MISSISSIPPI LEGISLATURE REGULAR SESSION 1999

By: Representative Flaggs To: Insurance; Appropriations

HOUSE BILL NO. 644

1 AN ACT TO AMEND SECTIONS 25-15-9 AND 25-15-255, MISSISSIPPI
2 CODE OF 1972, TO PROVIDE THAT THE STATE EMPLOYEES HEALTH INSURANCE
3 PLAN AND THE PUBLIC SCHOOL EMPLOYEES HEALTH INSURANCE PLAN SHALL
4 INCLUDE COUNSELING SERVICES PROVIDED BY LICENSED PROFESSIONAL
5 COUNSELORS; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
6 TO PROVIDE MEDICAID REIMBURSEMENT FOR COUNSELING SERVICES PROVIDED
7 BY LICENSED PROFESSIONAL COUNSELORS; TO BRING FORWARD SECTION
8 83-41-211, MISSISSIPPI CODE OF 1972, WHICH RELATES TO INSURANCE
9 PLAN BENEFICIARIES' FREEDOM OF CHOICE OF PRACTITIONER IN THE
10 TREATMENT OF MENTAL, NERVOUS OR EMOTIONAL DISORDERS; AND FOR
11 RELATED PURPOSES.

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

13 SECTION 1. Section 25-15-9, Mississippi Code of 1972, is
14 amended as follows:

15 25-15-9. (1) (a) The department shall design a plan of
16 health insurance for state employees which provides benefits for
17 semiprivate rooms in addition to other incidental coverages which
18 the department deems necessary. The amount of the coverages shall
19 be in such reasonable amount as may be determined by the
20 department to be adequate, after due consideration of current
21 health costs in Mississippi. The plan shall also include major
22 medical benefits in such amounts as the department * * *
23 determines. The plan shall also include counseling services that
24 are provided to individuals by licensed professional counselors
25 who are licensed under Section 73-30-1 et seq. The department is
26 also authorized to accept bids for such alternate coverage and
27 optional benefits as the department * * * deems proper. The
28 department may employ or contract for such consulting or actuarial
29 services as may be necessary to formulate the State Employees
30 Health Insurance Plan, and to assist the department in the
31 preparation of specifications and in the process of advertising

32 for the bids for the plan. The department is authorized to
33 promulgate rules and regulations to implement the provisions of
34 this subsection.
35 The department shall develop plans for the insurance plan
36 authorized by this section in accordance with the provisions of
37 Section 25-15-5.
38 (b) There is created an advisory council to advise the
39 department in the formulation of the State Employees Health
40 Insurance Plan. The council shall be composed of the State
41 Insurance Commissioner or his designee, an employee-representative
42 of the institutions of higher learning appointed by the board of
43 trustees thereof, an employee-representative of the Department of
44 Transportation appointed by the director thereof, an
45 employee-representative of the State Tax Commission appointed by
46 the Commissioner of Revenue, an employee-representative of the
47 Mississippi Department of Health appointed by the State Health
48 Officer, an employee-representative of the Mississippi Department
49 of Corrections appointed by the Commissioner of Corrections, and
50 an employee-representative of the Department of Human Services
51 appointed by the Executive Director of Human Services.
52 The Lieutenant Governor may designate the Secretary of the
53 Senate, the Chairman of the Senate Appropriations Committee and
54 the Chairman of the Senate Insurance Committee, and the Speaker of
55 the House of Representatives may designate the Clerk of the House,
56 the Chairman of the House Appropriations Committee and the
57 Chairman of the House Insurance Committee, to attend any meeting
58 of the State Employees Insurance Advisory Council. The appointing
59 authorities may designate an alternate member from their
60 respective houses to serve when the regular designee is unable to
61 attend such meetings of the council. Such designees shall have
62 no jurisdiction or vote on any matter within the jurisdiction of
63 the council. For attending meetings of the council, such
64 legislators shall receive per diem and expenses which shall be
65 paid from the contingent expense funds of their respective houses
66 in the same amounts as provided for committee meetings when the
67 Legislature is not in session; however, no per diem and expenses
68 for attending meetings of the council will be paid while the
69 Legislature is in session. No per diem and expenses will be paid

70 except for attending meetings of the council without prior
71 approval of the proper committee in their respective houses.
72 (c) No change in the terms of the State Employees
73 Health Insurance Plan may be made effective unless the Executive
74 Director of the Department of Finance and Administration, or his
75 designee, has provided notice to the State Employees Health
76 Insurance Advisory Council and has called a meeting of the council
77 at least fifteen (15) days before the effective date of such
78 change. In the event that the State Employees Health Insurance
79 Council does not meet to advise the department on the proposed
80 changes, the changes to the plan shall become effective at such
81 time as the department has informed the council that the changes
82 shall become effective.
83 (d) **Medical benefits for retired employees and**
84 **dependents under age sixty-five (65) years.** The same health
85 insurance coverage as for all other active employees and their
86 dependents shall be available to retired employees and all
87 dependents under age sixty-five (65) years, the level of benefits
88 to be the same level as for all other active participants. This
89 section will apply to those employees who retire due to one
90 hundred percent (100%) medical disability as well as those
91 employees electing early retirement.
92 (e) **Medical benefits for retired employees over age**
93 **sixty-five (65) years.** The health insurance coverage available to
94 retired employees over age sixty-five (65) years, and all
95 dependents over age sixty-five (65) years, shall be the major
96 medical coverage with the lifetime maximum of One Million Dollars
97 ($1,000,000.00). Benefits shall be reduced by Medicare benefits
98 as though such Medicare benefits were the base plan.
99 All covered individuals shall be assumed to have full
100 Medicare coverage, Parts A and B; and any Medicare payments under
101 both Parts A and B shall be computed to reduce benefits payable
102 under this plan.
103 (2) Nonduplication of benefits--reduction of benefits by

104 Title XIX benefits: When benefits would be payable under more
105 than one (1) group plan, benefits under those plans will be
106 coordinated to the extent that the total benefits under all plans
107 will not exceed the total expenses incurred.
108   Benefits for hospital or surgical or medical benefits shall
109 be reduced by any similar benefits payable in accordance with
110 Title XIX of the Social Security Act or under any amendments
111 thereto, or any implementing legislation.
112   Benefits for hospital or surgical or medical benefits shall
113 be reduced by any similar benefits payable by workers'
114 compensation.   (3) Schedule of life insurance
115 benefits--group term: The amount of term life insurance for each
116 active employee shall not be in excess of One Hundred Thousand
117 Dollars ($100,000.00), or twice the amount of the employee's
118 annual wage to the next highest One Thousand Dollars ($1,000.00),
119 whichever may be less, but in no case less than Thirty Thousand
120 Dollars ($30,000.00), with a like amount for accidental death and
121 dismemberment on a twenty-four-hour basis. The plan will further
122 contain a premium waiver provision if a covered employee becomes
123 totally and permanently disabled prior to age sixty-five (65)
124 years. Retired employees shall be eligible to continue life
125 insurance coverage in an amount of Two Thousand Dollars
126 ($2,000.00), Four Thousand Dollars ($4,000.00) or Ten Thousand
127 Dollars ($10,000.00) into retirement. The Department of Finance
128 and Administration shall prepare a report to the Legislative
129 Budget Office on or before October 1, 1995, recommending any
130 changes to the maximum group life coverages applicable to retired
131 employees prescribed herein, and providing options as to any
132 expected additional costs associated with increasing such
133 benefits.
134   (4) Any eligible employee who on March 1, 1971, was
135 participating in a group life insurance program which has
136 provisions different from those included herein and for which the
137 State of Mississippi was paying a part of the premium may, at his

138 discretion, continue to participate in such plan. Such employee
139 shall pay in full all additional costs, if any, above the minimum
140 program established by this article. Under no circumstances shall
141 any individual who begins employment with the state after March 1,
142 1971, be eligible for the provisions of this paragraph.
143 (5) Any participant of the State Employees Health Insurance
144 Plan who otherwise would lose coverage and who would be eligible
145 as a dependent under an existing Public School Employees Health
146 Insurance Plan contract may transfer to the Public School
147 Employees Health Insurance Plan as a dependent under the existing
148 contract. Any participant of the Public School Employees Health
149 Insurance Plan who otherwise would lose coverage and who would be
150 eligible as a dependent under an existing State Employees Health
151 Insurance Plan contract may transfer to the State Employees Health
152 Insurance Plan as a dependent under the existing contract. A
153 transfer pursuant to this subsection must occur within thirty-one
154 (31) days of losing coverage. Credit shall be given for any
155 deductible amount satisfied, out-of-pocket expenses and time
156 served toward the twelve-month pre-existing waiting period.
157 (6) If both spouses are eligible employees who participate
158 in the plan, the benefits shall apply individually to each spouse
159 by virtue of his or her participation in the plan. If those
160 spouses also have one or more eligible dependents participating in
161 the plan, the cost of their dependents shall be calculated at a
162 special family plan rate. The cost for participation by the
163 dependents shall be paid by the spouse who elects to carry such
164 dependents under his or her coverage. The special family plan
165 rate shall also apply if the state employee's spouse is a covered
166 eligible employee under the Public School Employees Health
167 Insurance Plan.
168 (7) (a) The department may offer medical savings accounts
169 as defined in Section 71-9-3 as a plan option. Provided, however,
170 that prior to offering such accounts as a plan option, the
171 Department of Finance and Administration shall prepare and present

172 to the Senate and House Insurance Committees by December 15, 1996,
173 a comprehensive study of medical savings accounts to include a
174 proposed implementation timetable and potential actuarial effects
175 of such accounts on the existing state employee health plan. The
176 department's study shall also include, but not be limited to,
177 recommended employer contribution levels, recommended employee
178 contribution levels, recommendations on annual rollover of
179 balances or withdrawals for nonmedical purposes, and
180 recommendations on medical coverage for persons who expend their
181 account balances. The department shall use existing staff
182 resources and those of other agencies to conduct this study. In
183 no case shall the department employ a consultant or contractor
184 other than an actuary to conduct this study. No later than July
185 15, 1996, the Department of Finance and Administration shall meet
186 with the staff of the PEER Committee and the Legislative Budget
187 Office to receive recommendations on the issues and methods which
188 the department shall consider in preparing its report. No later
189 than October 15, 1996, the Department of Finance and
190 Administration shall submit a copy of its draft report to the PEER
191 Committee and the Legislative Budget Office which shall analyze
192 the report and prepare comments for publication in the final
193 report to be submitted to the House and Senate Insurance
194 Committees on December 15, 1996.
195 (b) In no case shall the department offer medical
196 savings accounts as an option to health plan participants prior to
197 January 1, 1998.
198 (8) Any premium differentials, differences in coverages,
199 discounts determined by risk or by any other factors shall be
200 uniformly applied to all active employees participating in the
201 insurance plan. It is the intent of the Legislature that the
202 state contribution to the plan be the same for each employee
203 throughout the state.
204 SECTION 2. Section 25-15-255, Mississippi Code of 1972, is
205 amended as follows:

206 25-15-255. (1) (a) The Department of Finance and
207 Administration shall design a plan of health insurance for
208 employees which provides benefits for semiprivate rooms in
209 addition to other incidental coverages which the department deems
210 necessary.
211 The amount of the coverages shall be in such reasonable
212 amount as may be determined by the department to be adequate,
213 after due consideration of current health costs in Mississippi.
214 The plan shall also include major medical benefits in such amounts
215 as the department * * * determines. The plan shall also include
216 counseling services that are provided to individuals by licensed
217 professional counselors who are licensed under Section 73-30-1 et
218 seq. The department is also authorized to accept bids for
219 alternate coverage and optional benefits. Any contract for
220 alternative coverage and optional benefits shall be awarded by the
221 department after it has carefully studied and evaluated the bids
222 and selected the best and most cost-effective bid. The department
223 may reject all such bids; however, the department shall notify all
224 bidders of the rejection and shall actively solicit new bids if
225 all bids are rejected.
226 It is the intent of the Legislature that coverage under this
227 plan may be self-insured by the State of Mississippi and the same
228 as coverage provided state employees under the Public Employees
229 Health Insurance Plan created in Section 25-15-3 et seq. The
230 department may contract the administration and service of the
231 self-insured program to a third party; however, before executing
232 any contract, the department shall actively solicit bids for the
233 administration and service of the program.
234 The department shall conduct the solicitation and contracting
235 process in strict accordance with Section 25-15-301.
236 Beginning on January 1, 1996, any contract entered into
237 between the department for the administration and/or service of
238 the self-insured plan and a third party shall be for the calendar
239 year that begins on the first day of January and expires on the

240 following thirty-first day of December.
241 The department may employ or contract for such consulting or
242 actuarial services as may be necessary to formulate the Public
243 School Employees Health Insurance Plan, and to assist the
244 department in the preparation of specifications and in the process
245 of advertising for the bids for the plan. Such contracts shall be
246 solicited and entered into in accordance with Section 25-15-5.
247 The department shall keep a record of all persons, agents and
248 corporations who contract with or assist the department in
249 preparing and developing the plan. The department, in a timely
250 manner, shall provide copies of this record to the members of the
251 advisory council created in paragraph (b) of this subsection and
252 those legislators, or their designees, who may attend meetings of
253 the advisory council. The department shall provide copies of this
254 record in the solicitation of bids for the administration and
255 servicing of the self-insured program. Each person, agent or
256 corporation which, during the previous fiscal year, has assisted
257 in the development of the plan or employed or compensated any
258 person who assisted in the development of the plan, and which bids
259 on the administration or servicing of the plan, shall submit to
260 the department a statement accompanying the bid explaining in
261 detail its participation with the development of the plan. This
262 statement shall include the amount of compensation paid by the
263 bidder to any such employee during the previous fiscal year. The
264 department shall make all such information available to the
265 members of the advisory council and those legislators, or their
266 designees, who may attend meetings of the advisory council before
267 any action is taken by the department on the bids submitted. The
268 failure of any bidder to fully and accurately comply with this
269 paragraph shall result in the rejection of any bid submitted by
270 that bidder or the cancellation of any contract executed when the
271 failure is discovered after the acceptance of that bid.
272 The department is authorized to promulgate rules and
273 regulations to implement the provisions of this subsection. After

274 expiration or termination of the contract between the state and
275 the administering corporation existing immediately before the date
276 on which the plan becomes self-insured by the State of
277 Mississippi, the remainder of funds in the Premium Stabilization
278 Fund shall revert to the Public School Employees Insurance Fund
279 and shall be used exclusively for payment of future premiums.
280 Any corporation, association, company or individual that
281 contracts with the department for the third-party claims
282 administration of the self-insured plan shall prepare and keep on
283 file an explanation of benefits for each claim processed. The
284 explanation of benefits shall contain such information relative to
285 each processed claim which the department deems necessary, and at
286 a minimum, each explanation shall provide the claimant's name,
287 claim number, provider number, provider name, service dates, type
288 of services, amount of charges, amount allowed to the claimant and
289 reason codes.
290 The information contained in the explanation of benefits
291 shall be available for inspection upon request by the department.
292 The department shall have access to all claims information
293 utilized in the issuance of payments to employees and providers.
294 Any corporation, association, company or individual that contracts
295 with the department for the administration and/or service of the
296 self-insured plan shall remit one hundred percent (100%) of all
297 savings or discounts resulting from any contract to the department
298 and/or participant. Any corporation, association, company or
299 individual that contracts with the department for the
300 administration and/or service of the self-insured plan shall
301 allow, upon notice by the department, the department or its
302 designee to audit records of the corporation, association, company
303 or individual relative to the corporation, association, company or
304 individual's performance under any contract with the department.
305 The information maintained by any corporation, association,
306 company or individual, relating to such contracts, shall be
307 available for inspection upon request by the department and such

308 information shall be compiled in a manner that will provide a
309 clear audit trail.
310 (b) There is created an advisory council to the
311 department to advise the department in the formulation of the
312 Public School Employees Health Insurance Plan. The advisory
313 council and those legislators, or their designees, authorized to
314 attend meetings of the advisory council pursuant to this
315 subsection shall be informed in a timely manner concerning each
316 aspect of the formulation and development of the plan. No change
317 in the terms of the Public School Employees Health Insurance Plan
318 may be made effective unless the Executive Director of the
319 Department of Finance and Administration, or his designee, has
320 provided notice to the Public School Employees Health Insurance
321 Advisory Council and has called a meeting of the council at least
322 fifteen (15) days before the effective date of such change. In
323 the event that the Public School Employees Health Insurance
324 Advisory Council does not meet to advise the department on the
325 proposed changes, the changes to the plan shall become effective
326 at such times as the department has informed the council that the
327 changes shall become effective.
328 The council shall be composed of the State Insurance
329 Commissioner or his designee, two (2) certificated public school
330 administrators appointed by the State Board of Education, two (2)
331 certificated classroom teachers appointed by the State Board of
332 Education, a noncertificated school employee appointed by the
333 State Board of Education, and a community/junior college employee
334 appointed by the State Board for Community and Junior Colleges.
335 Members of the council shall serve at the will and pleasure of the
336 appointing authorities; however, no member shall serve for a
337 period of less than one (1) year. The members of the council
338 shall serve without compensation, per diem or expense
339 reimbursement.
340 The Chairman of the Senate Insurance Committee, the Chairman
341 of the Senate Education Committee, the Chairman of the House of

342 Representatives Insurance Committee and the Chairman of the House
343 of Representatives Education Committee, and/or their designees
344 from their respective houses, may attend any meeting of the
345 advisory council. The legislators, or their designees, shall have
346 no jurisdiction or vote on any matter within the jurisdiction of
347 the council. For attending meetings of the council, the
348 legislators shall receive per diem and expenses which shall be
349 paid from the contingent expense funds of their respective houses
350 in the same amounts as provided for committee meetings when the
351 Legislature is not in session; however, no per diem and expenses
352 for attending meetings of the council will be paid while the
353 Legislature is in session. No per diem and expenses will be paid
354 except for attending meetings of the council without prior
355 approval of the proper committee in their respective houses.
356 (c) **Medical benefits for retired employees and**
357 **dependents under age sixty-five (65) years.** The same health
358 insurance coverage as for all other active employees and their
359 dependents shall be available to retired employees and all
360 dependents under age sixty-five (65) years, the level of benefits
361 to be the same level as for all other active participants. This
362 section will apply to those employees who retire due to one
363 hundred percent (100%) medical disability as well as those
364 employees electing early retirement.
365 (d) **Medical benefits for retired employees over age**
366 **sixty-five (65)**. The health insurance coverage available to
367 retired employees over age sixty-five (65) years, and all
368 dependents over age sixty-five (65) years, shall be the major
369 medical coverage with the lifetime maximum of One Million Dollars
370 ($1,000,000.00). Benefits shall be reduced by Medicare benefits
371 as though such Medicare benefits were the base plan.
372 All covered individuals shall be assumed to have full
373 Medicare coverage, Parts A and B; and any Medicare payments under
374 both Parts A and B shall be computed to reduce benefits payable
375 under this plan.

376 (2) **Nonduplication of benefits-reduction of benefits by**
377 **Title XIX benefits.** When benefits would be payable under more
378 than one group plan, benefits under those plans will be
379 coordinated to the extent that the total benefits under all plans
380 will not exceed the total expenses incurred.

381 Benefits for hospital or surgical or medical benefits shall
382 be reduced by any similar benefits payable in accordance with
383 Title XIX of the Social Security Act or under any amendments
384 thereto, or any implementing legislation.

385 Benefits for hospital or surgical or medical benefits shall
386 be reduced by any similar benefits payable by workers'
387 compensation.

388 (3) The department is hereby authorized to determine the
389 manner in which premiums and contributions by the state and local
390 school districts shall be collected to provide the self-insured
391 health insurance program for school employees and community/junior
392 college employees as provided under this article.

393 (4) Any premium differentials, differences in coverages,
394 discounts determined by risk or by any other factors shall be
395 uniformly applied to all active employees participating in the
396 insurance plan. It is the intent of the Legislature that the
397 state contribution to the plan be the same for each employee
398 throughout the state.

399 (5) Any participant of the State Employees Health Insurance
400 Plan who otherwise would lose coverage and who would be eligible
401 as a dependent under an existing Public School Employees Health
402 Insurance Plan contract may transfer to the Public School
403 Employees Health Insurance Plan as a dependent under the existing
404 contract. Any participant of the Public School Employees Health
405 Insurance Plan who otherwise would lose coverage and who would be
406 eligible as a dependent under an existing State Employees Health
407 Insurance Plan contract may transfer to the State Employees Health
408 Insurance Plan as a dependent under the existing contract. A
409 transfer pursuant to this subsection must occur within thirty-one

410 (31) days of losing coverage. Credit shall be given for any
411 deductible amount satisfied, out-of-pocket expenses and time
412 served toward the twelve-month pre-existing waiting period.
413 (6) The Department of Finance and Administration shall
414 annually report to the Joint Legislative Budget Committee the
415 condition of the Public School Employees Health Insurance Plan.
416 Such report shall contain, but not be limited to, a report of the
417 plan's financial condition at the close of the most recent
418 complete calendar year. The report shall also include all
419 recommendations made to the department by consultants regarding
420 the plan and its administration, including a complete departmental
421 response to each recommendation. The department shall also list
422 the history of yearly claims paid and premiums received for each
423 employee subgroup, including, but not limited to, active
424 employees, dependents and retirees and shall also publish the loss
425 ratios for these subgroups. For purposes of this subsection, the
426 term "loss ratios" shall mean claims paid by the plan for each
427 subgroup divided by premiums received by the plan for the
428 insurance coverage of the members in that subgroup. Any plan
429 revisions made during the previous year shall also be listed in
430 the report and fully described in the report. The department
431 shall also provide the Joint Legislative Budget Committee with a
432 monthly statement of plan utilization.
433 In addition to the information provided for herein, the
434 department shall provide to the Joint Legislative Budget Committee
435 budgetary information on the Public School Employees Health
436 Insurance Plan. All information shall be provided to the Joint
437 Legislative Budget Committee in a format designated by the
438 committee. The information shall be provided in September of each
439 year, and at such times throughout the year as the committee deems
440 necessary. The information shall include, but not be limited to:
441 (a) A detailed breakdown of all expenditures of the
442 plan, administrative and otherwise, for the most recently
443 completed fiscal year and projected expenditures for the current

444 fiscal year;

445 (b) A schedule of all contracts, administrative and
446 otherwise, executed for the benefit of the plan during the most
447 recent completed fiscal year, and those executed and anticipated
448 for the current fiscal year;

449 (c) Anticipated plan expenditures, administrative and
450 otherwise, for the next fiscal year.

451 The department shall also provide to the Joint Legislative
452 Committee on Performance Evaluation and Expenditure Review (PEER)
453 all information described in paragraph (b) in this subsection.
454 The PEER Committee shall prepare a report by January 1 of each
455 year on all contractors utilized by the department for the health
456 plans, excluding the third-party administrator contract. The
457 committee's report shall address the processes by which the
458 department procured the contractors, the contractors' work
459 products and contract expenditures. The review provided for
460 herein shall be supplemental to the review provided for in Section
461 25-15-301.

462 (7) (a) The department may offer medical savings accounts
463 as defined in Section 71-9-3 as a plan option. Provided, however,
464 that prior to offering such accounts as a plan option, the
465 Department of Finance and Administration shall prepare and present
466 to the Legislature by December 15, 1996, a comprehensive study of
467 medical savings accounts to include a proposed implementation
468 timetable and potential actuarial effects of such accounts on the
469 existing public school employees' health plan. The department's
470 study shall also include, but not be limited to, recommended
471 employer contribution levels, recommended employee contribution
472 levels, recommendations on annual rollover of balances or
473 withdrawals for nonmedical purposes, and, recommendations on
474 medical coverage for persons who expend their account balances.
475 The department shall use existing staff resources and those of
476 other agencies to conduct this study. In no case shall the
477 department employ a consultant or contractor other than an actuary

478 to conduct this study. No later than July 15, 1996, the
479 Department of Finance and Administration shall meet with the staff
480 of the PEER Committee and the Legislative Budget Office to receive
481 recommendations on the issues and methods which the department
482 shall consider in preparing its report. No later than October 15,
483 1996, the Department of Finance and Administration shall submit a
484 copy of its draft report to the PEER Committee and the Legislative
485 Budget Office which shall analyze the report and prepare comments
486 for publication in the final report to be submitted to the House
487 and Senate Insurance Committees on December 15, 1996.
488 (b) In no case shall the department offer medical
489 savings accounts as an option to health plan participants prior to
490 January 1, 1998.
491 SECTION 3. Section 43-13-117, Mississippi Code of 1972, is
492 amended as follows:
493 43-13-117. Medical assistance as authorized by this article
494 shall include payment of part or all of the costs, at the
495 discretion of the division or its successor, with approval of the
496 Governor, of the following types of care and services rendered to
497 eligible applicants who shall have been determined to be eligible
498 for such care and services, within the limits of state
499 appropriations and federal matching funds:
500 (1) Inpatient hospital services.
501 (a) The division shall allow thirty (30) days of
502 inpatient hospital care annually for all Medicaid recipients;
503 however, before any recipient will be allowed more than fifteen
504 (15) days of inpatient hospital care in any one (1) year, he must
505 obtain prior approval therefor from the division. The division
506 shall be authorized to allow unlimited days in disproportionate
507 hospitals as defined by the division for eligible infants under
508 the age of six (6) years.
509 (b) From and after July 1, 1994, the Executive Director
510 of the Division of Medicaid shall amend the Mississippi Title XIX
511 Inpatient Hospital Reimbursement Plan to remove the occupancy rate

512 penalty from the calculation of the Medicaid Capital Cost
513 Component utilized to determine total hospital costs allocated to
514 the Medicaid Program.
515 (2) Outpatient hospital services. Provided that where the
516 same services are reimbursed as clinic services, the division may
517 revise the rate or methodology of outpatient reimbursement to
518 maintain consistency, efficiency, economy and quality of care.
519 (3) Laboratory and X-ray services.
520 (4) Nursing facility services.
521 (a) The division shall make full payment to nursing
522 facilities for each day, not exceeding thirty-six (36) days per
523 year, that a patient is absent from the facility on home leave.
524 However, before payment may be made for more than eighteen (18)
525 home leave days in a year for a patient, the patient must have
526 written authorization from a physician stating that the patient is
527 physically and mentally able to be away from the facility on home
528 leave. Such authorization must be filed with the division before
529 it will be effective and the authorization shall be effective for
530 three (3) months from the date it is received by the division,
531 unless it is revoked earlier by the physician because of a change
532 in the condition of the patient.
533 (b) Repealed.
534 (c) From and after July 1, 1997, all state-owned
535 nursing facilities shall be reimbursed on a full reasonable costs
536 basis. From and after July 1, 1997, payments by the division to
537 nursing facilities for return on equity capital shall be made at
538 the rate paid under Medicare (Title XVIII of the Social Security
539 Act), but shall be no less than seven and one-half percent (7.5%)
540 nor greater than ten percent (10%).
541 (d) A Review Board for nursing facilities is
542 established to conduct reviews of the Division of Medicaid's
543 decision in the areas set forth below:
544 (i) Review shall be heard in the following areas:
545 (A) Matters relating to cost reports

546 including, but not limited to, allowable costs and cost
547 adjustments resulting from desk reviews and audits.
548 (B) Matters relating to the Minimum Data Set
549 Plus (MDS +) or successor assessment formats including but not
550 limited to audits, classifications and submissions.
551 (ii) The Review Board shall be composed of six (6)
552 members, three (3) having expertise in one (1) of the two (2)
553 areas set forth above and three (3) having expertise in the other
554 area set forth above. Each panel of three (3) shall only review
555 appeals arising in its area of expertise. The members shall be
556 appointed as follows:
557 (A) In each of the areas of expertise defined
558 under subparagraphs (i)(A) and (i)(B), the Executive Director of
559 the Division of Medicaid shall appoint one (1) person chosen from
560 the private sector nursing home industry in the state, which may
561 include independent accountants and consultants serving the
562 industry;
563 (B) In each of the areas of expertise defined
564 under subparagraphs (i)(A) and (i)(B), the Executive Director of
565 the Division of Medicaid shall appoint one (1) person who is
566 employed by the state who does not participate directly in desk
567 reviews or audits of nursing facilities in the two (2) areas of
568 review;
569 (C) The two (2) members appointed by the
570 Executive Director of the Division of Medicaid in each area of
571 expertise shall appoint a third member in the same area of
572 expertise.
573 In the event of a conflict of interest on the part of any
574 Review Board members, the Executive Director of the Division of
575 Medicaid or the other two (2) panel members, as applicable, shall
576 appoint a substitute member for conducting a specific review.
577 (iii) The Review Board panels shall have the power
578 to preserve and enforce order during hearings; to issue subpoenas;
579 to administer oaths; to compel attendance and testimony of

580 witnesses; or to compel the production of books, papers, documents
581 and other evidence; or the taking of depositions before any
582 designated individual competent to administer oaths; to examine
583 witnesses; and to do all things conformable to law that may be
584 necessary to enable it effectively to discharge its duties. The
585 Review Board panels may appoint such person or persons as they
586 shall deem proper to execute and return process in connection
587 therewith.

588 (iv) The Review Board shall promulgate, publish
589 and disseminate to nursing facility providers rules of procedure
590 for the efficient conduct of proceedings, subject to the approval
591 of the Executive Director of the Division of Medicaid and in
592 accordance with federal and state administrative hearing laws and
593 regulations.

594 (v) Proceedings of the Review Board shall be of
595 record.

596 (vi) Appeals to the Review Board shall be in
597 writing and shall set out the issues, a statement of alleged facts
598 and reasons supporting the provider's position. Relevant
599 documents may also be attached. The appeal shall be filed within
600 thirty (30) days from the date the provider is notified of the
601 action being appealed or, if informal review procedures are taken,
602 as provided by administrative regulations of the Division of
603 Medicaid, within thirty (30) days after a decision has been
604 rendered through informal hearing procedures.

605 (vii) The provider shall be notified of the
606 hearing date by certified mail within thirty (30) days from the
607 date the Division of Medicaid receives the request for appeal.
608 Notification of the hearing date shall in no event be less than
609 thirty (30) days before the scheduled hearing date. The appeal
610 may be heard on shorter notice by written agreement between the
611 provider and the Division of Medicaid.

612 (viii) Within thirty (30) days from the date of
613 the hearing, the Review Board panel shall render a written

614 recommendation to the Executive Director of the Division of
615 Medicaid setting forth the issues, findings of fact and applicable
616 law, regulations or provisions.
617 (ix) The Executive Director of the Division of
618 Medicaid shall, upon review of the recommendation, the proceedings
619 and the record, prepare a written decision which shall be mailed
620 to the nursing facility provider no later than twenty (20) days
621 after the submission of the recommendation by the panel. The
622 decision of the executive director is final, subject only to
623 judicial review.
624 (x) Appeals from a final decision shall be made to
625 the Chancery Court of Hinds County. The appeal shall be filed
626 with the court within thirty (30) days from the date the decision
627 of the Executive Director of the Division of Medicaid becomes
628 final.
629 (xi) The action of the Division of Medicaid under
630 review shall be stayed until all administrative proceedings have
631 been exhausted.
632 (xii) Appeals by nursing facility providers
633 involving any issues other than those two (2) specified in
634 subparagraphs (i)(A) and (ii)(B) shall be taken in accordance with
635 the administrative hearing procedures established by the Division
636 of Medicaid.
637 (e) When a facility of a category that does not require
638 a certificate of need for construction and that could not be
639 eligible for Medicaid reimbursement is constructed to nursing
640 facility specifications for licensure and certification, and the
641 facility is subsequently converted to a nursing facility pursuant
642 to a certificate of need that authorizes conversion only and the
643 applicant for the certificate of need was assessed an application
644 review fee based on capital expenditures incurred in constructing
645 the facility, the division shall allow reimbursement for capital
646 expenditures necessary for construction of the facility that were
647 incurred within the twenty-four (24) consecutive calendar months

648 immediately preceding the date that the certificate of need
649 authorizing such conversion was issued, to the same extent that
650 reimbursement would be allowed for construction of a new nursing
651 facility pursuant to a certificate of need that authorizes such
652 construction. The reimbursement authorized in this subparagraph
653 (e) may be made only to facilities the construction of which was
654 completed after June 30, 1989. Before the division shall be
655 authorized to make the reimbursement authorized in this
656 subparagraph (e), the division first must have received approval
657 from the Health Care Financing Administration of the United States
658 Department of Health and Human Services of the change in the state
659 Medicaid plan providing for such reimbursement.
660 (5) Periodic screening and diagnostic services for
661 individuals under age twenty-one (21) years as are needed to
662 identify physical and mental defects and to provide health care
663 treatment and other measures designed to correct or ameliorate
664 defects and physical and mental illness and conditions discovered
665 by the screening services regardless of whether these services are
666 included in the state plan. The division may include in its
667 periodic screening and diagnostic program those discretionary
668 services authorized under the federal regulations adopted to
669 implement Title XIX of the federal Social Security Act, as
670 amended. The division, in obtaining physical therapy services,
671 occupational therapy services, and services for individuals with
672 speech, hearing and language disorders, may enter into a
673 cooperative agreement with the State Department of Education for
674 the provision of such services to handicapped students by public
675 school districts using state funds which are provided from the
676 appropriation to the Department of Education to obtain federal
677 matching funds through the division. The division, in obtaining
678 medical and psychological evaluations for children in the custody
679 of the State Department of Human Services may enter into a
680 cooperative agreement with the State Department of Human Services
681 for the provision of such services using state funds which are

682 provided from the appropriation to the Department of Human
683 Services to obtain federal matching funds through the division.
684 On July 1, 1993, all fees for periodic screening and
685 diagnostic services under this paragraph (5) shall be increased by
686 twenty-five percent (25%) of the reimbursement rate in effect on
687 June 30, 1993.
688 (6) Physician's services. On January 1, 1996, all fees for
689 physicians' services shall be reimbursed at seventy percent (70%)
690 of the rate established on January 1, 1994, under Medicare (Title
691 XVIII of the Social Security Act), as amended, and the division
692 may adjust the physicians' reimbursement schedule to reflect the
693 differences in relative value between Medicaid and Medicare.
694 (7) (a) Home health services for eligible persons, not to
695 exceed in cost the prevailing cost of nursing facility services,
696 not to exceed sixty (60) visits per year.
697 (b) Repealed.
698 (8) Emergency medical transportation services. On January
699 1, 1994, emergency medical transportation services shall be
700 reimbursed at seventy percent (70%) of the rate established under
701 Medicare (Title XVIII of the Social Security Act), as amended.
702 "Emergency medical transportation services" shall mean, but shall
703 not be limited to, the following services by a properly permitted
704 ambulance operated by a properly licensed provider in accordance
705 with the Emergency Medical Services Act of 1974 (Section 41-59-1
706 et seq.): (i) basic life support, (ii) advanced life support,
707 (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi)
708 disposable supplies, (vii) similar services.
709 (9) Legend and other drugs as may be determined by the
710 division. The division may implement a program of prior approval
711 for drugs to the extent permitted by law. Payment by the division
712 for covered multiple source drugs shall be limited to the lower of
713 the upper limits established and published by the Health Care
714 Financing Administration (HCFA) plus a dispensing fee of Four
715 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition

716 cost (EAC) as determined by the division plus a dispensing fee of
717 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual
718 and customary charge to the general public. The division shall
719 allow five (5) prescriptions per month for noninstitutionalized
720 Medicaid recipients.
721 Payment for other covered drugs, other than multiple source
722 drugs with HCFA upper limits, shall not exceed the lower of the
723 estimated acquisition cost as determined by the division plus a
724 dispensing fee of Four Dollars and Ninety-one Cents ($4.91) or the
725 providers' usual and customary charge to the general public.
726 Payment for nonlegend or over-the-counter drugs covered on
727 the division's formulary shall be reimbursed at the lower of the
728 division's estimated shelf price or the providers' usual and
729 customary charge to the general public. No dispensing fee shall
730 be paid.
731 The division shall develop and implement a program of payment
732 for additional pharmacist services, with payment to be based on
733 demonstrated savings, but in no case shall the total payment
734 exceed twice the amount of the dispensing fee.
735 As used in this paragraph (9), "estimated acquisition cost"
736 means the division's best estimate of what price providers
737 generally are paying for a drug in the package size that providers
738 buy most frequently. Product selection shall be made in
739 compliance with existing state law; however, the division may
740 reimburse as if the prescription had been filled under the generic
741 name. The division may provide otherwise in the case of specified
742 drugs when the consensus of competent medical advice is that
743 trademarked drugs are substantially more effective.
744 (10) Dental care that is an adjunct to treatment of an acute
745 medical or surgical condition; services of oral surgeons and
746 dentists in connection with surgery related to the jaw or any
747 structure contiguous to the jaw or the reduction of any fracture
748 of the jaw or any facial bone; and emergency dental extractions
749 and treatment related thereto. On January 1, 1994, all fees for

750 dental care and surgery under authority of this paragraph (10)
751 shall be increased by twenty percent (20%) of the reimbursement
752 rate as provided in the Dental Services Provider Manual in effect
753 on December 31, 1993.
754 (11) Eyeglasses necessitated by reason of eye surgery, and
755 as prescribed by a physician skilled in diseases of the eye or an
756 optometrist, whichever the patient may select.
757 (12) Intermediate care facility services.
758 (a) The division shall make full payment to all
759 intermediate care facilities for the mentally retarded for each
760 day, not exceeding thirty-six (36) days per year, that a patient
761 is absent from the facility on home leave. However, before
762 payment may be made for more than eighteen (18) home leave days in
763 a year for a patient, the patient must have written authorization
764 from a physician stating that the patient is physically and
765 mentally able to be away from the facility on home leave. Such
766 authorization must be filed with the division before it will be
767 effective, and the authorization shall be effective for three (3)
768 months from the date it is received by the division, unless it is
769 revoked earlier by the physician because of a change in the
770 condition of the patient.
771 (b) All state-owned intermediate care facilities for
772 the mentally retarded shall be reimbursed on a full reasonable
773 cost basis.
774 (13) Family planning services, including drugs, supplies and
775 devices, when such services are under the supervision of a
776 physician.
777 (14) Clinic services. Such diagnostic, preventive,
778 therapeutic, rehabilitative or palliative services furnished to an
779 outpatient by or under the supervision of a physician or dentist
780 in a facility which is not a part of a hospital but which is
781 organized and operated to provide medical care to outpatients.
782 Clinic services shall include any services reimbursed as
783 outpatient hospital services which may be rendered in such a

784 facility, including those that become so after July 1, 1991. On
785 January 1, 1994, all fees for physicians' services reimbursed
786 under authority of this paragraph (14) shall be reimbursed at
787 seventy percent (70%) of the rate established on January 1, 1993,
788 under Medicare (Title XVIII of the Social Security Act), as
789 amended, or the amount that would have been paid under the
790 division's fee schedule that was in effect on December 31, 1993,
791 whichever is greater, and the division may adjust the physicians'
792 reimbursement schedule to reflect the differences in relative
793 value between Medicaid and Medicare. However, on January 1, 1994,
794 the division may increase any fee for physicians' services in the
795 division's fee schedule on December 31, 1993, that was greater
796 than seventy percent (70%) of the rate established under Medicare
797 by no more than ten percent (10%). On January 1, 1994, all fees
798 for dentists' services reimbursed under authority of this
799 paragraph (14) shall be increased by twenty percent (20%) of the
800 reimbursement rate as provided in the Dental Services Provider
801 Manual in effect on December 31, 1993.
802 (15) Home- and community-based services, as provided under
803 Title XIX of the federal Social Security Act, as amended, under
804 waivers, subject to the availability of funds specifically
805 appropriated therefor by the Legislature. Payment for such
806 services shall be limited to individuals who would be eligible for
807 and would otherwise require the level of care provided in a
808 nursing facility. The division shall certify case management
809 agencies to provide case management services and provide for home-
810 and community-based services for eligible individuals under this
811 paragraph. The home- and community-based services under this
812 paragraph and the activities performed by certified case
813 management agencies under this paragraph shall be funded using
814 state funds that are provided from the appropriation to the
815 Division of Medicaid and used to match federal funds under a
816 cooperative agreement between the division and the Department of
817 Human Services.

818 (16) Mental health services. Approved therapeutic and case
819 management services provided by (a) an approved regional mental
820 health/retardation center established under Sections 41-19-31
821 through 41-19-39, or by another community mental health service
822 provider meeting the requirements of the Department of Mental
823 Health to be an approved mental health/retardation center if
824 determined necessary by the Department of Mental Health, using
825 state funds which are provided from the appropriation to the State
826 Department of Mental Health and used to match federal funds under
827 a cooperative agreement between the division and the department,
828 or (b) a facility which is certified by the State Department of
829 Mental Health to provide therapeutic and case management services,
830 to be reimbursed on a fee for service basis. Any such services
831 provided by a facility described in paragraph (b) must have the
832 prior approval of the division to be reimbursable under this
833 section. After June 30, 1997, mental health services provided by
834 regional mental health/retardation centers established under
835 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
836 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
837 psychiatric residential treatment facilities as defined in Section
838 43-11-1, or by another community mental health service provider
839 meeting the requirements of the Department of Mental Health to be
840 an approved mental health/retardation center if determined
841 necessary by the Department of Mental Health, shall not be
842 included in or provided under any capitated managed care pilot
843 program provided for under paragraph (24) of this section.
844 (17) Durable medical equipment services and medical supplies
845 restricted to patients receiving home health services unless
846 waived on an individual basis by the division. The division shall
847 not expend more than Three Hundred Thousand Dollars ($300,000.00)
848 of state funds annually to pay for medical supplies authorized
849 under this paragraph.
850 (18) Notwithstanding any other provision of this section to
851 the contrary, the division shall make additional reimbursement to

852 hospitals which serve a disproportionate share of low-income
853 patients and which meet the federal requirements for such payments
854 as provided in Section 1923 of the federal Social Security Act and
855 any applicable regulations.
856 (19) (a) Perinatal risk management services. The division
857 shall promulgate regulations to be effective from and after
858 October 1, 1988, to establish a comprehensive perinatal system for
859 risk assessment of all pregnant and infant Medicaid recipients and
860 for management, education and follow-up for those who are
861 determined to be at risk. Services to be performed include case
862 management, nutrition assessment/counseling, psychosocial
863 assessment/counseling and health education. The division shall
864 set reimbursement rates for providers in conjunction with the
865 State Department of Health.
866 (b) Early intervention system services. The division
867 shall cooperate with the State Department of Health, acting as
868 lead agency, in the development and implementation of a statewide
869 system of delivery of early intervention services, pursuant to
870 Part H of the Individuals with Disabilities Education Act (IDEA).
871 The State Department of Health shall certify annually in writing
872 to the director of the division the dollar amount of state early
873 intervention funds available which shall be utilized as a
874 certified match for Medicaid matching funds. Those funds then
875 shall be used to provide expanded targeted case management
876 services for Medicaid eligible children with special needs who are
877 eligible for the state's early intervention system.
878 Qualifications for persons providing service coordination shall be
879 determined by the State Department of Health and the Division of
880 Medicaid.
881 (20) Home- and community-based services for physically
882 disabled approved services as allowed by a waiver from the U.S.
883 Department of Health and Human Services for home- and
884 community-based services for physically disabled people using
885 state funds which are provided from the appropriation to the State

886 Department of Rehabilitation Services and used to match federal
887 funds under a cooperative agreement between the division and the
888 department, provided that funds for these services are
889 specifically appropriated to the Department of Rehabilitation
890 Services.

891 (21) Nurse practitioner services. Services furnished by a
892 registered nurse who is licensed and certified by the Mississippi
893 Board of Nursing as a nurse practitioner including, but not
894 limited to, nurse anesthetists, nurse midwives, family nurse
895 practitioners, family planning nurse practitioners, pediatric
896 nurse practitioners, obstetrics-gynecology nurse practitioners and
897 neonatal nurse practitioners, under regulations adopted by the
898 division. Reimbursement for such services shall not exceed ninety
899 percent (90%) of the reimbursement rate for comparable services
900 rendered by a physician.

901 (22) Ambulatory services delivered in federally qualified
902 health centers and in clinics of the local health departments of
903 the State Department of Health for individuals eligible for
904 medical assistance under this article based on reasonable costs as
905 determined by the division.

906 (23) Inpatient psychiatric services. Inpatient psychiatric
907 services to be determined by the division for recipients under age
908 twenty-one (21) which are provided under the direction of a
909 physician in an inpatient program in a licensed acute care
910 psychiatric facility or in a licensed psychiatric residential
911 treatment facility, before the recipient reaches age twenty-one
912 (21) or, if the recipient was receiving the services immediately
913 before he reached age twenty-one (21), before the earlier of the
914 date he no longer requires the services or the date he reaches age
915 twenty-two (22), as provided by federal regulations. Recipients
916 shall be allowed forty-five (45) days per year of psychiatric
917 services provided in acute care psychiatric facilities, and shall
918 be allowed unlimited days of psychiatric services provided in
919 licensed psychiatric residential treatment facilities.

920 (24) Managed care services in a program to be developed by
921 the division by a public or private provider. Notwithstanding any
922 other provision in this article to the contrary, the division
923 shall establish rates of reimbursement to providers rendering care
924 and services authorized under this section, and may revise such
925 rates of reimbursement without amendment to this section by the
926 Legislature for the purpose of achieving effective and accessible
927 health services, and for responsible containment of costs. This
928 shall include, but not be limited to, one (1) module of capitated
929 managed care in a rural area, and one (1) module of capitated
930 managed care in an urban area.
931 (25) Birthing center services.
932 (26) Hospice care. As used in this paragraph, the term
933 "hospice care" means a coordinated program of active professional
934 medical attention within the home and outpatient and inpatient
935 care which treats the terminally ill patient and family as a unit,
936 employing a medically directed interdisciplinary team. The
937 program provides relief of severe pain or other physical symptoms
938 and supportive care to meet the special needs arising out of
939 physical, psychological, spiritual, social and economic stresses
940 which are experienced during the final stages of illness and
941 during dying and bereavement and meets the Medicare requirements
942 for participation as a hospice as provided in 42 CFR Part 418.
943 (27) Group health plan premiums and cost sharing if it is
944 cost effective as defined by the Secretary of Health and Human
945 Services.
946 (28) Other health insurance premiums which are cost
947 effective as defined by the Secretary of Health and Human
948 Services. Medicare eligible must have Medicare Part B before
949 other insurance premiums can be paid.
950 (29) The Division of Medicaid may apply for a waiver from
951 the Department of Health and Human Services for home- and
952 community-based services for developmentally disabled people using
953 state funds which are provided from the appropriation to the State

954 Department of Mental Health and used to match federal funds under
955 a cooperative agreement between the division and the department,
956 provided that funds for these services are specifically
957 appropriated to the Department of Mental Health.
958 (30) Pediatric skilled nursing services for eligible persons
959 under twenty-one (21) years of age.
960 (31) Targeted case management services for children with
961 special needs, under waivers from the U.S. Department of Health
962 and Human Services, using state funds that are provided from the
963 appropriation to the Mississippi Department of Human Services and
964 used to match federal funds under a cooperative agreement between
965 the division and the department.
966 (32) Care and services provided in Christian Science
967 Sanatoria operated by or listed and certified by The First Church
968 of Christ Scientist, Boston, Massachusetts, rendered in connection
969 with treatment by prayer or spiritual means to the extent that
970 such services are subject to reimbursement under Section 1903 of
971 the Social Security Act.
972 (33) Podiatrist services.
973 (34) Personal care services provided in a pilot program to
974 not more than forty (40) residents at a location or locations to
975 be determined by the division and delivered by individuals
976 qualified to provide such services, as allowed by waivers under
977 Title XIX of the Social Security Act, as amended. The division
978 shall not expend more than Three Hundred Thousand Dollars
979 ($300,000.00) annually to provide such personal care services.
980 The division shall develop recommendations for the effective
981 regulation of any facilities that would provide personal care
982 services which may become eligible for Medicaid reimbursement
983 under this section, and shall present such recommendations with
984 any proposed legislation to the 1996 Regular Session of the
985 Legislature on or before January 1, 1996.
986 (35) Services and activities authorized in Sections
987 43-27-101 and 43-27-103, using state funds that are provided from

988 the appropriation to the State Department of Human Services and
989 used to match federal funds under a cooperative agreement between
990 the division and the department.
991 (36) Nonemergency transportation services for
992 Medicaid-eligible persons, to be provided by the Department of
993 Human Services. The division may contract with additional
994 entities to administer nonemergency transportation services as it
995 deems necessary. All providers shall have a valid driver's
996 license, vehicle inspection sticker and a standard liability
997 insurance policy covering the vehicle.
998 (37) Targeted case management services for individuals with
999 chronic diseases, with expanded eligibility to cover services to
1000 uninsured recipients, on a pilot program basis. This paragraph
1001 (37) shall be contingent upon continued receipt of special funds
1002 from the Health Care Financing Authority and private foundations
1003 who have granted funds for planning these services. No funding
1004 for these services shall be provided from State General Funds.
1005 (38) Chiropractic services: a chiropractor's manual
1006 manipulation of the spine to correct a subluxation, if x-ray
1007 demonstrates that a subluxation exists and if the subluxation has
1008 resulted in a neuromusculoskeletal condition for which
1009 manipulation is appropriate treatment. Reimbursement for
1010 chiropractic services shall not exceed Seven Hundred Dollars
1011 ($700.00) per year per recipient.
1012
1013 (39) Counseling services, which are determined to be
1014 medically necessary by the division and are prior approved by the
1015 division, provided to individuals under twenty-one (21) years of
1016 age by licensed professional counselors who are licensed under
1017 Section 73-30-1 et seq.
1018 Notwithstanding any provision of this article, except as
1019 authorized in the following paragraph and in Section 43-13-139,
1020 neither (a) the limitations on quantity or frequency of use of or
1021 the fees or charges for any of the care or services available to

1022 recipients under this section, nor (b) the payments or rates of
1023 reimbursement to providers rendering care or services authorized
1024 under this section to recipients, may be increased, decreased or
1025 otherwise changed from the levels in effect on July 1, 1986,
1026 unless such is authorized by an amendment to this section by the
1027 Legislature. However, the restriction in this paragraph shall not
1028 prevent the division from changing the payments or rates of
1029 reimbursement to providers without an amendment to this section
1030 whenever such changes are required by federal law or regulation,
1031 or whenever such changes are necessary to correct administrative
1032 errors or omissions in calculating such payments or rates of
1033 reimbursement.

1034 Notwithstanding any provision of this article, no new groups
1035 or categories of recipients and new types of care and services may
1036 be added without enabling legislation from the Mississippi
1037 Legislature, except that the division may authorize such changes
1038 without enabling legislation when such addition of recipients or
1039 services is ordered by a court of proper authority. The director
1040 shall keep the Governor advised on a timely basis of the funds
1041 available for expenditure and the projected expenditures. In the
1042 event current or projected expenditures can be reasonably
1043 anticipated to exceed the amounts appropriated for any fiscal
1044 year, the Governor, after consultation with the director, shall
1045 discontinue any or all of the payment of the types of care and
1046 services as provided herein which are deemed to be optional
1047 services under Title XIX of the federal Social Security Act, as
1048 amended, for any period necessary to not exceed appropriated
1049 funds, and when necessary shall institute any other cost
1050 containment measures on any program or programs authorized under
1051 the article to the extent allowed under the federal law governing
1052 such program or programs, it being the intent of the Legislature
1053 that expenditures during any fiscal year shall not exceed the
1054 amounts appropriated for such fiscal year.

1055 SECTION 4. Section 83-41-211, Mississippi Code of 1972, is

1056 brought forward as follows:

1057 83-41-211. Whenever any policy of insurance or any medical
1058 service plan or hospital service contract or hospital and medical
1059 service contract issued in this state provides for reimbursement
1060 for any diagnosis and treatment of mental, nervous or emotional
1061 disorders only which are within the lawful scope of practice of a
1062 duly licensed psychologist as defined in Section 73-31-3, within
1063 the lawful scope of practice of a duly licensed professional
1064 counselor as defined in Section 73-30-3, or within the lawful
1065 scope of practice of a duly licensed clinical social worker as
1066 defined in Section 73-53-3, the insured or other person entitled
1067 to benefits under such policy shall be entitled to reimbursement
1068 for such services, whether such services are performed by a duly
1069 licensed physician or by a duly licensed psychologist, by a duly
1070 licensed professional counselor or by a duly licensed clinical
1071 social worker, notwithstanding any provision to the contrary in
1072 any statute or in such policy, plan or contract. Duly licensed
1073 psychologists shall be entitled to participate in such policies,
1074 plans or contracts providing for the diagnosis and treatment of
1075 mental, nervous or emotional disorders only as authorized by
1076 Section 73-31-3. A duly licensed professional counselor shall be
1077 entitled to participate in such policies, plans or contracts
1078 providing for the diagnosis and treatment of mental, nervous or
1079 emotional disorders only as authorized by Section 73-30-3. A duly
1080 licensed clinical social worker shall be entitled to participate
1081 in such policies, plans or contracts providing for the diagnosis
1082 and treatment of mental, nervous or emotional disorders only as
1083 authorized by Section 73-53-3.

1084 SECTION 5. This act shall take effect and be in force from
1085 and after July 1, 1999.