency, in the development and implementation of a
404 statewide system of delivery of early intervention services, under
405 Part C of the Individuals with Disabilities Education Act (IDEA).
406 The State Department of Health shall certify annually in writing
407 to the executive director of the division the dollar amount of
408 state early intervention funds available that will be utilized as
409 a certified match for Medicaid matching funds. Those funds then
410 shall be used to provide expanded targeted case management
411 services for Medicaid eligible children with special needs who are
412 eligible for the state's early intervention system.
413 Qualifications for persons providing service coordination shall be
414 determined by the State Department of Health and the Division of
415 Medicaid.
416 (20) Home- and community-based services for physically
417 disabled approved services as allowed by a waiver from the United
418 States Department of Health and Human Services for home- and
419 community-based services for physically disabled people using
420 state funds that are provided from the appropriation to the State

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

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

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

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

454 (24) [Deleted]
455 (25) [Deleted]
456 (26) Hospice care. As used in this paragraph, the term
457 "hospice care" means a coordinated program of active professional
458 medical attention within the home and outpatient and inpatient
459 care that treats the terminally ill patient and family as a unit,
460 employing a medically directed interdisciplinary team. The
461 program provides relief of severe pain or other physical symptoms
462 and supportive care to meet the special needs arising out of
463 physical, psychological, spiritual, social and economic stresses
464 that are experienced during the final stages of illness and during
465 dying and bereavement and meets the Medicare requirements for
466 participation as a hospice as provided in federal regulations.
467 (27) Group health plan premiums and cost sharing if it
468 is cost effective as defined by the United States Secretary of
469 Health and Human Services.
470 (28) Other health insurance premiums that are cost
471 effective as defined by the United States Secretary of Health and
472 Human Services. Medicare eligible must have Medicare Part B
473 before other insurance premiums can be paid.
474 (29) The Division of Medicaid may apply for a waiver
475 from the United States Department of Health and Human Services for
476 home- and community-based services for developmentally disabled
477 people using state funds that are provided from the appropriation
478 to the State Department of Mental Health and/or funds transferred
479 to the department by a political subdivision or instrumentality of
480 the state and used to match federal funds under a cooperative
481 agreement between the division and the department, provided that
482 funds for these services are specifically appropriated to the
483 Department of Mental Health and/or transferred to the department
484 by a political subdivision or instrumentality of the state.
485 (30) Pediatric skilled nursing services for eligible
486 persons under twenty-one (21) years of age.

487 (31) Targeted case management services for children
488 with special needs, under waivers from the United States
489 Department of Health and Human Services, using state funds that
490 are provided from the appropriation to the Mississippi Department
491 of Human Services and used to match federal funds under a
492 cooperative agreement between the division and the department.
493 (32) Care and services provided in Christian Science
494 Sanatoria listed and certified by the Commission for Accreditation
495 of Christian Science Nursing Organizations/Facilities, Inc.,
496 rendered in connection with treatment by prayer or spiritual means
497 to the extent that those services are subject to reimbursement
498 under Section 1903 of the federal Social Security Act.
499 (33) Podiatrist services.
500 (34) Assisted living services as provided through home-
501 and community-based services under Title XIX of the federal Social
502 Security Act, as amended, subject to the availability of funds
503 specifically appropriated for that purpose by the Legislature.
504 (35) Services and activities authorized in Sections
505 43-27-101 and 43-27-103, using state funds that are provided from
506 the appropriation to the State Department of Human Services and
507 used to match federal funds under a cooperative agreement between
508 the division and the department.
509 (36) Nonemergency transportation services for
510 Medicaid-eligible persons, to be provided by the Division of
511 Medicaid. The division may contract with additional entities to
512 administer nonemergency transportation services as it deems
513 necessary. All providers shall have a valid driver's license,
514 vehicle inspection sticker, valid vehicle license tags and a
515 standard liability insurance policy covering the vehicle. The
516 division may pay providers a flat fee based on mileage tiers, or
517 in the alternative, may reimburse on actual miles traveled. The
518 division may apply to the Center for Medicare and Medicaid
519 Services (CMS) for a waiver to draw federal matching funds for

520 nonemergency transportation services as a covered service instead
521 of an administrative cost.
522 (37) [Deleted]
523 (38) Chiropractic services. A chiropractor's manual
524 manipulation of the spine to correct a subluxation, if x-ray
525 demonstrates that a subluxation exists and if the subluxation has
526 resulted in a neuromusculoskeletal condition for which
527 manipulation is appropriate treatment, and related spinal x-rays
528 performed to document these conditions. Reimbursement for
529 chiropractic services shall not exceed Seven Hundred Dollars
530 ($700.00) per year per beneficiary.
531 (39) Dually eligible Medicare/Medicaid beneficiaries.
532 The division shall pay the Medicare deductible and coinsurance
533 amounts for services available under Medicare, as determined by
534 the division.
535 (40) [Deleted]
536 (41) Services provided by the State Department of
537 Rehabilitation Services for the care and rehabilitation of persons
538 with spinal cord injuries or traumatic brain injuries, as allowed
539 under waivers from the United States Department of Health and
540 Human Services, using up to seventy-five percent (75%) of the
541 funds that are appropriated to the Department of Rehabilitation
542 Services from the Spinal Cord and Head Injury Trust Fund
543 established under Section 37-33-261 and used to match federal
544 funds under a cooperative agreement between the division and the
545 department.
546 (42) Notwithstanding any other provision in this
547 article to the contrary, the division may develop a population
548 health management program for women and children health services
549 through the age of one (1) year. This program is primarily for
550 obstetrical care associated with low birth weight and pre-term
551 babies. The division may apply to the federal Centers for
552 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or

553 any other waivers that may enhance the program. In order to
554 effect cost savings, the division may develop a revised payment
555 methodology that may include at-risk capitated payments, and may
556 require member participation in accordance with the terms and
557 conditions of an approved federal waiver.

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

563 (44) Nursing facility services for the severely
564 disabled.

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

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

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

579 (46) The division shall make application to the federal
580 Centers for Medicare and Medicaid Services (CMS) for a waiver to
581 develop and provide services for children with serious emotional
582 disturbances as defined in Section 43-14-1(1), which may include
583 home- and community-based services, case management services or
584 managed care services through mental health providers certified by
585 the Department of Mental Health. The division may implement and

586 provide services under this waivered program only if funds for
587 these services are specifically appropriated for this purpose by
588 the Legislature, or if funds are voluntarily provided by affected
589 agencies.

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

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

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

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

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

617 (f) Prescription drugs that are provided to
618 individuals under the prescription drug home delivery component

619 shall be limited only to those drugs that are used for the
620 treatment, management or care of asthma, diabetes or hypertension.
621 (48) Pediatric long-term acute care hospital services.
622 (a) Pediatric long-term acute care hospital
623 services means services provided to eligible persons under
624 twenty-one (21) years of age by a freestanding Medicare-certified
625 hospital that has an average length of inpatient stay greater than
626 twenty-five (25) days and that is primarily engaged in providing
627 chronic or long-term medical care to persons under twenty-one (21)
628 years of age.
629 (b) The services under this paragraph (48) shall
630 be reimbursed as a separate category of hospital services.
631 (49) The division shall establish co-payments and/or
632 coinsurance for all Medicaid services for which co-payments and/or
633 coinsurance are allowable under federal law or regulation, and
634 shall set the amount of the co-payment and/or coinsurance for each
635 of those services at the maximum amount allowable under federal
636 law or regulation.
637 (50) Services provided by the State Department of
638 Rehabilitation Services for the care and rehabilitation of persons
639 who are deaf and blind, as allowed under waivers from the United
640 States Department of Health and Human Services to provide home-
641 and community-based services using state funds that are provided
642 from the appropriation to the State Department of Rehabilitation
643 Services or if funds are voluntarily provided by another agency.
644 (51) Upon determination of Medicaid eligibility and in
645 association with annual redetermination of Medicaid eligibility,
646 beneficiaries shall be encouraged to undertake a physical
647 examination that will establish a base-line level of health and
648 identification of a usual and customary source of care (a medical
649 home) to aid utilization of disease management tools. This
650 physical examination and utilization of these disease management

651 tools shall be consistent with current United States Preventive
652 Services Task Force or other recognized authority recommendations.
653 For persons who are determined ineligible for Medicaid, the
654 division will provide information and direction for accessing
655 medical care and services in the area of their residence.
656 (52) Notwithstanding any provisions of this article,
657 the division may pay enhanced reimbursement fees related to trauma
658 care, as determined by the division in conjunction with the State
659 Department of Health, using funds appropriated to the State
660 Department of Health for trauma care and services and used to
661 match federal funds under a cooperative agreement between the
662 division and the State Department of Health. The division, in
663 conjunction with the State Department of Health, may use grants,
664 waivers, demonstrations, or other projects as necessary in the
665 development and implementation of this reimbursement program.
666 (53) Targeted case management services for high-cost
667 beneficiaries shall be developed by the division for all services
668 under this section.
669 Notwithstanding any other provision of this article to the
670 contrary, the division shall reduce the rate of reimbursement to
671 providers for any service provided under this section by five
672 percent (5%) of the allowed amount for that service. However, the
673 reduction in the reimbursement rates required by this paragraph
674 shall not apply to inpatient hospital services, nursing facility
675 services, intermediate care facility services, psychiatric
676 residential treatment facility services, pharmacy services
677 provided under paragraph (9) of this section, or any service
678 provided by the University of Mississippi Medical Center or a
679 state agency, a state facility or a public agency that either
680 provides its own state match through intergovernmental transfer or
681 certification of funds to the division, or a service for which the
682 federal government sets the reimbursement methodology and rate.
683 In addition, the reduction in the reimbursement rates required by

684 this paragraph shall not apply to case management services and
685 home-delivered meals provided under the home- and community-based
686 services program for the elderly and disabled by a planning and
687 development district (PDD). Planning and development districts
688 participating in the home- and community-based services program
689 for the elderly and disabled as case management providers shall be
690 reimbursed for case management services at the maximum rate
691 approved by the Centers for Medicare and Medicaid Services (CMS).

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

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

716 errors or omissions in calculating those payments or rates of
717 reimbursement.

718 Notwithstanding any provision of this article, no new groups
719 or categories of recipients and new types of care and services may
720 be added without enabling legislation from the Mississippi
721 Legislature, except that the division may authorize those changes
722 without enabling legislation when the addition of recipients or
723 services is ordered by a court of proper authority.

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

745 Notwithstanding any other provision of this article, it shall
746 be the duty of each nursing facility, intermediate care facility
747 for the mentally retarded, psychiatric residential treatment
748 facility, and nursing facility for the severely disabled that is

749 participating in the Medicaid program to keep and maintain books,
750 documents and other records as prescribed by the Division of
751 Medicaid in substantiation of its cost reports for a period of
752 three (3) years after the date of submission to the Division of
753 Medicaid of an original cost report, or three (3) years after the
754 date of submission to the Division of Medicaid of an amended cost
755 report.

756 **SECTION 2.** This act shall take effect and be in force from
757 and after July 1, 2007.

ST: Medicaid; provide coverage for unlimited inpatient hospital days for infants and children.