

By: Representatives Upshaw, Clarke

To: Medicaid; Public Health
and Human Services

HOUSE BILL NO. 29

1 AN ACT TO AMEND SECTION 41-23-37, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE THAT FEMALE CHILDREN MUST BE VACCINATED AGAINST THE
3 HUMAN PAPILLOMAVIRUS (HPV) BEFORE THEY MAY ENROLL IN AND ATTEND
4 THE SIXTH GRADE AT ANY SCHOOL; TO AMEND SECTION 43-13-117,
5 MISSISSIPPI CODE OF 1972, TO PROVIDE MEDICAID REIMBURSEMENT FOR
6 HPV VACCINATIONS FOR WOMEN WHO ARE AT LEAST NINETEEN YEARS OF AGE
7 BUT NOT MORE THAN TWENTY-SIX YEARS OF AGE; TO CODIFY NEW SECTION
8 83-9-34.1, MISSISSIPPI CODE OF 1972, TO REQUIRE HEALTH BENEFIT
9 PLANS THAT ARE ISSUED OR RENEWED ON OR AFTER JANUARY 1, 2009, TO
10 PROVIDE COVERAGE FOR IMMUNIZATION AGAINST HPV FOR EACH FEMALE
11 CHILD OF THE INSURED WHO IS AT LEAST NINE YEARS OF AGE BUT NOT
12 MORE THAN TWENTY-SIX YEARS OF AGE; AND FOR RELATED PURPOSES.

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

14 **SECTION 1.** Section 41-23-37, Mississippi Code of 1972, is
15 amended as follows:

16 41-23-37. (1) Whenever indicated, the State Health Officer
17 shall specify such immunization practices as may be considered
18 best for the control of vaccine preventable diseases. A listing
19 shall be promulgated annually or more often, if necessary.

20 (2) (a) Except as provided otherwise in this section, it
21 shall be unlawful for any child to attend any school, kindergarten
22 or similar type facility intended for the instruction of children
23 (in this section, called "schools"), either public or private,
24 with the exception of any legitimate home instruction program as
25 defined in Section 37-13-91 for ten (10) or fewer children who are
26 related within the third degree computed according to the civil
27 law to the operator, unless the child first has been vaccinated
28 against those diseases specified by the State Health Officer.

29 (b) Except as otherwise provided in this section, it
30 shall be unlawful for any female child to enroll in and attend the
31 sixth grade at any school or similar type facility intended for



32 the instruction of children (in this section, called "schools"),
33 either public or private, with the exception of any legitimate
34 home instruction program as defined in Section 37-13-91 for ten
35 (10) or fewer children who are related within the third degree
36 computed according to the civil law to the operator, unless the
37 child first has been vaccinated against the human papillomavirus
38 (HPV).

39 (3) A certificate of exemption from vaccination for medical
40 reasons may be offered on behalf of a child by a duly licensed
41 physician and may be accepted by the local health officer when, in
42 his opinion, the exemption will not cause undue risk to the
43 community.

44 (4) Certificates of vaccination shall be issued by local
45 health officers or physicians on forms specified by the
46 Mississippi State Board of Health. These forms shall be the only
47 acceptable means for showing compliance with these immunization
48 requirements, and the responsible school officials shall file the
49 form with the child's record.

50 (5) If a child * * * offers to enroll at a school without
51 having completed the required vaccinations, the local health
52 officer may grant a period of time up to ninety (90) days for
53 that completion when, in the opinion of the health officer, the
54 delay will not cause undue risk to the child, the school or the
55 community. No child shall be enrolled without having had at least
56 one (1) dose of each specified vaccine.

57 (6) Within thirty (30) days after the opening of the fall
58 term of school (on or before October 1 of each year) the person in
59 charge of each school shall report to the county or local health
60 officer, on forms provided by the Mississippi State Board of
61 Health, the number of children enrolled by age or grade or both,
62 the number fully vaccinated, the number in process of completing
63 vaccination requirements, and the number exempt from vaccination
64 by reason for the exemption.



65 (7) Within one hundred twenty (120) days after the opening
66 of the fall term (on or before December 31), the person in charge
67 of each school shall certify to the local or county health officer
68 that all children enrolled are in compliance with immunization
69 requirements.

70 (8) For the purpose of assisting in supervising the
71 immunization status of the children the local health officer, or
72 his designee, may inspect the children's records or be furnished
73 certificates of immunization compliance by the school.

74 (9) It shall be the responsibility of the person in charge
75 of each school to enforce the requirements for immunization. Any
76 child not in compliance at the end of ninety (90) days from the
77 opening of the fall term must be suspended until in compliance,
78 unless the health officer * * * attributes the delay to lack of
79 supply of vaccine or some other such factor clearly making
80 compliance impossible.

81 (10) Failure to enforce provisions of this section shall
82 constitute a misdemeanor and upon conviction be punishable by fine
83 or imprisonment or both.

84 **SECTION 2.** Section 43-13-117, Mississippi Code of 1972, is
85 amended as follows:

86 43-13-117. Medicaid as authorized by this article shall
87 include payment of part or all of the costs, at the discretion of
88 the division, with approval of the Governor, of the following
89 types of care and services rendered to eligible applicants who
90 have been determined to be eligible for that care and services,
91 within the limits of state appropriations and federal matching
92 funds:

93 (1) Inpatient hospital services.

94 (a) The division shall allow thirty (30) days of
95 inpatient hospital care annually for all Medicaid recipients.
96 Precertification of inpatient days must be obtained as required by
97 the division. The division may allow unlimited days in



98 disproportionate hospitals as defined by the division for eligible
99 infants and children under the age of six (6) years if certified
100 as medically necessary as required by the division.

101 (b) From and after July 1, 1994, the Executive
102 Director of the Division of Medicaid shall amend the Mississippi
103 Title XIX Inpatient Hospital Reimbursement Plan to remove the
104 occupancy rate penalty from the calculation of the Medicaid
105 Capital Cost Component utilized to determine total hospital costs
106 allocated to the Medicaid program.

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

114 (2) Outpatient hospital services.

115 (a) Emergency services. The division shall allow
116 six (6) medically necessary emergency room visits per beneficiary
117 per fiscal year.

118 (b) Other outpatient hospital services. The
119 division shall allow benefits for other medically necessary
120 outpatient hospital services (such as chemotherapy, radiation,
121 surgery and therapy). Where the same services are reimbursed as
122 clinic services, the division may revise the rate or methodology
123 of outpatient reimbursement to maintain consistency, efficiency,
124 economy and quality of care.

125 (3) Laboratory and x-ray services.

126 (4) Nursing facility services.

127 (a) The division shall make full payment to
128 nursing facilities for each day, not exceeding fifty-two (52) days
129 per year, that a patient is absent from the facility on home
130 leave. Payment may be made for the following home leave days in



131 addition to the fifty-two-day limitation: Christmas, the day
132 before Christmas, the day after Christmas, Thanksgiving, the day
133 before Thanksgiving and the day after Thanksgiving.

134 (b) From and after July 1, 1997, the division
135 shall implement the integrated case-mix payment and quality
136 monitoring system, which includes the fair rental system for
137 property costs and in which recapture of depreciation is
138 eliminated. The division may reduce the payment for hospital
139 leave and therapeutic home leave days to the lower of the case-mix
140 category as computed for the resident on leave using the
141 assessment being utilized for payment at that point in time, or a
142 case-mix score of 1.000 for nursing facilities, and shall compute
143 case-mix scores of residents so that only services provided at the
144 nursing facility are considered in calculating a facility's per
145 diem.

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

149 (d) When a facility of a category that does not
150 require a certificate of need for construction and that could not
151 be eligible for Medicaid reimbursement is constructed to nursing
152 facility specifications for licensure and certification, and the
153 facility is subsequently converted to a nursing facility under a
154 certificate of need that authorizes conversion only and the
155 applicant for the certificate of need was assessed an application
156 review fee based on capital expenditures incurred in constructing
157 the facility, the division shall allow reimbursement for capital
158 expenditures necessary for construction of the facility that were
159 incurred within the twenty-four (24) consecutive calendar months
160 immediately preceding the date that the certificate of need
161 authorizing the conversion was issued, to the same extent that
162 reimbursement would be allowed for construction of a new nursing
163 facility under a certificate of need that authorizes that



164 construction. The reimbursement authorized in this subparagraph
165 (d) may be made only to facilities the construction of which was
166 completed after June 30, 1989. Before the division shall be
167 authorized to make the reimbursement authorized in this
168 subparagraph (d), the division first must have received approval
169 from the Centers for Medicare and Medicaid Services (CMS) of the
170 change in the state Medicaid plan providing for the reimbursement.

171 (e) The division shall develop and implement, not
172 later than January 1, 2001, a case-mix payment add-on determined
173 by time studies and other valid statistical data that will
174 reimburse a nursing facility for the additional cost of caring for
175 a resident who has a diagnosis of Alzheimer's or other related
176 dementia and exhibits symptoms that require special care. Any
177 such case-mix add-on payment shall be supported by a determination
178 of additional cost. The division shall also develop and implement
179 as part of the fair rental reimbursement system for nursing
180 facility beds, an Alzheimer's resident bed depreciation enhanced
181 reimbursement system that will provide an incentive to encourage
182 nursing facilities to convert or construct beds for residents with
183 Alzheimer's or other related dementia.

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

188 The division shall apply for necessary federal waivers to
189 assure that additional services providing alternatives to nursing
190 facility care are made available to applicants for nursing
191 facility care.

192 (5) Periodic screening and diagnostic services for
193 individuals under age twenty-one (21) years as are needed to
194 identify physical and mental defects and to provide health care
195 treatment and other measures designed to correct or ameliorate
196 defects and physical and mental illness and conditions discovered



197 by the screening services, regardless of whether these services
198 are included in the state plan. The division may include in its
199 periodic screening and diagnostic program those discretionary
200 services authorized under the federal regulations adopted to
201 implement Title XIX of the federal Social Security Act, as
202 amended. The division, in obtaining physical therapy services,
203 occupational therapy services, and services for individuals with
204 speech, hearing and language disorders, may enter into a
205 cooperative agreement with the State Department of Education for
206 the provision of those services to handicapped students by public
207 school districts using state funds that are provided from the
208 appropriation to the Department of Education to obtain federal
209 matching funds through the division. The division, in obtaining
210 medical and psychological evaluations for children in the custody
211 of the Mississippi Department of Human Services may enter into a
212 cooperative agreement with the Mississippi Department of Human
213 Services for the provision of those services using state funds
214 that are provided from the appropriation to the Department of
215 Human Services to obtain federal matching funds through the
216 division.

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

228 (7) (a) Home health services for eligible persons, not
229 to exceed in cost the prevailing cost of nursing facility



230 services, not to exceed twenty-five (25) visits per year. All
231 home health visits must be precertified as required by the
232 division.

233 (b) [Repealed]

234 (8) Emergency medical transportation services. On
235 January 1, 1994, emergency medical transportation services shall
236 be reimbursed at seventy percent (70%) of the rate established
237 under Medicare (Title XVIII of the federal Social Security Act, as
238 amended). "Emergency medical transportation services" shall mean,
239 but shall not be limited to, the following services by a properly
240 permitted ambulance operated by a properly licensed provider in
241 accordance with the Emergency Medical Services Act of 1974
242 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
243 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
244 (vi) disposable supplies, (vii) similar services.

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

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

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

260 The division shall allow for a combination of prescriptions
261 for single source and innovator multiple source drugs and generic
262 drugs to meet the needs of the beneficiaries, not to exceed five



263 (5) prescriptions per month for each noninstitutionalized Medicaid
264 beneficiary, with not more than two (2) of those prescriptions
265 being for single source or innovator multiple source drugs.

266 The executive director may approve specific maintenance drugs
267 for beneficiaries with certain medical conditions, which may be
268 prescribed and dispensed in three-month supply increments.

269 Drugs prescribed for a resident of a psychiatric residential
270 treatment facility must be provided in true unit doses when
271 available. The division may require that drugs not covered by
272 Medicare Part D for a resident of a long-term care facility be
273 provided in true unit doses when available. Those drugs that were
274 originally billed to the division but are not used by a resident
275 in any of those facilities shall be returned to the billing
276 pharmacy for credit to the division, in accordance with the
277 guidelines of the State Board of Pharmacy and any requirements of
278 federal law and regulation. Drugs shall be dispensed to a
279 recipient and only one (1) dispensing fee per month may be
280 charged. The division shall develop a methodology for reimbursing
281 for restocked drugs, which shall include a restock fee as
282 determined by the division not exceeding Seven Dollars and
283 Eighty-two Cents (\$7.82).

284 The voluntary preferred drug list shall be expanded to
285 function in the interim in order to have a manageable prior
286 authorization system, thereby minimizing disruption of service to
287 beneficiaries.

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

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



296 All claims for drugs for dually eligible Medicare/Medicaid
297 beneficiaries that are paid for by Medicare must be submitted to
298 Medicare for payment before they may be processed by the
299 division's online payment system.

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

305 The division shall develop and implement a method or methods
306 by which the division will provide on a regular basis to Medicaid
307 providers who are authorized to prescribe drugs, information about
308 the costs to the Medicaid program of single source drugs and
309 innovator multiple source drugs, and information about other drugs
310 that may be prescribed as alternatives to those single source
311 drugs and innovator multiple source drugs and the costs to the
312 Medicaid program of those alternative drugs.

313 Notwithstanding any law or regulation, information obtained
314 or maintained by the division regarding the prescription drug
315 program, including trade secrets and manufacturer or labeler
316 pricing, is confidential and not subject to disclosure except to
317 other state agencies.

318 (b) Payment by the division for covered
319 multisource drugs shall be limited to the lower of the upper
320 limits established and published by the Centers for Medicare and
321 Medicaid Services (CMS) plus a dispensing fee, or the estimated
322 acquisition cost (EAC) as determined by the division, plus a
323 dispensing fee, or the providers' usual and customary charge to
324 the general public.

325 Payment for other covered drugs, other than multisource drugs
326 with CMS upper limits, shall not exceed the lower of the estimated
327 acquisition cost as determined by the division, plus a dispensing



328 fee or the providers' usual and customary charge to the general
329 public.

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

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

338 The division shall not reimburse for single source or
339 innovator multiple source drugs if there are equally effective
340 generic equivalents available and if the generic equivalents are
341 the least expensive.

342 It is the intent of the Legislature that the pharmacists
343 providers be reimbursed for the reasonable costs of filling and
344 dispensing prescriptions for Medicaid beneficiaries.

345 (10) (a) Dental care that is an adjunct to treatment
346 of an acute medical or surgical condition; services of oral
347 surgeons and dentists in connection with surgery related to the
348 jaw or any structure contiguous to the jaw or the reduction of any
349 fracture of the jaw or any facial bone; and emergency dental
350 extractions and treatment related thereto. On July 1, 2007, fees
351 for dental care and surgery under authority of this paragraph (10)
352 shall be reimbursed as provided in paragraph (b). It is the
353 intent of the Legislature that this rate revision for dental
354 services will be an incentive designed to increase the number of
355 dentists who actively provide Medicaid services. This dental
356 services rate revision shall be known as the "James Russell Dumas
357 Medicaid Dental Incentive Program."

358 The division shall annually determine the effect of this
359 incentive by evaluating the number of dentists who are Medicaid
360 providers, the number who and the degree to which they are



361 actively billing Medicaid, the geographic trends of where dentists
362 are offering what types of Medicaid services and other statistics
363 pertinent to the goals of this legislative intent. This data
364 shall be presented to the Chair of the Senate Public Health and
365 Welfare Committee and the Chair of the House Medicaid Committee.

366 (b) The Division of Medicaid shall establish a fee
367 schedule, to be effective from and after July 1, 2007, for dental
368 services. The schedule shall provide for a fee for each dental
369 service that is equal to a percentile of normal and customary
370 private provider fees, as defined by the Ingenix Customized Fee
371 Analyzer Report, which percentile shall be determined by the
372 division. The schedule shall be reviewed annually by the division
373 and dental fees shall be adjusted to reflect the percentile
374 determined by the division.

375 (c) For fiscal year 2008, the amount of state
376 funds appropriated for reimbursement for dental care and surgery
377 shall be increased by ten percent (10%) of the amount of state
378 fund expenditures for that purpose for fiscal year 2007. For each
379 of fiscal years 2009 and 2010, the amount of state funds
380 appropriated for reimbursement for dental care and surgery shall
381 be increased by ten percent (10%) of the amount of state fund
382 expenditures for that purpose for the preceding fiscal year.

383 (d) The division shall establish an annual benefit
384 limit of Two Thousand Five Hundred Dollars (\$2,500.00) in dental
385 expenditures per Medicaid-eligible recipient; however, a recipient
386 may exceed the annual limit on dental expenditures provided in
387 this paragraph with prior approval of the division.

388 (e) The division shall include dental services as
389 a necessary component of overall health services provided to
390 children who are eligible for services.

391 (f) This paragraph (10) shall stand repealed on
392 July 1, 2010.



393 (11) Eyeglasses for all Medicaid beneficiaries who have
394 (a) had surgery on the eyeball or ocular muscle that results in a
395 vision change for which eyeglasses or a change in eyeglasses is
396 medically indicated within six (6) months of the surgery and is in
397 accordance with policies established by the division, or (b) one
398 (1) pair every five (5) years and in accordance with policies
399 established by the division. In either instance, the eyeglasses
400 must be prescribed by a physician skilled in diseases of the eye
401 or an optometrist, whichever the beneficiary may select.

402 (12) Intermediate care facility services.

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

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

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

417 (14) Clinic services. Such diagnostic, preventive,
418 therapeutic, rehabilitative or palliative services furnished to an
419 outpatient by or under the supervision of a physician or dentist
420 in a facility that is not a part of a hospital but that is
421 organized and operated to provide medical care to outpatients.
422 Clinic services shall include any services reimbursed as
423 outpatient hospital services that may be rendered in such a
424 facility, including those that become so after July 1, 1991. On
425 July 1, 1999, all fees for physicians' services reimbursed under



426 authority of this paragraph (14) shall be reimbursed at ninety
427 percent (90%) of the rate established on January 1, 1999, and as
428 may be adjusted each July thereafter, under Medicare (Title XVIII
429 of the federal Social Security Act, as amended). The division may
430 develop and implement a different reimbursement model or schedule
431 for physician's services provided by physicians based at an
432 academic health care center and by physicians at rural health
433 centers that are associated with an academic health care center.

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

439 (16) Mental health services. Approved therapeutic and
440 case management services (a) provided by an approved regional
441 mental health/retardation center established under Sections
442 41-19-31 through 41-19-39, or by another community mental health
443 service provider meeting the requirements of the Department of
444 Mental Health to be an approved mental health/retardation center
445 if determined necessary by the Department of Mental Health, using
446 state funds that are provided from the appropriation to the State
447 Department of Mental Health and/or funds transferred to the
448 department by a political subdivision or instrumentality of the
449 state and used to match federal funds under a cooperative
450 agreement between the division and the department, or (b) provided
451 by a facility that is certified by the State Department of Mental
452 Health to provide therapeutic and case management services, to be
453 reimbursed on a fee for service basis, or (c) provided in the
454 community by a facility or program operated by the Department of
455 Mental Health. Any such services provided by a facility described
456 in subparagraph (b) must have the prior approval of the division
457 to be reimbursable under this section. After June 30, 1997,
458 mental health services provided by regional mental



459 health/retardation centers established under Sections 41-19-31
460 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
461 and/or their subsidiaries and divisions, or by psychiatric
462 residential treatment facilities as defined in Section 43-11-1, or
463 by another community mental health service provider meeting the
464 requirements of the Department of Mental Health to be an approved
465 mental health/retardation center if determined necessary by the
466 Department of Mental Health, shall not be included in or provided
467 under any capitated managed care pilot program provided for under
468 paragraph (24) of this section.

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

475 (18) (a) Notwithstanding any other provision of this
476 section to the contrary, the division shall make additional
477 reimbursement to hospitals that serve a disproportionate share of
478 low-income patients and that meet the federal requirements for
479 those payments as provided in Section 1923 of the federal Social
480 Security Act and any applicable regulations. It is the intent of
481 the Legislature that the division shall draw down all available
482 federal funds allotted to the state for disproportionate share
483 hospitals. However, from and after January 1, 1999, no public
484 hospital shall participate in the Medicaid disproportionate share
485 program unless the public hospital participates in an
486 intergovernmental transfer program as provided in Section 1903 of
487 the federal Social Security Act and any applicable regulations.

488 (b) The division shall establish a Medicare Upper
489 Payment Limits Program, as defined in Section 1902(a)(30) of the
490 federal Social Security Act and any applicable federal
491 regulations, for hospitals, and may establish a Medicare Upper



492 Payment Limits Program for nursing facilities. The division shall
493 assess each hospital and, if the program is established for
494 nursing facilities, shall assess each nursing facility, based on
495 Medicaid utilization or other appropriate method consistent with
496 federal regulations. The assessment will remain in effect as long
497 as the state participates in the Medicare Upper Payment Limits
498 Program. The division shall make additional reimbursement to
499 hospitals and, if the program is established for nursing
500 facilities, shall make additional reimbursement to nursing
501 facilities, for the Medicare Upper Payment Limits, as defined in
502 Section 1902(a)(30) of the federal Social Security Act and any
503 applicable federal regulations.

504 (19) (a) Perinatal risk management services. The
505 division shall promulgate regulations to be effective from and
506 after October 1, 1988, to establish a comprehensive perinatal
507 system for risk assessment of all pregnant and infant Medicaid
508 recipients and for management, education and follow-up for those
509 who are determined to be at risk. Services to be performed
510 include case management, nutrition assessment/counseling,
511 psychosocial assessment/counseling and health education.

512 (b) Early intervention system services. The
513 division shall cooperate with the State Department of Health,
514 acting as lead agency, in the development and implementation of a
515 statewide system of delivery of early intervention services, under
516 Part C of the Individuals with Disabilities Education Act (IDEA).
517 The State Department of Health shall certify annually in writing
518 to the executive director of the division the dollar amount of
519 state early intervention funds available that will be utilized as
520 a certified match for Medicaid matching funds. Those funds then
521 shall be used to provide expanded targeted case management
522 services for Medicaid eligible children with special needs who are
523 eligible for the state's early intervention system.

524 Qualifications for persons providing service coordination shall be



525 determined by the State Department of Health and the Division of
526 Medicaid.

527 (20) Home- and community-based services for physically
528 disabled approved services as allowed by a waiver from the United
529 States Department of Health and Human Services for home- and
530 community-based services for physically disabled people using
531 state funds that are provided from the appropriation to the State
532 Department of Rehabilitation Services and used to match federal
533 funds under a cooperative agreement between the division and the
534 department, provided that funds for these services are
535 specifically appropriated to the Department of Rehabilitation
536 Services.

537 (21) Nurse practitioner services. Services furnished
538 by a registered nurse who is licensed and certified by the
539 Mississippi Board of Nursing as a nurse practitioner, including,
540 but not limited to, nurse anesthetists, nurse midwives, family
541 nurse practitioners, family planning nurse practitioners,
542 pediatric nurse practitioners, obstetrics-gynecology nurse
543 practitioners and neonatal nurse practitioners, under regulations
544 adopted by the division. Reimbursement for those services shall
545 not exceed ninety percent (90%) of the reimbursement rate for
546 comparable services rendered by a physician.

547 (22) Ambulatory services delivered in federally
548 qualified health centers, rural health centers and clinics of the
549 local health departments of the State Department of Health for
550 individuals eligible for Medicaid under this article based on
551 reasonable costs as determined by the division.

552 (23) Inpatient psychiatric services. Inpatient
553 psychiatric services to be determined by the division for
554 recipients under age twenty-one (21) that are provided under the
555 direction of a physician in an inpatient program in a licensed
556 acute care psychiatric facility or in a licensed psychiatric
557 residential treatment facility, before the recipient reaches age



558 twenty-one (21) or, if the recipient was receiving the services
559 immediately before he or she reached age twenty-one (21), before
560 the earlier of the date he or she no longer requires the services
561 or the date he or she reaches age twenty-two (22), as provided by
562 federal regulations. Precertification of inpatient days and
563 residential treatment days must be obtained as required by the
564 division.

565 (24) [Deleted]

566 (25) [Deleted]

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

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

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

585 (29) The Division of Medicaid may apply for a waiver
586 from the United States Department of Health and Human Services for
587 home- and community-based services for developmentally disabled
588 people using state funds that are provided from the appropriation
589 to the State Department of Mental Health and/or funds transferred
590 to the department by a political subdivision or instrumentality of



591 the state and used to match federal funds under a cooperative
592 agreement between the division and the department, provided that
593 funds for these services are specifically appropriated to the
594 Department of Mental Health and/or transferred to the department
595 by a political subdivision or instrumentality of the state.

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

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

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

610 (33) Podiatrist services.

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

615 (35) Services and activities authorized in Sections
616 43-27-101 and 43-27-103, using state funds that are provided from
617 the appropriation to the Mississippi Department of Human Services
618 and used to match federal funds under a cooperative agreement
619 between the division and the department.

620 (36) Nonemergency transportation services for
621 Medicaid-eligible persons, to be provided by the Division of
622 Medicaid. The division may contract with additional entities to
623 administer nonemergency transportation services as it deems



624 necessary. All providers shall have a valid driver's license,
625 vehicle inspection sticker, valid vehicle license tags and a
626 standard liability insurance policy covering the vehicle. The
627 division may pay providers a flat fee based on mileage tiers, or
628 in the alternative, may reimburse on actual miles traveled. The
629 division may apply to the Center for Medicare and Medicaid
630 Services (CMS) for a waiver to draw federal matching funds for
631 nonemergency transportation services as a covered service instead
632 of an administrative cost. The PEER Committee shall conduct a
633 performance evaluation of the nonemergency transportation program
634 to evaluate the administration of the program and the providers of
635 transportation services to determine the most cost effective ways
636 of providing nonemergency transportation services to the patients
637 served under the program. The performance evaluation shall be
638 completed and provided to the members of the Senate Public Health
639 and Welfare Committee and the House Medicaid Committee not later
640 than January 15, 2008.

641 (37) [Deleted]

642 (38) Chiropractic services. A chiropractor's manual
643 manipulation of the spine to correct a subluxation, if x-ray
644 demonstrates that a subluxation exists and if the subluxation has
645 resulted in a neuromusculoskeletal condition for which
646 manipulation is appropriate treatment, and related spinal x-rays
647 performed to document these conditions. Reimbursement for
648 chiropractic services shall not exceed Seven Hundred Dollars
649 (\$700.00) per year per beneficiary.

650 (39) Dually eligible Medicare/Medicaid beneficiaries.
651 The division shall pay the Medicare deductible and coinsurance
652 amounts for services available under Medicare, as determined by
653 the division.

654 (40) [Deleted]

655 (41) Services provided by the State Department of
656 Rehabilitation Services for the care and rehabilitation of persons



657 with spinal cord injuries or traumatic brain injuries, as allowed
658 under waivers from the United States Department of Health and
659 Human Services, using up to seventy-five percent (75%) of the
660 funds that are appropriated to the Department of Rehabilitation
661 Services from the Spinal Cord and Head Injury Trust Fund
662 established under Section 37-33-261 and used to match federal
663 funds under a cooperative agreement between the division and the
664 department.

665 (42) Notwithstanding any other provision in this
666 article to the contrary, the division may develop a population
667 health management program for women and children health services
668 through the age of one (1) year. This program is primarily for
669 obstetrical care associated with low birth weight and pre-term
670 babies. The division may apply to the federal Centers for
671 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
672 any other waivers that may enhance the program. In order to
673 effect cost savings, the division may develop a revised payment
674 methodology that may include at-risk capitated payments, and may
675 require member participation in accordance with the terms and
676 conditions of an approved federal waiver.

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

682 (44) Nursing facility services for the severely
683 disabled.

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

687 (b) Those services must be provided in a long-term
688 care nursing facility dedicated to the care and treatment of



689 persons with severe disabilities, and shall be reimbursed as a
690 separate category of nursing facilities.

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

698 (46) The division shall make application to the federal
699 Centers for Medicare and Medicaid Services (CMS) for a waiver to
700 develop and provide services for children with serious emotional
701 disturbances as defined in Section 43-14-1(1), which may include
702 home- and community-based services, case management services or
703 managed care services through mental health providers certified by
704 the Department of Mental Health. The division may implement and
705 provide services under this waived program only if funds for
706 these services are specifically appropriated for this purpose by
707 the Legislature, or if funds are voluntarily provided by affected
708 agencies.

709 (47) (a) Notwithstanding any other provision in this
710 article to the contrary, the division may develop and implement
711 disease management programs for individuals with high-cost chronic
712 diseases and conditions, including the use of grants, waivers,
713 demonstrations or other projects as necessary.

714 (b) Participation in any disease management
715 program implemented under this paragraph (47) is optional with the
716 individual. An individual must affirmatively elect to participate
717 in the disease management program in order to participate, and
718 may elect to discontinue participation in the program at any time.

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

720 (a) Pediatric long-term acute care hospital
721 services means services provided to eligible persons under



722 twenty-one (21) years of age by a freestanding Medicare-certified
723 hospital that has an average length of inpatient stay greater than
724 twenty-five (25) days and that is primarily engaged in providing
725 chronic or long-term medical care to persons under twenty-one (21)
726 years of age.

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

729 (49) The division shall establish copayments and/or
730 coinsurance for all Medicaid services for which copayments and/or
731 coinsurance are allowable under federal law or regulation, and
732 shall set the amount of the copayment and/or coinsurance for each
733 of those services at the maximum amount allowable under federal
734 law or regulation.

735 (50) Services provided by the State Department of
736 Rehabilitation Services for the care and rehabilitation of persons
737 who are deaf and blind, as allowed under waivers from the United
738 States Department of Health and Human Services to provide home-
739 and community-based services using state funds that are provided
740 from the appropriation to the State Department of Rehabilitation
741 Services or if funds are voluntarily provided by another agency.

742 (51) Upon determination of Medicaid eligibility and in
743 association with annual redetermination of Medicaid eligibility,
744 beneficiaries shall be encouraged to undertake a physical
745 examination that will establish a base-line level of health and
746 identification of a usual and customary source of care (a medical
747 home) to aid utilization of disease management tools. This
748 physical examination and utilization of these disease management
749 tools shall be consistent with current United States Preventive
750 Services Task Force or other recognized authority recommendations.

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



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

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

767 (54) Adult foster care services pilot program. Social
768 and protective services on a pilot program basis in an approved
769 foster care facility for vulnerable adults who would otherwise
770 need care in a long-term care facility, to be implemented in an
771 area of the state with the greatest need for such program, under
772 the Medicaid Waivers for the Elderly and Disabled program or an
773 assisted living waiver. The division may use grants, waivers,
774 demonstrations or other projects as necessary in the development
775 and implementation of this adult foster care services pilot
776 program.

777 (55) Therapy services. The plan of care for therapy
778 services may be developed to cover a period of treatment for up to
779 six (6) months, but in no event shall the plan of care exceed a
780 six-month period of treatment. The projected period of treatment
781 must be indicated on the initial plan of care and must be updated
782 with each subsequent revised plan of care. Based on medical
783 necessity, the division shall approve certification periods for
784 less than or up to six (6) months, but in no event shall the
785 certification period exceed the period of treatment indicated on
786 the plan of care. The appeal process for any reduction in therapy



787 services shall be consistent with the appeal process in federal
788 regulations.

789 (56) Human papillomavirus (HPV) vaccinations. The
790 division shall provide reimbursement to providers for the costs of
791 the vaccine and administration of the vaccine against the human
792 papillomavirus (HPV) for women who are at least nineteen (19)
793 years of age but not more than twenty-six (26) years of age.

794 Notwithstanding any other provision of this article to the
795 contrary, the division shall reduce the rate of reimbursement to
796 providers for any service provided under this section by five
797 percent (5%) of the allowed amount for that service. However, the
798 reduction in the reimbursement rates required by this paragraph
799 shall not apply to inpatient hospital services, nursing facility
800 services, intermediate care facility services, psychiatric
801 residential treatment facility services, pharmacy services
802 provided under paragraph (9) of this section, or any service
803 provided by the University of Mississippi Medical Center or a
804 state agency, a state facility or a public agency that either
805 provides its own state match through intergovernmental transfer or
806 certification of funds to the division, or a service for which the
807 federal government sets the reimbursement methodology and rate.
808 In addition, the reduction in the reimbursement rates required by
809 this paragraph shall not apply to case management services and
810 home-delivered meals provided under the home- and community-based
811 services program for the elderly and disabled by a planning and
812 development district (PDD). Planning and development districts
813 participating in the home- and community-based services program
814 for the elderly and disabled as case management providers shall be
815 reimbursed for case management services at the maximum rate
816 approved by the Centers for Medicare and Medicaid Services (CMS).

817 The division may pay to those providers who participate in
818 and accept patient referrals from the division's emergency room
819 redirection program a percentage, as determined by the division,



820 of savings achieved according to the performance measures and
821 reduction of costs required of that program. Federally qualified
822 health centers may participate in the emergency room redirection
823 program, and the division may pay those centers a percentage of
824 any savings to the Medicaid program achieved by the centers'
825 accepting patient referrals through the program, as provided in
826 this paragraph.

827 Notwithstanding any provision of this article, except as
828 authorized in the following paragraph and in Section 43-13-139,
829 neither (a) the limitations on quantity or frequency of use of or
830 the fees or charges for any of the care or services available to
831 recipients under this section, nor (b) the payments or rates of
832 reimbursement to providers rendering care or services authorized
833 under this section to recipients, may be increased, decreased or
834 otherwise changed from the levels in effect on July 1, 1999,
835 unless they are authorized by an amendment to this section by the
836 Legislature. However, the restriction in this paragraph shall not
837 prevent the division from changing the payments or rates of
838 reimbursement to providers without an amendment to this section
839 whenever those changes are required by federal law or regulation,
840 or whenever those changes are necessary to correct administrative
841 errors or omissions in calculating those payments or rates of
842 reimbursement.

843 Notwithstanding any provision of this article, no new groups
844 or categories of recipients and new types of care and services may
845 be added without enabling legislation from the Mississippi
846 Legislature, except that the division may authorize those changes
847 without enabling legislation when the addition of recipients or
848 services is ordered by a court of proper authority.

849 The executive director shall keep the Governor advised on a
850 timely basis of the funds available for expenditure and the
851 projected expenditures. If current or projected expenditures of
852 the division are reasonably anticipated to exceed the amount of



853 funds appropriated to the division for any fiscal year, the
854 Governor, after consultation with the executive director, shall
855 discontinue any or all of the payment of the types of care and
856 services as provided in this section that are deemed to be
857 optional services under Title XIX of the federal Social Security
858 Act, as amended, and when necessary, shall institute any other
859 cost containment measures on any program or programs authorized
860 under the article to the extent allowed under the federal law
861 governing that program or programs. However, the Governor shall
862 not be authorized to discontinue or eliminate any service under
863 this section that is mandatory under federal law, or to
864 discontinue or eliminate, or adjust income limits or resource
865 limits for, any eligibility category or group under Section
866 43-13-115. It is the intent of the Legislature that the
867 expenditures of the division during any fiscal year shall not
868 exceed the amounts appropriated to the division for that fiscal
869 year.

870 Notwithstanding any other provision of this article, it shall
871 be the duty of each nursing facility, intermediate care facility
872 for the mentally retarded, psychiatric residential treatment
873 facility, and nursing facility for the severely disabled that is
874 participating in the Medicaid program to keep and maintain books,
875 documents and other records as prescribed by the Division of
876 Medicaid in substantiation of its cost reports for a period of
877 three (3) years after the date of submission to the Division of
878 Medicaid of an original cost report, or three (3) years after the
879 date of submission to the Division of Medicaid of an amended cost
880 report.

881 **SECTION 3.** The following shall be codified as Section
882 83-9-34.1, Mississippi Code of 1972:

883 83-9-34.1. (1) As used in this section, "health benefit
884 plan" means a plan that provides benefits for medical or surgical
885 expenses incurred as a result of a health condition, accident or



886 sickness and that is offered by any insurance company, group
887 hospital service corporation or health maintenance organization
888 that delivers or issues for delivery an individual, group, blanket
889 or franchise insurance policy or insurance agreement, a group
890 hospital service contract or an evidence of coverage or, to the
891 extent permitted, by the Employee Retirement Income Security Act
892 of 1974 (29 USCS Section 1001 et seq.), by a multiple employer
893 welfare arrangement as defined by Section 3, Employee Retirement
894 Income Security Act of 1974 (29 USCS Section 1002) or any other
895 analogous benefit arrangement. This term does not include:

896 (a) A plan that provides coverage:

897 (i) Only for a specified disease;

898 (ii) Only for accidental death or dismemberment;

899 (iii) For wages or payments in lieu of wages for a
900 period during which an employee is absent from work because of
901 sickness or injury; or

902 (iv) As a supplement to liability insurance.

903 (b) A Medicare supplemental policy as defined by
904 Section 1882(g)(1) of the federal Social Security Act (42 USCS
905 Section 1395ss);

906 (c) Workers' compensation insurance coverage;

907 (d) Medical payment insurance issued as part of a motor
908 vehicle insurance policy;

909 (e) A long-term care policy, including a nursing home
910 fixed indemnity policy, unless the commissioner determines that
911 the policy provides benefit coverage so comprehensive that the
912 policy meets the definition of a health benefit plan; or

913 (f) A hospital indemnity only policy.

914 (2) A health benefit plan that provides benefits for a
915 family member of the insured shall provide coverage for
916 immunization against the human papillomavirus (HPV) for each
917 female child of the insured who is at least nine (9) years of age
918 but not more than twenty-six (26) years of age. The benefits



919 required to be offered under this subsection may not be made
920 subject to a deductible, copayment or coinsurance requirement.

921 (3) This section applies only to a health benefit plan that
922 is delivered, issued for delivery or renewed on or after January
923 1, 2009. A health benefit plan that is delivered, issued for
924 delivery or renewed before January 1, 2009, is governed by the law
925 as it existed immediately before January 1, 2009, and that law is
926 continued in effect for this purpose.

927 **SECTION 4.** This act shall take effect and be in force from
928 and after July 1, 2008.

