

By: Representatives Evans, Scott (80th)

To: Public Health and  
Welfare;  
Appropriations

## HOUSE BILL NO. 403

1 AN ACT TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972,  
2 TO ALLOW DISABLED WORKERS TO PURCHASE MEDICAID COVERAGE; TO AMEND  
3 SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO INCREASE THE  
4 NUMBER OF MEDICAID PRESCRIPTIONS UNDER CERTAIN CIRCUMSTANCES; AND  
5 FOR RELATED PURPOSES.

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

7 SECTION 1. Section 43-13-115, Mississippi Code of 1972, is  
8 amended as follows:

9 43-13-115. Recipients of medical assistance shall be the  
10 following persons only:

11 (1) Who are qualified for public assistance grants under  
12 provisions of Title IV-A and E of the federal Social Security Act,  
13 as amended, including those statutorily deemed to be IV-A as  
14 determined by the State Department of Human Services and certified  
15 to the Division of Medicaid, but not optional groups unless  
16 otherwise specifically covered in this section. For the purposes  
17 of this paragraph (1) and paragraphs (3), (4), (8), (14), (17) and  
18 (18) of this section, any reference to Title IV-A or to Part A of  
19 Title IV of the federal Social Security Act, as amended, or the  
20 state plan under Title IV-A or Part A of Title IV, shall be  
21 considered as a reference to Title IV-A of the federal Social  
22 Security Act, as amended, and the state plan under Title IV-A,  
23 including the income and resource standards and methodologies  
24 under Title IV-A and the state plan, as they existed on July 16,  
25 1996.

26 (2) Those qualified for Supplemental Security Income (SSI)  
27 benefits under Title XVI of the federal Social Security Act, as  
28 amended. The eligibility of individuals covered in this paragraph

29 shall be determined by the Social Security Administration and  
30 certified to the Division of Medicaid.

31 (3) Qualified pregnant women as defined in Section 1905(n)  
32 of the federal Social Security Act, as amended, and as determined  
33 to be eligible by the State Department of Human Services and  
34 certified to the Division of Medicaid, who:

35 (a) Would be eligible for assistance under Part A of  
36 Title IV (or would be eligible for such assistance if coverage  
37 under the state plan under Part A of Title IV included assistance  
38 pursuant to Section 407 of Title IV-A of the federal Social  
39 Security Act, as amended) if her child had been born and was  
40 living with her in the month such assistance would be paid, and  
41 such pregnancy has been medically verified; or

42 (b) Is a member of a family which would be eligible  
43 for assistance under the state plan under Part A of Title IV of  
44 the federal Social Security Act, as amended, pursuant to Section  
45 407 if the plan required the payment of assistance pursuant to  
46 such section.

47 (4) Qualified children who are under five (5) years of age,  
48 who were born after September 30, 1983, and who meet the income  
49 and resource requirements of the state plan under Part A of Title  
50 IV of the federal Social Security Act, as amended. The  
51 eligibility of individuals covered in this paragraph shall be  
52 determined by the State Department of Human Services and certified  
53 to the Division of Medicaid.

54 (5) A child born on or after October 1, 1984, to a woman  
55 eligible for and receiving medical assistance under the state plan  
56 on the date of the child's birth shall be deemed to have applied  
57 for medical assistance and to have been found eligible for such  
58 assistance under such plan on the date of such birth and will  
59 remain eligible for such assistance for a period of one (1) year  
60 so long as the child is a member of the woman's household and the  
61 woman remains eligible for such assistance or would be eligible  
62 for assistance if pregnant. The eligibility of individuals  
63 covered in this paragraph shall be determined by the State  
64 Department of Human Services and certified to the Division of  
65 Medicaid.

66 (6) Children certified by the State Department of Human

67 Services to the Division of Medicaid of whom the state and county  
68 human services agency has custody and financial responsibility,  
69 and children who are in adoptions subsidized in full or part by  
70 the Department of Human Services, who are approvable under Title  
71 XIX of the Medicaid program.

72 (7) (a) Persons certified by the Division of Medicaid who  
73 are patients in a medical facility (nursing home, hospital,  
74 tuberculosis sanatorium or institution for treatment of mental  
75 diseases), and who, except for the fact that they are patients in  
76 such medical facility, would qualify for grants under Title IV,  
77 supplementary security income benefits under Title XVI or state  
78 supplements, and those aged, blind and disabled persons who would  
79 not be eligible for supplemental security income benefits under  
80 Title XVI or state supplements if they were not institutionalized  
81 in a medical facility but whose income is below the maximum  
82 standard set by the Division of Medicaid, which standard shall not  
83 exceed that prescribed by federal regulation;

84 (b) Individuals who have elected to receive hospice  
85 care benefits and who are eligible using the same criteria and  
86 special income limits as those in institutions as described in  
87 subparagraph (a) of this paragraph (7).

88 (8) Children under eighteen (18) years of age and pregnant  
89 women (including those in intact families) who meet the financial  
90 standards of the state plan approved under Title IV-A of the  
91 federal Social Security Act, as amended. The eligibility of  
92 children covered under this paragraph shall be determined by the  
93 State Department of Human Services and certified to the Division  
94 of Medicaid.

95 (9) Individuals who are:

96 (a) Children born after September 30, 1983, who have  
97 not attained the age of nineteen (19), with family income that  
98 does not exceed one hundred percent (100%) of the nonfarm official  
99 poverty line;

100 (b) Pregnant women, infants and children who have not

101 attained the age of six (6), with family income that does not  
102 exceed one hundred thirty-three percent (133%) of the federal  
103 poverty level; and

104 (c) Pregnant women and infants who have not attained  
105 the age of one (1), with family income that does not exceed one  
106 hundred eighty-five percent (185%) of the federal poverty level.

107 The eligibility of individuals covered in (a), (b) and (c) of  
108 this paragraph shall be determined by the Department of Human  
109 Services.

110 (10) Certain disabled children age eighteen (18) or under  
111 who are living at home, who would be eligible, if in a medical  
112 institution, for SSI or a state supplemental payment under Title  
113 XVI of the federal Social Security Act, as amended, and therefore  
114 for Medicaid under the plan, and for whom the state has made a  
115 determination as required under Section 1902(e)(3)(b) of the  
116 federal Social Security Act, as amended. The eligibility of  
117 individuals under this paragraph shall be determined by the  
118 Division of Medicaid.

119 (11) Individuals who are sixty-five (65) years of age or  
120 older or are disabled as determined under Section 1614(a)(3) of  
121 the federal Social Security Act, as amended, and who meet the  
122 following criteria:

123 (a) Whose income does not exceed one hundred percent  
124 (100%) of the nonfarm official poverty line as defined by the  
125 Office of Management and Budget and revised annually.

126 (b) Whose resources do not exceed those allowed under  
127 the Supplemental Security Income (SSI) program.

128 The eligibility of individuals covered under this paragraph  
129 shall be determined by the Division of Medicaid, and such  
130 individuals determined eligible shall receive the same Medicaid  
131 services as other categorical eligible individuals.

132 (12) Individuals who are qualified Medicare beneficiaries  
133 (QMB) entitled to Part A Medicare as defined under Section 301,  
134 Public Law 100-360, known as the Medicare Catastrophic Coverage

135 Act of 1988, and who meet the following criteria:

136 (a) Whose income does not exceed one hundred percent  
137 (100%) of the nonfarm official poverty line as defined by the  
138 Office of Management and Budget and revised annually.

139 (b) Whose resources do not exceed two hundred percent  
140 (200%) of the amount allowed under the Supplemental Security  
141 Income (SSI) program as more fully prescribed under Section 301,  
142 Public Law 100-360.

143 The eligibility of individuals covered under this paragraph  
144 shall be determined by the Division of Medicaid, and such  
145 individuals determined eligible shall receive Medicare  
146 cost-sharing expenses only as more fully defined by the Medicare  
147 Catastrophic Coverage Act of 1988.

148 (13) Individuals who are entitled to Medicare Part B as  
149 defined in Section 4501 of the Omnibus Budget Reconciliation Act  
150 of 1990, and who meet the following criteria:

151 (a) Whose income does not exceed the percentage of the  
152 nonfarm official poverty line as defined by the Office of  
153 Management and Budget and revised annually which, on or after:

154 (i) January 1, 1993, is one hundred ten percent  
155 (110%); and

156 (ii) January 1, 1995, is one hundred twenty  
157 percent (120%).

158 (b) Whose resources do not exceed two hundred percent  
159 (200%) of the amount allowed under the Supplemental Security  
160 Income (SSI) program as described in Section 301 of the Medicare  
161 Catastrophic Coverage Act of 1988.

162 The eligibility of individuals covered under this paragraph  
163 shall be determined by the Division of Medicaid, and such  
164 individuals determined eligible shall receive Medicare cost  
165 sharing.

166 (14) Individuals in families who would be eligible for the  
167 unemployed parent program under Section 407 of Title IV-A of the  
168 federal Social Security Act, as amended but do not receive

169 payments pursuant to that section. The eligibility of individuals  
170 covered in this paragraph shall be determined by the Department of  
171 Human Services.

172 (15) Disabled workers who are eligible to enroll in Part A  
173 Medicare as required by Public Law 101-239, known as the Omnibus  
174 Budget Reconciliation Act of 1989, and whose income does not  
175 exceed two hundred percent (200%) of the federal poverty level as  
176 determined in accordance with the Supplemental Security Income  
177 (SSI) program. The eligibility of individuals covered under this  
178 paragraph shall be determined by the Division of Medicaid and such  
179 individuals shall be entitled to buy-in coverage of Medicare Part  
180 A premiums only under the provisions of this paragraph (15).

181 (16) In accordance with the terms and conditions of approved  
182 Title XIX waiver from the United States Department of Health and  
183 Human Services, persons provided home- and community-based  
184 services who are physically disabled and certified by the Division  
185 of Medicaid as eligible due to applying the income and deeming  
186 requirements as if they were institutionalized.

187 (17) In accordance with the terms of the federal Personal  
188 Responsibility and Work Opportunity Reconciliation Act of 1996  
189 (Public Law 104-193), persons who become ineligible for assistance  
190 under Title IV-A of the federal Social Security Act, as amended  
191 because of increased income from or hours of employment of the  
192 caretaker relative or because of the expiration of the applicable  
193 earned income disregards, who were eligible for Medicaid for at  
194 least three (3) of the six (6) months preceding the month in which  
195 such ineligibility begins, shall be eligible for Medicaid  
196 assistance for up to twenty-four (24) months; however, Medicaid  
197 assistance for more than twelve (12) months may be provided only  
198 if a federal waiver is obtained to provide such assistance for  
199 more than twelve (12) months and federal and state funds are  
200 available to provide such assistance.

201 (18) Persons who become ineligible for assistance under  
202 Title IV-A of the federal Social Security Act, as amended, as a

203 result, in whole or in part, of the collection or increased  
204 collection of child or spousal support under Title IV-D of the  
205 federal Social Security Act, as amended, who were eligible for  
206 Medicaid for at least three (3) of the six (6) months immediately  
207 preceding the month in which such ineligibility begins, shall be  
208 eligible for Medicaid for an additional four (4) months beginning  
209 with the month in which such ineligibility begins.

210 (19) Disabled workers, whose incomes are above the Medicaid  
211 eligibility limits, but below Two Hundred Fifty Percent (250%) of  
212 the federal poverty level, shall be allowed to purchase Medicaid  
213 coverage on a sliding fee scale developed by the Division of  
214 Medicaid.

215 SECTION 2. Section 43-13-117, Mississippi Code of 1972, is  
216 amended as follows:

217 43-13-117. Medical assistance as authorized by this article  
218 shall include payment of part or all of the costs, at the  
219 discretion of the division or its successor, with approval of the  
220 Governor, of the following types of care and services rendered to  
221 eligible applicants who shall have been determined to be eligible  
222 for such care and services, within the limits of state  
223 appropriations and federal matching funds:

224 (1) Inpatient hospital services.

225 (a) The division shall allow thirty (30) days of  
226 inpatient hospital care annually for all Medicaid recipients;  
227 however, before any recipient will be allowed more than fifteen  
228 (15) days of inpatient hospital care in any one (1) year, he must  
229 obtain prior approval therefor from the division. The division  
230 shall be authorized to allow unlimited days in disproportionate  
231 hospitals as defined by the division for eligible infants under  
232 the age of six (6) years.

233 (b) From and after July 1, 1994, the Executive Director  
234 of the Division of Medicaid shall amend the Mississippi Title XIX  
235 Inpatient Hospital Reimbursement Plan to remove the occupancy rate  
236 penalty from the calculation of the Medicaid Capital Cost

237 Component utilized to determine total hospital costs allocated to  
238 the Medicaid Program.

239 (2) Outpatient hospital services. Provided that where the  
240 same services are reimbursed as clinic services, the division may  
241 revise the rate or methodology of outpatient reimbursement to  
242 maintain consistency, efficiency, economy and quality of care.

243 (3) Laboratory and X-ray services.

244 (4) Nursing facility services.

245 (a) The division shall make full payment to nursing  
246 facilities for each day, not exceeding thirty-six (36) days per  
247 year, that a patient is absent from the facility on home leave.  
248 However, before payment may be made for more than eighteen (18)  
249 home leave days in a year for a patient, the patient must have  
250 written authorization from a physician stating that the patient is  
251 physically and mentally able to be away from the facility on home  
252 leave. Such authorization must be filed with the division before  
253 it will be effective and the authorization shall be effective for  
254 three (3) months from the date it is received by the division,  
255 unless it is revoked earlier by the physician because of a change  
256 in the condition of the patient.

257 (b) Repealed.

258 (c) From and after July 1, 1997, all state-owned  
259 nursing facilities shall be reimbursed on a full reasonable costs  
260 basis. From and after July 1, 1997, payments by the division to  
261 nursing facilities for return on equity capital shall be made at  
262 the rate paid under Medicare (Title XVIII of the Social Security  
263 Act), but shall be no less than seven and one-half percent (7.5%)  
264 nor greater than ten percent (10%).

265 (d) A Review Board for nursing facilities is  
266 established to conduct reviews of the Division of Medicaid's  
267 decision in the areas set forth below:

268 (i) Review shall be heard in the following areas:

269 (A) Matters relating to cost reports

270 including, but not limited to, allowable costs and cost



271 adjustments resulting from desk reviews and audits.

272 (B) Matters relating to the Minimum Data Set  
273 Plus (MDS +) or successor assessment formats including but not  
274 limited to audits, classifications and submissions.

275 (ii) The Review Board shall be composed of six (6)  
276 members, three (3) having expertise in one (1) of the two (2)  
277 areas set forth above and three (3) having expertise in the other  
278 area set forth above. Each panel of three (3) shall only review  
279 appeals arising in its area of expertise. The members shall be  
280 appointed as follows:

281 (A) In each of the areas of expertise defined  
282 under subparagraphs (i)(A) and (i)(B), the Executive Director of  
283 the Division of Medicaid shall appoint one (1) person chosen from  
284 the private sector nursing home industry in the state, which may  
285 include independent accountants and consultants serving the  
286 industry;

287 (B) In each of the areas of expertise defined  
288 under subparagraphs (i)(A) and (i)(B), the Executive Director of  
289 the Division of Medicaid shall appoint one (1) person who is  
290 employed by the state who does not participate directly in desk  
291 reviews or audits of nursing facilities in the two (2) areas of  
292 review;

293 (C) The two (2) members appointed by the  
294 Executive Director of the Division of Medicaid in each area of  
295 expertise shall appoint a third member in the same area of  
296 expertise.

297 In the event of a conflict of interest on the part of any  
298 Review Board members, the Executive Director of the Division of  
299 Medicaid or the other two (2) panel members, as applicable, shall  
300 appoint a substitute member for conducting a specific review.

301 (iii) The Review Board panels shall have the power  
302 to preserve and enforce order during hearings; to issue subpoenas;  
303 to administer oaths; to compel attendance and testimony of  
304 witnesses; or to compel the production of books, papers, documents

305 and other evidence; or the taking of depositions before any  
306 designated individual competent to administer oaths; to examine  
307 witnesses; and to do all things conformable to law that may be  
308 necessary to enable it effectively to discharge its duties. The  
309 Review Board panels may appoint such person or persons as they  
310 shall deem proper to execute and return process in connection  
311 therewith.

312 (iv) The Review Board shall promulgate, publish  
313 and disseminate to nursing facility providers rules of procedure  
314 for the efficient conduct of proceedings, subject to the approval  
315 of the Executive Director of the Division of Medicaid and in  
316 accordance with federal and state administrative hearing laws and  
317 regulations.

318 (v) Proceedings of the Review Board shall be of  
319 record.

320 (vi) Appeals to the Review Board shall be in  
321 writing and shall set out the issues, a statement of alleged facts  
322 and reasons supporting the provider's position. Relevant  
323 documents may also be attached. The appeal shall be filed within  
324 thirty (30) days from the date the provider is notified of the  
325 action being appealed or, if informal review procedures are taken,  
326 as provided by administrative regulations of the Division of  
327 Medicaid, within thirty (30) days after a decision has been  
328 rendered through informal hearing procedures.

329 (vii) The provider shall be notified of the  
330 hearing date by certified mail within thirty (30) days from the  
331 date the Division of Medicaid receives the request for appeal.  
332 Notification of the hearing date shall in no event be less than  
333 thirty (30) days before the scheduled hearing date. The appeal  
334 may be heard on shorter notice by written agreement between the  
335 provider and the Division of Medicaid.

336 (viii) Within thirty (30) days from the date of  
337 the hearing, the Review Board panel shall render a written  
338 recommendation to the Executive Director of the Division of

339 Medicaid setting forth the issues, findings of fact and applicable  
340 law, regulations or provisions.

341           (ix) The Executive Director of the Division of  
342 Medicaid shall, upon review of the recommendation, the proceedings  
343 and the record, prepare a written decision which shall be mailed  
344 to the nursing facility provider no later than twenty (20) days  
345 after the submission of the recommendation by the panel. The  
346 decision of the executive director is final, subject only to  
347 judicial review.

348           (x) Appeals from a final decision shall be made to  
349 the Chancery Court of Hinds County. The appeal shall be filed  
350 with the court within thirty (30) days from the date the decision  
351 of the Executive Director of the Division of Medicaid becomes  
352 final.

353           (xi) The action of the Division of Medicaid under  
354 review shall be stayed until all administrative proceedings have  
355 been exhausted.

356           (xii) Appeals by nursing facility providers  
357 involving any issues other than those two (2) specified in  
358 subparagraphs (i)(A) and (ii)(B) shall be taken in accordance with  
359 the administrative hearing procedures established by the Division  
360 of Medicaid.

361           (e) When a facility of a category that does not require  
362 a certificate of need for construction and that could not be  
363 eligible for Medicaid reimbursement is constructed to nursing  
364 facility specifications for licensure and certification, and the  
365 facility is subsequently converted to a nursing facility pursuant  
366 to a certificate of need that authorizes conversion only and the  
367 applicant for the certificate of need was assessed an application  
368 review fee based on capital expenditures incurred in constructing  
369 the facility, the division shall allow reimbursement for capital  
370 expenditures necessary for construction of the facility that were  
371 incurred within the twenty-four (24) consecutive calendar months  
372 immediately preceding the date that the certificate of need

373 authorizing such conversion was issued, to the same extent that  
374 reimbursement would be allowed for construction of a new nursing  
375 facility pursuant to a certificate of need that authorizes such  
376 construction. The reimbursement authorized in this subparagraph  
377 (e) may be made only to facilities the construction of which was  
378 completed after June 30, 1989. Before the division shall be  
379 authorized to make the reimbursement authorized in this  
380 subparagraph (e), the division first must have received approval  
381 from the Health Care Financing Administration of the United States  
382 Department of Health and Human Services of the change in the state  
383 Medicaid plan providing for such reimbursement.

384 (5) Periodic screening and diagnostic services for  
385 individuals under age twenty-one (21) years as are needed to  
386 identify physical and mental defects and to provide health care  
387 treatment and other measures designed to correct or ameliorate  
388 defects and physical and mental illness and conditions discovered  
389 by the screening services regardless of whether these services are  
390 included in the state plan. The division may include in its  
391 periodic screening and diagnostic program those discretionary  
392 services authorized under the federal regulations adopted to  
393 implement Title XIX of the federal Social Security Act, as  
394 amended. The division, in obtaining physical therapy services,  
395 occupational therapy services, and services for individuals with  
396 speech, hearing and language disorders, may enter into a  
397 cooperative agreement with the State Department of Education for  
398 the provision of such services to handicapped students by public  
399 school districts using state funds which are provided from the  
400 appropriation to the Department of Education to obtain federal  
401 matching funds through the division. The division, in obtaining  
402 medical and psychological evaluations for children in the custody  
403 of the State Department of Human Services may enter into a  
404 cooperative agreement with the State Department of Human Services  
405 for the provision of such services using state funds which are  
406 provided from the appropriation to the Department of Human

407 Services to obtain federal matching funds through the division.

408 On July 1, 1993, all fees for periodic screening and  
409 diagnostic services under this paragraph (5) shall be increased by  
410 twenty-five percent (25%) of the reimbursement rate in effect on  
411 June 30, 1993.

412 (6) Physician's services. On January 1, 1996, all fees for  
413 physicians' services shall be reimbursed at seventy percent (70%)  
414 of the rate established on January 1, 1994, under Medicare (Title  
415 XVIII of the Social Security Act), as amended, and the division  
416 may adjust the physicians' reimbursement schedule to reflect the  
417 differences in relative value between Medicaid and Medicare.

418 (7) (a) Home health services for eligible persons, not to  
419 exceed in cost the prevailing cost of nursing facility services,  
420 not to exceed sixty (60) visits per year.

421 (b) Repealed.

422 (8) Emergency medical transportation services. On January  
423 1, 1994, emergency medical transportation services shall be  
424 reimbursed at seventy percent (70%) of the rate established under  
425 Medicare (Title XVIII of the Social Security Act), as amended.  
426 "Emergency medical transportation services" shall mean, but shall  
427 not be limited to, the following services by a properly permitted  
428 ambulance operated by a properly licensed provider in accordance  
429 with the Emergency Medical Services Act of 1974 (Section 41-59-1  
430 et seq.): (i) basic life support, (ii) advanced life support,  
431 (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi)  
432 disposable supplies, (vii) similar services.

433 (9) Legend and other drugs as may be determined by the  
434 division. The division may implement a program of prior approval  
435 for drugs to the extent permitted by law. Payment by the division  
436 for covered multiple source drugs shall be limited to the lower of  
437 the upper limits established and published by the Health Care  
438 Financing Administration (HCFA) plus a dispensing fee of Four  
439 Dollars and Ninety-one Cents (\$4.91), or the estimated acquisition  
440 cost (EAC) as determined by the division plus a dispensing fee of

441 Four Dollars and Ninety-one Cents (\$4.91), or the providers' usual  
442 and customary charge to the general public. The division shall  
443 allow five (5) prescriptions per month for noninstitutionalized  
444 Medicaid recipients; however, exceptions for up to ten (10)  
445 prescriptions per month shall be allowed, with the approval of the  
446 Director.

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

452 Payment for nonlegend or over-the-counter drugs covered on  
453 the division's formulary shall be reimbursed at the lower of the  
454 division's estimated shelf price or the providers' usual and  
455 customary charge to the general public. No dispensing fee shall  
456 be paid.

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

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

470 (10) Dental care that is an adjunct to treatment of an acute  
471 medical or surgical condition; services of oral surgeons and  
472 dentists in connection with surgery related to the jaw or any  
473 structure contiguous to the jaw or the reduction of any fracture  
474 of the jaw or any facial bone; and emergency dental extractions

475 and treatment related thereto. On January 1, 1994, all fees for  
476 dental care and surgery under authority of this paragraph (10)  
477 shall be increased by twenty percent (20%) of the reimbursement  
478 rate as provided in the Dental Services Provider Manual in effect  
479 on December 31, 1993.

480 (11) Eyeglasses necessitated by reason of eye surgery, and  
481 as prescribed by a physician skilled in diseases of the eye or an  
482 optometrist, whichever the patient may select.

483 (12) Intermediate care facility services.

484 (a) The division shall make full payment to all  
485 intermediate care facilities for the mentally retarded for each  
486 day, not exceeding thirty-six (36) days per year, that a patient  
487 is absent from the facility on home leave. However, before  
488 payment may be made for more than eighteen (18) home leave days in  
489 a year for a patient, the patient must have written authorization  
490 from a physician stating that the patient is physically and  
491 mentally able to be away from the facility on home leave. Such  
492 authorization must be filed with the division before it will be  
493 effective, and the authorization shall be effective for three (3)  
494 months from the date it is received by the division, unless it is  
495 revoked earlier by the physician because of a change in the  
496 condition of the patient.

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

500 (13) Family planning services, including drugs, supplies and  
501 devices, when such services are under the supervision of a  
502 physician.

503 (14) Clinic services. Such diagnostic, preventive,  
504 therapeutic, rehabilitative or palliative services furnished to an  
505 outpatient by or under the supervision of a physician or dentist  
506 in a facility which is not a part of a hospital but which is  
507 organized and operated to provide medical care to outpatients.

508 Clinic services shall include any services reimbursed as

509 outpatient hospital services which may be rendered in such a  
510 facility, including those that become so after July 1, 1991. On  
511 January 1, 1994, all fees for physicians' services reimbursed  
512 under authority of this paragraph (14) shall be reimbursed at  
513 seventy percent (70%) of the rate established on January 1, 1993,  
514 under Medicare (Title XVIII of the Social Security Act), as  
515 amended, or the amount that would have been paid under the  
516 division's fee schedule that was in effect on December 31, 1993,  
517 whichever is greater, and the division may adjust the physicians'  
518 reimbursement schedule to reflect the differences in relative  
519 value between Medicaid and Medicare. However, on January 1, 1994,  
520 the division may increase any fee for physicians' services in the  
521 division's fee schedule on December 31, 1993, that was greater  
522 than seventy percent (70%) of the rate established under Medicare  
523 by no more than ten percent (10%). On January 1, 1994, all fees  
524 for dentists' services reimbursed under authority of this  
525 paragraph (14) shall be increased by twenty percent (20%) of the  
526 reimbursement rate as provided in the Dental Services Provider  
527 Manual in effect on December 31, 1993.

528 (15) Home- and community-based services, as provided under  
529 Title XIX of the federal Social Security Act, as amended, under  
530 waivers, subject to the availability of funds specifically  
531 appropriated therefor by the Legislature. Payment for such  
532 services shall be limited to individuals who would be eligible for  
533 and would otherwise require the level of care provided in a  
534 nursing facility. The division shall certify case management  
535 agencies to provide case management services and provide for home-  
536 and community-based services for eligible individuals under this  
537 paragraph. The home- and community-based services under this  
538 paragraph and the activities performed by certified case  
539 management agencies under this paragraph shall be funded using  
540 state funds that are provided from the appropriation to the  
541 Division of Medicaid and used to match federal funds under a  
542 cooperative agreement between the division and the Department of



543 Human Services.

544 (16) Mental health services. Approved therapeutic and case  
545 management services provided by (a) an approved regional mental  
546 health/retardation center established under Sections 41-19-31  
547 through 41-19-39, or by another community mental health service  
548 provider meeting the requirements of the Department of Mental  
549 Health to be an approved mental health/retardation center if  
550 determined necessary by the Department of Mental Health, using  
551 state funds which are provided from the appropriation to the State  
552 Department of Mental Health and used to match federal funds under  
553 a cooperative agreement between the division and the department,  
554 or (b) a facility which is certified by the State Department of  
555 Mental Health to provide therapeutic and case management services,  
556 to be reimbursed on a fee for service basis. Any such services  
557 provided by a facility described in paragraph (b) must have the  
558 prior approval of the division to be reimbursable under this  
559 section. After June 30, 1997, mental health services provided by  
560 regional mental health/retardation centers established under  
561 Sections 41-19-31 through 41-19-39, or by hospitals as defined in  
562 Section 41-9-3(a) and/or their subsidiaries and divisions, or by  
563 psychiatric residential treatment facilities as defined in Section  
564 43-11-1, or by another community mental health service provider  
565 meeting the requirements of the Department of Mental Health to be  
566 an approved mental health/retardation center if determined  
567 necessary by the Department of Mental Health, shall not be  
568 included in or provided under any capitated managed care pilot  
569 program provided for under paragraph (24) of this section.

570 (17) Durable medical equipment services and medical supplies  
571 restricted to patients receiving home health services unless  
572 waived on an individual basis by the division. The division shall  
573 not expend more than Three Hundred Thousand Dollars (\$300,000.00)  
574 of state funds annually to pay for medical supplies authorized  
575 under this paragraph.

576 (18) Notwithstanding any other provision of this section to

577 the contrary, the division shall make additional reimbursement to  
578 hospitals which serve a disproportionate share of low-income  
579 patients and which meet the federal requirements for such payments  
580 as provided in Section 1923 of the federal Social Security Act and  
581 any applicable regulations.

582 (19) (a) Perinatal risk management services. The division  
583 shall promulgate regulations to be effective from and after  
584 October 1, 1988, to establish a comprehensive perinatal system for  
585 risk assessment of all pregnant and infant Medicaid recipients and  
586 for management, education and follow-up for those who are  
587 determined to be at risk. Services to be performed include case  
588 management, nutrition assessment/counseling, psychosocial  
589 assessment/counseling and health education. The division shall  
590 set reimbursement rates for providers in conjunction with the  
591 State Department of Health.

592 (b) Early intervention system services. The division  
593 shall cooperate with the State Department of Health, acting as  
594 lead agency, in the development and implementation of a statewide  
595 system of delivery of early intervention services, pursuant to  
596 Part H of the Individuals with Disabilities Education Act (IDEA).

597 The State Department of Health shall certify annually in writing  
598 to the director of the division the dollar amount of state early  
599 intervention funds available which shall be utilized as a  
600 certified match for Medicaid matching funds. Those funds then  
601 shall be used to provide expanded targeted case management  
602 services for Medicaid eligible children with special needs who are  
603 eligible for the state's early intervention system.

604 Qualifications for persons providing service coordination shall be  
605 determined by the State Department of Health and the Division of  
606 Medicaid.

607 (20) Home- and community-based services for physically  
608 disabled approved services as allowed by a waiver from the U.S.  
609 Department of Health and Human Services for home- and  
610 community-based services for physically disabled people using

611 state funds which are provided from the appropriation to the State  
612 Department of Rehabilitation Services and used to match federal  
613 funds under a cooperative agreement between the division and the  
614 department, provided that funds for these services are  
615 specifically appropriated to the Department of Rehabilitation  
616 Services.

617 (21) Nurse practitioner services. Services furnished by a  
618 registered nurse who is licensed and certified by the Mississippi  
619 Board of Nursing as a nurse practitioner including, but not  
620 limited to, nurse anesthetists, nurse midwives, family nurse  
621 practitioners, family planning nurse practitioners, pediatric  
622 nurse practitioners, obstetrics-gynecology nurse practitioners and  
623 neonatal nurse practitioners, under regulations adopted by the  
624 division. Reimbursement for such services shall not exceed ninety  
625 percent (90%) of the reimbursement rate for comparable services  
626 rendered by a physician.

627 (22) Ambulatory services delivered in federally qualified  
628 health centers and in clinics of the local health departments of  
629 the State Department of Health for individuals eligible for  
630 medical assistance under this article based on reasonable costs as  
631 determined by the division.

632 (23) Inpatient psychiatric services. Inpatient psychiatric  
633 services to be determined by the division for recipients under age  
634 twenty-one (21) which are provided under the direction of a  
635 physician in an inpatient program in a licensed acute care  
636 psychiatric facility or in a licensed psychiatric residential  
637 treatment facility, before the recipient reaches age twenty-one  
638 (21) or, if the recipient was receiving the services immediately  
639 before he reached age twenty-one (21), before the earlier of the  
640 date he no longer requires the services or the date he reaches age  
641 twenty-two (22), as provided by federal regulations. Recipients  
642 shall be allowed forty-five (45) days per year of psychiatric  
643 services provided in acute care psychiatric facilities, and shall  
644 be allowed unlimited days of psychiatric services provided in

645 licensed psychiatric residential treatment facilities.

646 (24) Managed care services in a program to be developed by  
647 the division by a public or private provider. Notwithstanding any  
648 other provision in this article to the contrary, the division  
649 shall establish rates of reimbursement to providers rendering care  
650 and services authorized under this section, and may revise such  
651 rates of reimbursement without amendment to this section by the  
652 Legislature for the purpose of achieving effective and accessible  
653 health services, and for responsible containment of costs. This  
654 shall include, but not be limited to, one (1) module of capitated  
655 managed care in a rural area, and one (1) module of capitated  
656 managed care in an urban area.

657 (25) Birthing center services.

658 (26) Hospice care. As used in this paragraph, the term  
659 "hospice care" means a coordinated program of active professional  
660 medical attention within the home and outpatient and inpatient  
661 care which treats the terminally ill patient and family as a unit,  
662 employing a medically directed interdisciplinary team. The  
663 program provides relief of severe pain or other physical symptoms  
664 and supportive care to meet the special needs arising out of  
665 physical, psychological, spiritual, social and economic stresses  
666 which are experienced during the final stages of illness and  
667 during dying and bereavement and meets the Medicare requirements  
668 for participation as a hospice as provided in 42 CFR Part 418.

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

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

676 (29) The Division of Medicaid may apply for a waiver from  
677 the Department of Health and Human Services for home- and  
678 community-based services for developmentally disabled people using

679 state funds which are provided from the appropriation to the State  
680 Department of Mental Health and used to match federal funds under  
681 a cooperative agreement between the division and the department,  
682 provided that funds for these services are specifically  
683 appropriated to the Department of Mental Health.

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

686 (31) Targeted case management services for children with  
687 special needs, under waivers from the U.S. Department of Health  
688 and Human Services, using state funds that are provided from the  
689 appropriation to the Mississippi Department of Human Services and  
690 used to match federal funds under a cooperative agreement between  
691 the division and the department.

692 (32) Care and services provided in Christian Science  
693 Sanatoria operated by or listed and certified by The First Church  
694 of Christ Scientist, Boston, Massachusetts, rendered in connection  
695 with treatment by prayer or spiritual means to the extent that  
696 such services are subject to reimbursement under Section 1903 of  
697 the Social Security Act.

698 (33) Podiatrist services.

699 (34) Personal care services provided in a pilot program to  
700 not more than forty (40) residents at a location or locations to  
701 be determined by the division and delivered by individuals  
702 qualified to provide such services, as allowed by waivers under  
703 Title XIX of the Social Security Act, as amended. The division  
704 shall not expend more than Three Hundred Thousand Dollars  
705 (\$300,000.00) annually to provide such personal care services.  
706 The division shall develop recommendations for the effective  
707 regulation of any facilities that would provide personal care  
708 services which may become eligible for Medicaid reimbursement  
709 under this section, and shall present such recommendations with  
710 any proposed legislation to the 1996 Regular Session of the  
711 Legislature on or before January 1, 1996.

712 (35) Services and activities authorized in Sections

713 43-27-101 and 43-27-103, using state funds that are provided from  
714 the appropriation to the State Department of Human Services and  
715 used to match federal funds under a cooperative agreement between  
716 the division and the department.

717 (36) Nonemergency transportation services for  
718 Medicaid-eligible persons, to be provided by the Department of  
719 Human Services. The division may contract with additional  
720 entities to administer nonemergency transportation services as it  
721 deems necessary. All providers shall have a valid driver's  
722 license, vehicle inspection sticker and a standard liability  
723 insurance policy covering the vehicle.

724 (37) Targeted case management services for individuals with  
725 chronic diseases, with expanded eligibility to cover services to  
726 uninsured recipients, on a pilot program basis. This paragraph  
727 (37) shall be contingent upon continued receipt of special funds  
728 from the Health Care Financing Authority and private foundations  
729 who have granted funds for planning these services. No funding  
730 for these services shall be provided from State General Funds.

731 (38) Chiropractic services: a chiropractor's manual  
732 manipulation of the spine to correct a subluxation, if x-ray  
733 demonstrates that a subluxation exists and if the subluxation has  
734 resulted in a neuromusculoskeletal condition for which  
735 manipulation is appropriate treatment. Reimbursement for  
736 chiropractic services shall not exceed Seven Hundred Dollars  
737 (\$700.00) per year per recipient.

738 Notwithstanding any provision of this article, except as  
739 authorized in the following paragraph and in Section 43-13-139,  
740 neither (a) the limitations on quantity or frequency of use of or  
741 the fees or charges for any of the care or services available to  
742 recipients under this section, nor (b) the payments or rates of  
743 reimbursement to providers rendering care or services authorized  
744 under this section to recipients, may be increased, decreased or  
745 otherwise changed from the levels in effect on July 1, 1986,  
746 unless such is authorized by an amendment to this section by the

747 Legislature. However, the restriction in this paragraph shall not  
748 prevent the division from changing the payments or rates of  
749 reimbursement to providers without an amendment to this section  
750 whenever such changes are required by federal law or regulation,  
751 or whenever such changes are necessary to correct administrative  
752 errors or omissions in calculating such payments or rates of  
753 reimbursement.

754 Notwithstanding any provision of this article, no new groups  
755 or categories of recipients and new types of care and services may  
756 be added without enabling legislation from the Mississippi  
757 Legislature, except that the division may authorize such changes  
758 without enabling legislation when such addition of recipients or  
759 services is ordered by a court of proper authority. The director  
760 shall keep the Governor advised on a timely basis of the funds  
761 available for expenditure and the projected expenditures. In the  
762 event current or projected expenditures can be reasonably  
763 anticipated to exceed the amounts appropriated for any fiscal  
764 year, the Governor, after consultation with the director, shall  
765 discontinue any or all of the payment of the types of care and  
766 services as provided herein which are deemed to be optional  
767 services under Title XIX of the federal Social Security Act, as  
768 amended, for any period necessary to not exceed appropriated  
769 funds, and when necessary shall institute any other cost  
770 containment measures on any program or programs authorized under  
771 the article to the extent allowed under the federal law governing  
772 such program or programs, it being the intent of the Legislature  
773 that expenditures during any fiscal year shall not exceed the  
774 amounts appropriated for such fiscal year.

775 SECTION 3. This act shall take effect and be in force from  
776 and after its passage.