

By: Senator(s) Nunnelee

To: Public Health and
Welfare; Appropriations

COMMITTEE SUBSTITUTE
FOR
SENATE BILL NO. 2242

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE THAT THE DIVISION OF MEDICAID SHALL ESTABLISH A FEE
3 SCHEDULE FOR DENTAL SERVICES THAT WILL REPRESENT THE AMOUNT
4 GENERATED BY CERTAIN ADDITIONAL APPROPRIATIONS OF STATE FUNDS TO
5 BE PHASED-IN IN ANNUAL INCREMENTS; TO PROVIDE THAT THE DIVISION
6 SHALL INCLUDE DENTAL SERVICES AS A NECESSARY COMPONENT OF OVERALL
7 HEALTH SERVICES PROVIDED TO CHILDREN WHO ARE ELIGIBLE FOR
8 SERVICES; AND FOR RELATED PURPOSES.

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

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

12 43-13-117. Medicaid as authorized by this article shall
13 include payment of part or all of the costs, at the discretion of
14 the division, with approval of the Governor, of the following
15 types of care and services rendered to eligible applicants who
16 have been determined to be eligible for that care and services,
17 within the limits of state appropriations and federal matching
18 funds:

19 (1) Inpatient hospital services.

20 (a) The division shall allow thirty (30) days of
21 inpatient hospital care annually for all Medicaid recipients.
22 Precertification of inpatient days must be obtained as required by
23 the division. The division may allow unlimited days in
24 disproportionate hospitals as defined by the division for eligible
25 infants and children under the age of six (6) years if certified
26 as medically necessary as required by the division.

27 (b) From and after July 1, 1994, the Executive
28 Director of the Division of Medicaid shall amend the Mississippi
29 Title XIX Inpatient Hospital Reimbursement Plan to remove the
30 occupancy rate penalty from the calculation of the Medicaid

31 Capital Cost Component utilized to determine total hospital costs
32 allocated to the Medicaid program.

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

40 (2) Outpatient hospital services.

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

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

51 (3) Laboratory and x-ray services.

52 (4) Nursing facility services.

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

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

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

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

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

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

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

114 The division shall apply for necessary federal waivers to
115 assure that additional services providing alternatives to nursing
116 facility care are made available to applicants for nursing
117 facility care.

118 (5) Periodic screening and diagnostic services for
119 individuals under age twenty-one (21) years as are needed to
120 identify physical and mental defects and to provide health care
121 treatment and other measures designed to correct or ameliorate
122 defects and physical and mental illness and conditions discovered
123 by the screening services, regardless of whether these services
124 are included in the state plan. The division may include in its
125 periodic screening and diagnostic program those discretionary
126 services authorized under the federal regulations adopted to
127 implement Title XIX of the federal Social Security Act, as
128 amended. The division, in obtaining physical therapy services,
129 occupational therapy services, and services for individuals with

130 speech, hearing and language disorders, may enter into a
131 cooperative agreement with the State Department of Education for
132 the provision of those services to handicapped students by public
133 school districts using state funds that are provided from the
134 appropriation to the Department of Education to obtain federal
135 matching funds through the division. The division, in obtaining
136 medical and psychological evaluations for children in the custody
137 of the State Department of Human Services may enter into a
138 cooperative agreement with the State Department of Human Services
139 for the provision of those services using state funds that are
140 provided from the appropriation to the Department of Human
141 Services to obtain federal matching funds through the division.

142 (6) Physician's services. The division shall allow
143 twelve (12) physician visits annually. All fees for physicians'
144 services that are covered only by Medicaid shall be reimbursed at
145 ninety percent (90%) of the rate established on January 1, 1999,
146 and as may be adjusted each July thereafter, under Medicare (Title
147 XVIII of the federal Social Security Act, as amended). The
148 division may develop and implement a different reimbursement model
149 or schedule for physician's services provided by physicians based
150 at an academic health care center and by physicians at rural
151 health centers that are associated with an academic health care
152 center.

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

158 (b) Repealed.

159 (8) Emergency medical transportation services. On
160 January 1, 1994, emergency medical transportation services shall
161 be reimbursed at seventy percent (70%) of the rate established
162 under Medicare (Title XVIII of the federal Social Security Act, as

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

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

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

176 The division may seek to establish relationships with other
177 states in order to lower acquisition costs of prescription drugs
178 to include single source and innovator multiple source drugs or
179 generic drugs. In addition, if allowed by federal law or
180 regulation, the division may seek to establish relationships with
181 and negotiate with other countries to facilitate the acquisition
182 of prescription drugs to include single source and innovator
183 multiple source drugs or generic drugs, if that will lower the
184 acquisition costs of those prescription drugs.

185 The division shall allow for a combination of prescriptions
186 for single source and innovator multiple source drugs and generic
187 drugs to meet the needs of the beneficiaries, not to exceed five
188 (5) prescriptions per month for each noninstitutionalized Medicaid
189 beneficiary, with not more than two (2) of those prescriptions
190 being for single source or innovator multiple source drugs.

191 The executive director may approve specific maintenance drugs
192 for beneficiaries with certain medical conditions, which may be
193 prescribed and dispensed in three-month supply increments. The
194 executive director may allow a state agency or agencies to be the
195 sole source purchaser and distributor of hemophilia factor

196 medications, HIV/AIDS medications and other medications as
197 determined by the executive director as allowed by federal
198 regulations.

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

214 The voluntary preferred drug list shall be expanded to
215 function in the interim in order to have a manageable prior
216 authorization system, thereby minimizing disruption of service to
217 beneficiaries.

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

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

226 All claims for drugs for dually eligible Medicare/Medicaid
227 beneficiaries that are paid for by Medicare must be submitted to

228 Medicare for payment before they may be processed by the
229 division's on-line payment system.

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

235 The division shall develop and implement a method or methods
236 by which the division will provide on a regular basis to Medicaid
237 providers who are authorized to prescribe drugs, information about
238 the costs to the Medicaid program of single source drugs and
239 innovator multiple source drugs, and information about other drugs
240 that may be prescribed as alternatives to those single source
241 drugs and innovator multiple source drugs and the costs to the
242 Medicaid program of those alternative drugs.

243 Notwithstanding any law or regulation, information obtained
244 or maintained by the division regarding the prescription drug
245 program, including trade secrets and manufacturer or labeler
246 pricing, is confidential and not subject to disclosure except to
247 other state agencies.

248 (b) Payment by the division for covered
249 multisource drugs shall be limited to the lower of the upper
250 limits established and published by the Centers for Medicare and
251 Medicaid Services (CMS) plus a dispensing fee, or the estimated
252 acquisition cost (EAC) as determined by the division, plus a
253 dispensing fee, or the providers' usual and customary charge to
254 the general public.

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

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

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

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

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

275 (10) (a) Dental care that is an adjunct to treatment
276 of an acute medical or surgical condition; services of oral
277 surgeons and dentists in connection with surgery related to the
278 jaw or any structure contiguous to the jaw or the reduction of any
279 fracture of the jaw or any facial bone; and emergency dental
280 extractions and treatment related thereto. On July 1, 2007, all
281 fees for dental care and surgery under authority of this paragraph
282 (10) shall be increased as provided in paragraph (b). It is the
283 intent of the Legislature to encourage more dentists to
284 participate in the Medicaid program.

285 (b) The Division of Medicaid shall establish a fee
286 schedule, to be effective from and after July 1, 2007, for dental
287 services. The schedule shall provide for a fee increase for each
288 dental service that will represent an amount resulting from an
289 additional appropriation of Three Million Dollars (\$3,000,000.00)
290 of state funds to support the Medicaid reimbursement for dental
291 services, to be phased-in as follows: In the fiscal year
292 beginning July 1, 2007, the Legislature shall appropriate an

293 additional One Million Dollars (\$1,000,000.00), in the fiscal year
294 beginning July 1, 2008, the Legislature shall appropriate an
295 additional Two Million Dollars (\$2,000,000.00), and in the fiscal
296 year beginning July 1, 2009, the Legislature shall appropriate an
297 additional Three Million Dollars (\$3,000,000.00).

298 (c) The division shall establish an annual
299 capitalization of Two Thousand Five Hundred Dollars (\$2,500.00) in
300 dental expenditures per Medicaid-eligible recipient.

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

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

313 (12) Intermediate care facility services.

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

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

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

328 (14) Clinic services. Such diagnostic, preventive,
329 therapeutic, rehabilitative or palliative services furnished to an
330 outpatient by or under the supervision of a physician or dentist
331 in a facility that is not a part of a hospital but that is
332 organized and operated to provide medical care to outpatients.
333 Clinic services shall include any services reimbursed as
334 outpatient hospital services that may be rendered in such a
335 facility, including those that become so after July 1, 1991. On
336 July 1, 1999, all fees for physicians' services reimbursed under
337 authority of this paragraph (14) shall be reimbursed at ninety
338 percent (90%) of the rate established on January 1, 1999, and as
339 may be adjusted each July thereafter, under Medicare (Title XVIII
340 of the federal Social Security Act, as amended). The division may
341 develop and implement a different reimbursement model or schedule
342 for physician's services provided by physicians based at an
343 academic health care center and by physicians at rural health
344 centers that are associated with an academic health care center.
345 On July 1, 1999, all fees for dentists' services reimbursed under
346 authority of this paragraph (14) shall be increased to one hundred
347 sixty percent (160%) of the amount of the reimbursement rate that
348 was in effect on June 30, 1999.

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

354 (16) Mental health services. Approved therapeutic and
355 case-management services (a) provided by an approved regional
356 mental health/retardation center established under Sections
357 41-19-31 through 41-19-39, or by another community mental health

358 service provider meeting the requirements of the Department of
359 Mental Health to be an approved mental health/retardation center
360 if determined necessary by the Department of Mental Health, using
361 state funds that are provided from the appropriation to the State
362 Department of Mental Health and/or funds transferred to the
363 department by a political subdivision or instrumentality of the
364 state and used to match federal funds under a cooperative
365 agreement between the division and the department, or (b) provided
366 by a facility that is certified by the State Department of Mental
367 Health to provide therapeutic and case-management services, to be
368 reimbursed on a fee for service basis, or (c) provided in the
369 community by a facility or program operated by the Department of
370 Mental Health. Any such services provided by a facility described
371 in subparagraph (b) must have the prior approval of the division
372 to be reimbursable under this section. After June 30, 1997,
373 mental health services provided by regional mental
374 health/retardation centers established under Sections 41-19-31
375 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
376 and/or their subsidiaries and divisions, or by psychiatric
377 residential treatment facilities as defined in Section 43-11-1, or
378 by another community mental health service provider meeting the
379 requirements of the Department of Mental Health to be an approved
380 mental health/retardation center if determined necessary by the
381 Department of Mental Health, shall not be included in or provided
382 under any capitated managed care pilot program provided for under
383 paragraph (24) of this section.

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

390 (18) (a) Notwithstanding any other provision of this
391 section to the contrary, the division shall make additional
392 reimbursement to hospitals that serve a disproportionate share of
393 low-income patients and that meet the federal requirements for
394 those payments as provided in Section 1923 of the federal Social
395 Security Act and any applicable regulations. However, from and
396 after January 1, 1999, no public hospital shall participate in the
397 Medicaid disproportionate share program unless the public hospital
398 participates in an intergovernmental transfer program as provided
399 in Section 1903 of the federal Social Security Act and any
400 applicable regulations.

401 (b) The division shall establish a Medicare Upper
402 Payment Limits Program, as defined in Section 1902(a)(30) of the
403 federal Social Security Act and any applicable federal
404 regulations, for hospitals, and may establish a Medicare Upper
405 Payments Limits Program for nursing facilities. The division
406 shall assess each hospital and, if the program is established for
407 nursing facilities, shall assess each nursing facility, based on
408 Medicaid utilization or other appropriate method consistent with
409 federal regulations. The assessment will remain in effect as long
410 as the state participates in the Medicare Upper Payment Limits
411 Program. The division shall make additional reimbursement to
412 hospitals and, if the program is established for nursing
413 facilities, shall make additional reimbursement to nursing
414 facilities, for the Medicare Upper Payment Limits, as defined in
415 Section 1902(a)(30) of the federal Social Security Act and any
416 applicable federal regulations.

417 (19) (a) Perinatal risk management services. The
418 division shall promulgate regulations to be effective from and
419 after October 1, 1988, to establish a comprehensive perinatal
420 system for risk assessment of all pregnant and infant Medicaid
421 recipients and for management, education and follow-up for those
422 who are determined to be at risk. Services to be performed

423 include case management, nutrition assessment/counseling,
424 psychosocial assessment/counseling and health education.

425 (b) Early intervention system services. The
426 division shall cooperate with the State Department of Health,
427 acting as lead agency, in the development and implementation of a
428 statewide system of delivery of early intervention services, under
429 Part C of the Individuals with Disabilities Education Act (IDEA).
430 The State Department of Health shall certify annually in writing
431 to the executive director of the division the dollar amount of
432 state early intervention funds available that will be utilized as
433 a certified match for Medicaid matching funds. Those funds then
434 shall be used to provide expanded targeted case-management
435 services for Medicaid-eligible children with special needs who are
436 eligible for the state's early intervention system.
437 Qualifications for persons providing service coordination shall be
438 determined by the State Department of Health and the Division of
439 Medicaid.

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

450 (21) Nurse practitioner services. Services furnished
451 by a registered nurse who is licensed and certified by the
452 Mississippi Board of Nursing as a nurse practitioner, including,
453 but not limited to, nurse anesthetists, nurse midwives, family
454 nurse practitioners, family planning nurse practitioners,
455 pediatric nurse practitioners, obstetrics-gynecology nurse

456 practitioners and neonatal nurse practitioners, under regulations
457 adopted by the division. Reimbursement for those services shall
458 not exceed ninety percent (90%) of the reimbursement rate for
459 comparable services rendered by a physician.

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

465 (23) Inpatient psychiatric services. Inpatient
466 psychiatric services to be determined by the division for
467 recipients under age twenty-one (21) that are provided under the
468 direction of a physician in an inpatient program in a licensed
469 acute care psychiatric facility or in a licensed psychiatric
470 residential treatment facility, before the recipient reaches age
471 twenty-one (21) or, if the recipient was receiving the services
472 immediately before he or she reached age twenty-one (21), before
473 the earlier of the date he or she no longer requires the services
474 or the date he or she reaches age twenty-two (22), as provided by
475 federal regulations. Precertification of inpatient days and
476 residential treatment days must be obtained as required by the
477 division.

478 (24) [Deleted]

479 (25) [Deleted]

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 that 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 that are experienced during the final stages of illness and during

489 dying and bereavement and meets the Medicare requirements for
490 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 United States Secretary of
493 Health and Human Services.

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

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

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

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

517 (32) Care and services provided in Christian Science
518 Sanatoria listed and certified by the Commission for Accreditation
519 of Christian Science Nursing Organizations/Facilities, Inc.,
520 rendered in connection with treatment by prayer or spiritual means

521 to the extent that those services are subject to reimbursement
522 under Section 1903 of the federal Social Security Act.

523 (33) Podiatrist services.

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

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

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

546 (37) [Deleted]

547 (38) Chiropractic services. A chiropractor's manual
548 manipulation of the spine to correct a subluxation, if x-ray
549 demonstrates that a subluxation exists and if the subluxation has
550 resulted in a neuromusculoskeletal condition for which
551 manipulation is appropriate treatment, and related spinal x-rays
552 performed to document these conditions. Reimbursement for

553 chiropractic services shall not exceed Seven Hundred Dollars
554 (\$700.00) per year per beneficiary.

555 (39) Dually eligible Medicare/Medicaid beneficiaries.
556 The division shall pay the Medicare deductible and coinsurance
557 amounts for services available under Medicare, as determined by
558 the division.

559 (40) [Deleted]

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

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

582 (43) The division shall provide reimbursement,
583 according to a payment schedule developed by the division, for
584 smoking cessation medications for pregnant women during their

585 pregnancy and other Medicaid-eligible women who are of
586 child-bearing age.

587 (44) Nursing facility services for the severely
588 disabled.

589 (a) Severe disabilities include, but are not
590 limited to, spinal cord injuries, closed head injuries and
591 ventilator dependent patients.

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

596 (45) Physician assistant services. Services furnished
597 by a physician assistant who is licensed by the State Board of
598 Medical Licensure and is practicing with physician supervision
599 under regulations adopted by the board, under regulations adopted
600 by the division. Reimbursement for those services shall not
601 exceed ninety percent (90%) of the reimbursement rate for
602 comparable services rendered by a physician.

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

614 (47) (a) Notwithstanding any other provision in this
615 article to the contrary, the division, in conjunction with the
616 State Department of Health, may develop and implement disease
617 management programs for individuals with high-cost chronic

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

620 (b) Participation in any disease management
621 program implemented under this paragraph (47) is optional with the
622 individual. An individual must affirmatively elect to participate
623 in the disease management program in order to participate.

624 (c) An individual who participates in the disease
625 management program has the option of participating in the
626 prescription drug home delivery component of the program at any
627 time while participating in the program. An individual must
628 affirmatively elect to participate in the prescription drug home
629 delivery component in order to participate.

630 (d) An individual who participates in the disease
631 management program may elect to discontinue participation in the
632 program at any time. An individual who participates in the
633 prescription drug home delivery component may elect to discontinue
634 participation in the prescription drug home delivery component at
635 any time.

636 (e) The division shall send written notice to all
637 individuals who participate in the disease management program
638 informing them that they may continue using their local pharmacy
639 or any other pharmacy of their choice to obtain their prescription
640 drugs while participating in the program.

641 (f) Prescription drugs that are provided to
642 individuals under the prescription drug home delivery component
643 shall be limited only to those drugs that are used for the
644 treatment, management or care of asthma, diabetes or hypertension.

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

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

651 chronic or long-term medical care to persons under twenty-one (21)
652 years of age.

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

655 (49) The division shall establish co-payments and/or
656 coinsurance for all Medicaid services for which co-payments and/or
657 coinsurance are allowable under federal law or regulation, and
658 shall set the amount of the co-payment and/or coinsurance for each
659 of those services at the maximum amount allowable under federal
660 law or regulation.

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

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

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

680 (52) Notwithstanding any provisions of this article,
681 the division may pay enhanced reimbursement fees related to trauma
682 care, as determined by the division in conjunction with the State
683 Department of Health, using funds appropriated to the State

684 Department of Health for trauma care and services and used to
685 match federal funds under a cooperative agreement between the
686 division and the State Department of Health. The division, in
687 conjunction with the State Department of Health, may use grants,
688 waivers, demonstrations, or other projects as necessary in the
689 development and implementation of this reimbursement program.

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

693 Notwithstanding any other provision of this article to the
694 contrary, the division shall reduce the rate of reimbursement to
695 providers for any service provided under this section by five
696 percent (5%) of the allowed amount for that service. However, the
697 reduction in the reimbursement rates required by this paragraph
698 shall not apply to inpatient hospital services, nursing facility
699 services, intermediate care facility services, psychiatric
700 residential treatment facility services, pharmacy services
701 provided under paragraph (9) of this section, or any service
702 provided by the University of Mississippi Medical Center or a
703 state agency, a state facility or a public agency that either
704 provides its own state match through intergovernmental transfer or
705 certification of funds to the division, or a service for which the
706 federal government sets the reimbursement methodology and rate.
707 In addition, the reduction in the reimbursement rates required by
708 this paragraph shall not apply to case-management services and
709 home-delivered meals provided under the home- and community-based
710 services program for the elderly and disabled by a planning and
711 development district (PDD). Planning and development districts
712 participating in the home- and community-based services program
713 for the elderly and disabled as case-management providers shall be
714 reimbursed for case-management services at the maximum rate
715 approved by the Centers for Medicare and Medicaid Services (CMS).

716 The division may pay to those providers who participate in
717 and accept patient referrals from the division's emergency room
718 redirection program a percentage, as determined by the division,
719 of savings achieved according to the performance measures and
720 reduction of costs required of that program. Federally qualified
721 health centers may participate in the emergency room redirection
722 program, and the division may pay those centers a percentage of
723 any savings to the Medicaid program achieved by the centers'
724 accepting patient referrals through the program, as provided in
725 this paragraph.

726 Notwithstanding any provision of this article, except as
727 authorized in the following paragraph and in Section 43-13-139,
728 neither (a) the limitations on quantity or frequency of use of or
729 the fees or charges for any of the care or services available to
730 recipients under this section, nor (b) the payments or rates of
731 reimbursement to providers rendering care or services authorized
732 under this section to recipients, may be increased, decreased or
733 otherwise changed from the levels in effect on July 1, 1999,
734 unless they are authorized by an amendment to this section by the
735 Legislature. However, the restriction in this paragraph shall not
736 prevent the division from changing the payments or rates of
737 reimbursement to providers without an amendment to this section
738 whenever those changes are required by federal law or regulation,
739 or whenever those changes are necessary to correct administrative
740 errors or omissions in calculating those payments or rates of
741 reimbursement.

742 Notwithstanding any provision of this article, no new groups
743 or categories of recipients and new types of care and services may
744 be added without enabling legislation from the Mississippi
745 Legislature, except that the division may authorize those changes
746 without enabling legislation when the addition of recipients or
747 services is ordered by a court of proper authority.

748 The executive director shall keep the Governor advised on a
749 timely basis of the funds available for expenditure and the
750 projected expenditures. If current or projected expenditures of
751 the division are reasonably anticipated to exceed the amount of
752 funds appropriated to the division for any fiscal year, the
753 Governor, after consultation with the executive director, shall
754 discontinue any or all of the payment of the types of care and
755 services as provided in this section that are deemed to be
756 optional services under Title XIX of the federal Social Security
757 Act, as amended, and when necessary, shall institute any other
758 cost containment measures on any program or programs authorized
759 under the article to the extent allowed under the federal law
760 governing that program or programs. However, the Governor shall
761 not be authorized to discontinue or eliminate any service under
762 this section that is mandatory under federal law, or to
763 discontinue or eliminate, or adjust income limits or resource
764 limits for, any eligibility category or group under Section
765 43-13-115. It is the intent of the Legislature that the
766 expenditures of the division during any fiscal year shall not
767 exceed the amounts appropriated to the division for that fiscal
768 year.

769 Notwithstanding any other provision of this article, it shall
770 be the duty of each nursing facility, intermediate care facility
771 for the mentally retarded, psychiatric residential treatment
772 facility, and nursing facility for the severely disabled that is
773 participating in the Medicaid program to keep and maintain books,
774 documents and other records as prescribed by the Division of
775 Medicaid in substantiation of its cost reports for a period of
776 three (3) years after the date of submission to the Division of
777 Medicaid of an original cost report, or three (3) years after the
778 date of submission to the Division of Medicaid of an amended cost
779 report.

780 **SECTION 2.** This act shall take effect and be in force from
781 and after July 1, 2007.