MISSISSIPPI LEGISLATURE REGULAR SESSION 2007

By: Senator(s) Fillingane

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2392

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE MEDICAID REIMBURSEMENT FOR FULL BODY CASTS FOR ADULTS
3 WHO HAVE SPINA BIFIDA IF A PHYSICIAN DETERMINES THAT IT IS
4 MEDICALLY NECESSARY TO PREVENT SIGNIFICANT DETERIORATION OF THE
5 PERSON'S PHYSICAL HEALTH FROM THE EFFECTS OF SPINA BIFIDA; AND FOR
6 RELATED PURPOSES.

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

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

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

17 (1) Inpatient hospital services.

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

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

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

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

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

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

95 (e) The division shall develop and implement, not
96 later than January 1, 2001, a case-mix payment add-on determined
97 by time studies and other valid statistical data that will
98 reimburse a nursing facility for the additional cost of caring for
99 a resident who has a diagnosis of Alzheimer's or other related
100 dementia and exhibits symptoms that require special care. Any
101 such case-mix add-on payment shall be supported by a determination
102 of additional cost. The division shall also develop and implement
103 as part of the fair rental reimbursement system for nursing
104 facility beds, an Alzheimer's resident bed depreciation enhanced
105 reimbursement system that will provide an incentive to encourage
106 nursing facilities to convert or construct beds for residents with
107 Alzheimer's or other related dementia.
108 (f) The division shall develop and implement an
109 assessment process for long-term care services. The division may
110 provide the assessment and related functions directly or through
111 contract with the area agencies on aging.
112 The division shall apply for necessary federal waivers to
113 assure that additional services providing alternatives to nursing
114 facility care are made available to applicants for nursing
115 facility care.
116 (5) Periodic screening and diagnostic services for
117 individuals under age twenty-one (21) years as are needed to
118 identify physical and mental defects and to provide health care
119 treatment and other measures designed to correct or ameliorate
120 defects and physical and mental illness and conditions discovered
121 by the screening services, regardless of whether these services
122 are included in the state plan. The division may include in its
123 periodic screening and diagnostic program those discretionary
124 services authorized under the federal regulations adopted to
125 implement Title XIX of the federal Social Security Act, as
126 amended. The division, in obtaining physical therapy services,
127 occupational therapy services, and services for individuals with

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

423 community-based services for physically disabled people using
424 state funds that are provided from the appropriation to the State
425 Department of Rehabilitation Services and used to match federal
426 funds under a cooperative agreement between the division and the
427 department, provided that funds for these services are
428 specifically appropriated to the Department of Rehabilitation
429 Services.
430 (21) Nurse practitioner services. Services furnished
431 by a registered nurse who is licensed and certified by the
432 Mississippi Board of Nursing as a nurse practitioner, including,
433 but not limited to, nurse anesthetists, nurse midwives, family
434 nurse practitioners, family planning nurse practitioners,
435 pediatric nurse practitioners, obstetrics-gynecology nurse
436 practitioners and neonatal nurse practitioners, under regulations
437 adopted by the division. Reimbursement for those services shall
438 not exceed ninety percent (90%) of the reimbursement rate for
439 comparable services rendered by a physician.
440 (22) Ambulatory services delivered in federally
441 qualified health centers, rural health centers and clinics of the
442 local health departments of the State Department of Health for
443 individuals eligible for Medicaid under this article based on
444 reasonable costs as determined by the division.
445 (23) Inpatient psychiatric services. Inpatient
446 psychiatric services to be determined by the division for
447 recipients under age twenty-one (21) that are provided under the
448 direction of a physician in an inpatient program in a licensed
449 acute care psychiatric facility or in a licensed psychiatric
450 residential treatment facility, before the recipient reaches age
451 twenty-one (21) or, if the recipient was receiving the services
452 immediately before he or she reached age twenty-one (21), before
453 the earlier of the date he or she no longer requires the services
454 or the date he or she reaches age twenty-two (22), as provided by
455 federal regulations. Precertification of inpatient days and

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

489 (30) Pediatric skilled nursing services for eligible
490 persons under twenty-one (21) years of age.
491 (31) Targeted case management services for children
492 with special needs, under waivers from the United States
493 Department of Health and Human Services, using state funds that
494 are provided from the appropriation to the Mississippi Department
495 of Human Services and used to match federal funds under a
496 cooperative agreement between the division and the department.
497 (32) Care and services provided in Christian Science
498 Sanatoria listed and certified by the Commission for Accreditation
499 of Christian Science Nursing Organizations/Facilities, Inc.,
500 rendered in connection with treatment by prayer or spiritual means
501 to the extent that those services are subject to reimbursement
502 under Section 1903 of the federal Social Security Act.
503 (33) Podiatrist services.
504 (34) Assisted living services as provided through home-
505 and community-based services under Title XIX of the federal Social
506 Security Act, as amended, subject to the availability of funds
507 specifically appropriated for that purpose by the Legislature.
508 (35) Services and activities authorized in Sections
509 43-27-101 and 43-27-103, using state funds that are provided from
510 the appropriation to the State Department of Human Services and
511 used to match federal funds under a cooperative agreement between
512 the division and the department.
513 (36) Nonemergency transportation services for
514 Medicaid-eligible persons, to be provided by the Division of
515 Medicaid. The division may contract with additional entities to
516 administer nonemergency transportation services as it deems
517 necessary. All providers shall have a valid driver's license,
518 vehicle inspection sticker, valid vehicle license tags and a
519 standard liability insurance policy covering the vehicle. The
520 division may pay providers a flat fee based on mileage tiers, or
521 in the alternative, may reimburse on actual miles traveled. The

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

526 (37) [Deleted]

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

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

539 (40) [Deleted]

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

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

555 babies. The division may apply to the federal Centers for
556 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
557 any other waivers that may enhance the program. In order to
558 effect cost savings, the division may develop a revised payment
559 methodology that may include at-risk capitated payments, and may
560 require member participation in accordance with the terms and
561 conditions of an approved federal waiver.
562 (43) The division shall provide reimbursement,
563 according to a payment schedule developed by the division, for
564 smoking cessation medications for pregnant women during their
565 pregnancy and other Medicaid-eligible women who are of
566 child-bearing age.
567 (44) Nursing facility services for the severely
568 disabled.
569 (a) Severe disabilities include, but are not
570 limited to, spinal cord injuries, closed head injuries and
571 ventilator dependent patients.
572 (b) Those services must be provided in a long-term
573 care nursing facility dedicated to the care and treatment of
574 persons with severe disabilities, and shall be reimbursed as a
575 separate category of nursing facilities.
576 (45) Physician assistant services. Services furnished
577 by a physician assistant who is licensed by the State Board of
578 Medical Licensure and is practicing with physician supervision
579 under regulations adopted by the board, under regulations adopted
580 by the division. Reimbursement for those services shall not
581 exceed ninety percent (90%) of the reimbursement rate for
582 comparable services rendered by a physician.
583 (46) The division shall make application to the federal
584 Centers for Medicare and Medicaid Services (CMS) for a waiver to
585 develop and provide services for children with serious emotional
586 disturbances as defined in Section 43-14-1(1), which may include
587 home- and community-based services, case management services or

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

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

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

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

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

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

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

654 physical examination and utilization of these disease management
655 tools shall be consistent with current United States Preventive
656 Services Task Force or other recognized authority recommendations.
657 For persons who are determined ineligible for Medicaid, the
658 division will provide information and direction for accessing
659 medical care and services in the area of their residence.
660 (52) Notwithstanding any provisions of this article,
661 the division may pay enhanced reimbursement fees related to trauma
662 care, as determined by the division in conjunction with the State
663 Department of Health, using funds appropriated to the State
664 Department of Health for trauma care and services and used to
665 match federal funds under a cooperative agreement between the
666 division and the State Department of Health. The division, in
667 conjunction with the State Department of Health, may use grants,
668 waivers, demonstrations, or other projects as necessary in the
669 development and implementation of this reimbursement program.
670 (53) Targeted case management services for high-cost
671 beneficiaries shall be developed by the division for all services
672 under this section.
673 (54) Full body casts for persons over twenty-one (21)
674 years of age who have spina bifida if a physician determines that
675 it is medically necessary to prevent significant deterioration of
676 the person's physical health from the effects of spina bifida.
677 Notwithstanding any other provision of this article to the
678 contrary, the division shall reduce the rate of reimbursement to
679 providers for any service provided under this section by five
680 percent (5%) of the allowed amount for that service. However, the
681 reduction in the reimbursement rates required by this paragraph
682 shall not apply to inpatient hospital services, nursing facility
683 services, intermediate care facility services, psychiatric
684 residential treatment facility services, pharmacy services
685 provided under paragraph (9) of this section, or any service
686 provided by the University of Mississippi Medical Center or a

687 state agency, a state facility or a public agency that either
688 provides its own state match through intergovernmental transfer or
689 certification of funds to the division, or a service for which the
690 federal government sets the reimbursement methodology and rate.
691 In addition, the reduction in the reimbursement rates required by
692 this paragraph shall not apply to case management services and
693 home-delivered meals provided under the home- and community-based
694 services program for the elderly and disabled by a planning and
695 development district (PDD). Planning and development districts
696 participating in the home- and community-based services program
697 for the elderly and disabled as case management providers shall be
698 reimbursed for case management services at the maximum rate
699 approved by the Centers for Medicare and Medicaid Services (CMS).
700 The division may pay to those providers who participate in
701 and accept patient referrals from the division's emergency room
702 redirection program a percentage, as determined by the division,
703 of savings achieved according to the performance measures and
704 reduction of costs required of that program. Federally qualified
705 health centers may participate in the emergency room redirection
706 program, and the division may pay those centers a percentage of
707 any savings to the Medicaid program achieved by the centers'
708 accepting patient referrals through the program, as provided in
709 this paragraph.
710 Notwithstanding any provision of this article, except as
711 authorized in the following paragraph and in Section 43-13-139,
712 neither (a) the limitations on quantity or frequency of use of or
713 the fees or charges for any of the care or services available to
714 recipients under this section, nor (b) the payments or rates of
715 reimbursement to providers rendering care or services authorized
716 under this section to recipients, may be increased, decreased or
717 otherwise changed from the levels in effect on July 1, 1999,
718 unless they are authorized by an amendment to this section by the
719 Legislature. However, the restriction in this paragraph shall not

720 prevent the division from changing the payments or rates of
721 reimbursement to providers without an amendment to this section
722 whenever those changes are required by federal law or regulation,
723 or whenever those changes are necessary to correct administrative
724 errors or omissions in calculating those payments or rates of
725 reimbursement.

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

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

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

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

ST: Medicaid; provide reimbursement for full body casts for certain adults with spina bifida.