MISSISSIPPI LEGISLATURE REGULAR SESSION 2007

By: Senator(s) Nunnelee, Burton, Butler, Dawkins, Dearing, Frazier, Gordon, Harden, Jackson (11th), Jackson (32nd), Jordan, Mettetal, Morgan, Posey, Thomas, Walls

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2242
(As Passed the Senate)

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; TO DEFINE HEALTH DISCOUNT PLANS AND HEALTH DISCOUNT
9 CARDS; TO PROVIDE LIMITATIONS ON THE DISTRIBUTION OF SUCH HEALTH
10 DISCOUNT PLANS AND CARDS; TO DIRECT THE MISSISSIPPI COMMISSIONER
11 OF INSURANCE TO ISSUE REGULATIONS REGARDING THE LIMITATIONS ON
12 SUCH PLANS AND CARDS; TO BRING FORWARD SECTION 83-5-85,
13 MISSISSIPPI CODE OF 1972, FOR EXPLANATION PURPOSES; AND FOR
14 RELATED PURPOSES.

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

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

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

25 (1) Inpatient hospital services.

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

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

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

46 (2) Outpatient hospital services.

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

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

57 (3) Laboratory and x-ray services.

58 (4) Nursing facility services.

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

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

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

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

99 authorized to make the reimbursement authorized in this
100 subparagraph (d), the division first must have received approval
101 from the Centers for Medicare and Medicaid Services (CMS) of the
102 change in the state Medicaid plan providing for the reimbursement.
103 (e) The division shall develop and implement, not
104 later than January 1, 2001, a case-mix payment add-on determined
105 by time studies and other valid statistical data that will
106 reimburse a nursing facility for the additional cost of caring for
107 a resident who has a diagnosis of Alzheimer's or other related
108 dementia and exhibits symptoms that require special care. Any
109 such case-mix add-on payment shall be supported by a determination
110 of additional cost. The division shall also develop and implement
111 as part of the fair rental reimbursement system for nursing
112 facility beds, an Alzheimer's resident bed depreciation enhanced
113 reimbursement system that will provide an incentive to encourage
114 nursing facilities to convert or construct beds for residents with
115 Alzheimer's or other related dementia.
116 (f) The division shall develop and implement an
117 assessment process for long-term care services. The division may
118 provide the assessment and related functions directly or through
119 contract with the area agencies on aging.
120 The division shall apply for necessary federal waivers to
121 assure that additional services providing alternatives to nursing
122 facility care are made available to applicants for nursing
123 facility care.
124 (5) Periodic screening and diagnostic services for
125 individuals under age twenty-one (21) years as are needed to
126 identify physical and mental defects and to provide health care
127 treatment and other measures designed to correct or ameliorate
128 defects and physical and mental illness and conditions discovered
129 by the screening services, regardless of whether these services
130 are included in the state plan. The division may include in its
131 periodic screening and diagnostic program those discretionary

132 services authorized under the federal regulations adopted to
133 implement Title XIX of the federal Social Security Act, as
134 amended. The division, in obtaining physical therapy services,
135 occupational therapy services, and services for individuals with
136 speech, hearing and language disorders, may enter into a
137 cooperative agreement with the State Department of Education for
138 the provision of those services to handicapped students by public
139 school districts using state funds that are provided from the
140 appropriation to the Department of Education to obtain federal
141 matching funds through the division. The division, in obtaining
142 medical and psychological evaluations for children in the custody
143 of the State Department of Human Services may enter into a
144 cooperative agreement with the State Department of Human Services
145 for the provision of those services using state funds that are
146 provided from the appropriation to the Department of Human
147 Services to obtain federal matching funds through the division.
148 (6) Physician's services. The division shall allow
149 twelve (12) physician visits annually. All fees for physicians'
150 services that are covered only by Medicaid shall be reimbursed at
151 ninety percent (90%) of the rate established on January 1, 1999,
152 and as may be adjusted each July thereafter, under Medicare (Title
153 XVIII of the federal Social Security Act, as amended). The
154 division may develop and implement a different reimbursement model
155 or schedule for physician's services provided by physicians based
156 at an academic health care center and by physicians at rural
157 health centers that are associated with an academic health care
158 center.
159 (7) (a) Home health services for eligible persons, not
160 to exceed in cost the prevailing cost of nursing facility
161 services, not to exceed twenty-five (25) visits per year. All
162 home health visits must be precertified as required by the
163 division.
164 (b) Repealed.

165 (8) Emergency medical transportation services. On
166 January 1, 1994, emergency medical transportation services shall
167 be reimbursed at seventy percent (70%) of the rate established
168 under Medicare (Title XVIII of the federal Social Security Act, as
169 amended). "Emergency medical transportation services" shall mean,
170 but shall not be limited to, the following services by a properly
171 permitted ambulance operated by a properly licensed provider in
172 accordance with the Emergency Medical Services Act of 1974
173 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
174 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
175 (vi) disposable supplies, (vii) similar services.
176 (9) (a) Legend and other drugs as may be determined by
177 the division.
178 The division shall establish a mandatory preferred drug list.
179 Drugs not on the mandatory preferred drug list shall be made
180 available by utilizing prior authorization procedures established
181 by the division.
182 The division may seek to establish relationships with other
183 states in order to lower acquisition costs of prescription drugs
184 to include single source and innovator multiple source drugs or
185 generic drugs. In addition, if allowed by federal law or
186 regulation, the division may seek to establish relationships with
187 and negotiate with other countries to facilitate the acquisition
188 of prescription drugs to include single source and innovator
189 multiple source drugs or generic drugs, if that will lower the
190 acquisition costs of those prescription drugs.
191 The division shall allow for a combination of prescriptions
192 for single source and innovator multiple source drugs and generic
193 drugs to meet the needs of the beneficiaries, not to exceed five
194 (5) prescriptions per month for each noninstitutionalized Medicaid
195 beneficiary, with not more than two (2) of those prescriptions
196 being for single source or innovator multiple source drugs.

197 The executive director may approve specific maintenance drugs
198 for beneficiaries with certain medical conditions, which may be
199 prescribed and dispensed in three-month supply increments. The
200 executive director may allow a state agency or agencies to be the
201 sole source purchaser and distributor of hemophilia factor
202 medications, HIV/AIDS medications and other medications as
203 determined by the executive director as allowed by federal
204 regulations.
205 Drugs prescribed for a resident of a psychiatric residential
206 treatment facility must be provided in true unit doses when
207 available. The division may require that drugs not covered by
208 Medicare Part D for a resident of a long-term care facility be
209 provided in true unit doses when available. Those drugs that were
210 originally billed to the division but are not used by a resident
211 in any of those facilities shall be returned to the billing
212 pharmacy for credit to the division, in accordance with the
213 guidelines of the State Board of Pharmacy and any requirements of
214 federal law and regulation. Drugs shall be dispensed to a
215 recipient and only one (1) dispensing fee per month may be
216 charged. The division shall develop a methodology for reimbursing
217 for restocked drugs, which shall include a restock fee as
218 determined by the division not exceeding Seven Dollars and
219 Eighty-two Cents ($7.82).
220 The voluntary preferred drug list shall be expanded to
221 function in the interim in order to have a manageable prior
222 authorization system, thereby minimizing disruption of service to
223 beneficiaries.
224 Except for those specific maintenance drugs approved by the
225 executive director, the division shall not reimburse for any
226 portion of a prescription that exceeds a thirty-one-day supply of
227 the drug based on the daily dosage.
228 The division shall develop and implement a program of payment
229 for additional pharmacist services, with payment to be based on

230 demonstrated savings, but in no case shall the total payment
231 exceed twice the amount of the dispensing fee.
232 All claims for drugs for dually eligible Medicare/Medicaid
233 beneficiaries that are paid for by Medicare must be submitted to
234 Medicare for payment before they may be processed by the
235 division's on-line payment system.
236 The division shall develop a pharmacy policy in which drugs
237 in tamper-resistant packaging that are prescribed for a resident
238 of a nursing facility but are not dispensed to the resident shall
239 be returned to the pharmacy and not billed to Medicaid, in
240 accordance with guidelines of the State Board of Pharmacy.
241 The division shall develop and implement a method or methods
242 by which the division will provide on a regular basis to Medicaid
243 providers who are authorized to prescribe drugs, information about
244 the costs to the Medicaid program of single source drugs and
245 innovator multiple source drugs, and information about other drugs
246 that may be prescribed as alternatives to those single source
247 drugs and innovator multiple source drugs and the costs to the
248 Medicaid program of those alternative drugs.
249 Notwithstanding any law or regulation, information obtained
250 or maintained by the division regarding the prescription drug
251 program, including trade secrets and manufacturer or labeler
252 pricing, is confidential and not subject to disclosure except to
253 other state agencies.
254 (b) Payment by the division for covered
255 multisource drugs shall be limited to the lower of the upper
256 limits established and published by the Centers for Medicare and
257 Medicaid Services (CMS) plus a dispensing fee, or the estimated
258 acquisition cost (EAC) as determined by the division, plus a
259 dispensing fee, or the providers' usual and customary charge to
260 the general public.
261 Payment for other covered drugs, other than multisource drugs
262 with CMS upper limits, shall not exceed the lower of the estimated

263 acquisition cost as determined by the division, plus a dispensing
264 fee or the providers' usual and customary charge to the general
265 public.
266 Payment for nonlegend or over-the-counter drugs covered by
267 the division shall be reimbursed at the lower of the division's
268 estimated shelf price or the providers' usual and customary charge
269 to the general public.
270 The dispensing fee for each new or refill prescription,
271 including nonlegend or over-the-counter drugs covered by the
272 division, shall be not less than Three Dollars and Ninety-one
273 Cents ($3.91), as determined by the division.
274 The division shall not reimburse for single source or
275 innovator multiple source drugs if there are equally effective
276 generic equivalents available and if the generic equivalents are
277 the least expensive.
278 It is the intent of the Legislature that the pharmacists
279 providers be reimbursed for the reasonable costs of filling and
280 dispensing prescriptions for Medicaid beneficiaries.
281 (10) (a) Dental care that is an adjunct to treatment
282 of an acute medical or surgical condition; services of oral
283 surgeons and dentists in connection with surgery related to the
284 jaw or any structure contiguous to the jaw or the reduction of any
285 fracture of the jaw or any facial bone; and emergency dental
286 extractions and treatment related thereto. On July 1, 2007, all
287 fees for dental care and surgery under authority of this paragraph
288 (10) shall be increased as provided in paragraph (b). It is the
289 intent of the Legislature to encourage more dentists to
290 participate in the Medicaid program.
291 (b) The Division of Medicaid shall establish a fee
292 schedule, to be effective from and after July 1, 2007, for dental
293 services. The schedule shall provide for a fee increase for each
294 dental service that will represent an amount resulting from an
295 additional appropriation of Three Million Dollars ($3,000,000.00)

296 of state funds to support the Medicaid reimbursement for dental
297 services, to be phased-in as follows: In the fiscal year
298 beginning July 1, 2007, the Legislature shall appropriate an
299 additional One Million Dollars ($1,000,000.00), in the fiscal year
300 beginning July 1, 2008, the Legislature shall appropriate an
301 additional Two Million Dollars ($2,000,000.00), and in the fiscal
302 year beginning July 1, 2009, the Legislature shall appropriate an
303 additional Three Million Dollars ($3,000,000.00).
304 (c) The division shall establish an annual
305 capitalization of Two Thousand Five Hundred Dollars ($2,500.00) in
306 dental expenditures per Medicaid-eligible recipient.
307 (d) The division shall include dental services as
308 a necessary component of overall health services provided to
309 children who are eligible for services.
310 (11) Eyeglasses for all Medicaid beneficiaries who have
311 (a) had surgery on the eyeball or ocular muscle that results in a
312 vision change for which eyeglasses or a change in eyeglasses is
313 medically indicated within six (6) months of the surgery and is in
314 accordance with policies established by the division, or (b) one
315 (1) pair every five (5) years and in accordance with policies
316 established by the division. In either instance, the eyeglasses
317 must be prescribed by a physician skilled in diseases of the eye
318 or an optometrist, whichever the beneficiary may select.
319 (12) Intermediate care facility services.
320 (a) The division shall make full payment to all
321 intermediate care facilities for the mentally retarded for each
322 day, not exceeding eighty-four (84) days per year, that a patient
323 is absent from the facility on home leave. Payment may be made
324 for the following home leave days in addition to the
325 eighty-four-day limitation: Christmas, the day before Christmas,
326 the day after Christmas, Thanksgiving, the day before Thanksgiving
327 and the day after Thanksgiving.

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

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

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

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

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

393 The Division of Medicaid may require durable medical equipment
394 providers to obtain a surety bond in the amount and to the
395 specifications as established by the Balanced Budget Act of 1997.
396 (18) (a) Notwithstanding any other provision of this
397 section to the contrary, the division shall make additional
398 reimbursement to hospitals that serve a disproportionate share of
399 low-income patients and that meet the federal requirements for
400 those payments as provided in Section 1923 of the federal Social
401 Security Act and any applicable regulations. However, from and
402 after January 1, 1999, no public hospital shall participate in the
403 Medicaid disproportionate share program unless the public hospital
404 participates in an intergovernmental transfer program as provided
405 in Section 1903 of the federal Social Security Act and any
406 applicable regulations.
407 (b) The division shall establish a Medicare Upper
408 Payment Limits Program, as defined in Section 1902(a)(30) of the
409 federal Social Security Act and any applicable federal
410 regulations, for hospitals, and may establish a Medicare Upper
411 Payments Limits Program for nursing facilities. The division
412 shall assess each hospital and, if the program is established for
413 nursing facilities, shall assess each nursing facility, based on
414 Medicaid utilization or other appropriate method consistent with
415 federal regulations. The assessment will remain in effect as long
416 as the state participates in the Medicare Upper Payment Limits
417 Program. The division shall make additional reimbursement to
418 hospitals and, if the program is established for nursing
419 facilities, shall make additional reimbursement to nursing
420 facilities, for the Medicare Upper Payment Limits, as defined in
421 Section 1902(a)(30) of the federal Social Security Act and any
422 applicable federal regulations.
423 (19) (a) Perinatal risk management services. The
424 division shall promulgate regulations to be effective from and
425 after October 1, 1988, to establish a comprehensive perinatal

426 system for risk assessment of all pregnant and infant Medicaid
427 recipients and for management, education and follow-up for those
428 who are determined to be at risk. Services to be performed
429 include case management, nutrition assessment/counseling,
430 psychosocial assessment/counseling and health education.
431 (b) Early intervention system services. The
432 division shall cooperate with the State Department of Health,
433 acting as lead agency, in the development and implementation of a
434 statewide system of delivery of early intervention services, under
435 Part C of the Individuals with Disabilities Education Act (IDEA).
436 The State Department of Health shall certify annually in writing
437 to the executive director of the division the dollar amount of
438 state early intervention funds available that will be utilized as
439 a certified match for Medicaid matching funds. Those funds then
440 shall be used to provide expanded targeted case-management
441 services for Medicaid-eligible children with special needs who are
442 eligible for the state's early intervention system.
443 Qualifications for persons providing service coordination shall be
444 determined by the State Department of Health and the Division of
445 Medicaid.
446 (20) Home- and community-based services for physically
447 disabled approved services as allowed by a waiver from the United
448 States Department of Health and Human Services for home- and
449 community-based services for physically disabled people using
450 state funds that are provided from the appropriation to the State
451 Department of Rehabilitation Services and used to match federal
452 funds under a cooperative agreement between the division and the
453 department, provided that funds for these services are
454 specifically appropriated to the Department of Rehabilitation
455 Services.
456 (21) Nurse practitioner services. Services furnished
457 by a registered nurse who is licensed and certified by the
458 Mississippi Board of Nursing as a nurse practitioner, including,

459 but not limited to, nurse anesthetists, nurse midwives, family
460 nurse practitioners, family planning nurse practitioners,
461 pediatric nurse practitioners, obstetrics-gynecology nurse
462 practitioners and neonatal nurse practitioners, under regulations
463 adopted by the division. Reimbursement for those services shall
464 not exceed ninety percent (90%) of the reimbursement rate for
465 comparable services rendered by a physician.
466 (22) Ambulatory services delivered in federally
467 qualified health centers, rural health centers and clinics of the
468 local health departments of the State Department of Health for
469 individuals eligible for Medicaid under this article based on
470 reasonable costs as determined by the division.
471 (23) Inpatient psychiatric services. Inpatient
472 psychiatric services to be determined by the division for
473 recipients under age twenty-one (21) that are provided under the
474 direction of a physician in an inpatient program in a licensed
475 acute care psychiatric facility or in a licensed psychiatric
476 residential treatment facility, before the recipient reaches age
477 twenty-one (21) or, if the recipient was receiving the services
478 immediately before he or she reached age twenty-one (21), before
479 the earlier of the date he or she no longer requires the services
480 or the date he or she reaches age twenty-two (22), as provided by
481 federal regulations. Precertification of inpatient days and
482 residential treatment days must be obtained as required by the
483 division.
484 (24) [Deleted]
485 (25) [Deleted]
486 (26) Hospice care. As used in this paragraph, the term
487 "hospice care" means a coordinated program of active professional
488 medical attention within the home and outpatient and inpatient
489 care that treats the terminally ill patient and family as a unit,
490 employing a medically directed interdisciplinary team. The
491 program provides relief of severe pain or other physical symptoms

492 and supportive care to meet the special needs arising out of
493 physical, psychological, spiritual, social and economic stresses
494 that are experienced during the final stages of illness and during
495 dying and bereavement and meets the Medicare requirements for
496 participation as a hospice as provided in federal regulations.

497 (27) Group health plan premiums and cost sharing if it
498 is cost effective as defined by the United States Secretary of
499 Health and Human Services.

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

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

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

517 (31) Targeted case-management services for children
518 with special needs, under waivers from the United States
519 Department of Health and Human Services, using state funds that
520 are provided from the appropriation to the Mississippi Department
521 of Human Services and used to match federal funds under a
522 cooperative agreement between the division and the department.

523 (32) Care and services provided in Christian Science
524 Sanatoria listed and certified by the Commission for Accreditation

525 of Christian Science Nursing Organizations/Facilities, Inc.,
526 rendered in connection with treatment by prayer or spiritual means
527 to the extent that those services are subject to reimbursement
528 under Section 1903 of the federal Social Security Act.
529 (33) Podiatrist services.
530 (34) Assisted living services as provided through home-
531 and community-based services under Title XIX of the federal Social
532 Security Act, as amended, subject to the availability of funds
533 specifically appropriated for that purpose by the Legislature.
534 (35) Services and activities authorized in Sections
535 43-27-101 and 43-27-103, using state funds that are provided from
536 the appropriation to the State Department of Human Services and
537 used to match federal funds under a cooperative agreement between
538 the division and the department.
539 (36) Nonemergency transportation services for
540 Medicaid-eligible persons, to be provided by the Division of
541 Medicaid. The division may contract with additional entities to
542 administer nonemergency transportation services as it deems
543 necessary. All providers shall have a valid driver's license,
544 vehicle inspection sticker, valid vehicle license tags and a
545 standard liability insurance policy covering the vehicle. The
546 division may pay providers a flat fee based on mileage tiers, or
547 in the alternative, may reimburse on actual miles traveled. The
548 division may apply to the Center for Medicare and Medicaid
549 Services (CMS) for a waiver to draw federal matching funds for
550 nonemergency transportation services as a covered service instead
551 of an administrative cost.
552 (37) [Deleted]
553 (38) Chiropractic services. A chiropractor's manual
554 manipulation of the spine to correct a subluxation, if x-ray
555 demonstrates that a subluxation exists and if the subluxation has
556 resulted in a neuromusculoskeletal condition for which
557 manipulation is appropriate treatment, and related spinal x-rays

558 performed to document these conditions. Reimbursement for
559 chiropractic services shall not exceed Seven Hundred Dollars
560 ($700.00) per year per beneficiary.
561 (39) Dually eligible Medicare/Medicaid beneficiaries.
562 The division shall pay the Medicare deductible and coinsurance
563 amounts for services available under Medicare, as determined by
564 the division.
565 (40) [Deleted]
566 (41) Services provided by the State Department of
567 Rehabilitation Services for the care and rehabilitation of persons
568 with spinal cord injuries or traumatic brain injuries, as allowed
569 under waivers from the United States Department of Health and
570 Human Services, using up to seventy-five percent (75%) of the
571 funds that are appropriated to the Department of Rehabilitation
572 Services from the Spinal Cord and Head Injury Trust Fund
573 established under Section 37-33-261 and used to match federal
574 funds under a cooperative agreement between the division and the
575 department.
576 (42) Notwithstanding any other provision in this
577 article to the contrary, the division may develop a population
578 health management program for women and children health services
579 through the age of one (1) year. This program is primarily for
580 obstetrical care associated with low birth weight and pre-term
581 babies. The division may apply to the federal Centers for
582 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
583 any other waivers that may enhance the program. In order to
584 effect cost savings, the division may develop a revised payment
585 methodology that may include at-risk capitated payments, and may
586 require member participation in accordance with the terms and
587 conditions of an approved federal waiver.
588 (43) The division shall provide reimbursement,
589 according to a payment schedule developed by the division, for
590 smoking cessation medications for pregnant women during their

591 pregnancy and other Medicaid-eligible women who are of
592 child-bearing age.
593 (44) Nursing facility services for the severely
594 disabled.
595 (a) Severe disabilities include, but are not
596 limited to, spinal cord injuries, closed head injuries and
597 ventilator dependent patients.
598 (b) Those services must be provided in a long-term
599 care nursing facility dedicated to the care and treatment of
600 persons with severe disabilities, and shall be reimbursed as a
601 separate category of nursing facilities.
602 (45) Physician assistant services. Services furnished
603 by a physician assistant who is licensed by the State Board of
604 Medical Licensure and is practicing with physician supervision
605 under regulations adopted by the board, under regulations adopted
606 by the division. Reimbursement for those services shall not
607 exceed ninety percent (90%) of the reimbursement rate for
608 comparable services rendered by a physician.
609 (46) The division shall make application to the federal
610 Centers for Medicare and Medicaid Services (CMS) for a waiver to
611 develop and provide services for children with serious emotional
612 disturbances as defined in Section 43-14-1(1), which may include
613 home- and community-based services, case-management services or
614 managed care services through mental health providers certified by
615 the Department of Mental Health. The division may implement and
616 provide services under this waivered program only if funds for
617 these services are specifically appropriated for this purpose by
618 the Legislature, or if funds are voluntarily provided by affected
619 agencies.
620 (47) (a) Notwithstanding any other provision in this
621 article to the contrary, the division, in conjunction with the
622 State Department of Health, may develop and implement disease
623 management programs for individuals with high-cost chronic

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

626 (b) Participation in any disease management
627 program implemented under this paragraph (47) is optional with the
628 individual. An individual must affirmatively elect to participate
629 in the disease management program in order to participate.

630 (c) An individual who participates in the disease
631 management program has the option of participating in the
632 prescription drug home delivery component of the program at any
633 time while participating in the program. An individual must
634 affirmatively elect to participate in the prescription drug home
635 delivery component in order to participate.

636 (d) An individual who participates in the disease
637 management program may elect to discontinue participation in the
638 program at any time. An individual who participates in the
639 prescription drug home delivery component may elect to discontinue
640 participation in the prescription drug home delivery component at
641 any time.

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

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

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

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

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

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

661 (49) The division shall establish co-payments and/or
662 coinsurance for all Medicaid services for which co-payments and/or
663 coinsurance are allowable under federal law or regulation, and
664 shall set the amount of the co-payment and/or coinsurance for each
665 of those services at the maximum amount allowable under federal
666 law or regulation.

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

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

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

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

690 Department of Health for trauma care and services and used to
691 match federal funds under a cooperative agreement between the
692 division and the State Department of Health. The division, in
693 conjunction with the State Department of Health, may use grants,
694 waivers, demonstrations, or other projects as necessary in the
695 development and implementation of this reimbursement program.
696 (53) Targeted case-management services for high-cost
697 beneficiaries shall be developed by the division for all services
698 under this section.
699 Notwithstanding any other provision of this article to the
700 contrary, the division shall reduce the rate of reimbursement to
701 providers for any service provided under this section by five
702 percent (5%) of the allowed amount for that service. However, the
703 reduction in the reimbursement rates required by this paragraph
704 shall not apply to inpatient hospital services, nursing facility
705 services, intermediate care facility services, psychiatric
706 residential treatment facility services, pharmacy services
707 provided under paragraph (9) of this section, or any service
708 provided by the University of Mississippi Medical Center or a
709 state agency, a state facility or a public agency that either
710 provides its own state match through intergovernmental transfer or
711 certification of funds to the division, or a service for which the
712 federal government sets the reimbursement methodology and rate.
713 In addition, the reduction in the reimbursement rates required by
714 this paragraph shall not apply to case-management services and
715 home-delivered meals provided under the home- and community-based
716 services program for the elderly and disabled by a planning and
717 development district (PDD). Planning and development districts
718 participating in the home- and community-based services program
719 for the elderly and disabled as case-management providers shall be
720 reimbursed for case-management services at the maximum rate
721 approved by the Centers for Medicare and Medicaid Services (CMS).

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

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

748 Notwithstanding any provision of this article, no new groups
749 or categories of recipients and new types of care and services may
750 be added without enabling legislation from the Mississippi
751 Legislature, except that the division may authorize those changes
752 without enabling legislation when the addition of recipients or
753 services is ordered by a court of proper authority.

754 The executive director shall keep the Governor advised on a
755 timely basis of the funds available for expenditure and the
756 projected expenditures. If current or projected expenditures of
757 the division are reasonably anticipated to exceed the amount of
758 funds appropriated to the division for any fiscal year, the
759 Governor, after consultation with the executive director, shall
760 discontinue any or all of the payment of the types of care and
761 services as provided in this section that are deemed to be
762 optional services under Title XIX of the federal Social Security
763 Act, as amended, and when necessary, shall institute any other
764 cost containment measures on any program or programs authorized
765 under the article to the extent allowed under the federal law
766 governing that program or programs. However, the Governor shall
767 not be authorized to discontinue or eliminate any service under
768 this section that is mandatory under federal law, or to
769 discontinue or eliminate, or adjust income limits or resource
770 limits for, any eligibility category or group under Section
771 43-13-115. It is the intent of the Legislature that the
772 expenditures of the division during any fiscal year shall not
773 exceed the amounts appropriated to the division for that fiscal
774 year.

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

786 **SECTION 2.** (1) "Health discount plan" means a card,
787 program, device, arrangement, contract or mechanism that purports
788 to offer discounts or access to discounts on health care services
789 or supplies that is not insurance or that does not provide
790 coverage for services or benefits regulated under Section 83-9-1
791 et seq., Mississippi Code of 1972.

792 (2) A person may not sell, market, promote, advertise or
793 otherwise distribute a health discount plan unless:

794 (a) Each advertisement, policy, document, information,
795 statement or other communication regarding the health discount
796 plan and the plan itself contain a statement, in bold and
797 prominent type, that the health discount plan is not insurance;

798 (b) The discounts offered under the health discount
799 plan are specifically authorized by a contract with each provider
800 of the services or supplies listed in conjunction with the plan;

801 (c) The health discount plan states the name, address
802 and telephone number of the administrator of the plan;

803 (d) The person makes readily available to the consumer
804 a complete, accurate and up-to-date list of providers
805 participating in the plan that offer discounted health care
806 services or supplies in the consumer's local area and the
807 discounts offered by the providers;

808 (e) The person provides the consumer the right to
809 cancel the health discount plan within thirty (30) days after
810 purchase of the plan; and

811 (f) The person provides the consumer with a full refund
812 of all payments made, except for a nominal processing fee, within
813 thirty (30) days after notification of cancellation of the plan
814 under paragraph (e) of this subsection.

815 (3) The Commissioner of Insurance may adopt regulations to
816 implement this section and to establish additional requirements
817 intended to prohibit unfair or deceptive practices relating to
818 health discount plans.

819 **SECTION 3.** Section 83-5-85, Mississippi Code of 1972, is
820 brought forward as follows:
821 83-5-85. For violation of any provisions of the insurance
822 laws of Mississippi, the penalty whereof is not specifically
823 provided, the offender shall be guilty of a misdemeanor and, on
824 conviction, shall be punished by a fine of not more than Five
825 Thousand Dollars ($5,000.00). For expenses in seeking out,
826 detecting and punishing violations of such laws, the commissioner
827 may assess an additional penalty to be paid by the offender as
828 restitution in an amount to cover such expenses as may be approved
829 by the court.
830 The penalties authorized by this section are cumulative and
831 supplemental to any other penalty, fine or other sanction, and
832 shall not be a bar to any other civil cause of action or criminal
833 prosecution.
834 **SECTION 4.** This act shall take effect and be in force from
835 and after July 1, 2007.

ST: Medicaid program; prescribe reimbursement rate for dental services.