

By: Senator(s) Browning

To: Public Health and
Welfare; Appropriations

SENATE BILL NO. 2002

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO AUTHORIZE MEDICAID REIMBURSEMENT FOR ADDITIONAL PHYSICIAN
3 VISITS FOR DISABLED RECIPIENTS OVER AGE 21 WHO HAD BEEN RECEIVING
4 EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)
5 SERVICES; 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 43-13-117. Medical assistance as authorized by this article
10 shall include payment of part or all of the costs, at the
11 discretion of the division or its successor, with approval of the
12 Governor, of the following types of care and services rendered to
13 eligible applicants who shall have been determined to be eligible
14 for such care and services, within the limits of state
15 appropriations and federal matching funds:

16 (1) Inpatient hospital services.

17 (a) The division shall allow thirty (30) days of
18 inpatient hospital care annually for all Medicaid recipients.
19 Precertification of inpatient days must be obtained as required by
20 the division. The division shall be authorized to allow unlimited
21 days in disproportionate hospitals as defined by the division for
22 eligible infants under the age of six (6) years.

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



29 (c) Hospitals will receive an additional payment
30 for the implantable programmable baclofen drug pump used to treat
31 spasticity which is implanted on an inpatient basis. The payment
32 pursuant to written invoice will be in addition to the facility's
33 per diem reimbursement and will represent a reduction of costs on
34 the facility's annual cost report, and shall not exceed Ten
35 Thousand Dollars (\$10,000.00) per year per recipient. This
36 paragraph (c) shall stand repealed on July 1, 2005.

37 (2) Outpatient hospital services. Provided that where
38 the same services are reimbursed as clinic services, the division
39 may revise the rate or methodology of outpatient reimbursement to
40 maintain consistency, efficiency, economy and quality of care.
41 The division shall develop a Medicaid-specific cost-to-charge
42 ratio calculation from data provided by hospitals to determine an
43 allowable rate payment for outpatient hospital services, and shall
44 submit a report thereon to the Medical Advisory Committee on or
45 before December 1, 1999. The committee shall make a
46 recommendation on the specific cost-to-charge reimbursement method
47 for outpatient hospital services to the 2000 Regular Session of
48 the Legislature.

49 (3) Laboratory and x-ray services.

50 (4) Nursing facility services.

51 (a) The division shall make full payment to
52 nursing facilities for each day, not exceeding fifty-two (52) days
53 per year, that a patient is absent from the facility on home
54 leave. Payment may be made for the following home leave days in
55 addition to the fifty-two-day limitation: Christmas, the day
56 before Christmas, the day after Christmas, Thanksgiving, the day
57 before Thanksgiving and the day after Thanksgiving.

58 (b) From and after July 1, 1997, the division
59 shall implement the integrated case-mix payment and quality
60 monitoring system, which includes the fair rental system for
61 property costs and in which recapture of depreciation is



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

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

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



94 Department of Health and Human Services of the change in the state
95 Medicaid plan providing for such reimbursement.

96 (e) The division shall develop and implement, not
97 later than January 1, 2001, a case-mix payment add-on determined
98 by time studies and other valid statistical data which will
99 reimburse a nursing facility for the additional cost of caring for
100 a resident who has a diagnosis of Alzheimer's or other related
101 dementia and exhibits symptoms that require special care. Any
102 such case-mix add-on payment shall be supported by a determination
103 of additional cost. The division shall also develop and implement
104 as part of the fair rental reimbursement system for nursing
105 facility beds, an Alzheimer's resident bed depreciation enhanced
106 reimbursement system which will provide an incentive to encourage
107 nursing facilities to convert or construct beds for residents with
108 Alzheimer's or other related dementia.

109 (f) The Division of Medicaid shall develop and
110 implement a referral process for long-term care alternatives for
111 Medicaid beneficiaries and applicants. No Medicaid beneficiary
112 shall be admitted to a Medicaid-certified nursing facility unless
113 a licensed physician certifies that nursing facility care is
114 appropriate for that person on a standardized form to be prepared
115 and provided to nursing facilities by the Division of Medicaid.
116 The physician shall forward a copy of that certification to the
117 Division of Medicaid within twenty-four (24) hours after it is
118 signed by the physician. Any physician who fails to forward the
119 certification to the Division of Medicaid within the time period
120 specified in this paragraph shall be ineligible for Medicaid
121 reimbursement for any physician's services performed for the
122 applicant. The Division of Medicaid shall determine, through an
123 assessment of the applicant conducted within two (2) business days
124 after receipt of the physician's certification, whether the
125 applicant also could live appropriately and cost-effectively at
126 home or in some other community-based setting if home- or



127 community-based services were available to the applicant. The
128 time limitation prescribed in this paragraph shall be waived in
129 cases of emergency. If the Division of Medicaid determines that a
130 home- or other community-based setting is appropriate and
131 cost-effective, the division shall:

132 (i) Advise the applicant or the applicant's
133 legal representative that a home- or other community-based setting
134 is appropriate;

135 (ii) Provide a proposed care plan and inform
136 the applicant or the applicant's legal representative regarding
137 the degree to which the services in the care plan are available in
138 a home- or in other community-based setting rather than nursing
139 facility care; and

140 (iii) Explain that such plan and services are
141 available only if the applicant or the applicant's legal
142 representative chooses a home- or community-based alternative to
143 nursing facility care, and that the applicant is free to choose
144 nursing facility care.

145 The Division of Medicaid may provide the services described
146 in this paragraph (f) directly or through contract with case
147 managers from the local Area Agencies on Aging, and shall
148 coordinate long-term care alternatives to avoid duplication with
149 hospital discharge planning procedures.

150 Placement in a nursing facility may not be denied by the
151 division if home- or community-based services that would be more
152 appropriate than nursing facility care are not actually available,
153 or if the applicant chooses not to receive the appropriate home-
154 or community-based services.

155 The division shall provide an opportunity for a fair hearing
156 under federal regulations to any applicant who is not given the
157 choice of home- or community-based services as an alternative to
158 institutional care.



159 The division shall make full payment for long-term care
160 alternative services.

161 The division shall apply for necessary federal waivers to
162 assure that additional services providing alternatives to nursing
163 facility care are made available to applicants for nursing
164 facility care.

165 (5) Periodic screening and diagnostic services for
166 individuals under age twenty-one (21) years as are needed to
167 identify physical and mental defects and to provide health care
168 treatment and other measures designed to correct or ameliorate
169 defects and physical and mental illness and conditions discovered
170 by the screening services regardless of whether these services are
171 included in the state plan. The division may include in its
172 periodic screening and diagnostic program those discretionary
173 services authorized under the federal regulations adopted to
174 implement Title XIX of the federal Social Security Act, as
175 amended. The division, in obtaining physical therapy services,
176 occupational therapy services, and services for individuals with
177 speech, hearing and language disorders, may enter into a
178 cooperative agreement with the State Department of Education for
179 the provision of such services to handicapped students by public
180 school districts using state funds which are provided from the
181 appropriation to the Department of Education to obtain federal
182 matching funds through the division. The division, in obtaining
183 medical and psychological evaluations for children in the custody
184 of the State Department of Human Services may enter into a
185 cooperative agreement with the State Department of Human Services
186 for the provision of such services using state funds which are
187 provided from the appropriation to the Department of Human
188 Services to obtain federal matching funds through the division.

189 On July 1, 1993, all fees for periodic screening and
190 diagnostic services under this paragraph (5) shall be increased by



191 twenty-five percent (25%) of the reimbursement rate in effect on
192 June 30, 1993.

193 (6) Physician's services. The division shall allow
194 twelve (12) physician visits annually. Provided, however, that
195 disabled recipients over age twenty-one (21) who had been
196 receiving early and periodic screening, diagnosis and treatment
197 (EPSDT) services before becoming twenty-one (21) years of age
198 shall be eligible to receive physician's services in addition to
199 the twelve (12) annual visit limitation, as determined to be
200 necessary by the division, with such additional physician visits
201 to be reimbursed from one hundred percent (100%) state funds.

202 All fees for physicians' services that are covered only by
203 Medicaid shall be reimbursed at ninety percent (90%) of the rate
204 established on January 1, 1999, and as adjusted each January
205 thereafter, under Medicare (Title XVIII of the Social Security
206 Act, as amended), and which shall in no event be less than seventy
207 percent (70%) of the rate established on January 1, 1994. All
208 fees for physicians' services that are covered by both Medicare
209 and Medicaid shall be reimbursed at ten percent (10%) of the
210 adjusted Medicare payment established on January 1, 1999, and as
211 adjusted each January thereafter, under Medicare (Title XVIII of
212 the Social Security Act, as amended), and which shall in no event
213 be less than seventy percent (70%) of the adjusted Medicare
214 payment established on January 1, 1994.

215 (7) (a) Home health services for eligible persons, not
216 to exceed in cost the prevailing cost of nursing facility
217 services, not to exceed sixty (60) visits per year. All home
218 health visits must be precertified as required by the division.

219 (b) Repealed.

220 (8) Emergency medical transportation services. On
221 January 1, 1994, emergency medical transportation services shall
222 be reimbursed at seventy percent (70%) of the rate established
223 under Medicare (Title XVIII of the Social Security Act, as



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

231 (9) Legend and other drugs as may be determined by the
232 division. The division may implement a program of prior approval
233 for drugs to the extent permitted by law. Payment by the division
234 for covered multiple source drugs shall be limited to the lower of
235 the upper limits established and published by the Health Care
236 Financing Administration (HCFA) plus a dispensing fee of Four
237 Dollars and Ninety-one Cents (\$4.91), or the estimated acquisition
238 cost (EAC) as determined by the division plus a dispensing fee of
239 Four Dollars and Ninety-one Cents (\$4.91), or the providers' usual
240 and customary charge to the general public. The division shall
241 allow ten (10) prescriptions per month for noninstitutionalized
242 Medicaid recipients.

243 Payment for other covered drugs, other than multiple source
244 drugs with HCFA upper limits, shall not exceed the lower of the
245 estimated acquisition cost as determined by the division plus a
246 dispensing fee of Four Dollars and Ninety-one Cents (\$4.91) or the
247 providers' usual and customary charge to the general public.

248 Payment for nonlegend or over-the-counter drugs covered on
249 the division's formulary shall be reimbursed at the lower of the
250 division's estimated shelf price or the providers' usual and
251 customary charge to the general public. No dispensing fee shall
252 be paid.

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



257 As used in this paragraph (9), "estimated acquisition cost"
258 means the division's best estimate of what price providers
259 generally are paying for a drug in the package size that providers
260 buy most frequently. Product selection shall be made in
261 compliance with existing state law; however, the division may
262 reimburse as if the prescription had been filled under the generic
263 name. The division may provide otherwise in the case of specified
264 drugs when the consensus of competent medical advice is that
265 trademarked drugs are substantially more effective.

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

277 (11) Eyeglasses necessitated by reason of eye surgery,
278 and as prescribed by a physician skilled in diseases of the eye or
279 an optometrist, whichever the patient may select, or one (1) pair
280 every three (3) years as prescribed by a physician or an
281 optometrist, whichever the patient may select.

282 (12) Intermediate care facility services.

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



289 the day after Christmas, Thanksgiving, the day before Thanksgiving
290 and the day after Thanksgiving.

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

294 (13) Family planning services, including drugs,
295 supplies and devices, when such services are under the supervision
296 of a physician.

297 (14) Clinic services. Such diagnostic, preventive,
298 therapeutic, rehabilitative or palliative services furnished to an
299 outpatient by or under the supervision of a physician or dentist
300 in a facility which is not a part of a hospital but which is
301 organized and operated to provide medical care to outpatients.
302 Clinic services shall include any services reimbursed as
303 outpatient hospital services which may be rendered in such a
304 facility, including those that become so after July 1, 1991. On
305 July 1, 1999, all fees for physicians' services reimbursed under
306 authority of this paragraph (14) shall be reimbursed at ninety
307 percent (90%) of the rate established on January 1, 1999, and as
308 adjusted each January thereafter, under Medicare (Title XVIII of
309 the Social Security Act, as amended), and which shall in no event
310 be less than seventy percent (70%) of the rate established on
311 January 1, 1994. All fees for physicians' services that are
312 covered by both Medicare and Medicaid shall be reimbursed at ten
313 percent (10%) of the adjusted Medicare payment established on
314 January 1, 1999, and as adjusted each January thereafter, under
315 Medicare (Title XVIII of the Social Security Act, as amended), and
316 which shall in no event be less than seventy percent (70%) of the
317 adjusted Medicare payment established on January 1, 1994. On July
318 1, 1999, all fees for dentists' services reimbursed under
319 authority of this paragraph (14) shall be increased to one hundred
320 sixty percent (160%) of the amount of the reimbursement rate that
321 was in effect on June 30, 1999.



322 (15) Home- and community-based services, as provided
323 under Title XIX of the federal Social Security Act, as amended,
324 under waivers, subject to the availability of funds specifically
325 appropriated therefor by the Legislature. Payment for such
326 services shall be limited to individuals who would be eligible for
327 and would otherwise require the level of care provided in a
328 nursing facility. The home- and community-based services
329 authorized under this paragraph shall be expanded over a five-year
330 period beginning July 1, 1999. The division shall certify case
331 management agencies to provide case management services and
332 provide for home- and community-based services for eligible
333 individuals under this paragraph. The home- and community-based
334 services under this paragraph and the activities performed by
335 certified case management agencies under this paragraph shall be
336 funded using state funds that are provided from the appropriation
337 to the Division of Medicaid and used to match federal funds.

338 (16) Mental health services. Approved therapeutic and
339 case management services provided by (a) an approved regional
340 mental health/retardation center established under Sections
341 41-19-31 through 41-19-39, or by another community mental health
342 service provider meeting the requirements of the Department of
343 Mental Health to be an approved mental health/retardation center
344 if determined necessary by the Department of Mental Health, using
345 state funds which are provided from the appropriation to the State
346 Department of Mental Health and used to match federal funds under
347 a cooperative agreement between the division and the department,
348 or (b) a facility which is certified by the State Department of
349 Mental Health to provide therapeutic and case management services,
350 to be reimbursed on a fee for service basis. Any such services
351 provided by a facility described in paragraph (b) must have the
352 prior approval of the division to be reimbursable under this
353 section. After June 30, 1997, mental health services provided by
354 regional mental health/retardation centers established under



355 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
356 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
357 psychiatric residential treatment facilities as defined in Section
358 43-11-1, or by another community mental health service provider
359 meeting the requirements of the Department of Mental Health to be
360 an approved mental health/retardation center if determined
361 necessary by the Department of Mental Health, shall not be
362 included in or provided under any capitated managed care pilot
363 program provided for under paragraph (24) of this section.

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

370 (18) (a) Notwithstanding any other provision of this
371 section to the contrary, the division shall make additional
372 reimbursement to hospitals which serve a disproportionate share of
373 low-income patients and which meet the federal requirements for
374 such payments as provided in Section 1923 of the federal Social
375 Security Act and any applicable regulations. However, from and
376 after January 1, 2000, no public hospital shall participate in the
377 Medicaid disproportionate share program unless the public hospital
378 participates in an intergovernmental transfer program as provided
379 in Section 1903 of the federal Social Security Act and any
380 applicable regulations. Administration and support for
381 participating hospitals shall be provided by the Mississippi
382 Hospital Association.

383 (b) The division shall establish a Medicare Upper
384 Payment Limits Program as defined in Section 1902(a)(30) of the
385 federal Social Security Act and any applicable federal
386 regulations. The division shall assess each hospital for the sole
387 purpose of financing the state portion of the Medicare Upper



388 Payment Limits Program. This assessment shall be based on
389 Medicaid utilization, or other appropriate method consistent with
390 federal regulations, and will remain in effect as long as the
391 state participates in the Medicare Upper Payment Limits Program.
392 The division shall make additional reimbursement to hospitals for
393 the Medicare Upper Payment Limits as defined in Section
394 1902(a)(30) of the federal Social Security Act and any applicable
395 federal regulations. This paragraph (b) shall stand repealed from
396 and after July 1, 2005.

397 (c) The division shall contract with the
398 Mississippi Hospital Association to provide administrative support
399 for the operation of the disproportionate share hospital program
400 and the Medicare Upper Payment Limits Program. This paragraph (c)
401 shall stand repealed from and after July 1, 2005.

402 (19) (a) Perinatal risk management services. The
403 division shall promulgate regulations to be effective from and
404 after October 1, 1988, to establish a comprehensive perinatal
405 system for risk assessment of all pregnant and infant Medicaid
406 recipients and for management, education and follow-up for those
407 who are determined to be at risk. Services to be performed
408 include case management, nutrition assessment/counseling,
409 psychosocial assessment/counseling and health education. The
410 division shall set reimbursement rates for providers in
411 conjunction with the State Department of Health.

412 (b) Early intervention system services. The
413 division shall cooperate with the State Department of Health,
414 acting as lead agency, in the development and implementation of a
415 statewide system of delivery of early intervention services,
416 pursuant to Part H of the Individuals with Disabilities Education
417 Act (IDEA). The State Department of Health shall certify annually
418 in writing to the director of the division the dollar amount of
419 state early intervention funds available which shall be utilized
420 as a certified match for Medicaid matching funds. Those funds



421 then shall be used to provide expanded targeted case management
422 services for Medicaid eligible children with special needs who are
423 eligible for the state's early intervention system.

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

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

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

447 (22) Ambulatory services delivered in federally
448 qualified health centers and in clinics of the local health
449 departments of the State Department of Health for individuals
450 eligible for medical assistance under this article based on
451 reasonable costs as determined by the division.

452 (23) Inpatient psychiatric services. Inpatient
453 psychiatric services to be determined by the division for



454 recipients under age twenty-one (21) which are provided under the
455 direction of a physician in an inpatient program in a licensed
456 acute care psychiatric facility or in a licensed psychiatric
457 residential treatment facility, before the recipient reaches age
458 twenty-one (21) or, if the recipient was receiving the services
459 immediately before he reached age twenty-one (21), before the
460 earlier of the date he no longer requires the services or the date
461 he reaches age twenty-two (22), as provided by federal
462 regulations. Precertification of inpatient days and residential
463 treatment days must be obtained as required by the division.

464 (24) Managed care services in a program to be developed
465 by the division by a public or private provider. If managed care
466 services are provided by the division to Medicaid recipients, and
467 those managed care services are operated, managed and controlled
468 by and under the authority of the division, the division shall be
469 responsible for educating the Medicaid recipients who are
470 participants in the managed care program regarding the manner in
471 which the participants should seek health care under the program.
472 Notwithstanding any other provision in this article to the
473 contrary, the division shall establish rates of reimbursement to
474 providers rendering care and services authorized under this
475 paragraph (24), and may revise such rates of reimbursement without
476 amendment to this section by the Legislature for the purpose of
477 achieving effective and accessible health services, and for
478 responsible containment of costs.

479 (25) Birthing center services.

480 (26) Hospice care. As used in this paragraph, the term
481 "hospice care" means a coordinated program of active professional
482 medical attention within the home and outpatient and inpatient
483 care which treats the terminally ill patient and family as a unit,
484 employing a medically directed interdisciplinary team. The
485 program provides relief of severe pain or other physical symptoms
486 and supportive care to meet the special needs arising out of



487 physical, psychological, spiritual, social and economic stresses
488 which are experienced during the final stages of illness and
489 during dying and bereavement and meets the Medicare requirements
490 for participation as a hospice as provided in federal regulations.

491 (27) Group health plan premiums and cost sharing if it
492 is cost effective as defined by the Secretary of Health and Human
493 Services.

494 (28) Other health insurance premiums which are cost
495 effective as defined by the Secretary of Health and Human
496 Services. Medicare eligible must have Medicare Part B before
497 other insurance premiums can be paid.

498 (29) The Division of Medicaid may apply for a waiver
499 from the Department of Health and Human Services for home- and
500 community-based services for developmentally disabled people using
501 state funds which are provided from the appropriation to the State
502 Department of Mental Health and used to match federal funds under
503 a cooperative agreement between the division and the department,
504 provided that funds for these services are specifically
505 appropriated to the Department of Mental Health.

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

508 (31) Targeted case management services for children
509 with special needs, under waivers from the United States
510 Department of Health and Human Services, using state funds that
511 are provided from the appropriation to the Mississippi Department
512 of Human Services and used to match federal funds under a
513 cooperative agreement between the division and the department.

514 (32) Care and services provided in Christian Science
515 Sanatoria operated by or listed and certified by The First Church
516 of Christ Scientist, Boston, Massachusetts, rendered in connection
517 with treatment by prayer or spiritual means to the extent that
518 such services are subject to reimbursement under Section 1903 of
519 the Social Security Act.



520 (33) Podiatrist services.

521 (34) The division shall make application to the United
522 States Health Care Financing Administration for a waiver to
523 develop a program of services to personal care and assisted living
524 homes in Mississippi. This waiver shall be completed by December
525 1, 1999.

526 (35) Services and activities authorized in Sections
527 43-27-101 and 43-27-103, using state funds that are provided from
528 the appropriation to the State Department of Human Services and
529 used to match federal funds under a cooperative agreement between
530 the division and the department.

531 (36) Nonemergency transportation services for
532 Medicaid-eligible persons, to be provided by the Division of
533 Medicaid. The division may contract with additional entities to
534 administer nonemergency transportation services as it deems
535 necessary. All providers shall have a valid driver's license,
536 vehicle inspection sticker, valid vehicle license tags and a
537 standard liability insurance policy covering the vehicle.

538 (37) Repealed.

539 (38) Chiropractic services: a chiropractor's manual
540 manipulation of the spine to correct a subluxation, if x-ray
541 demonstrates that a subluxation exists and if the subluxation has
542 resulted in a neuromusculoskeletal condition for which
543 manipulation is appropriate treatment. Reimbursement for
544 chiropractic services shall not exceed Seven Hundred Dollars
545 (\$700.00) per year per recipient.

546 (39) Dually eligible Medicare/Medicaid beneficiaries.
547 The division shall pay the Medicare deductible and ten percent
548 (10%) coinsurance amounts for services available under Medicare
549 for the duration and scope of services otherwise available under
550 the Medicaid program.

551 (40) Repealed.



552 (41) Services provided by the State Department of
553 Rehabilitation Services for the care and rehabilitation of persons
554 with spinal cord injuries or traumatic brain injuries, as allowed
555 under waivers from the United States Department of Health and
556 Human Services, using up to seventy-five percent (75%) of the
557 funds that are appropriated to the Department of Rehabilitation
558 Services from the Spinal Cord and Head Injury Trust Fund
559 established under Section 37-33-261 and used to match federal
560 funds under a cooperative agreement between the division and the
561 department.

562 (42) Notwithstanding any other provision in this
563 article to the contrary, the division is hereby authorized to
564 develop a population health management program for women and
565 children health services through the age of two (2). This program
566 is primarily for obstetrical care associated with low birth weight
567 and pre-term babies. In order to effect cost savings, the
568 division may develop a revised payment methodology which may
569 include at-risk capitated payments.

570 (43) The division shall provide reimbursement,
571 according to a payment schedule developed by the division, for
572 smoking cessation medications for pregnant women during their
573 pregnancy and other Medicaid-eligible women who are of
574 child-bearing age.

575 (44) Nursing facility services for the severely
576 disabled.

577 (a) Severe disabilities include, but are not
578 limited to, spinal cord injuries, closed head injuries and
579 ventilator dependent patients.

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



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

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

602 Notwithstanding any provision of this article, except as
603 authorized in the following paragraph and in Section 43-13-139,
604 neither (a) the limitations on quantity or frequency of use of or
605 the fees or charges for any of the care or services available to
606 recipients under this section, nor (b) the payments or rates of
607 reimbursement to providers rendering care or services authorized
608 under this section to recipients, may be increased, decreased or
609 otherwise changed from the levels in effect on July 1, 1999,
610 unless such is authorized by an amendment to this section by the
611 Legislature. However, the restriction in this paragraph shall not
612 prevent the division from changing the payments or rates of
613 reimbursement to providers without an amendment to this section
614 whenever such changes are required by federal law or regulation,
615 or whenever such changes are necessary to correct administrative



616 errors or omissions in calculating such payments or rates of
617 reimbursement.

618 Notwithstanding any provision of this article, no new groups
619 or categories of recipients and new types of care and services may
620 be added without enabling legislation from the Mississippi
621 Legislature, except that the division may authorize such changes
622 without enabling legislation when such addition of recipients or
623 services is ordered by a court of proper authority. The director
624 shall keep the Governor advised on a timely basis of the funds
625 available for expenditure and the projected expenditures. In the
626 event current or projected expenditures can be reasonably
627 anticipated to exceed the amounts appropriated for any fiscal
628 year, the Governor, after consultation with the director, shall
629 discontinue any or all of the payment of the types of care and
630 services as provided herein which are deemed to be optional
631 services under Title XIX of the federal Social Security Act, as
632 amended, for any period necessary to not exceed appropriated
633 funds, and when necessary shall institute any other cost
634 containment measures on any program or programs authorized under
635 the article to the extent allowed under the federal law governing
636 such program or programs, it being the intent of the Legislature
637 that expenditures during any fiscal year shall not exceed the
638 amounts appropriated for such fiscal year.

639 Notwithstanding any other provision of this article, it shall
640 be the duty of each nursing facility, intermediate care facility
641 for the mentally retarded, psychiatric residential treatment
642 facility, and nursing facility for the severely disabled that is
643 participating in the medical assistance program to keep and
644 maintain books, documents, and other records as prescribed by the
645 Division of Medicaid in substantiation of its cost reports for a
646 period of three (3) years after the date of submission to the
647 Division of Medicaid of an original cost report, or three (3)



648 years after the date of submission to the Division of Medicaid of
649 an amended cost report.

650 **SECTION 2.** This act shall take effect and be in force from
651 and after July 1, 2002.

