MISSISSIPPI LEGISLATURE REGULAR SESSION 2005

By: Representative Scott

To: Public Health and Human Services; Ways and Means

HOUSE BILL NO. 1508

1 AN ACT TO PROVIDE FOR THE REIMBURSEMENT OF RELOCATION
2 EXPENSES FOR LICENSED PHYSICIANS TO MOVE AND PRACTICE FAMILY
3 MEDICINE IN CRITICAL NEEDS AREAS FOR PRIMARY MEDICAL CARE; TO
4 PROVIDE FOR THE PAYMENT OF START-UP EXPENSES AND MEDICAL
5 MALPRACTICE INSURANCE PREMIUMS FOR THOSE PHYSICIANS; TO PROVIDE
6 FOR THE PAYMENT OF ANNUAL INCOME SUBSIDIES FOR THOSE PHYSICIANS;
7 TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO PROVIDE
8 AN ADDITIONAL 10% FEE INCREASE IN MEDICAID REIMBURSEMENT FOR
9 PHYSICIANS WHO PRACTICE IN CRITICAL NEEDS AREAS FOR PRIMARY
10 MEDICAL CARE; TO PROVIDE A CREDIT AGAINST STATE INCOME TAXES FOR
11 PHYSICIANS WHO PRACTICE FULL TIME IN CRITICAL NEEDS AREAS FOR
12 PRIMARY MEDICAL CARE; AND FOR RELATED PURPOSES.

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

14 **SECTION 1.** (1) The Board of Trustees of State Institutions
15 of Higher Learning shall prescribe rules and regulations that,
16 subject to available appropriations, allow for reimbursement to
17 licensed physicians who practice family medicine in a critical
18 needs area for primary medical care as designated under subsection
19 (4) of Section 37-143-6, for the expense of moving when the
20 employment necessitates the relocation of the physician or his
21 family to a different geographical area than that in which the
22 physician resides. If the reimbursement is approved, the board of
23 trustees shall provide funds to reimburse the physician an amount
24 not to exceed One Thousand Dollars ($1,000.00) for the documented
25 actual expenses incurred in the course of relocating, including
26 the expense of any professional moving company or persons employed
27 to assist with the move, rented moving vehicles or equipment,
28 mileage in the amount authorized for state employees under Section
29 25-3-41 if the physician used his personal vehicle for the move,
30 meals and such other expenses associated with the relocation in
31 accordance with the established rules and regulations.

32 (2) The Board of Trustees of State Institutions of Higher
33 Learning shall prescribe rules and regulations that, subject to
34 available appropriations, allow for reimbursement to licensed
35 physicians to practice family medicine in a critical needs area
36 for primary medical care as designated under subsection (4) of
37 Section 37-143-6, for the direct expense associated with starting
38 a full-time medical practice, including the cost of building,
39 lease payments, equipment purchases, furniture, medical supplies
40 and medical malpractice insurance associated with a family
41 practice. If the reimbursement is approved, the board of trustees
42 shall provide funds to reimburse the physician an amount not to
43 exceed Twenty Thousand Dollars ($20,000.00) over a two (2) year
44 period for the documented actual expenses incurred in starting a
45 physician's practice.
46 (3) The Board of Trustees of State Institutions of Higher
47 Learning shall prescribe rules and regulations that, subject to
48 available appropriations, allow income subsidies for licensed
49 physicians who practice family medicine full time in a critical
50 needs area for primary medical care as designated under subsection
51 (4) of Section 37-143-6, to recognize the reduced earning capacity
52 associated with practicing in a rural area. If the income subsidy
53 is approved, the board of trustees shall provide funds to
54 compensate the physician in an amount not to exceed Twenty
55 Thousand Dollars ($20,000.00) annually.
56 **SECTION 2.** Section 43-13-117, Mississippi Code of 1972, is
57 amended as follows:
58 43-13-117. Medicaid as authorized by this article shall
59 include payment of part or all of the costs, at the discretion of
60 the division, with approval of the Governor, of the following
61 types of care and services rendered to eligible applicants who
62 have been determined to be eligible for that care and services,
63 within the limits of state appropriations and federal matching
64 funds:

65 (1) Inpatient hospital services.
66 (a) The division shall allow thirty (30) days of
67 inpatient hospital care annually for all Medicaid recipients.
68 Precertification of inpatient days must be obtained as required by
69 the division. The division may allow unlimited days in
70 disproportionate hospitals as defined by the division for eligible
71 infants under the age of six (6) years if certified as medically
72 necessary as required by the division.
73 (b) From and after July 1, 1994, the Executive
74 Director of the Division of Medicaid shall amend the Mississippi
75 Title XIX Inpatient Hospital Reimbursement Plan to remove the
76 occupancy rate penalty from the calculation of the Medicaid
77 Capital Cost Component utilized to determine total hospital costs
78 allocated to the Medicaid program.
79 (c) Hospitals will receive an additional payment
80 for the implantable programmable baclofen drug pump used to treat
81 spasticity that is implanted on an inpatient basis. The payment
82 pursuant to written invoice will be in addition to the facility's
83 per diem reimbursement and will represent a reduction of costs on
84 the facility's annual cost report, and shall not exceed Ten
85 Thousand Dollars ($10,000.00) per year per recipient. This
86 subparagraph (c) shall stand repealed on July 1, 2005.
87 (2) Outpatient hospital services. Where the same
88 services are reimbursed as clinic services, the division may
89 revise the rate or methodology of outpatient reimbursement to
90 maintain consistency, efficiency, economy and quality of care.
91 (3) Laboratory and x-ray services.
92 (4) Nursing facility services.
93 (a) The division shall make full payment to
94 nursing facilities for each day, not exceeding fifty-two (52) days
95 per year, that a patient is absent from the facility on home
96 leave. Payment may be made for the following home leave days in
97 addition to the fifty-two-day limitation: Christmas, the day

98 before Christmas, the day after Christmas, Thanksgiving, the day
99 before Thanksgiving and the day after Thanksgiving.
100 (b) From and after July 1, 1997, the division
101 shall implement the integrated case-mix payment and quality
102 monitoring system, which includes the fair rental system for
103 property costs and in which recapture of depreciation is
104 eliminated. The division may reduce the payment for hospital
105 leave and therapeutic home leave days to the lower of the case-mix
106 category as computed for the resident on leave using the
107 assessment being utilized for payment at that point in time, or a
108 case-mix score of 1.000 for nursing facilities, and shall compute
109 case-mix scores of residents so that only services provided at the
110 nursing facility are considered in calculating a facility's per
111 diem.
112 (c) From and after July 1, 1997, all state-owned
113 nursing facilities shall be reimbursed on a full reasonable cost
114 basis.
115 (d) When a facility of a category that does not
116 require a certificate of need for construction and that could not
117 be eligible for Medicaid reimbursement is constructed to nursing
118 facility specifications for licensure and certification, and the
119 facility is subsequently converted to a nursing facility under a
120 certificate of need that authorizes conversion only and the
121 applicant for the certificate of need was assessed an application
122 review fee based on capital expenditures incurred in constructing
123 the facility, the division shall allow reimbursement for capital
124 expenditures necessary for construction of the facility that were
125 incurred within the twenty-four (24) consecutive calendar months
126 immediately preceding the date that the certificate of need
127 authorizing the conversion was issued, to the same extent that
128 reimbursement would be allowed for construction of a new nursing
129 facility under a certificate of need that authorizes that
130 construction. The reimbursement authorized in this subparagraph

131 (d) may be made only to facilities the construction of which was
132 completed after June 30, 1989. Before the division shall be
133 authorized to make the reimbursement authorized in this
134 subparagraph (d), the division first must have received approval
135 from the Centers for Medicare and Medicaid Services (CMS) of the
136 change in the state Medicaid plan providing for the reimbursement.
137 (e) The division shall develop and implement, not
138 later than January 1, 2001, a case-mix payment add-on determined
139 by time studies and other valid statistical data that will
140 reimburse a nursing facility for the additional cost of caring for
141 a resident who has a diagnosis of Alzheimer's or other related
142 dementia and exhibits symptoms that require special care. Any
143 such case-mix add-on payment shall be supported by a determination
144 of additional cost. The division shall also develop and implement
145 as part of the fair rental reimbursement system for nursing
146 facility beds, an Alzheimer's resident bed depreciation enhanced
147 reimbursement system that will provide an incentive to encourage
148 nursing facilities to convert or construct beds for residents with
149 Alzheimer's or other related dementia.
150 (f) The division shall develop and implement an
151 assessment process for long-term care services. The division may
152 provide the assessment and related functions directly or through
153 contract with the area agencies on aging.
154 The division shall apply for necessary federal waivers to
155 assure that additional services providing alternatives to nursing
156 facility care are made available to applicants for nursing
157 facility care.
158 (5) Periodic screening and diagnostic services for
159 individuals under age twenty-one (21) years as are needed to
160 identify physical and mental defects and to provide health care
161 treatment and other measures designed to correct or ameliorate
162 defects and physical and mental illness and conditions discovered
163 by the screening services, regardless of whether these services

164 are included in the state plan. The division may include in its
165 periodic screening and diagnostic program those discretionary
166 services authorized under the federal regulations adopted to
167 implement Title XIX of the federal Social Security Act, as
168 amended. The division, in obtaining physical therapy services,
169 occupational therapy services, and services for individuals with
170 speech, hearing and language disorders, may enter into a
171 cooperative agreement with the State Department of Education for
172 the provision of those services to handicapped students by public
173 school districts using state funds that are provided from the
174 appropriation to the Department of Education to obtain federal
175 matching funds through the division. The division, in obtaining
176 medical and psychological evaluations for children in the custody
177 of the State Department of Human Services may enter into a
178 cooperative agreement with the State Department of Human Services
179 for the provision of those services using state funds that are
180 provided from the appropriation to the Department of Human
181 Services to obtain federal matching funds through the division.
182 (6) Physician's services. The division shall allow
183 twelve (12) physician visits annually. All fees for physicians'
184 services that are covered only by Medicaid shall be reimbursed at
185 ninety percent (90%) of the rate established on January 1, 1999,
186 and as adjusted each January thereafter, under Medicare (Title
187 XVIII of the federal Social Security Act, as amended), and which
188 shall in no event be less than seventy percent (70%) of the rate
189 established on January 1, 1994. All fees for physicians' services
190 that are covered by Medicaid shall be reimbursed at one hundred
191 ten percent (110%) of the current rate for licensed physicians who
192 practice family medicine in critical needs areas for primary
193 medical care as designated under subsection (4) of Section
194 37-143-6.
195 (7) (a) Home health services for eligible persons, not
196 to exceed in cost the prevailing cost of nursing facility

197 services, not to exceed sixty (60) visits per year. All home
198 health visits must be precertified as required by the division.
199 (b) Repealed.
200 (8) Emergency medical transportation services. On
201 January 1, 1994, emergency medical transportation services shall
202 be reimbursed at seventy percent (70%) of the rate established
203 under Medicare (Title XVIII of the federal Social Security Act, as
204 amended). "Emergency medical transportation services" shall mean,
205 but shall not be limited to, the following services by a properly
206 permitted ambulance operated by a properly licensed provider in
207 accordance with the Emergency Medical Services Act of 1974
208 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
209 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
210 (vi) disposable supplies, (vii) similar services.
211 (9) (a) Legend and other drugs as may be determined by
212 the division. The division shall establish a mandatory preferred
213 drug list. Drugs not on the mandatory preferred drug list shall
214 be made available by utilizing prior authorization procedures
215 established by the division. The division may seek to establish
216 relationships with other states in order to lower acquisition
217 costs of prescription drugs to include single source and innovator
218 multiple source drugs or generic drugs. In addition, if allowed
219 by federal law or regulation, the division may seek to establish
220 relationships with and negotiate with other countries to
221 facilitate the acquisition of prescription drugs to include single
222 source and innovator multiple source drugs or generic drugs, if
223 that will lower the acquisition costs of those prescription drugs.
224 The division shall allow for a combination of prescriptions for
225 single source and innovator multiple source drugs and generic
226 drugs to meet the needs of the beneficiaries, not to exceed four
227 (4) prescriptions for single source or innovator multiple source
228 drugs per month for each noninstitutionalized Medicaid
229 beneficiary. The division shall allow for unlimited prescriptions

230 for generic drugs. The division shall establish a prior
231 authorization process under which the division may allow more than
232 four (4) prescriptions for single source or innovator multiple
233 source drugs per month for those beneficiaries whose conditions
234 require a medical regimen that will not be covered by the
235 combination of prescriptions for single source and innovator
236 multiple source drugs and generic drugs that are otherwise allowed
237 under this paragraph (9). The voluntary preferred drug list shall
238 be expanded to function in the interim in order to have a
239 manageable prior authorization system, thereby minimizing
240 disruption of service to beneficiaries. The division shall not
241 reimburse for any portion of a prescription that exceeds a
242 thirty-four-day supply of the drug based on the daily dosage.

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

247 All claims for drugs for dually eligible Medicare/Medicaid
248 beneficiaries that are paid for by Medicare must be submitted to
249 Medicare for payment before they may be processed by the
250 division's on-line payment system.

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

256 The division shall develop and implement a program that
257 requires Medicaid providers who prescribe drugs to use a
258 counterfeit-proof prescription pad for Medicaid prescriptions for
259 controlled substances; however, this shall not prevent the filling
260 of prescriptions for controlled substances by means of electronic
261 communications between a prescriber and pharmacist as allowed by
262 federal law.

263 (b) Payment by the division for covered
264 multisource drugs shall be limited to the lower of the upper
265 limits established and published by the Centers for Medicare and
266 Medicaid Services (CMS) plus a dispensing fee, or the estimated
267 acquisition cost (EAC) as determined by the division, plus a
268 dispensing fee, or the providers' usual and customary charge to
269 the general public.

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

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

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

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

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

290 (10) Dental care that is an adjunct to treatment of an
291 acute medical or surgical condition; services of oral surgeons and
292 dentists in connection with surgery related to the jaw or any
293 structure contiguous to the jaw or the reduction of any fracture
294 of the jaw or any facial bone; and emergency dental extractions
295 and treatment related thereto. On July 1, 1999, all fees for

296 dental care and surgery under authority of this paragraph (10)
297 shall be increased to one hundred sixty percent (160%) of the
298 amount of the reimbursement rate that was in effect on June 30,
299 1999. It is the intent of the Legislature to encourage more
300 dentists to participate in the Medicaid program.

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

310 (12) Intermediate care facility services.

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

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

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

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

329 organized and operated to provide medical care to outpatients.
330 Clinic services shall include any services reimbursed as
331 outpatient hospital services that may be rendered in such a
332 facility, including those that become so after July 1, 1991. On
333 July 1, 1999, all fees for physicians' services reimbursed under
334 authority of this paragraph (14) shall be reimbursed at ninety
335 percent (90%) of the rate established on January 1, 1999, and as
336 adjusted each January thereafter, under Medicare (Title XVIII of
337 the federal Social Security Act, as amended), and which shall in
338 no event be less than seventy percent (70%) of the rate
339 established on January 1, 1994. On July 1, 1999, all fees for
340 dentists' services reimbursed under authority of this paragraph
341 (14) shall be increased to one hundred sixty percent (160%) of the
342 amount of the reimbursement rate that was in effect on June 30,
343 1999.

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

349 (16) Mental health services. Approved therapeutic and
350 case management services (a) provided by an approved regional
351 mental health/retardation center established under Sections
352 41-19-31 through 41-19-39, or by another community mental health
353 service provider meeting the requirements of the Department of
354 Mental Health to be an approved mental health/retardation center
355 if determined necessary by the Department of Mental Health, using
356 state funds that are provided from the appropriation to the State
357 Department of Mental Health and/or funds transferred to the
358 department by a political subdivision or instrumentality of the
359 state and used to match federal funds under a cooperative
360 agreement between the division and the department, or (b) provided
361 by a facility that is certified by the State Department of Mental

362 Health to provide therapeutic and case management services, to be
363 reimbursed on a fee for service basis, or (c) provided in the
364 community by a facility or program operated by the Department of
365 Mental Health. Any such services provided by a facility described
366 in subparagraph (b) must have the prior approval of the division
367 to be reimbursable under this section. After June 30, 1997,
368 mental health services provided by regional mental
369 health/retardation centers established under Sections 41-19-31
370 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
371 and/or their subsidiaries and divisions, or by psychiatric
372 residential treatment facilities as defined in Section 43-11-1, or
373 by another community mental health service provider meeting the
374 requirements of the Department of Mental Health to be an approved
375 mental health/retardation center if determined necessary by the
376 Department of Mental Health, shall not be included in or provided
377 under any capitated managed care pilot program provided for under
378 paragraph (24) of this section.
379 (17) Durable medical equipment services and medical
380 supplies. Precertification of durable medical equipment and
381 medical supplies must be obtained as required by the division.
382 The Division of Medicaid may require durable medical equipment
383 providers to obtain a surety bond in the amount and to the
384 specifications as established by the Balanced Budget Act of 1997.
385 (18) (a) Notwithstanding any other provision of this
386 section to the contrary, the division shall make additional
387 reimbursement to hospitals that serve a disproportionate share of
388 low-income patients and that meet the federal requirements for
389 those payments as provided in Section 1923 of the federal Social
390 Security Act and any applicable regulations. However, from and
391 after January 1, 1999, no public hospital shall participate in the
392 Medicaid disproportionate share program unless the public hospital
393 participates in an intergovernmental transfer program as provided

394 in Section 1903 of the federal Social Security Act and any
395 applicable regulations.
396 (b) The division shall establish a Medicare Upper
397 Payment Limits Program, as defined in Section 1902(a)(30) of the
398 federal Social Security Act and any applicable federal
399 regulations, for hospitals, and may establish a Medicare Upper
400 Payments Limits Program for nursing facilities. The division
401 shall assess each hospital and, if the program is established for
402 nursing facilities, shall assess each nursing facility, based on
403 Medicaid utilization or other appropriate method consistent with
404 federal regulations. The assessment will remain in effect as long
405 as the state participates in the Medicare Upper Payment Limits
406 Program. The division shall make additional reimbursement to
407 hospitals and, if the program is established for nursing
408 facilities, shall make additional reimbursement to nursing
409 facilities, for the Medicare Upper Payment Limits, as defined in
410 Section 1902(a)(30) of the federal Social Security Act and any
411 applicable federal regulations. This subparagraph (b) shall stand
412 repealed from and after July 1, 2005.
413 (19) (a) Perinatal risk management services. The
414 division shall promulgate regulations to be effective from and
415 after October 1, 1988, to establish a comprehensive perinatal
416 system for risk assessment of all pregnant and infant Medicaid
417 recipients and for management, education and follow-up for those
418 who are determined to be at risk. Services to be performed
419 include case management, nutrition assessment/counseling,
420 psychosocial assessment/counseling and health education.
421 (b) Early intervention system services. The
422 division shall cooperate with the State Department of Health,
423 acting as lead agency, in the development and implementation of a
424 statewide system of delivery of early intervention services, under
425 Part C of the Individuals with Disabilities Education Act (IDEA).
426 The State Department of Health shall certify annually in writing

427 to the executive director of the division the dollar amount of
428 state early intervention funds available that will be utilized as
429 a certified match for Medicaid matching funds. Those funds then
430 shall be used to provide expanded targeted case management
431 services for Medicaid eligible children with special needs who are
432 eligible for the state's early intervention system.
433 Qualifications for persons providing service coordination shall be
434 determined by the State Department of Health and the Division of
435 Medicaid.

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

446 (21) Nurse practitioner services. Services furnished
447 by a registered nurse who is licensed and certified by the
448 Mississippi Board of Nursing as a nurse practitioner, including,
449 but not limited to, nurse anesthetists, nurse midwives, family
450 nurse practitioners, family planning nurse practitioners,
451 pediatric nurse practitioners, obstetrics-gynecology nurse
452 practitioners and neonatal nurse practitioners, under regulations
453 adopted by the division. Reimbursement for those services shall
454 not exceed ninety percent (90%) of the reimbursement rate for
455 comparable services rendered by a physician.

456 (22) Ambulatory services delivered in federally
457 qualified health centers, rural health centers and clinics of the
458 local health departments of the State Department of Health for

459 individuals eligible for Medicaid under this article based on
460 reasonable costs as determined by the division.
461 (23) Inpatient psychiatric services. Inpatient
462 psychiatric services to be determined by the division for
463 recipients under age twenty-one (21) that are provided under the
464 direction of a physician in an inpatient program in a licensed
465 acute care psychiatric facility or in a licensed psychiatric
466 residential treatment facility, before the recipient reaches age
467 twenty-one (21) or, if the recipient was receiving the services
468 immediately before he or she reached age twenty-one (21), before
469 the earlier of the date he or she no longer requires the services
470 or the date he or she reaches age twenty-two (22), as provided by
471 federal regulations. Precertification of inpatient days and
472 residential treatment days must be obtained as required by the
473 division.
474 (24) [Deleted]
475 (25) [Deleted]
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 that 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 that are experienced during the final stages of illness and during
485 dying and bereavement and meets the Medicare requirements for
486 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 United States Secretary of
489 Health and Human Services.
490 (28) Other health insurance premiums that are cost
491 effective as defined by the United States Secretary of Health and

492 Human Services. Medicare eligible must have Medicare Part B
493 before other insurance premiums can be paid.
494 (29) The Division of Medicaid may apply for a waiver
495 from the United States Department of Health and Human Services for
496 home- and community-based services for developmentally disabled
497 people using state funds that are provided from the appropriation
498 to the State Department of Mental Health and/or funds transferred
499 to the department by a political subdivision or instrumentality of
500 the state and used to match federal funds under a cooperative
501 agreement between the division and the department, provided that
502 funds for these services are specifically appropriated to the
503 Department of Mental Health and/or transferred to the department
504 by a political subdivision or instrumentality of the state.
505 (30) Pediatric skilled nursing services for eligible
506 persons under twenty-one (21) years of age.
507 (31) Targeted case management services for children
508 with special needs, under waivers from the United States
509 Department of Health and Human Services, using state funds that
510 are provided from the appropriation to the Mississippi Department
511 of Human Services and used to match federal funds under a
512 cooperative agreement between the division and the department.
513 (32) Care and services provided in Christian Science
514 Sanatoria listed and certified by the Commission for Accreditation
515 of Christian Science Nursing Organizations/Facilities, Inc.,
516 rendered in connection with treatment by prayer or spiritual means
517 to the extent that those services are subject to reimbursement
518 under Section 1903 of the federal Social Security Act.
519 (33) Podiatrist services.
520 (34) Assisted living services as provided through home-
521 and community-based services under Title XIX of the federal Social
522 Security Act, as amended, subject to the availability of funds
523 specifically appropriated for that purpose by the Legislature.

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

529 (36) Nonemergency transportation services for
530 Medicaid-eligible persons, to be provided by the Division of
531 Medicaid. The division may contract with additional entities to
532 administer nonemergency transportation services as it deems
533 necessary. All providers shall have a valid driver's license,
534 vehicle inspection sticker, valid vehicle license tags and a
535 standard liability insurance policy covering the vehicle. The
536 division may pay providers a flat fee based on mileage tiers, or
537 in the alternative, may reimburse on actual miles traveled. The
538 division may apply to the Center for Medicare and Medicaid
539 Services (CMS) for a waiver to draw federal matching funds for
540 nonemergency transportation services as a covered service instead
541 of an administrative cost.

542 (37) [Deleted]

543 (38) Chiropractic services. A chiropractor's manual
544 manipulation of the spine to correct a subluxation, if x-ray
545 demonstrates that a subluxation exists and if the subluxation has
546 resulted in a neuromusculoskeletal condition for which
547 manipulation is appropriate treatment, and related spinal x-rays
548 performed to document these conditions. Reimbursement for
549 chiropractic services shall not exceed Seven Hundred Dollars
550 ($700.00) per year per beneficiary.

551 (39) Dually eligible Medicare/Medicaid beneficiaries.
552 The division shall pay the Medicare deductible and coinsurance
553 amounts for services available under Medicare, as determined by
554 the division.

555 (40) [Deleted]

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

566 (42) Notwithstanding any other provision in this
567 article to the contrary, the division may develop a population
568 health management program for women and children health services
569 through the age of one (1) year. This program is primarily for
570 obstetrical care associated with low birth weight and pre-term
571 babies. The division may apply to the federal Centers for
572 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
573 any other waivers that may enhance the program. In order to
574 effect cost savings, the division may develop a revised payment
575 methodology that may include at-risk capitated payments, and may
576 require member participation in accordance with the terms and
577 conditions of an approved federal waiver.

578 (43) The division shall provide reimbursement,
579 according to a payment schedule developed by the division, for
580 smoking cessation medications for pregnant women during their
581 pregnancy and other Medicaid-eligible women who are of
582 child-bearing age.

583 (44) Nursing facility services for the severely
584 disabled.

585 (a) Severe disabilities include, but are not
586 limited to, spinal cord injuries, closed head injuries and
587 ventilator dependent patients.

588 (b) Those services must be provided in a long-term
589 care nursing facility dedicated to the care and treatment of
590 persons with severe disabilities, and shall be reimbursed as a
591 separate category of nursing facilities.
592 (45) Physician assistant services. Services furnished
593 by a physician assistant who is licensed by the State Board of
594 Medical Licensure and is practicing with physician supervision
595 under regulations adopted by the board, under regulations adopted
596 by the division. Reimbursement for those services shall not
597 exceed ninety percent (90%) of the reimbursement rate for
598 comparable services rendered by a physician.
599 (46) The division shall make application to the federal
600 Centers for Medicare and Medicaid Services (CMS) for a waiver to
601 develop and provide services for children with serious emotional
602 disturbances as defined in Section 43-14-1(1), which may include
603 home- and community-based services, case management services or
604 managed care services through mental health providers certified by
605 the Department of Mental Health. The division may implement and
606 provide services under this waivered program only if funds for
607 these services are specifically appropriated for this purpose by
608 the Legislature, or if funds are voluntarily provided by affected
609 agencies.
610 (47) (a) Notwithstanding any other provision in this
611 article to the contrary, the division, in conjunction with the
612 State Department of Health, shall develop and implement disease
613 management programs for individuals with asthma, diabetes or
614 hypertension, including the use of grants, waivers, demonstrations
615 or other projects as necessary.
616 (b) Participation in any disease management
617 program implemented under this paragraph (47) is optional with the
618 individual. An individual must affirmatively elect to participate
619 in the disease management program in order to participate.

620 (c) An individual who participates in the disease
621 management program has the option of participating in the
622 prescription drug home delivery component of the program at any
623 time while participating in the program. An individual must
624 affirmatively elect to participate in the prescription drug home
625 delivery component in order to participate.
626 (d) An individual who participates in the disease
627 management program may elect to discontinue participation in the
628 program at any time. An individual who participates in the
629 prescription drug home delivery component may elect to discontinue
630 participation in the prescription drug home delivery component at
631 any time.
632 (e) The division shall send written notice to all
633 individuals who participate in the disease management program
634 informing them that they may continue using their local pharmacy
635 or any other pharmacy of their choice to obtain their prescription
636 drugs while participating in the program.
637 (f) Prescription drugs that are provided to
638 individuals under the prescription drug home delivery component
639 shall be limited only to those drugs that are used for the
640 treatment, management or care of asthma, diabetes or hypertension.
641 (48) Pediatric long-term acute care hospital services.
642 (a) Pediatric long-term acute care hospital
643 services means services provided to eligible persons under
644 twenty-one (21) years of age by a freestanding Medicare-certified
645 hospital that has an average length of inpatient stay greater than
646 twenty-five (25) days and that is primarily engaged in providing
647 chronic or long-term medical care to persons under twenty-one (21)
648 years of age.
649 (b) The services under this paragraph (48) shall
650 be reimbursed as a separate category of hospital services.
651 (49) The division shall establish co-payments and/or
652 coinsurance for all Medicaid services for which co-payments and/or

653 coinsurance are allowable under federal law or regulation, and
654 shall set the amount of the co-payment and/or coinsurance for each
655 of those services at the maximum amount allowable under federal
656 law or regulation.

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

664 (51) Upon determination of Medicaid eligibility and in
665 association with annual redetermination of Medicaid eligibility,
666 beneficiaries shall be encouraged to undertake a physical
667 examination that will establish a base-line level of health and
668 identification of a usual and customary source of care (a medical
669 home) to aid utilization of disease management tools. This
670 physical examination and utilization of these disease management
671 tools shall be consistent with current United States Preventive
672 Services Task Force or other recognized authority recommendations.

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

676 (52) Notwithstanding any provisions of this article,
677 the division may pay enhanced reimbursement fees related to trauma
678 care, as determined by the division in conjunction with the State
679 Department of Health, using funds appropriated to the State
680 Department of Health for trauma care and services and used to
681 match federal funds under a cooperative agreement between the
682 division and the State Department of Health. The division, in
683 conjunction with the State Department of Health, may use grants,
684 waivers, demonstrations, or other projects as necessary in the
685 development and implementation of this reimbursement program.

686 Notwithstanding any other provision of this article to the
687 contrary, the division shall reduce the rate of reimbursement to
688 providers for any service provided under this section by five
689 percent (5%) of the allowed amount for that service. However, the
690 reduction in the reimbursement rates required by this paragraph
691 shall not apply to inpatient hospital services, nursing facility
692 services, intermediate care facility services, psychiatric
693 residential treatment facility services, pharmacy services
694 provided under paragraph (9) of this section, or any service
695 provided by the University of Mississippi Medical Center or a
696 state agency, a state facility or a public agency that either
697 provides its own state match through intergovernmental transfer or
698 certification of funds to the division, or a service for which the
699 federal government sets the reimbursement methodology and rate.
700 In addition, the reduction in the reimbursement rates required by
701 this paragraph shall not apply to case management services and
702 home-delivered meals provided under the home- and community-based
703 services program for the elderly and disabled by a planning and
704 development district (PDD). Planning and development districts
705 participating in the home- and community-based services program
706 for the elderly and disabled as case management providers shall be
707 reimbursed for case management services at the maximum rate
708 approved by the Centers for Medicare and Medicaid Services (CMS).
709 The division may pay to those providers who participate in
710 and accept patient referrals from the division's emergency room
711 redirection program a percentage, as determined by the division,
712 of savings achieved according to the performance measures and
713 reduction of costs required of that program.
714 Notwithstanding any provision of this article, except as
715 authorized in the following paragraph and in Section 43-13-139,
716 neither (a) the limitations on quantity or frequency of use of or
717 the fees or charges for any of the care or services available to
718 recipients under this section, nor (b) the payments or rates of

719 reimbursement to providers rendering care or services authorized
720 under this section to recipients, may be increased, decreased or
721 otherwise changed from the levels in effect on July 1, 1999,
722 unless they are authorized by an amendment to this section by the
723 Legislature. However, the restriction in this paragraph shall not
724 prevent the division from changing the payments or rates of
725 reimbursement to providers without an amendment to this section
726 whenever those changes are required by federal law or regulation,
727 or whenever those changes are necessary to correct administrative
728 errors or omissions in calculating those payments or rates of
729 reimbursement.

730 Notwithstanding any provision of this article, no new groups
731 or categories of recipients and new types of care and services may
732 be added without enabling legislation from the Mississippi
733 Legislature, except that the division may authorize those changes
734 without enabling legislation when the addition of recipients or
735 services is ordered by a court of proper authority. The executive
736 director shall keep the Governor advised on a timely basis of the
737 funds available for expenditure and the projected expenditures.
738 If current or projected expenditures of the division during the
739 first six (6) months of any fiscal year are reasonably anticipated
740 to be not more than twelve percent (12%) above the amount of the
741 appropriated funds that is authorized to be expended during the
742 first allotment period of the fiscal year, the Governor, after
743 consultation with the executive director, may discontinue any or
744 all of the payment of the types of care and services as provided
745 in this section that are deemed to be optional services under
746 Title XIX of the federal Social Security Act, as amended, and when
747 necessary may institute any other cost containment measures on any
748 program or programs authorized under the article to the extent
749 allowed under the federal law governing that program or programs.
750 If current or projected expenditures of the division during the
751 first six (6) months of any fiscal year can be reasonably

752 anticipated to exceed the amount of the appropriated funds that is
753 authorized to be expended during the first allotment period of the
754 fiscal year by more than twelve percent (12%), the Governor, after
755 consultation with the executive director, shall discontinue any or
756 all of the payment of the types of care and services as provided
757 in this section that are deemed to be optional services under
758 Title XIX of the federal Social Security Act, as amended, for any
759 period necessary to ensure that the actual expenditures of the
760 division will not exceed the amount of the appropriated funds that
761 is authorized to be expended during the first allotment period of
762 the fiscal year by more than twelve percent (12%), and when
763 necessary shall institute any other cost containment measures on
764 any program or programs authorized under the article to the extent
765 allowed under the federal law governing that program or programs.
766 If current or projected expenditures of the division during the
767 last six (6) months of any fiscal year can be reasonably
768 anticipated to exceed the amount of the appropriated funds that is
769 authorized to be expended during the second allotment period of
770 the fiscal year, the Governor, after consultation with the
771 executive director, shall discontinue any or all of the payment of
772 the types of care and services as provided in this section that
773 are deemed to be optional services under Title XIX of the federal
774 Social Security Act, as amended, for any period necessary to
775 ensure that the actual expenditures of the division will not
776 exceed the amount of the appropriated funds that is authorized to
777 be expended during the second allotment period of the fiscal year,
778 and when necessary shall institute any other cost containment
779 measures on any program or programs authorized under the article
780 to the extent allowed under the federal law governing that program
781 or programs. It is the intent of the Legislature that the
782 expenditures of the division during any fiscal year shall not
783 exceed the amounts appropriated to the division for that fiscal
784 year.

785 Notwithstanding any other provision of this article, it shall
786 be the duty of each nursing facility, intermediate care facility
787 for the mentally retarded, psychiatric residential treatment
788 facility, and nursing facility for the severely disabled that is
789 participating in the Medicaid program to keep and maintain books,
790 documents and other records as prescribed by the Division of
791 Medicaid in substantiation of its cost reports for a period of
792 three (3) years after the date of submission to the Division of
793 Medicaid of an original cost report, or three (3) years after the
794 date of submission to the Division of Medicaid of an amended cost
795 report.
796 This section shall stand repealed on July 1, 2007.
797 **SECTION 3.** (1) Any licensed physician who practices full
798 time in any critical needs area for primary medical care as
799 designated under subsection (4) of Section 37-143-6 shall be
800 allowed a credit against the taxes imposed by this chapter in an
801 amount equal to fifty percent (50%) of the physician's income tax
802 liability that results from income derived from his or her
803 practice in any such underserved area. The credit shall be
804 allowed for a maximum of ten (10) years for all practice in any
805 such critical needs areas for primary medical care in which the
806 physician practices during his or her career.
807 (2) Subsection (1) of this section shall be codified as a
808 new section in Article 1, Chapter 7, Title 27, Mississippi Code of
809 1972.
810 **SECTION 4.** This act shall take effect and be in force from
811 and after July 1, 2005; provided that Section 3 of this act shall
812 take effect and be in force from and after January 1, 2005.

ST: Physicians; provide grants and tax credits to practice family medicine in critical needs areas.