

By: Senator(s) Huggins

To: Public Health and
Welfare; Appropriations

COMMITTEE SUBSTITUTE
FOR
SENATE BILL NO. 3060

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO AUTHORIZE COMMUNITY MENTAL HEALTH CENTER TRANSFER FUNDS TO BE
3 USED AS MEDICAID MATCH FOR REIMBURSEMENT OF MENTAL HEALTH SERVICES
4 OR HOME- AND COMMUNITY-BASED SERVICES; AND FOR RELATED PURPOSES.

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

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

8 43-13-117. Medical assistance as authorized by this article
9 shall include payment of part or all of the costs, at the
10 discretion of the division or its successor, with approval of the
11 Governor, of the following types of care and services rendered to
12 eligible applicants who shall have been determined to be eligible
13 for such care and services, within the limits of state
14 appropriations and federal matching funds:

15 (1) Inpatient hospital services.

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

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



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35 paragraph (c) shall stand repealed on July 1, 2005.

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

48 (3) Laboratory and x-ray services.

49 (4) Nursing facility services.

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

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



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

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

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



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

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

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



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

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

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

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

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

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

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



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

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

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

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



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

192 (6) Physician's services. The division shall allow
193 twelve (12) physician visits annually. All fees for physicians'
194 services that are covered only by Medicaid shall be reimbursed at
195 ninety percent (90%) of the rate established on January 1, 1999,
196 and as adjusted each January thereafter, under Medicare (Title
197 XVIII of the Social Security Act, as amended), and which shall in
198 no event be less than seventy percent (70%) of the rate
199 established on January 1, 1994. All fees for physicians' services
200 that are covered by both Medicare and Medicaid shall be reimbursed
201 at ten percent (10%) of the adjusted Medicare payment established
202 on January 1, 1999, and as adjusted each January thereafter, under
203 Medicare (Title XVIII of the Social Security Act, as amended), and
204 which shall in no event be less than seventy percent (70%) of the
205 adjusted Medicare payment established on January 1, 1994.

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

210 (b) Repealed.

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



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

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

239 Payment for nonlegend or over-the-counter drugs covered on
240 the division's formulary shall be reimbursed at the lower of the
241 division's estimated shelf price or the providers' usual and
242 customary charge to the general public. No dispensing fee shall
243 be paid.

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

248 As used in this paragraph (9), "estimated acquisition cost"
249 means the division's best estimate of what price providers
250 generally are paying for a drug in the package size that providers
251 buy most frequently. Product selection shall be made in
252 compliance with existing state law; however, the division may
253 reimburse as if the prescription had been filled under the generic
254 name. The division may provide otherwise in the case of specified



255 drugs when the consensus of competent medical advice is that
256 trademarked drugs are substantially more effective.

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

268 (11) Eyeglasses necessitated by reason of eye surgery,
269 and as prescribed by a physician skilled in diseases of the eye or
270 an optometrist, whichever the patient may select, or one (1) pair
271 every three (3) years as prescribed by a physician or an
272 optometrist, whichever the patient may select.

273 (12) Intermediate care facility services.

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

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

285 (13) Family planning services, including drugs,
286 supplies and devices, when such services are under the supervision
287 of a physician.



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

313 (15) Home- and community-based services, as provided
314 under Title XIX of the federal Social Security Act, as amended,
315 under waivers, subject to the availability of funds specifically
316 appropriated therefor by the Legislature and/or funds transferred
317 to a state agency by a political subdivision or instrumentality of
318 the state. Payment for those services shall be limited to
319 individuals who would be eligible for and would otherwise require
320 the level of care provided in a nursing facility. The home- and



321 community-based services authorized under this paragraph shall be
322 expanded over a five-year period beginning July 1, 1999. The
323 division shall certify case management agencies to provide case
324 management services and provide for home- and community-based
325 services for eligible individuals under this paragraph. The home-
326 and community-based services under this paragraph and the
327 activities performed by certified case management agencies under
328 this paragraph shall be funded using state funds that are provided
329 from the appropriation to the Division of Medicaid and/or funds
330 transferred to a state agency by a political subdivision or
331 instrumentality of the state and used to match federal funds.

332 (16) Mental health services. Approved therapeutic and
333 case management services provided by (a) an approved regional
334 mental health/retardation center established under Sections
335 41-19-31 through 41-19-39, or by another community mental health
336 service provider meeting the requirements of the Department of
337 Mental Health to be an approved mental health/retardation center
338 if determined necessary by the Department of Mental Health, using
339 state funds that are provided from the appropriation to the State
340 Department of Mental Health and/or funds transferred to a state
341 agency by a political subdivision or instrumentality of the state
342 and used to match federal funds under a cooperative agreement
343 between the division and the department, or (b) a facility that is
344 certified by the State Department of Mental Health to provide
345 therapeutic and case management services, to be reimbursed on a
346 fee for service basis. Any such services provided by a facility
347 described in paragraph (b) must have the prior approval of the
348 division to be reimbursable under this section. After June 30,
349 1997, mental health services provided by regional mental
350 health/retardation centers established under Sections 41-19-31
351 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
352 and/or their subsidiaries and divisions, or by psychiatric
353 residential treatment facilities as defined in Section 43-11-1, or



354 by another community mental health service provider meeting the
355 requirements of the Department of Mental Health to be an approved
356 mental health/retardation center if determined necessary by the
357 Department of Mental Health, shall not be included in or provided
358 under any capitated managed care pilot program provided for under
359 paragraph (24) of this section.

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

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

379 (b) The division shall establish a Medicare Upper
380 Payment Limits Program as defined in Section 1902 (a)(30) of the
381 federal Social Security Act and any applicable federal
382 regulations. The division shall assess each hospital for the sole
383 purpose of financing the state portion of the Medicare Upper
384 Payment Limits Program. This assessment shall be based on
385 Medicaid utilization, or other appropriate method consistent with
386 federal regulations, and will remain in effect as long as the



387 state participates in the Medicare Upper Payment Limits Program.
388 The division shall make additional reimbursement to hospitals for
389 the Medicare Upper Payment Limits as defined in Section 1902
390 (a) (30) of the federal Social Security Act and any applicable
391 federal regulations. This paragraph (b) shall stand repealed from
392 and after July 1, 2005.

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

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

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



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

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

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

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

448 (23) Inpatient psychiatric services. Inpatient
449 psychiatric services to be determined by the division for
450 recipients under age twenty-one (21) which are provided under the
451 direction of a physician in an inpatient program in a licensed
452 acute care psychiatric facility or in a licensed psychiatric



453 residential treatment facility, before the recipient reaches age
454 twenty-one (21) or, if the recipient was receiving the services
455 immediately before he reached age twenty-one (21), before the
456 earlier of the date he no longer requires the services or the date
457 he reaches age twenty-two (22), as provided by federal
458 regulations. Precertification of inpatient days and residential
459 treatment days must be obtained as required by the division.

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

475 (25) Birthing center services.

476 (26) Hospice care. As used in this paragraph, the term
477 "hospice care" means a coordinated program of active professional
478 medical attention within the home and outpatient and inpatient
479 care which treats the terminally ill patient and family as a unit,
480 employing a medically directed interdisciplinary team. The
481 program provides relief of severe pain or other physical symptoms
482 and supportive care to meet the special needs arising out of
483 physical, psychological, spiritual, social and economic stresses
484 which are experienced during the final stages of illness and



485 during dying and bereavement and meets the Medicare requirements
486 for participation as a hospice as provided in federal regulations.

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

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

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

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

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

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

516 (33) Podiatrist services.



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

522 (35) Services and activities authorized in Sections
523 43-27-101 and 43-27-103, using state funds that are provided from
524 the appropriation to the State Department of Human Services and
525 used to match federal funds under a cooperative agreement between
526 the division and the department.

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

534 (37) [Deleted]

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

542 (39) Dually eligible Medicare/Medicaid beneficiaries.
543 The division shall pay the Medicare deductible and ten percent
544 (10%) coinsurance amounts for services available under Medicare
545 for the duration and scope of services otherwise available under
546 the Medicaid program.

547 (40) [Deleted]

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



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

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

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

571 (44) Nursing facility services for the severely
572 disabled.

573 (a) Severe disabilities include, but are not
574 limited to, spinal cord injuries, closed head injuries and
575 ventilator dependent patients.

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

580 (45) Physician assistant services. Services furnished
581 by a physician assistant who is licensed by the State Board of
582 Medical Licensure and is practicing with physician supervision



583 under regulations adopted by the board, under regulations adopted
584 by the division. Reimbursement for those services shall not
585 exceed ninety percent (90%) of the reimbursement rate for
586 comparable services rendered by a physician.

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

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

614 Notwithstanding any provision of this article, no new groups
615 or categories of recipients and new types of care and services may



616 be added without enabling legislation from the Mississippi
617 Legislature, except that the division may authorize such changes
618 without enabling legislation when such addition of recipients or
619 services is ordered by a court of proper authority. The director
620 shall keep the Governor advised on a timely basis of the funds
621 available for expenditure and the projected expenditures. In the
622 event current or projected expenditures can be reasonably
623 anticipated to exceed the amounts appropriated for any fiscal
624 year, the Governor, after consultation with the director, shall
625 discontinue any or all of the payment of the types of care and
626 services as provided herein which are deemed to be optional
627 services under Title XIX of the federal Social Security Act, as
628 amended, for any period necessary to not exceed appropriated
629 funds, and when necessary shall institute any other cost
630 containment measures on any program or programs authorized under
631 the article to the extent allowed under the federal law governing
632 such program or programs, it being the intent of the Legislature
633 that expenditures during any fiscal year shall not exceed the
634 amounts appropriated for such fiscal year.

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

646 **SECTION 2.** Any contribution or transfer of funds to a state
647 agency by a political subdivision or instrumentality of the state
648 before the effective date of Senate Bill No. 3060, 2002 Regular



649 Session, which funds were used to match federal funds to provide
650 services under paragraph (15) or (16) of Section 43-13-117, is
651 ratified, approved and confirmed.

652 **SECTION 3.** This act shall take effect and be in force from
653 and after its passage.

