By: Representative Holland

To: Medicaid; Appropriations

HOUSE BILL NO. 1197

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE THAT CERTAIN PROSTHETIC DEVICES WILL BE REIMBURSABLE
3 UNDER THE MEDICAID PROGRAM; 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 may allow unlimited days in
19 disproportionate hospitals as defined by the division for eligible
20 infants and children under the age of six (6) years if certified
21 as medically necessary as required by the division.

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

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

61 category as computed for the resident on leave using the
62 assessment being utilized for payment at that point in time, or a
63 case-mix score of 1.000 for nursing facilities, and shall compute
64 case-mix scores of residents so that only services provided at the
65 nursing facility are considered in calculating a facility's per
66 diem.
67 (c) From and after July 1, 1997, all state-owned
68 nursing facilities shall be reimbursed on a full reasonable cost
69 basis.
70 (d) When a facility of a category that does not
71 require a certificate of need for construction and that could not
72 be eligible for Medicaid reimbursement is constructed to nursing
73 facility specifications for licensure and certification, and the
74 facility is subsequently converted to a nursing facility under a
75 certificate of need that authorizes conversion only and the
76 applicant for the certificate of need was assessed an application
77 review fee based on capital expenditures incurred in constructing
78 the facility, the division shall allow reimbursement for capital
79 expenditures necessary for construction of the facility that were
80 incurred within the twenty-four (24) consecutive calendar months
81 immediately preceding the date that the certificate of need
82 authorizing the conversion was issued, to the same extent that
83 reimbursement would be allowed for construction of a new nursing
84 facility under a certificate of need that authorizes that
85 construction. The reimbursement authorized in this subparagraph
86 (d) may be made only to facilities the construction of which was
87 completed after June 30, 1989. Before the division shall be
88 authorized to make the reimbursement authorized in this
89 subparagraph (d), the division first must have received approval
90 from the Centers for Medicare and Medicaid Services (CMS) of the
91 change in the state Medicaid plan providing for the reimbursement.
92 (e) The division shall develop and implement, not
93 later than January 1, 2001, a case-mix payment add-on determined

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

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

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

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

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

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

192 determined by the executive director as allowed by federal
193 regulations.
194 Drugs prescribed for a resident of a psychiatric residential
195 treatment facility must be provided in true unit doses when
196 available. The division may require that drugs not covered by
197 Medicare Part D for a resident of a long-term care facility be
198 provided in true unit doses when available. Those drugs that were
199 originally billed to the division but are not used by a resident
200 in any of those facilities shall be returned to the billing
201 pharmacy for credit to the division, in accordance with the
202 guidelines of the State Board of Pharmacy and any requirements of
203 federal law and regulation. Drugs shall be dispensed to a
204 recipient and only one (1) dispensing fee per month may be
205 charged. The division shall develop a methodology for reimbursing
206 for restocked drugs, which shall include a restock fee as
207 determined by the division not exceeding Seven Dollars and
208 Eighty-two Cents ($7.82).
209 The voluntary preferred drug list shall be expanded to
210 function in the interim in order to have a manageable prior
211 authorization system, thereby minimizing disruption of service to
212 beneficiaries.
213 Except for those specific maintenance drugs approved by the
214 executive director, the division shall not reimburse for any
215 portion of a prescription that exceeds a thirty-one-day supply of
216 the drug based on the daily dosage.
217 The division shall develop and implement a program of payment
218 for additional pharmacist services, with payment to be based on
219 demonstrated savings, but in no case shall the total payment
220 exceed twice the amount of the dispensing fee.
221 All claims for drugs for dually eligible Medicare/Medicaid
222 beneficiaries that are paid for by Medicare must be submitted to
223 Medicare for payment before they may be processed by the
224 division's on-line payment system.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

356 requirements of the Department of Mental Health to be an approved
357 mental health/retardation center if determined necessary by the
358 Department of Mental Health, shall not be included in or provided
359 under any capitated managed care pilot program provided for under
360 paragraph (24) of this section.
361 (17) Durable medical equipment services and medical
362 supplies, including certain prosthetic devices as approved by the
363 Division of Medicaid. Precertification of durable medical
364 equipment and medical supplies must be obtained as required by the
365 division. The Division of Medicaid shall require vendors who
366 provide approved prosthetic devices to submit proof of
367 certification by the American Board for Certification in Orthotics
368 and Prosthetics. The Division of Medicaid may require durable
369 medical equipment providers to obtain a surety bond in the amount
370 and to the specifications as established by the Balanced Budget
371 Act of 1997. As used in this paragraph (17), the term "prosthetic
372 device" means any artificial device that is not surgically
373 implanted and that is used to replace a missing limb, appendage or
374 other external human body part, including devices such as
375 artificial legs, hands, feet, but excluding artificial eyes or
376 appliances for the eyes, dental plates and largely cosmetic
377 devices such as wigs, artificial breasts, eyelashes, ears and
378 noses or other devices that could not by their use have a
379 significantly detrimental impact upon the musculoskeletal
380 functions of the body.
381 (18) (a) Notwithstanding any other provision of this
382 section to the contrary, the division shall make additional
383 reimbursement to hospitals that serve a disproportionate share of
384 low-income patients and that meet the federal requirements for
385 those payments as provided in Section 1923 of the federal Social
386 Security Act and any applicable regulations. However, from and
387 after January 1, 1999, no public hospital shall participate in the
388 Medicaid disproportionate share program unless the public hospital

389 participates in an intergovernmental transfer program as provided
390 in Section 1903 of the federal Social Security Act and any
391 applicable regulations.
392 (b) The division shall establish a Medicare Upper
393 Payment Limits Program, as defined in Section 1902(a)(30) of the
394 federal Social Security Act and any applicable federal
395 regulations, for hospitals, and may establish a Medicare Upper
396 Payments Limits Program for nursing facilities. The division
397 shall assess each hospital and, if the program is established for
398 nursing facilities, shall assess each nursing facility, based on
399 Medicaid utilization or other appropriate method consistent with
400 federal regulations. The assessment will remain in effect as long
401 as the state participates in the Medicare Upper Payment Limits
402 Program. The division shall make additional reimbursement to
403 hospitals and, if the program is established for nursing
404 facilities, shall make additional reimbursement to nursing
405 facilities, for the Medicare Upper Payment Limits, as defined in
406 Section 1902(a)(30) of the federal Social Security Act and any
407 applicable federal regulations.
408 (19) (a) Perinatal risk management services. The
409 division shall promulgate regulations to be effective from and
410 after October 1, 1988, to establish a comprehensive perinatal
411 system for risk assessment of all pregnant and infant Medicaid
412 recipients and for management, education and follow-up for those
413 who are determined to be at risk. Services to be performed
414 include case management, nutrition assessment/counseling,
415 psychosocial assessment/counseling and health education.
416 (b) Early intervention system services. The
417 division shall cooperate with the State Department of Health,
418 acting as lead agency, in the development and implementation of a
419 statewide system of delivery of early intervention services, under
420 Part C of the Individuals with Disabilities Education Act (IDEA).
421 The State Department of Health shall certify annually in writing

422 to the executive director of the division the dollar amount of
423 state early intervention funds available that will be utilized as
424 a certified match for Medicaid matching funds. Those funds then
425 shall be used to provide expanded targeted case management
426 services for Medicaid eligible children with special needs who are
427 eligible for the state's early intervention system.
428 Qualifications for persons providing service coordination shall be
429 determined by the State Department of Health and the Division of
430 Medicaid.

431 (20) Home- and community-based services for physically
432 disabled approved services as allowed by a waiver from the United
433 States Department of Health and Human Services for home- and
434 community-based services for physically disabled people using
435 state funds that are provided from the appropriation to the State
436 Department of Rehabilitation Services and used to match federal
437 funds under a cooperative agreement between the division and the
438 department, provided that funds for these services are
439 specifically appropriated to the Department of Rehabilitation
440 Services.

441 (21) Nurse practitioner services. Services furnished
442 by a registered nurse who is licensed and certified by the
443 Mississippi Board of Nursing as a nurse practitioner, including,
444 but not limited to, nurse anesthetists, nurse midwives, family
445 nurse practitioners, family planning nurse practitioners,
446 pediatric nurse practitioners, obstetrics-gynecology nurse
447 practitioners and neonatal nurse practitioners, under regulations
448 adopted by the division. Reimbursement for those services shall
449 not exceed ninety percent (90%) of the reimbursement rate for
450 comparable services rendered by a physician.

451 (22) Ambulatory services delivered in federally
452 qualified health centers, rural health centers and clinics of the
453 local health departments of the State Department of Health for

454 individuals eligible for Medicaid under this article based on
455 reasonable costs as determined by the division.
456 (23) Inpatient psychiatric services. Inpatient
457 psychiatric services to be determined by the division for
458 recipients under age twenty-one (21) that are provided under the
459 direction of a physician in an inpatient program in a licensed
460 acute care psychiatric facility or in a licensed psychiatric
461 residential treatment facility, before the recipient reaches age
462 twenty-one (21) or, if the recipient was receiving the services
463 immediately before he or she reached age twenty-one (21), before
464 the earlier of the date he or she no longer requires the services
465 or the date he or she reaches age twenty-two (22), as provided by
466 federal regulations. Precertification of inpatient days and
467 residential treatment days must be obtained as required by the
468 division.
469 (24) [Deleted]
470 (25) [Deleted]
471 (26) Hospice care. As used in this paragraph, the term
472 "hospice care" means a coordinated program of active professional
473 medical attention within the home and outpatient and inpatient
474 care that treats the terminally ill patient and family as a unit,
475 employing a medically directed interdisciplinary team. The
476 program provides relief of severe pain or other physical symptoms
477 and supportive care to meet the special needs arising out of
478 physical, psychological, spiritual, social and economic stresses
479 that are experienced during the final stages of illness and during
480 dying and bereavement and meets the Medicare requirements for
481 participation as a hospice as provided in federal regulations.
482 (27) Group health plan premiums and cost sharing if it
483 is cost effective as defined by the United States Secretary of
484 Health and Human Services.
485 (28) Other health insurance premiums that are cost
486 effective as defined by the United States Secretary of Health and

487 Human Services. Medicare eligible must have Medicare Part B
488 before other insurance premiums can be paid.
489 (29) The Division of Medicaid may apply for a waiver
490 from the United States Department of Health and Human Services for
491 home- and community-based services for developmentally disabled
492 people using state funds that are provided from the appropriation
493 to the State Department of Mental Health and/or funds transferred
494 to the department by a political subdivision or instrumentality of
495 the state and used to match federal funds under a cooperative
496 agreement between the division and the department, provided that
497 funds for these services are specifically appropriated to the
498 Department of Mental Health and/or transferred to the department
499 by a political subdivision or instrumentality of the state.
500 (30) Pediatric skilled nursing services for eligible
501 persons under twenty-one (21) years of age.
502 (31) Targeted case management services for children
503 with special needs, under waivers from the United States
504 Department of Health and Human Services, using state funds that
505 are provided from the appropriation to the Mississippi Department
506 of Human Services and used to match federal funds under a
507 cooperative agreement between the division and the department.
508 (32) Care and services provided in Christian Science
509 Sanatoria listed and certified by the Commission for Accreditation
510 of Christian Science Nursing Organizations/Facilities, Inc.,
511 rendered in connection with treatment by prayer or spiritual means
512 to the extent that those services are subject to reimbursement
513 under Section 1903 of the federal Social Security Act.
514 (33) Podiatrist services.
515 (34) Assisted living services as provided through home-
516 and community-based services under Title XIX of the federal Social
517 Security Act, as amended, subject to the availability of funds
518 specifically appropriated for that purpose by the Legislature.

519 (35) Services and activities authorized in Sections
520 43-27-101 and 43-27-103, using state funds that are provided from
521 the appropriation to the State Department of Human Services and
522 used to match federal funds under a cooperative agreement between
523 the division and the department.
524 (36) Nonemergency transportation services for
525 Medicaid-eligible persons, to be provided by the Division of
526 Medicaid. The division may contract with additional entities to
527 administer nonemergency transportation services as it deems
528 necessary. All providers shall have a valid driver's license,
529 vehicle inspection sticker, valid vehicle license tags and a
530 standard liability insurance policy covering the vehicle. The
531 division may pay providers a flat fee based on mileage tiers, or
532 in the alternative, may reimburse on actual miles traveled. The
533 division may apply to the Center for Medicare and Medicaid
534 Services (CMS) for a waiver to draw federal matching funds for
535 nonemergency transportation services as a covered service instead
536 of an administrative cost.
537 (37) [Deleted]
538 (38) Chiropractic services. A chiropractor's manual
539 manipulation of the spine to correct a subluxation, if x-ray
540 demonstrates that a subluxation exists and if the subluxation has
541 resulted in a neuromusculoskeletal condition for which
542 manipulation is appropriate treatment, and related spinal x-rays
543 performed to document these conditions. Reimbursement for
544 chiropractic services shall not exceed Seven Hundred Dollars
545 ($700.00) per year per beneficiary.
546 (39) Dually eligible Medicare/Medicaid beneficiaries.
547 The division shall pay the Medicare deductible and coinsurance
548 amounts for services available under Medicare, as determined by
549 the division.
550 (40) [Deleted]

551 (41) Services provided by the State Department of
552 Rehabilitation Services for the care and rehabilitation of persons
553 with spinal cord injuries or traumatic brain injuries, as allowed
554 under waivers from the United States Department of Health and
555 Human Services, using up to seventy-five percent (75%) of the
556 funds that are appropriated to the Department of Rehabilitation
557 Services from the Spinal Cord and Head Injury Trust Fund
558 established under Section 37-33-261 and used to match federal
559 funds under a cooperative agreement between the division and the
560 department.
561 (42) Notwithstanding any other provision in this
562 article to the contrary, the division may develop a population
563 health management program for women and children health services
564 through the age of one (1) year. This program is primarily for
565 obstetrical care associated with low birth weight and pre-term
566 babies. The division may apply to the federal Centers for
567 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
568 any other waivers that may enhance the program. In order to
569 effect cost savings, the division may develop a revised payment
570 methodology that may include at-risk capitated payments, and may
571 require member participation in accordance with the terms and
572 conditions of an approved federal waiver.
573 (43) The division shall provide reimbursement,
574 according to a payment schedule developed by the division, for
575 smoking cessation medications for pregnant women during their
576 pregnancy and other Medicaid-eligible women who are of
577 child-bearing age.
578 (44) Nursing facility services for the severely
579 disabled.
580 (a) Severe disabilities include, but are not
581 limited to, spinal cord injuries, closed head injuries and
582 ventilator dependent patients.

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

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

594 (46) The division shall make application to the federal
595 Centers for Medicare and Medicaid Services (CMS) for a waiver to
596 develop and provide services for children with serious emotional
597 disturbances as defined in Section 43-14-1(1), which may include
598 home- and community-based services, case management services or
599 managed care services through mental health providers certified by
600 the Department of Mental Health. The division may implement and
601 provide services under this waivered program only if funds for
602 these services are specifically appropriated for this purpose by
603 the Legislature, or if funds are voluntarily provided by affected
604 agencies.

605 (47) (a) Notwithstanding any other provision in this
606 article to the contrary, the division, in conjunction with the
607 State Department of Health, may develop and implement disease
608 management programs for individuals with high-cost chronic
609 diseases and conditions, including the use of grants, waivers,
610 demonstrations or other projects as necessary.

611 (b) Participation in any disease management
612 program implemented under this paragraph (47) is optional with the
613 individual. An individual must affirmatively elect to participate
614 in the disease management program in order to participate.

615 (c) An individual who participates in the disease
616 management program has the option of participating in the
617 prescription drug home delivery component of the program at any
618 time while participating in the program. An individual must
619 affirmatively elect to participate in the prescription drug home
620 delivery component in order to participate.
621 (d) An individual who participates in the disease
622 management program may elect to discontinue participation in the
623 program at any time. An individual who participates in the
624 prescription drug home delivery component may elect to discontinue
625 participation in the prescription drug home delivery component at
626 any time.
627 (e) The division shall send written notice to all
628 individuals who participate in the disease management program
629 informing them that they may continue using their local pharmacy
630 or any other pharmacy of their choice to obtain their prescription
631 drugs while participating in the program.
632 (f) Prescription drugs that are provided to
633 individuals under the prescription drug home delivery component
634 shall be limited only to those drugs that are used for the
635 treatment, management or care of asthma, diabetes or hypertension.
636 (48) Pediatric long-term acute care hospital services.
637 (a) Pediatric long-term acute care hospital
638 services means services provided to eligible persons under
639 twenty-one (21) years of age by a freestanding Medicare-certified
640 hospital that has an average length of inpatient stay greater than
641 twenty-five (25) days and that is primarily engaged in providing
642 chronic or long-term medical care to persons under twenty-one (21)
643 years of age.
644 (b) The services under this paragraph (48) shall
645 be reimbursed as a separate category of hospital services.
646 (49) The division shall establish co-payments and/or
647 coinsurance for all Medicaid services for which co-payments and/or

648 coinsurance are allowable under federal law or regulation, and
649 shall set the amount of the co-payment and/or coinsurance for each
650 of those services at the maximum amount allowable under federal
651 law or regulation.

652 (50) Services provided by the State Department of
653 Rehabilitation Services for the care and rehabilitation of persons
654 who are deaf and blind, as allowed under waivers from the United
655 States Department of Health and Human Services to provide home-
656 and community-based services using state funds that are provided
657 from the appropriation to the State Department of Rehabilitation
658 Services or if funds are voluntarily provided by another agency.

659 (51) Upon determination of Medicaid eligibility and in
660 association with annual redetermination of Medicaid eligibility,
661 beneficiaries shall be encouraged to undertake a physical
662 examination that will establish a base-line level of health and
663 identification of a usual and customary source of care (a medical
664 home) to aid utilization of disease management tools. This
665 physical examination and utilization of these disease management
666 tools shall be consistent with current United States Preventive
667 Services Task Force or other recognized authority recommendations.

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

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

681 (53) Targeted case management services for high-cost
682 beneficiaries shall be developed by the division for all services
683 under this section.
684 Notwithstanding any other provision of this article to the
685 contrary, the division shall reduce the rate of reimbursement to
686 providers for any service provided under this section by five
687 percent (5%) of the allowed amount for that service. However, the
688 reduction in the reimbursement rates required by this paragraph
689 shall not apply to inpatient hospital services, nursing facility
690 services, intermediate care facility services, psychiatric
691 residential treatment facility services, pharmacy services
692 provided under paragraph (9) of this section, or any service
693 provided by the University of Mississippi Medical Center or a
694 state agency, a state facility or a public agency that either
695 provides its own state match through intergovernmental transfer or
696 certification of funds to the division, or a service for which the
697 federal government sets the reimbursement methodology and rate.
698 In addition, the reduction in the reimbursement rates required by
699 this paragraph shall not apply to case management services and
700 home-delivered meals provided under the home- and community-based
701 services program for the elderly and disabled by a planning and
702 development district (PDD). Planning and development districts
703 participating in the home- and community-based services program
704 for the elderly and disabled as case management providers shall be
705 reimbursed for case management services at the maximum rate
706 approved by the Centers for Medicare and Medicaid Services (CMS).
707 The division may pay to those providers who participate in
708 and accept patient referrals from the division's emergency room
709 redirection program a percentage, as determined by the division,
710 of savings achieved according to the performance measures and
711 reduction of costs required of that program. Federally qualified
712 health centers may participate in the emergency room redirection
713 program, and the division may pay those centers a percentage of

714 any savings to the Medicaid program achieved by the centers'
715 accepting patient referrals through the program, as provided in
716 this paragraph.
717 Notwithstanding any provision of this article, except as
718 authorized in the following paragraph and in Section 43-13-139,
719 neither (a) the limitations on quantity or frequency of use of or
720 the fees or charges for any of the care or services available to
721 recipients under this section, nor (b) the payments or rates of
722 reimbursement to providers rendering care or services authorized
723 under this section to recipients, may be increased, decreased or
724 otherwise changed from the levels in effect on July 1, 1999,
725 unless they are authorized by an amendment to this section by the
726 Legislature. However, the restriction in this paragraph shall not
727 prevent the division from changing the payments or rates of
728 reimbursement to providers without an amendment to this section
729 whenever those changes are required by federal law or regulation,
730 or whenever those changes are necessary to correct administrative
731 errors or omissions in calculating those payments or rates of
732 reimbursement.
733 Notwithstanding any provision of this article, no new groups
734 or categories of recipients and new types of care and services may
735 be added without enabling legislation from the Mississippi
736 Legislature, except that the division may authorize those changes
737 without enabling legislation when the addition of recipients or
738 services is ordered by a court of proper authority.
739 The executive director shall keep the Governor advised on a
740 timely basis of the funds available for expenditure and the
741 projected expenditures. If current or projected expenditures of
742 the division are reasonably anticipated to exceed the amount of
743 funds appropriated to the division for any fiscal year, the
744 Governor, after consultation with the executive director, shall
745 discontinue any or all of the payment of the types of care and
746 services as provided in this section that are deemed to be

747 optional services under Title XIX of the federal Social Security
748 Act, as amended, and when necessary, shall institute any other
749 cost containment measures on any program or programs authorized
750 under the article to the extent allowed under the federal law
751 governing that program or programs. However, the Governor shall
752 not be authorized to discontinue or eliminate any service under
753 this section that is mandatory under federal law, or to
754 discontinue or eliminate, or adjust income limits or resource
755 limits for, any eligibility category or group under Section
756 43-13-115. It is the intent of the Legislature that the
757 expenditures of the division during any fiscal year shall not
758 exceed the amounts appropriated to the division for that fiscal
759 year.

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

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

ST: Medicaid; certain prosthetic devices will be reimbursable under.