

By: Representative Holland

To: Medicaid

HOUSE BILL NO. 1522

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE THAT REGIONAL MENTAL HEALTH/MENTAL RETARDATION CENTERS
3 SHALL NOT BE REQUIRED TO USE LOCAL FUNDS TO MATCH FEDERAL FUNDS
4 BEFORE RECEIVING REIMBURSEMENT FOR MENTAL HEALTH SERVICES UNDER
5 MEDICAID; AND FOR RELATED PURPOSES.

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

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

9 **[The following amendments to this section shall not become**
10 **effective until the hospital assessment provided for in the 2009**
11 **amendments to Section 43-13-145 becomes effective. If the**
12 **hospital assessment shall not take effect and/or shall cease to be**
13 **imposed, the provisions of Section 43-13-117 shall remain in**
14 **effect as existed on June 30, 2009.]**

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

22 (1) Inpatient hospital services.

23 (a) The division shall allow thirty (30) days of
24 inpatient hospital care annually for all Medicaid recipients.
25 Medicaid recipients requiring transplants shall not have those
26 days included in the transplant hospital stay count against the
27 thirty-day limit for inpatient hospital care. Precertification of
28 inpatient days must be obtained as required by the division.



29 (b) From and after July 1, 1994, the Executive
30 Director of the Division of Medicaid shall amend the Mississippi
31 Title XIX Inpatient Hospital Reimbursement Plan to remove the
32 occupancy rate penalty from the calculation of the Medicaid
33 Capital Cost Component utilized to determine total hospital costs
34 allocated to the Medicaid program.

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

42 (2) Outpatient hospital services.

43 (a) Emergency services. The division shall allow
44 six (6) medically necessary emergency room visits per beneficiary
45 per fiscal year.

46 (b) Other outpatient hospital services. The
47 division shall allow benefits for other medically necessary
48 outpatient hospital services (such as chemotherapy, radiation,
49 surgery and therapy), including outpatient services in a clinic or
50 other facility that is not located inside the hospital, but that
51 has been designated as an outpatient facility by the hospital, and
52 that was in operation or under construction on July 1, 2009,
53 provided that the costs and charges associated with the operation
54 of the hospital clinic are included in the hospital's cost report.
55 In addition, the Medicare thirty-five-mile rule will apply to
56 those hospital clinics not located inside the hospital that are
57 constructed after July 1, 2009. Where the same services are
58 reimbursed as clinic services, the division may revise the rate or
59 methodology of outpatient reimbursement to maintain consistency,
60 efficiency, economy and quality of care.

61 (3) Laboratory and x-ray services.



62 (4) Nursing facility services.

63 (a) The division shall make full payment to
64 nursing facilities for each day, not exceeding fifty-two (52) days
65 per year, that a patient is absent from the facility on home
66 leave. Payment may be made for the following home leave days in
67 addition to the fifty-two-day limitation: Christmas, the day
68 before Christmas, the day after Christmas, Thanksgiving, the day
69 before Thanksgiving and the day after Thanksgiving.

70 (b) From and after July 1, 1997, the division
71 shall implement the integrated case-mix payment and quality
72 monitoring system, which includes the fair rental system for
73 property costs and in which recapture of depreciation is
74 eliminated. The division may reduce the payment for hospital
75 leave and therapeutic home leave days to the lower of the case-mix
76 category as computed for the resident on leave using the
77 assessment being utilized for payment at that point in time, or a
78 case-mix score of 1.000 for nursing facilities, and shall compute
79 case-mix scores of residents so that only services provided at the
80 nursing facility are considered in calculating a facility's per
81 diem.

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

85 (d) When a facility of a category that does not
86 require a certificate of need for construction and that could not
87 be eligible for Medicaid reimbursement is constructed to nursing
88 facility specifications for licensure and certification, and the
89 facility is subsequently converted to a nursing facility under a
90 certificate of need that authorizes conversion only and the
91 applicant for the certificate of need was assessed an application
92 review fee based on capital expenditures incurred in constructing
93 the facility, the division shall allow reimbursement for capital
94 expenditures necessary for construction of the facility that were



95 incurred within the twenty-four (24) consecutive calendar months
96 immediately preceding the date that the certificate of need
97 authorizing the conversion was issued, to the same extent that
98 reimbursement would be allowed for construction of a new nursing
99 facility under a certificate of need that authorizes that
100 construction. The reimbursement authorized in this subparagraph
101 (d) may be made only to facilities the construction of which was
102 completed after June 30, 1989. Before the division shall be
103 authorized to make the reimbursement authorized in this
104 subparagraph (d), the division first must have received approval
105 from the Centers for Medicare and Medicaid Services (CMS) of the
106 change in the state Medicaid plan providing for the reimbursement.

107 (e) The division shall develop and implement, not
108 later than January 1, 2001, a case-mix payment add-on determined
109 by time studies and other valid statistical data that will
110 reimburse a nursing facility for the additional cost of caring for
111 a resident who has a diagnosis of Alzheimer's or other related
112 dementia and exhibits symptoms that require special care. Any
113 such case-mix add-on payment shall be supported by a determination
114 of additional cost. The division shall also develop and implement
115 as part of the fair rental reimbursement system for nursing
116 facility beds, an Alzheimer's resident bed depreciation enhanced
117 reimbursement system that will provide an incentive to encourage
118 nursing facilities to convert or construct beds for residents with
119 Alzheimer's or other related dementia.

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

124 The division shall apply for necessary federal waivers to
125 assure that additional services providing alternatives to nursing
126 facility care are made available to applicants for nursing
127 facility care.



128 (5) Periodic screening and diagnostic services for
129 individuals under age twenty-one (21) years as are needed to
130 identify physical and mental defects and to provide health care
131 treatment and other measures designed to correct or ameliorate
132 defects and physical and mental illness and conditions discovered
133 by the screening services, regardless of whether these services
134 are included in the state plan. The division may include in its
135 periodic screening and diagnostic program those discretionary
136 services authorized under the federal regulations adopted to
137 implement Title XIX of the federal Social Security Act, as
138 amended. The division, in obtaining physical therapy services,
139 occupational therapy services, and services for individuals with
140 speech, hearing and language disorders, may enter into a
141 cooperative agreement with the State Department of Education for
142 the provision of those services to handicapped students by public
143 school districts using state funds that are provided from the
144 appropriation to the Department of Education to obtain federal
145 matching funds through the division. The division, in obtaining
146 medical and mental health assessments for children who are in, or
147 at risk of being put in, the custody of the Mississippi Department
148 of Human Services may enter into a cooperative agreement with the
149 Mississippi Department of Human Services for the provision of
150 those services using state funds that are provided from the
151 appropriation to the Department of Human Services to obtain
152 federal matching funds through the division.

153 (6) Physician's services. The division shall allow
154 twelve (12) physician visits annually. All fees for physicians'
155 services that are covered only by Medicaid shall be reimbursed at
156 ninety percent (90%) of the rate established on January 1, 1999,
157 and as may be adjusted each July thereafter, under Medicare (Title
158 XVIII of the federal Social Security Act, as amended). The
159 division may develop and implement a different reimbursement model
160 or schedule for physician's services provided by physicians based



at an academic health care center and by physicians at rural health centers that are associated with an academic health care center. From and after January 1, 2010, all fees for physicians' services that are covered only by Medicaid shall be increased to ninety percent (90%) of the rate established on January 1, 2010, and as may be adjusted each July thereafter, under Medicare.

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

(b) [Repealed]

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

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

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

The division may seek to establish relationships with other states in order to lower acquisition costs of prescription drugs to include single source and innovator multiple source drugs or generic drugs. In addition, if allowed by federal law or



194 regulation, the division may seek to establish relationships with
195 and negotiate with other countries to facilitate the acquisition
196 of prescription drugs to include single source and innovator
197 multiple source drugs or generic drugs, if that will lower the
198 acquisition costs of those prescription drugs.

199 The division shall allow for a combination of prescriptions
200 for single source and innovator multiple source drugs and generic
201 drugs to meet the needs of the beneficiaries, not to exceed five
202 (5) prescriptions per month for each noninstitutionalized Medicaid
203 beneficiary, with not more than two (2) of those prescriptions
204 being for single source or innovator multiple source drugs.

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

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

223 The voluntary preferred drug list shall be expanded to
224 function in the interim in order to have a manageable prior
225 authorization system, thereby minimizing disruption of service to
226 beneficiaries.



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

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

235 All claims for drugs for dually eligible Medicare/Medicaid
236 beneficiaries that are paid for by Medicare must be submitted to
237 Medicare for payment before they may be processed by the
238 division's online payment system.

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

244 The division shall develop and implement a method or methods
245 by which the division will provide on a regular basis to Medicaid
246 providers who are authorized to prescribe drugs, information about
247 the costs to the Medicaid program of single source drugs and
248 innovator multiple source drugs, and information about other drugs
249 that may be prescribed as alternatives to those single source
250 drugs and innovator multiple source drugs and the costs to the
251 Medicaid program of those alternative drugs.

252 Notwithstanding any law or regulation, information obtained
253 or maintained by the division regarding the prescription drug
254 program, including trade secrets and manufacturer or labeler
255 pricing, is confidential and not subject to disclosure except to
256 other state agencies.

257 (b) Payment by the division for covered
258 multisource drugs shall be limited to the lower of the upper
259 limits established and published by the Centers for Medicare and



Medicaid Services (CMS) plus a dispensing fee, or the estimated acquisition cost (EAC) as determined by the division, plus a dispensing fee, or the providers' usual and customary charge to the general public.

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

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

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

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

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

(10) (a) Dental care that is an adjunct to treatment of an acute medical or surgical condition; services of oral surgeons and dentists in connection with surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone; and emergency dental extractions and treatment related thereto. On July 1, 2007, fees for dental care and surgery under authority of this paragraph (10) shall be reimbursed as provided in subparagraph (b). It is the intent of the Legislature that this rate revision for dental



services will be an incentive designed to increase the number of dentists who actively provide Medicaid services. This dental services rate revision shall be known as the "James Russell Dumas Medicaid Dental Incentive Program."

The division shall annually determine the effect of this incentive by evaluating the number of dentists who are Medicaid providers, the number who and the degree to which they are actively billing Medicaid, the geographic trends of where dentists are offering what types of Medicaid services and other statistics pertinent to the goals of this legislative intent. This data shall be presented to the Chair of the Senate Public Health and Welfare Committee and the Chair of the House Medicaid Committee.

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

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

(d) The division shall establish an annual benefit limit of Two Thousand Five Hundred Dollars (\$2,500.00) in dental expenditures per Medicaid-eligible recipient; however, a recipient



may exceed the annual limit on dental expenditures provided in this paragraph with prior approval of the division.

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

(f) This paragraph (10) shall stand repealed on July 1, 2012.

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

(12) Intermediate care facility services.

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

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

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

(14) Clinic services. Such diagnostic, preventive, therapeutic, rehabilitative or palliative services furnished to an



outpatient by or under the supervision of a physician or dentist in a facility that is not a part of a hospital but that is organized and operated to provide medical care to outpatients. Clinic services shall include any services reimbursed as outpatient hospital services that may be rendered in such a facility, including those that become so after July 1, 1991. On July 1, 1999, all fees for physicians' services reimbursed under authority of this paragraph (14) shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as may be adjusted each July thereafter, under Medicare (Title XVIII of the federal Social Security Act, as amended). The division may develop and implement a different reimbursement model or schedule for physician's services provided by physicians based at an academic health care center and by physicians at rural health centers that are associated with an academic health care center.

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

(16) Mental health services. Approved therapeutic and case management services (a) provided by an approved regional mental health/retardation center established under Sections 41-19-31 through 41-19-39, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/retardation center if determined necessary by the Department of Mental Health, using state funds that are provided from the appropriation to the State Department of Mental Health and/or funds transferred to the department by a political subdivision or instrumentality of the state and used to match federal funds under a cooperative agreement between the division and the department, or (b) provided by a facility that is certified by the State Department of Mental



Health to provide therapeutic and case management services, to be reimbursed on a fee for service basis, or (c) provided in the community by a facility or program operated by the Department of Mental Health. No regional mental health/mental retardation center established under Sections 41-19-31 through 41-19-39 shall be required to use local funds to match federal funds before receiving reimbursement for services provided under this paragraph (16). Any such services provided by a facility described in subparagraph (b) must have the prior approval of the division to be reimbursable under this section. After June 30, 1997, mental health services provided by regional mental health/retardation centers established under Sections 41-19-31 through 41-19-39, or by hospitals as defined in Section 41-9-3(a) and/or their subsidiaries and divisions, or by psychiatric residential treatment facilities as defined in Section 43-11-1, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/retardation center if determined necessary by the Department of Mental Health, shall not be included in or provided under any capitated managed care pilot program provided for under paragraph (24) of this section.

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

(18) (a) Notwithstanding any other provision of this section to the contrary, as provided in the Medicaid state plan amendment or amendments as defined in Section 43-13-145(10), the division shall make additional reimbursement to hospitals that serve a disproportionate share of low-income patients and that meet the federal requirements for those payments as provided in



424 Section 1923 of the federal Social Security Act and any applicable
425 regulations. It is the intent of the Legislature that the
426 division shall draw down all available federal funds allotted to
427 the state for disproportionate share hospitals. However, from and
428 after January 1, 1999, public hospitals participating in the
429 Medicaid disproportionate share program may be required to
430 participate in an intergovernmental transfer program as provided
431 in Section 1903 of the federal Social Security Act and any
432 applicable regulations.

433 (b) The division shall establish a Medicare Upper
434 Payment Limits Program, as defined in Section 1902(a)(30) of the
435 federal Social Security Act and any applicable federal
436 regulations, for hospitals, and may establish a Medicare Upper
437 Payment Limits Program for nursing facilities. The division shall
438 assess each hospital and, if the program is established for
439 nursing facilities, shall assess each nursing facility, for the
440 sole purpose of financing the state portion of the Medicare Upper
441 Payment Limits Program. The hospital assessment shall be as
442 provided in Section 43-13-145(4)(a) and the nursing facility
443 assessment, if established, shall be based on Medicaid utilization
444 or other appropriate method consistent with federal regulations.
445 The assessment will remain in effect as long as the state
446 participates in the Medicare Upper Payment Limits Program. As
447 provided in the Medicaid state plan amendment or amendments as
448 defined in Section 43-13-145(10), the division shall make
449 additional reimbursement to hospitals and, if the program is
450 established for nursing facilities, shall make additional
451 reimbursement to nursing facilities, for the Medicare Upper
452 Payment Limits, as defined in Section 1902(a)(30) of the federal
453 Social Security Act and any applicable federal regulations.

454 (19) (a) Perinatal risk management services. The
455 division shall promulgate regulations to be effective from and
456 after October 1, 1988, to establish a comprehensive perinatal



system for risk assessment of all pregnant and infant Medicaid recipients and for management, education and follow-up for those who are determined to be at risk. Services to be performed include case management, nutrition assessment/counseling, psychosocial assessment/counseling and health education.

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

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

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

(21) Nurse practitioner services. Services furnished by a registered nurse who is licensed and certified by the Mississippi Board of Nursing as a nurse practitioner, including,



but not limited to, nurse anesthetists, nurse midwives, family nurse practitioners, family planning nurse practitioners, pediatric nurse practitioners, obstetrics-gynecology nurse practitioners and neonatal nurse practitioners, under regulations adopted by the division. Reimbursement for those services shall not exceed ninety percent (90%) of the reimbursement rate for comparable services rendered by a physician.

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

(23) Inpatient psychiatric services. Inpatient psychiatric services to be determined by the division for recipients under age twenty-one (21) that are provided under the direction of a physician in an inpatient program in a licensed acute care psychiatric facility or in a licensed psychiatric residential treatment facility, before the recipient reaches age twenty-one (21) or, if the recipient was receiving the services immediately before he or she reached age twenty-one (21), before the earlier of the date he or she no longer requires the services or the date he or she reaches age twenty-two (22), as provided by federal regulations. Precertification of inpatient days and residential treatment days must be obtained as required by the division. From and after July 1, 2009, all state-owned and state-operated facilities that provide inpatient psychiatric services to persons under age twenty-one (21) who are eligible for Medicaid reimbursement shall be reimbursed for those services on a full reasonable cost basis.

(24) [Deleted]

(25) [Deleted]

(26) Hospice care. As used in this paragraph, the term "hospice care" means a coordinated program of active professional



523 medical attention within the home and outpatient and inpatient
524 care that treats the terminally ill patient and family as a unit,
525 employing a medically directed interdisciplinary team. The
526 program provides relief of severe pain or other physical symptoms
527 and supportive care to meet the special needs arising out of
528 physical, psychological, spiritual, social and economic stresses
529 that are experienced during the final stages of illness and during
530 dying and bereavement and meets the Medicare requirements for
531 participation as a hospice as provided in federal regulations.

532 (27) Group health plan premiums and cost sharing if it
533 is cost-effective as defined by the United States Secretary of
534 Health and Human Services.

535 (28) Other health insurance premiums that are
536 cost-effective as defined by the United States Secretary of Health
537 and Human Services. Medicare eligible must have Medicare Part B
538 before other insurance premiums can be paid.

539 (29) The Division of Medicaid may apply for a waiver
540 from the United States Department of Health and Human Services for
541 home- and community-based services for developmentally disabled
542 people using state funds that are provided from the appropriation
543 to the State Department of Mental Health and/or funds transferred
544 to the department by a political subdivision or instrumentality of
545 the state and used to match federal funds under a cooperative
546 agreement between the division and the department, provided that
547 funds for these services are specifically appropriated to the
548 Department of Mental Health and/or transferred to the department
549 by a political subdivision or instrumentality of the state.

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

552 (31) Targeted case management services for children
553 with special needs, under waivers from the United States
554 Department of Health and Human Services, using state funds that
555 are provided from the appropriation to the Mississippi Department



of Human Services and used to match federal funds under a cooperative agreement between the division and the department.

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

(33) Podiatrist services.

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

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

(36) Nonemergency transportation services for Medicaid-eligible persons, to be provided by the Division of Medicaid. The division may contract with additional entities to administer nonemergency transportation services as it deems necessary. All providers shall have a valid driver's license, vehicle inspection sticker, valid vehicle license tags and a standard liability insurance policy covering the vehicle. The division may pay providers a flat fee based on mileage tiers, or in the alternative, may reimburse on actual miles traveled. The division may apply to the Center for Medicare and Medicaid Services (CMS) for a waiver to draw federal matching funds for nonemergency transportation services as a covered service instead of an administrative cost. The PEER Committee shall conduct a performance evaluation of the nonemergency transportation program to evaluate the administration of the program and the providers of



589 transportation services to determine the most cost-effective ways
590 of providing nonemergency transportation services to the patients
591 served under the program. The performance evaluation shall be
592 completed and provided to the members of the Senate Public Health
593 and Welfare Committee and the House Medicaid Committee not later
594 than January 15, 2008.

595 (37) [Deleted]

596 (38) Chiropractic services. A chiropractor's manual
597 manipulation of the spine to correct a subluxation, if x-ray
598 demonstrates that a subluxation exists and if the subluxation has
599 resulted in a neuromusculoskeletal condition for which
600 manipulation is appropriate treatment, and related spinal x-rays
601 performed to document these conditions. Reimbursement for
602 chiropractic services shall not exceed Seven Hundred Dollars
603 (\$700.00) per year per beneficiary.

604 (39) Dually eligible Medicare/Medicaid beneficiaries.
605 The division shall pay the Medicare deductible and coinsurance
606 amounts for services available under Medicare, as determined by
607 the division. From and after July 1, 2009, the division shall
608 reimburse crossover claims for inpatient hospital services and
609 crossover claims covered under Medicare Part B in the same manner
610 that was in effect on January 1, 2008, unless specifically
611 authorized by the Legislature to change this method.

612 (40) [Deleted]

613 (41) Services provided by the State Department of
614 Rehabilitation Services for the care and rehabilitation of persons
615 with spinal cord injuries or traumatic brain injuries, as allowed
616 under waivers from the United States Department of Health and
617 Human Services, using up to seventy-five percent (75%) of the
618 funds that are appropriated to the Department of Rehabilitation
619 Services from the Spinal Cord and Head Injury Trust Fund
620 established under Section 37-33-261 and used to match federal



621 funds under a cooperative agreement between the division and the
622 department.

623 (42) Notwithstanding any other provision in this
624 article to the contrary, the division may develop a population
625 health management program for women and children health services
626 through the age of one (1) year. This program is primarily for
627 obstetrical care associated with low birth weight and preterm
628 babies. The division may apply to the federal Centers for
629 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
630 any other waivers that may enhance the program. In order to
631 effect cost savings, the division may develop a revised payment
632 methodology that may include at-risk capitated payments, and may
633 require member participation in accordance with the terms and
634 conditions of an approved federal waiver.

635 (43) The division shall provide reimbursement,
636 according to a payment schedule developed by the division, for
637 smoking cessation medications for pregnant women during their
638 pregnancy and other Medicaid-eligible women who are of
639 child-bearing age.

640 (44) Nursing facility services for the severely
641 disabled.

642 (a) Severe disabilities include, but are not
643 limited to, spinal cord injuries, closed head injuries and
644 ventilator dependent patients.

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

649 (45) Physician assistant services. Services furnished
650 by a physician assistant who is licensed by the State Board of
651 Medical Licensure and is practicing with physician supervision
652 under regulations adopted by the board, under regulations adopted
653 by the division. Reimbursement for those services shall not



exceed ninety percent (90%) of the reimbursement rate for comparable services rendered by a physician.

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

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

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

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

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

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



687 (49) The division shall establish copayments and/or
688 coinsurance for all Medicaid services for which copayments and/or
689 coinsurance are allowable under federal law or regulation, and
690 shall set the amount of the copayment and/or coinsurance for each
691 of those services at the maximum amount allowable under federal
692 law or regulation.

693 (50) Services provided by the State Department of
694 Rehabilitation Services for the care and rehabilitation of persons
695 who are deaf and blind, as allowed under waivers from the United
696 States Department of Health and Human Services to provide home-
697 and community-based services using state funds that are provided
698 from the appropriation to the State Department of Rehabilitation
699 Services or if funds are voluntarily provided by another agency.

700 (51) Upon determination of Medicaid eligibility and in
701 association with annual redetermination of Medicaid eligibility,
702 beneficiaries shall be encouraged to undertake a physical
703 examination that will establish a base-line level of health and
704 identification of a usual and customary source of care (a medical
705 home) to aid utilization of disease management tools. This
706 physical examination and utilization of these disease management
707 tools shall be consistent with current United States Preventive
708 Services Task Force or other recognized authority recommendations.

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

712 (52) Notwithstanding any provisions of this article,
713 the division may pay enhanced reimbursement fees related to trauma
714 care, as determined by the division in conjunction with the State
715 Department of Health, using funds appropriated to the State
716 Department of Health for trauma care and services and used to
717 match federal funds under a cooperative agreement between the
718 division and the State Department of Health. The division, in
719 conjunction with the State Department of Health, may use grants,



waivers, demonstrations, or other projects as necessary in the development and implementation of this reimbursement program.

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

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

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

(B) Notwithstanding any other provision of this article to the contrary, the division shall reduce the rate of reimbursement to providers for any service provided under this section by five percent (5%) of the allowed amount for that service. However, the reduction in the reimbursement rates required by this subsection (B) shall not apply to inpatient hospital services, nursing



753 facility services, intermediate care facility services,
754 psychiatric residential treatment facility services, pharmacy
755 services provided under subsection (A)(9) of this section, or any
756 service provided by the University of Mississippi Medical Center
757 or a state agency, a state facility or a public agency that either
758 provides its own state match through intergovernmental transfer or
759 certification of funds to the division, or a service for which the
760 federal government sets the reimbursement methodology and rate.
761 From and after January 1, 2010, the reduction in the reimbursement
762 rates required by this subsection (B) shall not apply to
763 physicians' services. In addition, the reduction in the
764 reimbursement rates required by this subsection (B) shall not
765 apply to case management services and home-delivered meals
766 provided under the home- and community-based services program for
767 the elderly and disabled by a planning and development district
768 (PDD). Planning and development districts participating in the
769 home- and community-based services program for the elderly and
770 disabled as case management providers shall be reimbursed for case
771 management services at the maximum rate approved by the Centers
772 for Medicare and Medicaid Services (CMS).

773 (C) The division may pay to those providers who participate
774 in and accept patient referrals from the division's emergency room
775 redirection program a percentage, as determined by the division,
776 of savings achieved according to the performance measures and
777 reduction of costs required of that program. Federally qualified
778 health centers may participate in the emergency room redirection
779 program, and the division may pay those centers a percentage of
780 any savings to the Medicaid program achieved by the centers'
781 accepting patient referrals through the program, as provided in
782 this subsection (C).

783 (D) Notwithstanding any provision of this article, except as
784 authorized in the following subsection and in Section 43-13-139,
785 neither (a) the limitations on quantity or frequency of use of or



786 the fees or charges for any of the care or services available to
787 recipients under this section, nor (b) the payments, payment
788 methodology as provided below in this subsection (D), or rates of
789 reimbursement to providers rendering care or services authorized
790 under this section to recipients, may be increased, decreased or
791 otherwise changed from the levels in effect on July 1, 1999,
792 unless they are authorized by an amendment to this section by the
793 Legislature. However, the restriction in this subsection shall
794 not prevent the division from changing the payments, payment
795 methodology as provided below in this subsection (D), or rates of
796 reimbursement to providers without an amendment to this section
797 whenever those changes are required by federal law or regulation,
798 or whenever those changes are necessary to correct administrative
799 errors or omissions in calculating those payments or rates of
800 reimbursement. The prohibition on any changes in payment
801 methodology provided in this subsection (D) shall apply only to
802 payment methodologies used for determining the rates of
803 reimbursement for inpatient hospital services, outpatient hospital
804 services and/or nursing facility services, except as required by
805 federal law, and the federally mandated rebasing of rates as
806 required by the Centers for Medicare and Medicaid Services (CMS)
807 shall not be considered payment methodology for purposes of this
808 subsection (D).

809 (E) Notwithstanding any provision of this article, no new
810 groups or categories of recipients and new types of care and
811 services may be added without enabling legislation from the
812 Mississippi Legislature, except that the division may authorize
813 those changes without enabling legislation when the addition of
814 recipients or services is ordered by a court of proper authority.

815 (F) The executive director shall keep the Governor advised
816 on a timely basis of the funds available for expenditure and the
817 projected expenditures. If current or projected expenditures of
818 the division are reasonably anticipated to exceed the amount of



819 funds appropriated to the division for any fiscal year, the
820 Governor, after consultation with the executive director, shall
821 discontinue any or all of the payment of the types of care and
822 services as provided in this section that are deemed to be
823 optional services under Title XIX of the federal Social Security
824 Act, as amended, and when necessary, shall institute any other
825 cost containment measures on any program or programs authorized
826 under the article to the extent allowed under the federal law
827 governing that program or programs. However, the Governor shall
828 not be authorized to discontinue or eliminate any service under
829 this section that is mandatory under federal law, or to
830 discontinue or eliminate, or adjust income limits or resource
831 limits for, any eligibility category or group under Section
832 43-13-115. Applicable in fiscal year 2010 only, no expenditure
833 reductions or cost containments or increases in assessments
834 recommended by the Executive Director of the Division of Medicaid
835 shall be implemented before February 1, unless the division
836 projects a shortfall so great that the entire Health Care
837 Expendable Fund balance would be reduced to zero. Beginning in
838 fiscal year 2010 and in fiscal years thereafter, when Medicaid
839 expenditures are projected to exceed funds available for any
840 quarter in the fiscal year, the division shall submit the expected
841 shortfall information to the PEER Committee, which shall review
842 the computations of the division and report its findings to the
843 Legislative Budget Office within thirty (30) days of such
844 notification by the division, and not later than January 7 in any
845 year. If expenditure reductions or cost containments are
846 implemented, the Governor may implement a maximum amount of state
847 share expenditure reductions to providers, of which hospitals will
848 be responsible for twenty-five percent (25%) of provider
849 reductions as follows: in fiscal year 2010, the maximum amount
850 shall be Twenty-four Million Dollars (\$24,000,000.00); in fiscal
851 year 2011, the maximum amount shall be Thirty-two Million Dollars



852 (\$32,000,000.00); and in fiscal year 2012 and thereafter, the
853 maximum amount shall be Forty Million Dollars (\$40,000,000.00).
854 However, instead of implementing cuts, the hospital share shall be
855 in the form of an additional assessment not to exceed Ten Million
856 Dollars (\$10,000,000.00) as provided in Section
857 43-13-145(4)(a)(ii). If Medicaid expenditures are projected to
858 exceed the amount of funds appropriated to the division in any
859 fiscal year in excess of the expenditure reductions to providers,
860 then funds shall be transferred by the State Fiscal Officer from
861 the Health Care Trust Fund into the Health Care Expendable Fund
862 and to the Governor's Office, Division of Medicaid, from the
863 Health Care Expendable Fund, in the amount and at such time as
864 requested by the Governor to reconcile the deficit. If the cost
865 containment measures described above have been implemented and
866 there are insufficient funds in the Health Care Trust Fund to
867 reconcile any remaining deficit in any fiscal year, the Governor
868 shall institute any other additional cost containment measures on
869 any program or programs authorized under this article to the
870 extent allowed under federal law. Hospitals shall be responsible
871 for twenty-five percent (25%) of any additional imposed provider
872 cuts. However, instead of implementing hospital expenditure
873 reductions, the hospital reductions shall be in the form of an
874 additional assessment not to exceed twenty-five percent (25%) of
875 provider expenditure reductions as provided in Section
876 43-13-145(4)(a)(ii). It is the intent of the Legislature that the
877 expenditures of the division during any fiscal year shall not
878 exceed the amounts appropriated to the division for that fiscal
879 year.

880 (G) Notwithstanding any other provision of this article, it
881 shall be the duty of each nursing facility, intermediate care
882 facility for the mentally retarded, psychiatric residential
883 treatment facility, and nursing facility for the severely disabled
884 that is participating in the Medicaid program to keep and maintain



885 books, documents and other records as prescribed by the Division
886 of Medicaid in substantiation of its cost reports for a period of
887 three (3) years after the date of submission to the Division of
888 Medicaid of an original cost report, or three (3) years after the
889 date of submission to the Division of Medicaid of an amended cost
890 report.

891 (H) (1) Notwithstanding any other provision of this
892 article, the division shall not be authorized to implement any
893 managed care program, coordinated care program, coordinated care
894 organization, health maintenance organization or similar program
895 in which services are paid for on a capitated basis, beyond the
896 level, scope or location of the program as it existed on October
897 1, 2008, until on or after January 1, 2010. Any managed care
898 program or coordinated care program implemented by the division
899 under this section shall be limited to a maximum of fifteen
900 percent (15%) of all Medicaid beneficiaries, and any Medicaid
901 beneficiary who is enrolled in the program shall have an annual
902 window of at least thirty (30) days in length during which the
903 beneficiary may disenroll from the program. In addition, any
904 payments made to providers by a managed care organization,
905 coordinated care organization, health maintenance organization or
906 other similar organization under a managed care program or
907 coordinated care program implemented by the division under this
908 section shall be considered to be regular Medicaid payments for
909 the purposes of calculating Medicare Upper Payment Limits (UPL)
910 payments and Disproportionate Share Hospital (DSH) payments to
911 hospitals. The division shall apply for any federal waiver or
912 waivers necessary to implement a managed care program or
913 coordinated care program that meets all of the requirements in
914 this paragraph. If the division does not receive a federal waiver
915 or waivers that authorizes it to implement a managed care program
916 or coordinated care program that meets all of the requirements in



917 this paragraph, then the division shall not be authorized to
918 implement a managed care program or coordinated care program.

919 (2) All health maintenance organizations, coordinated
920 care organizations or other organizations paid for services on a
921 capitated basis by the division under any managed care program or
922 coordinated care program implemented by the division under this
923 section shall reimburse all providers in those organizations at
924 rates no lower than those provided under this section for
925 beneficiaries who are not participating in those programs.

926 (3) No health maintenance organization, coordinated
927 care organization or other organization paid for services on a
928 capitated basis by the division under any managed care program or
929 coordinated care program implemented by the division under this
930 section shall require its providers or beneficiaries to use any
931 pharmacy that ships, mails or delivers prescription drugs or
932 legend drugs or devices.

933 (4) After a managed care program or coordinated care
934 program is implemented by the division under this section, the
935 PEER Committee shall conduct a comprehensive performance
936 evaluation of the managed care program or coordinated care
937 program, which shall include, but not be limited to, a
938 determination of any cost savings to the division, quality of care
939 to the beneficiaries, and access to care by the beneficiaries.
940 The PEER Committee shall provide regular reports on the status of
941 the managed care program or coordinated care program to the
942 members of the Senate Public Health and Welfare Committee and the
943 House Medicaid Committee, and shall complete the performance
944 evaluation and provide it to the members of those committees not
945 later than December 15, 2011. As a condition of participation in
946 a managed care program or coordinated care program implemented by
947 the division under this section, a provider must agree to provide
948 any information that the PEER Committee requests to conduct the
949 performance evaluation of the program, and all those providers



shall fully cooperate with the PEER Committee in any request to provide information to the committee.

(I) The division shall develop and publish reimbursement rates for each APR-DRG proposed by the division at least equal to the prevailing corresponding Medicare DRG rate or a closely related Medicare DRG rate, applying to each hospital, the applicable federal wage index being used by CMS for the hospital's geographic location, but the division shall not implement that rate schedule or APR-DRG methodology until after July 1, 2010. The PEER Committee shall study the benefits and liabilities of implementing an APR-DRG reimbursement rate schedule, and report its findings to the members of the Senate Public Health and Welfare Committee and the House Medicaid Committee on or before December 15, 2009.

(J) There shall be no cuts in inpatient and outpatient hospital payments, or allowable days or volumes, as long as the hospital assessment provided in Section 43-13-145 is in effect.

(K) This section shall stand repealed on July 1, 2012.

[If the hospital assessment in the 2009 amendments to Section 43-13-145 does not take effect and/or shall cease to be imposed, the provisions of Section 43-13-117 shall remain in effect as existed on June 30, 2009, and this section shall read as follows:]

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

(1) Inpatient hospital services.

(a) The division shall allow thirty (30) days of inpatient hospital care annually for all Medicaid recipients. Medicaid recipients requiring transplants shall not have those



days included in the transplant case rate count against the thirty-day limit for inpatient hospital care. Precertification of inpatient days must be obtained as required by the division. The division may allow unlimited days in disproportionate hospitals as defined by the division for eligible infants and children under the age of six (6) years if certified as medically necessary as required by the division.

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

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

(2) Outpatient hospital services.

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

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

(3) Laboratory and x-ray services.

(4) Nursing facility services.



1016 (a) The division shall make full payment to
1017 nursing facilities for each day, not exceeding fifty-two (52) days
1018 per year, that a patient is absent from the facility on home
1019 leave. Payment may be made for the following home leave days in
1020 addition to the fifty-two-day limitation: Christmas, the day
1021 before Christmas, the day after Christmas, Thanksgiving, the day
1022 before Thanksgiving and the day after Thanksgiving.

1023 (b) From and after July 1, 1997, the division
1024 shall implement the integrated case-mix payment and quality
1025 monitoring system, which includes the fair rental system for
1026 property costs and in which recapture of depreciation is
1027 eliminated. The division may reduce the payment for hospital
1028 leave and therapeutic home leave days to the lower of the case-mix
1029 category as computed for the resident on leave using the
1030 assessment being utilized for payment at that point in time, or a
1031 case-mix score of 1.000 for nursing facilities, and shall compute
1032 case-mix scores of residents so that only services provided at the
1033 nursing facility are considered in calculating a facility's per
1034 diem.

1035 (c) From and after July 1, 1997, all state-owned
1036 nursing facilities shall be reimbursed on a full reasonable cost
1037 basis.

1038 (d) When a facility of a category that does not
1039 require a certificate of need for construction and that could not
1040 be eligible for Medicaid reimbursement is constructed to nursing
1041 facility specifications for licensure and certification, and the
1042 facility is subsequently converted to a nursing facility under a
1043 certificate of need that authorizes conversion only and the
1044 applicant for the certificate of need was assessed an application
1045 review fee based on capital expenditures incurred in constructing
1046 the facility, the division shall allow reimbursement for capital
1047 expenditures necessary for construction of the facility that were
1048 incurred within the twenty-four (24) consecutive calendar months



1049 immediately preceding the date that the certificate of need
1050 authorizing the conversion was issued, to the same extent that
1051 reimbursement would be allowed for construction of a new nursing
1052 facility under a certificate of need that authorizes that
1053 construction. The reimbursement authorized in this subparagraph
1054 (d) may be made only to facilities the construction of which was
1055 completed after June 30, 1989. Before the division shall be
1056 authorized to make the reimbursement authorized in this
1057 subparagraph (d), the division first must have received approval
1058 from the Centers for Medicare and Medicaid Services (CMS) of the
1059 change in the state Medicaid plan providing for the reimbursement.

1060 (e) The division shall develop and implement, not
1061 later than January 1, 2001, a case-mix payment add-on determined
1062 by time studies and other valid statistical data that will
1063 reimburse a nursing facility for the additional cost of caring for
1064 a resident who has a diagnosis of Alzheimer's or other related
1065 dementia and exhibits symptoms that require special care. Any
1066 such case-mix add-on payment shall be supported by a determination
1067 of additional cost. The division shall also develop and implement
1068 as part of the fair rental reimbursement system for nursing
1069 facility beds, an Alzheimer's resident bed depreciation enhanced
1070 reimbursement system that will provide an incentive to encourage
1071 nursing facilities to convert or construct beds for residents with
1072 Alzheimer's or other related dementia.

1073 (f) The division shall develop and implement an
1074 assessment process for long-term care services. The division may
1075 provide the assessment and related functions directly or through
1076 contract with the area agencies on aging.

1077 The division shall apply for necessary federal waivers to
1078 assure that additional services providing alternatives to nursing
1079 facility care are made available to applicants for nursing
1080 facility care.



1081 (5) Periodic screening and diagnostic services for
1082 individuals under age twenty-one (21) years as are needed to
1083 identify physical and mental defects and to provide health care
1084 treatment and other measures designed to correct or ameliorate
1085 defects and physical and mental illness and conditions discovered
1086 by the screening services, regardless of whether these services
1087 are included in the state plan. The division may include in its
1088 periodic screening and diagnostic program those discretionary
1089 services authorized under the federal regulations adopted to
1090 implement Title XIX of the federal Social Security Act, as
1091 amended. The division, in obtaining physical therapy services,
1092 occupational therapy services, and services for individuals with
1093 speech, hearing and language disorders, may enter into a
1094 cooperative agreement with the State Department of Education for
1095 the provision of those services to handicapped students by public
1096 school districts using state funds that are provided from the
1097 appropriation to the Department of Education to obtain federal
1098 matching funds through the division. The division, in obtaining
1099 medical and psychological evaluations for children in the custody
1100 of the Mississippi Department of Human Services may enter into a
1101 cooperative agreement with the Mississippi Department of Human
1102 Services for the provision of those services using state funds
1103 that are provided from the appropriation to the Department of
1104 Human Services to obtain federal matching funds through the
1105 division.

1106 (6) Physician's services. The division shall allow
1107 twelve (12) physician visits annually. All fees for physicians'
1108 services that are covered only by Medicaid shall be reimbursed at
1109 ninety percent (90%) of the rate established on January 1, 1999,
1110 and as may be adjusted each July thereafter, under Medicare (Title
1111 XVIII of the federal Social Security Act, as amended). The
1112 division may develop and implement a different reimbursement model
1113 or schedule for physician's services provided by physicians based



1114 at an academic health care center and by physicians at rural
1115 health centers that are associated with an academic health care
1116 center.

1117 (7) (a) Home health services for eligible persons, not
1118 to exceed in cost the prevailing cost of nursing facility
1119 services, not to exceed twenty-five (25) visits per year. All
1120 home health visits must be precertified as required by the
1121 division.

1122 (b) [Repealed]

1123 (8) Emergency medical transportation services. On
1124 January 1, 1994, emergency medical transportation services shall
1125 be reimbursed at seventy percent (70%) of the rate established
1126 under Medicare (Title XVIII of the federal Social Security Act, as
1127 amended). "Emergency medical transportation services" shall mean,
1128 but shall not be limited to, the following services by a properly
1129 permitted ambulance operated by a properly licensed provider in
1130 accordance with the Emergency Medical Services Act of 1974
1131 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
1132 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
1133 (vi) disposable supplies, (vii) similar services.

1134 (9) (a) Legend and other drugs as may be determined by
1135 the division.

1136 The division shall establish a mandatory preferred drug list.
1137 Drugs not on the mandatory preferred drug list shall be made
1138 available by utilizing prior authorization procedures established
1139 by the division.

1140 The division may seek to establish relationships with other
1141 states in order to lower acquisition costs of prescription drugs
1142 to include single source and innovator multiple source drugs or
1143 generic drugs. In addition, if allowed by federal law or
1144 regulation, the division may seek to establish relationships with
1145 and negotiate with other countries to facilitate the acquisition
1146 of prescription drugs to include single source and innovator



1147 multiple source drugs or generic drugs, if that will lower the
1148 acquisition costs of those prescription drugs.

1149 The division shall allow for a combination of prescriptions
1150 for single source and innovator multiple source drugs and generic
1151 drugs to meet the needs of the beneficiaries, not to exceed five
1152 (5) prescriptions per month for each noninstitutionalized Medicaid
1153 beneficiary, with not more than two (2) of those prescriptions
1154 being for single source or innovator multiple source drugs.

1155 The executive director may approve specific maintenance drugs
1156 for beneficiaries with certain medical conditions, which may be
1157 prescribed and dispensed in three-month supply increments.

1158 Drugs prescribed for a resident of a psychiatric residential
1159 treatment facility must be provided in true unit doses when
1160 available. The division may require that drugs not covered by
1161 Medicare Part D for a resident of a long-term care facility be
1162 provided in true unit doses when available. Those drugs that were
1163 originally billed to the division but are not used by a resident
1164 in any of those facilities shall be returned to the billing
1165 pharmacy for credit to the division, in accordance with the
1166 guidelines of the State Board of Pharmacy and any requirements of
1167 federal law and regulation. Drugs shall be dispensed to a
1168 recipient and only one (1) dispensing fee per month may be
1169 charged. The division shall develop a methodology for reimbursing
1170 for restocked drugs, which shall include a restock fee as
1171 determined by the division not exceeding Seven Dollars and
1172 Eighty-two Cents (\$7.82).

1173 The voluntary preferred drug list shall be expanded to
1174 function in the interim in order to have a manageable prior
1175 authorization system, thereby minimizing disruption of service to
1176 beneficiaries.

1177 Except for those specific maintenance drugs approved by the
1178 executive director, the division shall not reimburse for any



1179 portion of a prescription that exceeds a thirty-one-day supply of
1180 the drug based on the daily dosage.

1181 The division shall develop and implement a program of payment
1182 for additional pharmacist services, with payment to be based on
1183 demonstrated savings, but in no case shall the total payment
1184 exceed twice the amount of the dispensing fee.

1185 All claims for drugs for dually eligible Medicare/Medicaid
1186 beneficiaries that are paid for by Medicare must be submitted to
1187 Medicare for payment before they may be processed by the
1188 division's online payment system.

1189 The division shall develop a pharmacy policy in which drugs
1190 in tamper-resistant packaging that are prescribed for a resident
1191 of a nursing facility but are not dispensed to the resident shall
1192 be returned to the pharmacy and not billed to Medicaid, in
1193 accordance with guidelines of the State Board of Pharmacy.

1194 The division shall develop and implement a method or methods
1195 by which the division will provide on a regular basis to Medicaid
1196 providers who are authorized to prescribe drugs, information about
1197 the costs to the Medicaid program of single source drugs and
1198 innovator multiple source drugs, and information about other drugs
1199 that may be prescribed as alternatives to those single source
1200 drugs and innovator multiple source drugs and the costs to the
1201 Medicaid program of those alternative drugs.

1202 Notwithstanding any law or regulation, information obtained
1203 or maintained by the division regarding the prescription drug
1204 program, including trade secrets and manufacturer or labeler
1205 pricing, is confidential and not subject to disclosure except to
1206 other state agencies.

1207 (b) Payment by the division for covered
1208 multisource drugs shall be limited to the lower of the upper
1209 limits established and published by the Centers for Medicare and
1210 Medicaid Services (CMS) plus a dispensing fee, or the estimated
1211 acquisition cost (EAC) as determined by the division, plus a



1212 dispensing fee, or the providers' usual and customary charge to
1213 the general public.

1214 Payment for other covered drugs, other than multisource drugs
1215 with CMS upper limits, shall not exceed the lower of the estimated
1216 acquisition cost as determined by the division, plus a dispensing
1217 fee or the providers' usual and customary charge to the general
1218 public.

1219 Payment for nonlegend or over-the-counter drugs covered by
1220 the division shall be reimbursed at the lower of the division's
1221 estimated shelf price or the providers' usual and customary charge
1222 to the general public.

1223 The dispensing fee for each new or refill prescription,
1224 including nonlegend or over-the-counter drugs covered by the
1225 division, shall be not less than Three Dollars and Ninety-one
1226 Cents (\$3.91), as determined by the division.

1227 The division shall not reimburse for single source or
1228 innovator multiple source drugs if there are equally effective
1229 generic equivalents available and if the generic equivalents are
1230 the least expensive.

1231 It is the intent of the Legislature that the pharmacists
1232 providers be reimbursed for the reasonable costs of filling and
1233 dispensing prescriptions for Medicaid beneficiaries.

1234 (10) (a) Dental care that is an adjunct to treatment
1235 of an acute medical or surgical condition; services of oral
1236 surgeons and dentists in connection with surgery related to the
1237 jaw or any structure contiguous to the jaw or the reduction of any
1238 fracture of the jaw or any facial bone; and emergency dental
1239 extractions and treatment related thereto. On July 1, 2007, fees
1240 for dental care and surgery under authority of this paragraph (10)
1241 shall be reimbursed as provided in subparagraph (b). It is the
1242 intent of the Legislature that this rate revision for dental
1243 services will be an incentive designed to increase the number of
1244 dentists who actively provide Medicaid services. This dental



1245 services rate revision shall be known as the "James Russell Dumas
1246 Medicaid Dental Incentive Program."

1247 The division shall annually determine the effect of this
1248 incentive by evaluating the number of dentists who are Medicaid
1249 providers, the number who and the degree to which they are
1250 actively billing Medicaid, the geographic trends of where dentists
1251 are offering what types of Medicaid services and other statistics
1252 pertinent to the goals of this legislative intent. This data
1253 shall be presented to the Chair of the Senate Public Health and
1254 Welfare Committee and the Chair of the House Medicaid Committee.

1255 (b) The Division of Medicaid shall establish a fee
1256 schedule, to be effective from and after July 1, 2007, for dental
1257 services. The schedule shall provide for a fee for each dental
1258 service that is equal to a percentile of normal and customary
1259 private provider fees, as defined by the Ingenix Customized Fee
1260 Analyzer Report, which percentile shall be determined by the
1261 division. The schedule shall be reviewed annually by the division
1262 and dental fees shall be adjusted to reflect the percentile
1263 determined by the division.

1264 (c) For fiscal year 2008, the amount of state
1265 funds appropriated for reimbursement for dental care and surgery
1266 shall be increased by ten percent (10%) of the amount of state
1267 fund expenditures for that purpose for fiscal year 2007. For each
1268 of fiscal years 2009 and 2010, the amount of state funds
1269 appropriated for reimbursement for dental care and surgery shall
1270 be increased by ten percent (10%) of the amount of state fund
1271 expenditures for that purpose for the preceding fiscal year.

1272 (d) The division shall establish an annual benefit
1273 limit of Two Thousand Five Hundred Dollars (\$2,500.00) in dental
1274 expenditures per Medicaid-eligible recipient; however, a recipient
1275 may exceed the annual limit on dental expenditures provided in
1276 this paragraph with prior approval of the division.



1277 (e) The division shall include dental services as
1278 a necessary component of overall health services provided to
1279 children who are eligible for services.

1280 (f) This paragraph (10) shall stand repealed on
1281 July 1, 2010.

1282 (11) Eyeglasses for all Medicaid beneficiaries who have
1283 (a) had surgery on the eyeball or ocular muscle that results in a
1284 vision change for which eyeglasses or a change in eyeglasses is
1285 medically indicated within six (6) months of the surgery and is in
1286 accordance with policies established by the division, or (b) one
1287 (1) pair every five (5) years and in accordance with policies
1288 established by the division. In either instance, the eyeglasses
1289 must be prescribed by a physician skilled in diseases of the eye
1290 or an optometrist, whichever the beneficiary may select.

1291 (12) Intermediate care facility services.

1292 (a) The division shall make full payment to all
1293 intermediate care facilities for the mentally retarded for each
1294 day, not exceeding eighty-four (84) days per year, that a patient
1295 is absent from the facility on home leave. Payment may be made
1296 for the following home leave days in addition to the
1297 eighty-four-day limitation: Christmas, the day before Christmas,
1298 the day after Christmas, Thanksgiving, the day before Thanksgiving
1299 and the day after Thanksgiving.

1300 (b) All state-owned intermediate care facilities
1301 for the mentally retarded shall be reimbursed on a full reasonable
1302 cost basis.

1303 (13) Family planning services, including drugs,
1304 supplies and devices, when those services are under the
1305 supervision of a physician or nurse practitioner.

1306 (14) Clinic services. Such diagnostic, preventive,
1307 therapeutic, rehabilitative or palliative services furnished to an
1308 outpatient by or under the supervision of a physician or dentist
1309 in a facility that is not a part of a hospital but that is



1310 organized and operated to provide medical care to outpatients.
1311 Clinic services shall include any services reimbursed as
1312 outpatient hospital services that may be rendered in such a
1313 facility, including those that become so after July 1, 1991. On
1314 July 1, 1999, all fees for physicians' services reimbursed under
1315 authority of this paragraph (14) shall be reimbursed at ninety
1316 percent (90%) of the rate established on January 1, 1999, and as
1317 may be adjusted each July thereafter, under Medicare (Title XVIII
1318 of the federal Social Security Act, as amended). The division may
1319 develop and implement a different reimbursement model or schedule
1320 for physician's services provided by physicians based at an
1321 academic health care center and by physicians at rural health
1322 centers that are associated with an academic health care center.

1323 (15) Home- and community-based services for the elderly
1324 and disabled, as provided under Title XIX of the federal Social
1325 Security Act, as amended, under waivers, subject to the
1326 availability of funds specifically appropriated for that purpose
1327 by the Legislature.

1328 (16) Mental health services. Approved therapeutic and
1329 case management services (a) provided by an approved regional
1330 mental health/retardation center established under Sections
1331 41-19-31 through 41-19-39, or by another community mental health
1332 service provider meeting the requirements of the Department of
1333 Mental Health to be an approved mental health/retardation center
1334 if determined necessary by the Department of Mental Health, using
1335 state funds that are provided from the appropriation to the State
1336 Department of Mental Health and/or funds transferred to the
1337 department by a political subdivision or instrumentality of the
1338 state and used to match federal funds under a cooperative
1339 agreement between the division and the department, or (b) provided
1340 by a facility that is certified by the State Department of Mental
1341 Health to provide therapeutic and case management services, to be
1342 reimbursed on a fee for service basis, or (c) provided in the



community by a facility or program operated by the Department of Mental Health. No regional mental health/mental retardation center established under Sections 41-19-31 through 41-19-39 shall be required to use local funds to match federal funds before receiving reimbursement for services provided under this paragraph (16). Any such services provided by a facility described in subparagraph (b) must have the prior approval of the division to be reimbursable under this section. After June 30, 1997, mental health services provided by regional mental health/retardation centers established under Sections 41-19-31 through 41-19-39, or by hospitals as defined in Section 41-9-3(a) and/or their subsidiaries and divisions, or by psychiatric residential treatment facilities as defined in Section 43-11-1, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/retardation center if determined necessary by the Department of Mental Health, shall not be included in or provided under any capitated managed care pilot program provided for under paragraph (24) of this section.

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

(18) (a) Notwithstanding any other provision of this section to the contrary, the division shall make additional reimbursement to hospitals that serve a disproportionate share of low-income patients and that meet the federal requirements for those payments as provided in Section 1923 of the federal Social Security Act and any applicable regulations. It is the intent of the Legislature that the division shall draw down all available federal funds allotted to the state for disproportionate share



1376 hospitals. However, from and after January 1, 1999, no public
1377 hospital shall participate in the Medicaid disproportionate share
1378 program unless the public hospital participates in an
1379 intergovernmental transfer program as provided in Section 1903 of
1380 the federal Social Security Act and any applicable regulations.

1381 (b) The division shall establish a Medicare Upper
1382 Payment Limits Program, as defined in Section 1902(a)(30) of the
1383 federal Social Security Act and any applicable federal
1384 regulations, for hospitals, and may establish a Medicare Upper
1385 Payment Limits Program for nursing facilities. The division shall
1386 assess each hospital and, if the program is established for
1387 nursing facilities, shall assess each nursing facility, based on
1388 Medicaid utilization or other appropriate method consistent with
1389 federal regulations. The assessment will remain in effect as long
1390 as the state participates in the Medicare Upper Payment Limits
1391 Program. The division shall make additional reimbursement to
1392 hospitals and, if the program is established for nursing
1393 facilities, shall make additional reimbursement to nursing
1394 facilities, for the Medicare Upper Payment Limits, as defined in
1395 Section 1902(a)(30) of the federal Social Security Act and any
1396 applicable federal regulations.

1397 (19) (a) Perinatal risk management services. The
1398 division shall promulgate regulations to be effective from and
1399 after October 1, 1988, to establish a comprehensive perinatal
1400 system for risk assessment of all pregnant and infant Medicaid
1401 recipients and for management, education and follow-up for those
1402 who are determined to be at risk. Services to be performed
1403 include case management, nutrition assessment/counseling,
1404 psychosocial assessment/counseling and health education.

1405 (b) Early intervention system services. The
1406 division shall cooperate with the State Department of Health,
1407 acting as lead agency, in the development and implementation of a
1408 statewide system of delivery of early intervention services, under



1409 Part C of the Individuals with Disabilities Education Act (IDEA).
1410 The State Department of Health shall certify annually in writing
1411 to the executive director of the division the dollar amount of
1412 state early intervention funds available that will be utilized as
1413 a certified match for Medicaid matching funds. Those funds then
1414 shall be used to provide expanded targeted case management
1415 services for Medicaid eligible children with special needs who are
1416 eligible for the state's early intervention system.

1417 Qualifications for persons providing service coordination shall be
1418 determined by the State Department of Health and the Division of
1419 Medicaid.

1420 (20) Home- and community-based services for physically
1421 disabled approved services as allowed by a waiver from the United
1422 States Department of Health and Human Services for home- and
1423 community-based services for physically disabled people using
1424 state funds that are provided from the appropriation to the State
1425 Department of Rehabilitation Services and used to match federal
1426 funds under a cooperative agreement between the division and the
1427 department, provided that funds for these services are
1428 specifically appropriated to the Department of Rehabilitation
1429 Services.

1430 (21) Nurse practitioner services. Services furnished
1431 by a registered nurse who is licensed and certified by the
1432 Mississippi Board of Nursing as a nurse practitioner, including,
1433 but not limited to, nurse anesthetists, nurse midwives, family
1434 nurse practitioners, family planning nurse practitioners,
1435 pediatric nurse practitioners, obstetrics-gynecology nurse
1436 practitioners and neonatal nurse practitioners, under regulations
1437 adopted by the division. Reimbursement for those services shall
1438 not exceed ninety percent (90%) of the reimbursement rate for
1439 comparable services rendered by a physician.

1440 (22) Ambulatory services delivered in federally
1441 qualified health centers, rural health centers and clinics of the



1442 local health departments of the State Department of Health for
1443 individuals eligible for Medicaid under this article based on
1444 reasonable costs as determined by the division.

1445 (23) Inpatient psychiatric services. Inpatient
1446 psychiatric services to be determined by the division for
1447 recipients under age twenty-one (21) that are provided under the
1448 direction of a physician in an inpatient program in a licensed
1449 acute care psychiatric facility or in a licensed psychiatric
1450 residential treatment facility, before the recipient reaches age
1451 twenty-one (21) or, if the recipient was receiving the services
1452 immediately before he or she reached age twenty-one (21), before
1453 the earlier of the date he or she no longer requires the services
1454 or the date he or she reaches age twenty-two (22), as provided by
1455 federal regulations. Precertification of inpatient days and
1456 residential treatment days must be obtained as required by the
1457 division.

1458 (24) [Deleted]

1459 (25) [Deleted]

1460 (26) Hospice care. As used in this paragraph, the term
1461 "hospice care" means a coordinated program of active professional
1462 medical attention within the home and outpatient and inpatient
1463 care that treats the terminally ill patient and family as a unit,
1464 employing a medically directed interdisciplinary team. The
1465 program provides relief of severe pain or other physical symptoms
1466 and supportive care to meet the special needs arising out of
1467 physical, psychological, spiritual, social and economic stresses
1468 that are experienced during the final stages of illness and during
1469 dying and bereavement and meets the Medicare requirements for
1470 participation as a hospice as provided in federal regulations.

1471 (27) Group health plan premiums and cost sharing if it
1472 is cost-effective as defined by the United States Secretary of
1473 Health and Human Services.



1474 (28) Other health insurance premiums that are
1475 cost-effective as defined by the United States Secretary of Health
1476 and Human Services. Medicare eligible must have Medicare Part B
1477 before other insurance premiums can be paid.

1478 (29) The Division of Medicaid may apply for a waiver
1479 from the United States Department of Health and Human Services for
1480 home- and community-based services for developmentally disabled
1481 people using state funds that are provided from the appropriation
1482 to the State Department of Mental Health and/or funds transferred
1483 to the department by a political subdivision or instrumentality of
1484 the state and used to match federal funds under a cooperative
1485 agreement between the division and the department, provided that
1486 funds for these services are specifically appropriated to the
1487 Department of Mental Health and/or transferred to the department
1488 by a political subdivision or instrumentality of the state.

1489 (30) Pediatric skilled nursing services for eligible
1490 persons under twenty-one (21) years of age.

1491 (31) Targeted case management services for children
1492 with special needs, under waivers from the United States
1493 Department of Health and Human Services, using state funds that
1494 are provided from the appropriation to the Mississippi Department
1495 of Human Services and used to match federal funds under a
1496 cooperative agreement between the division and the department.

1497 (32) Care and services provided in Christian Science
1498 Sanatoria listed and certified by the Commission for Accreditation
1499 of Christian Science Nursing Organizations/Facilities, Inc.,
1500 rendered in connection with treatment by prayer or spiritual means
1501 to the extent that those services are subject to reimbursement
1502 under Section 1903 of the federal Social Security Act.

1503 (33) Podiatrist services.

1504 (34) Assisted living services as provided through home-
1505 and community-based services under Title XIX of the federal Social



1506 Security Act, as amended, subject to the availability of funds
1507 specifically appropriated for that purpose by the Legislature.

1508 (35) Services and activities authorized in Sections
1509 43-27-101 and 43-27-103, using state funds that are provided from
1510 the appropriation to the Mississippi Department of Human Services
1511 and used to match federal funds under a cooperative agreement
1512 between the division and the department.

1513 (36) Nonemergency transportation services for
1514 Medicaid-eligible persons, to be provided by the Division of
1515 Medicaid. The division may contract with additional entities to
1516 administer nonemergency transportation services as it deems
1517 necessary. All providers shall have a valid driver's license,
1518 vehicle inspection sticker, valid vehicle license tags and a
1519 standard liability insurance policy covering the vehicle. The
1520 division may pay providers a flat fee based on mileage tiers, or
1521 in the alternative, may reimburse on actual miles traveled. The
1522 division may apply to the Center for Medicare and Medicaid
1523 Services (CMS) for a waiver to draw federal matching funds for
1524 nonemergency transportation services as a covered service instead
1525 of an administrative cost. The PEER Committee shall conduct a
1526 performance evaluation of the nonemergency transportation program
1527 to evaluate the administration of the program and the providers of
1528 transportation services to determine the most cost-effective ways
1529 of providing nonemergency transportation services to the patients
1530 served under the program. The performance evaluation shall be
1531 completed and provided to the members of the Senate Public Health
1532 and Welfare Committee and the House Medicaid Committee not later
1533 than January 15, 2008.

1534 (37) [Deleted]

1535 (38) Chiropractic services. A chiropractor's manual
1536 manipulation of the spine to correct a subluxation, if x-ray
1537 demonstrates that a subluxation exists and if the subluxation has
1538 resulted in a neuromusculoskeletal condition for which



1539 manipulation is appropriate treatment, and related spinal x-rays
1540 performed to document these conditions. Reimbursement for
1541 chiropractic services shall not exceed Seven Hundred Dollars
1542 (\$700.00) per year per beneficiary.

1543 (39) Dually eligible Medicare/Medicaid beneficiaries.
1544 The division shall pay the Medicare deductible and coinsurance
1545 amounts for services available under Medicare, as determined by
1546 the division.

1547 (40) [Deleted]

1548 (41) Services provided by the State Department of
1549 Rehabilitation Services for the care and rehabilitation of persons
1550 with spinal cord injuries or traumatic brain injuries, as allowed
1551 under waivers from the United States Department of Health and
1552 Human Services, using up to seventy-five percent (75%) of the
1553 funds that are appropriated to the Department of Rehabilitation
1554 Services from the Spinal Cord and Head Injury Trust Fund
1555 established under Section 37-33-261 and used to match federal
1556 funds under a cooperative agreement between the division and the
1557 department.

1558 (42) Notwithstanding any other provision in this
1559 article to the contrary, the division may develop a population
1560 health management program for women and children health services
1561 through the age of one (1) year. This program is primarily for
1562 obstetrical care associated with low birth weight and pre-term
1563 babies. The division may apply to the federal Centers for
1564 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
1565 any other waivers that may enhance the program. In order to
1566 effect cost savings, the division may develop a revised payment
1567 methodology that may include at-risk capitated payments, and may
1568 require member participation in accordance with the terms and
1569 conditions of an approved federal waiver.

1570 (43) The division shall provide reimbursement,
1571 according to a payment schedule developed by the division, for



1572 smoking cessation medications for pregnant women during their
1573 pregnancy and other Medicaid-eligible women who are of
1574 child-bearing age.

1575 (44) Nursing facility services for the severely
1576 disabled.

1577 (a) Severe disabilities include, but are not
1578 limited to, spinal cord injuries, closed head injuries and
1579 ventilator dependent patients.

1580 (b) Those services must be provided in a long-term
1581 care nursing facility dedicated to the care and treatment of
1582 persons with severe disabilities, and shall be reimbursed as a
1583 separate category of nursing facilities.

1584 (45) Physician assistant services. Services furnished
1585 by a physician assistant who is licensed by the State Board of
1586 Medical Licensure and is practicing with physician supervision
1587 under regulations adopted by the board, under regulations adopted
1588 by the division. Reimbursement for those services shall not
1589 exceed ninety percent (90%) of the reimbursement rate for
1590 comparable services rendered by a physician.

1591 (46) The division shall make application to the federal
1592 Centers for Medicare and Medicaid Services (CMS) for a waiver to
1593 develop and provide services for children with serious emotional
1594 disturbances as defined in Section 43-14-1(1), which may include
1595 home- and community-based services, case management services or
1596 managed care services through mental health providers certified by
1597 the Department of Mental Health. The division may implement and
1598 provide services under this waived program only if funds for
1599 these services are specifically appropriated for this purpose by
1600 the Legislature, or if funds are voluntarily provided by affected
1601 agencies.

1602 (47) (a) Notwithstanding any other provision in this
1603 article to the contrary, the division may develop and implement
1604 disease management programs for individuals with high-cost chronic



diseases and conditions, including the use of grants, waivers, demonstrations or other projects as necessary.

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

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

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

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

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

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

(51) Upon determination of Medicaid eligibility and in association with annual redetermination of Medicaid eligibility, beneficiaries shall be encouraged to undertake a physical



1638 examination that will establish a base-line level of health and
1639 identification of a usual and customary source of care (a medical
1640 home) to aid utilization of disease management tools. This
1641 physical examination and utilization of these disease management
1642 tools shall be consistent with current United States Preventive
1643 Services Task Force or other recognized authority recommendations.

1644 For persons who are determined ineligible for Medicaid, the
1645 division will provide information and direction for accessing
1646 medical care and services in the area of their residence.

1647 (52) Notwithstanding any provisions of this article,
1648 the division may pay enhanced reimbursement fees related to trauma
1649 care, as determined by the division in conjunction with the State
1650 Department of Health, using funds appropriated to the State
1651 Department of Health for trauma care and services and used to
1652 match federal funds under a cooperative agreement between the
1653 division and the State Department of Health. The division, in
1654 conjunction with the State Department of Health, may use grants,
1655 waivers, demonstrations, or other projects as necessary in the
1656 development and implementation of this reimbursement program.

1657 (53) Targeted case management services for high-cost
1658 beneficiaries shall be developed by the division for all services
1659 under this section.

1660 (54) Adult foster care services pilot program. Social
1661 and protective services on a pilot program basis in an approved
1662 foster care facility for vulnerable adults who would otherwise
1663 need care in a long-term care facility, to be implemented in an
1664 area of the state with the greatest need for such program, under
1665 the Medicaid Waivers for the Elderly and Disabled program or an
1666 assisted living waiver. The division may use grants, waivers,
1667 demonstrations or other projects as necessary in the development
1668 and implementation of this adult foster care services pilot
1669 program.



1670 (55) Therapy services. The plan of care for therapy
1671 services may be developed to cover a period of treatment for up to
1672 six (6) months, but in no event shall the plan of care exceed a
1673 six-month period of treatment. The projected period of treatment
1674 must be indicated on the initial plan of care and must be updated
1675 with each subsequent revised plan of care. Based on medical
1676 necessity, the division shall approve certification periods for
1677 less than or up to six (6) months, but in no event shall the
1678 certification period exceed the period of treatment indicated on
1679 the plan of care. The appeal process for any reduction in therapy
1680 services shall be consistent with the appeal process in federal
1681 regulations.

1682 Notwithstanding any other provision of this article to the
1683 contrary, the division shall reduce the rate of reimbursement to
1684 providers for any service provided under this section by five
1685 percent (5%) of the allowed amount for that service. However, the
1686 reduction in the reimbursement rates required by this paragraph
1687 shall not apply to inpatient hospital services, nursing facility
1688 services, intermediate care facility services, psychiatric
1689 residential treatment facility services, pharmacy services
1690 provided under paragraph (9) of this section, or any service
1691 provided by the University of Mississippi Medical Center or a
1692 state agency, a state facility or a public agency that either
1693 provides its own state match through intergovernmental transfer or
1694 certification of funds to the division, or a service for which the
1695 federal government sets the reimbursement methodology and rate.
1696 In addition, the reduction in the reimbursement rates required by
1697 this paragraph shall not apply to case management services and
1698 home-delivered meals provided under the home- and community-based
1699 services program for the elderly and disabled by a planning and
1700 development district (PDD). Planning and development districts
1701 participating in the home- and community-based services program
1702 for the elderly and disabled as case management providers shall be



1703 reimbursed for case management services at the maximum rate
1704 approved by the Centers for Medicare and Medicaid Services (CMS).

1705 The division may pay to those providers who participate in
1706 and accept patient referrals from the division's emergency room
1707 redirection program a percentage, as determined by the division,
1708 of savings achieved according to the performance measures and
1709 reduction of costs required of that program. Federally qualified
1710 health centers may participate in the emergency room redirection
1711 program, and the division may pay those centers a percentage of
1712 any savings to the Medicaid program achieved by the centers'
1713 accepting patient referrals through the program, as provided in
1714 this paragraph.

1715 Notwithstanding any provision of this article, except as
1716 authorized in the following paragraph and in Section 43-13-139,
1717 neither (a) the limitations on quantity or frequency of use of or
1718 the fees or charges for any of the care or services available to
1719 recipients under this section, nor (b) the payments or rates of
1720 reimbursement to providers rendering care or services authorized
1721 under this section to recipients, may be increased, decreased or
1722 otherwise changed from the levels in effect on July 1, 1999,
1723 unless they are authorized by an amendment to this section by the
1724 Legislature. However, the restriction in this paragraph shall not
1725 prevent the division from changing the payments or rates of
1726 reimbursement to providers without an amendment to this section
1727 whenever those changes are required by federal law or regulation,
1728 or whenever those changes are necessary to correct administrative
1729 errors or omissions in calculating those payments or rates of
1730 reimbursement.

1731 Notwithstanding any provision of this article, no new groups
1732 or categories of recipients and new types of care and services may
1733 be added without enabling legislation from the Mississippi
1734 Legislature, except that the division may authorize those changes



1735 without enabling legislation when the addition of recipients or
1736 services is ordered by a court of proper authority.

1737 The executive director shall keep the Governor advised on a
1738 timely basis of the funds available for expenditure and the
1739 projected expenditures. If current or projected expenditures of
1740 the division are reasonably anticipated to exceed the amount of
1741 funds appropriated to the division for any fiscal year, the
1742 Governor, after consultation with the executive director, shall
1743 discontinue any or all of the payment of the types of care and
1744 services as provided in this section that are deemed to be
1745 optional services under Title XIX of the federal Social Security
1746 Act, as amended, and when necessary, shall institute any other
1747 cost containment measures on any program or programs authorized
1748 under the article to the extent allowed under the federal law
1749 governing that program or programs. However, the Governor shall
1750 not be authorized to discontinue or eliminate any service under
1751 this section that is mandatory under federal law, or to
1752 discontinue or eliminate, or adjust income limits or resource
1753 limits for, any eligibility category or group under Section
1754 43-13-115. It is the intent of the Legislature that the
1755 expenditures of the division during any fiscal year shall not
1756 exceed the amounts appropriated to the division for that fiscal
1757 year.

1758 Notwithstanding any other provision of this article, it shall
1759 be the duty of each nursing facility, intermediate care facility
1760 for the mentally retarded, psychiatric residential treatment
1761 facility, and nursing facility for the severely disabled that is
1762 participating in the Medicaid program to keep and maintain books,
1763 documents and other records as prescribed by the Division of
1764 Medicaid in substantiation of its cost reports for a period of
1765 three (3) years after the date of submission to the Division of
1766 Medicaid of an original cost report, or three (3) years after the



1767 date of submission to the Division of Medicaid of an amended cost
1768 report.

1769 **SECTION 2.** This act shall take effect and be in force from
1770 and after July 1, 2010.

