By: Representatives Grist, Scott (80th)

To: Public Health and Welfare; Appropriations

HOUSE BILL NO. 1018
(As Passed the House)

1 AN ACT TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE THAT PERSONS WHO LIVE AT HOME BUT WOULD BE ELIGIBLE FOR
3 SERVICES IN A NURSING HOME, WHO REGULARLY SPEND MORE THAN 50% OF
4 THEIR MONTHLY INCOME ON PRESCRIPTION DRUGS AND OVER-THE-COUNTER
5 DRUGS, SHALL BE ELIGIBLE FOR MEDICAID; TO PROVIDE THAT THOSE
6 PERSONS SHALL BE ELIGIBLE ONLY FOR PRESCRIPTION DRUGS AND
7 OVER-THE-COUNTER DRUGS COVERED UNDER MEDICAID; TO DIRECT THE
8 DIVISION OF MEDICAID TO APPLY FOR A FEDERAL WAIVER TO ALLOW FOR
9 THE IMPLEMENTATION OF THE PRECEDING PROVISIONS; TO AMEND SECTION
10 43-13-117, MISSISSIPPI CODE OF 1972, TO INCREASE THE NUMBER OF
11 MEDICAID PRESCRIPTIONS UNDER CERTAIN CIRCUMSTANCES; AND FOR
12 RELATED PURPOSES.

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

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

16 43-13-115. Recipients of medical assistance shall be the
17 following persons only:

18 (1) Who are qualified for public assistance grants under
19 provisions of Title IV-A and E of the federal Social Security Act,
20 as amended, including those statutorily deemed to be IV-A as
21 determined by the State Department of Human Services and certified
22 to the Division of Medicaid, but not optional groups unless
23 otherwise specifically covered in this section. For the purposes
24 of this paragraph (1) and paragraphs (3), (4), (8), (14), (17) and
25 (18) of this section, any reference to Title IV-A or to Part A of
26 Title IV of the federal Social Security Act, as amended, or the

27 state plan under Title IV-A or Part A of Title IV, shall be
28 considered as a reference to Title IV-A of the federal Social
29 Security Act, as amended, and the state plan under Title IV-A,
30 including the income and resource standards and methodologies
31 under Title IV-A and the state plan, as they existed on July 16,
32 1996.

33 (2) Those qualified for Supplemental Security Income (SSI)
34 benefits under Title XVI of the federal Social Security Act, as
35 amended. The eligibility of individuals covered in this paragraph
36 shall be determined by the Social Security Administration and
37 certified to the Division of Medicaid.

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

42 (a) Would be eligible for assistance under Part A of
43 Title IV (or would be eligible for such assistance if coverage
44 under the state plan under Part A of Title IV included assistance
45 pursuant to Section 407 of Title IV-A of the federal Social
46 Security Act, as amended) if her child had been born and was
47 living with her in the month such assistance would be paid, and
48 such pregnancy has been medically verified; or

49 (b) Is a member of a family which would be eligible
50 for assistance under the state plan under Part A of Title IV of
51 the federal Social Security Act, as amended, pursuant to Section
52 407 if the plan required the payment of assistance pursuant to
53 such section.

54 (4) Qualified children who are under five (5) years of age,
55 who were born after September 30, 1983, and who meet the income
56 and resource requirements of the state plan under Part A of Title
57 IV of the federal Social Security Act, as amended. The
58 eligibility of individuals covered in this paragraph shall be

59 determined by the State Department of Human Services and certified
60 to the Division of Medicaid.

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

73 (6) Children certified by the State Department of Human
74 Services to the Division of Medicaid of whom the state and county
75 human services agency has custody and financial responsibility,
76 and children who are in adoptions subsidized in full or part by
77 the Department of Human Services, who are approvable under Title
78 XIX of the Medicaid program.

79 (7) (a) Persons certified by the Division of Medicaid who
80 are patients in a medical facility (nursing home, hospital,
81 tuberculosis sanatorium or institution for treatment of mental
82 diseases), and who, except for the fact that they are patients in
83 such medical facility, would qualify for grants under Title IV,
84 supplementary security income benefits under Title XVI or state
85 supplements, and those aged, blind and disabled persons who would
86 not be eligible for supplemental security income benefits under
87 Title XVI or state supplements if they were not institutionalized

88 in a medical facility but whose income is below the maximum
89 standard set by the Division of Medicaid, which standard shall not
90 exceed that prescribed by federal regulation;
91 (b) Individuals who have elected to receive hospice
92 care benefits and who are eligible using the same criteria and
93 special income limits as those in institutions as described in
94 subparagraph (a) of this paragraph (7).
95 (8) Children under eighteen (18) years of age and pregnant
96 women (including those in intact families) who meet the financial
97 standards of the state plan approved under Title IV-A of the
98 federal Social Security Act, as amended. The eligibility of
99 children covered under this paragraph shall be determined by the
100 State Department of Human Services and certified to the Division
101 of Medicaid.
102 (9) Individuals who are:
103 (a) Children born after September 30, 1983, who have
104 not attained the age of nineteen (19), with family income that
105 does not exceed one hundred percent (100%) of the nonfarm official
106 poverty line;
107 (b) Pregnant women, infants and children who have not
108 attained the age of six (6), with family income that does not
109 exceed one hundred thirty-three percent (133%) of the federal
110 poverty level; and
111 (c) Pregnant women and infants who have not attained
112 the age of one (1), with family income that does not exceed one
113 hundred eighty-five percent (185%) of the federal poverty level.
114 The eligibility of individuals covered in (a), (b) and (c) of
115 this paragraph shall be determined by the Department of Human
116 Services.

117 (10) Certain disabled children age eighteen (18) or under
118 who are living at home, who would be eligible, if in a medical
119 institution, for SSI or a state supplemental payment under Title
120 XVI of the federal Social Security Act, as amended, and therefore
121 for Medicaid under the plan, and for whom the state has made a
122 determination as required under Section 1902(e)(3)(b) of the
123 federal Social Security Act, as amended. The eligibility of
124 individuals under this paragraph shall be determined by the
125 Division of Medicaid.
126 (11) Individuals who are sixty-five (65) years of age or
127 older or are disabled as determined under Section 1614(a)(3) of
128 the federal Social Security Act, as amended, and who meet the
129 following criteria:
130 (a) Whose income does not exceed one hundred percent
131 (100%) of the nonfarm official poverty line as defined by the
132 Office of Management and Budget and revised annually.
133 (b) Whose resources do not exceed those allowed under
134 the Supplemental Security Income (SSI) program.
135 The eligibility of individuals covered under this paragraph
136 shall be determined by the Division of Medicaid, and such
137 individuals determined eligible shall receive the same Medicaid
138 services as other categorical eligible individuals.
139 (12) Individuals who are qualified Medicare beneficiaries
140 (QMB) entitled to Part A Medicare as defined under Section 301,
141 Public Law 100-360, known as the Medicare Catastrophic Coverage
142 Act of 1988, and who meet the following criteria:
143 (a) Whose income does not exceed one hundred percent
144 (100%) of the nonfarm official poverty line as defined by the
145 Office of Management and Budget and revised annually.

146 (b) Whose resources do not exceed two hundred percent
147 (200%) of the amount allowed under the Supplemental Security
148 Income (SSI) program as more fully prescribed under Section 301,
149 Public Law 100-360.
150 The eligibility of individuals covered under this paragraph
151 shall be determined by the Division of Medicaid, and such
152 individuals determined eligible shall receive Medicare
153 cost-sharing expenses only as more fully defined by the Medicare
154 Catastrophic Coverage Act of 1988.
155 (13) Individuals who are entitled to Medicare Part B as
156 defined in Section 4501 of the Omnibus Budget Reconciliation Act
157 of 1990, and who meet the following criteria:
158 (a) Whose income does not exceed the percentage of the
159 nonfarm official poverty line as defined by the Office of
160 Management and Budget and revised annually which, on or after:
161 (i) January 1, 1993, is one hundred ten percent
162 (110%); and
163 (ii) January 1, 1995, is one hundred twenty
164 percent (120%).
165 (b) Whose resources do not exceed two hundred percent
166 (200%) of the amount allowed under the Supplemental Security
167 Income (SSI) program as described in Section 301 of the Medicare
168 Catastrophic Coverage Act of 1988.
169 The eligibility of individuals covered under this paragraph
170 shall be determined by the Division of Medicaid, and such
171 individuals determined eligible shall receive Medicare cost
172 sharing.
173 (14) Individuals in families who would be eligible for the
174 unemployed parent program under Section 407 of Title IV-A of the

175 federal Social Security Act, as amended but do not receive
176 payments pursuant to that section. The eligibility of individuals
177 covered in this paragraph shall be determined by the Department of
178 Human Services.
179 (15) Disabled workers who are eligible to enroll in Part A
180 Medicare as required by Public Law 101-239, known as the Omnibus
181 Budget Reconciliation Act of 1989, and whose income does not
182 exceed two hundred percent (200%) of the federal poverty level as
183 determined in accordance with the Supplemental Security Income
184 (SSI) program. The eligibility of individuals covered under this
185 paragraph shall be determined by the Division of Medicaid and such
186 individuals shall be entitled to buy-in coverage of Medicare Part
187 A premiums only under the provisions of this paragraph (15).
188 (16) In accordance with the terms and conditions of approved
189 Title XIX waiver from the United States Department of Health and
190 Human Services, persons provided home- and community-based
191 services who are physically disabled and certified by the Division
192 of Medicaid as eligible due to applying the income and deeming
193 requirements as if they were institutionalized.
194 (17) In accordance with the terms of the federal Personal
195 Responsibility and Work Opportunity Reconciliation Act of 1996
196 (Public Law 104-193), persons who become ineligible for assistance
197 under Title IV-A of the federal Social Security Act, as amended
198 because of increased income from or hours of employment of the
199 caretaker relative or because of the expiration of the applicable
200 earned income disregards, who were eligible for Medicaid for at
201 least three (3) of the six (6) months preceding the month in which
202 such ineligibility begins, shall be eligible for Medicaid
203 assistance for up to twenty-four (24) months; however, Medicaid

204 assistance for more than twelve (12) months may be provided only
205 if a federal waiver is obtained to provide such assistance for
206 more than twelve (12) months and federal and state funds are
207 available to provide such assistance.
208 (18) Persons who become ineligible for assistance under
209 Title IV-A of the federal Social Security Act, as amended, as a
210 result, in whole or in part, of the collection or increased
211 collection of child or spousal support under Title IV-D of the
212 federal Social Security Act, as amended, who were eligible for
213 Medicaid for at least three (3) of the six (6) months immediately
214 preceding the month in which such ineligibility begins, shall be
215 eligible for Medicaid for an additional four (4) months beginning
216 with the month in which such ineligibility begins.
217 (19) Individuals who would be eligible for services in a
218 nursing home but who live in their own place of residence, whose
219 income does not exceed the amount prescribed by federal regulation
220 for nursing home care, and who regularly expend more than fifty
221 percent (50%) of their monthly income on prescription drugs and
222 over-the-counter drugs.
223 The eligibility of individuals covered under this paragraph
224 (19) shall be determined by the Division of Medicaid. The
225 individuals determined eligible shall be eligible only for
226 prescription drugs and over-the-counter drugs covered under
227 Section 43-13-117(9) and not for any other services covered under
228 Section 43-13-117.
229
230 The Division of Medicaid shall apply to the United States
231 Secretary of Health and Human Services for a federal waiver of the
232 applicable provisions of Title XIX of the federal Social Security

233 Act, as amended, and any other applicable provisions of federal
234 law as necessary to allow for the implementation of this paragraph
235 (19). The provisions of this paragraph (19) shall be implemented
236 from and after the date that the Division of Medicaid receives the
237 federal waiver.

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

240 43-13-117. Medical assistance as authorized by this article
241 shall include payment of part or all of the costs, at the
242 discretion of the division or its successor, with approval of the
243 Governor, of the following types of care and services rendered to
244 eligible applicants who shall have been determined to be eligible
245 for such care and services, within the limits of state
246 appropriations and federal matching funds:

247 (1) Inpatient hospital services.

248 (a) The division shall allow thirty (30) days of
249 inpatient hospital care annually for all Medicaid recipients;
250 however, before any recipient will be allowed more than fifteen
251 (15) days of inpatient hospital care in any one (1) year, he must
252 obtain prior approval therefor from the division. The division
253 shall be authorized to allow unlimited days in disproportionate
254 hospitals as defined by the division for eligible infants under
255 the age of six (6) years.

256 (b) From and after July 1, 1994, the Executive Director
257 of the Division of Medicaid shall amend the Mississippi Title XIX
258 Inpatient Hospital Reimbursement Plan to remove the occupancy rate
259 penalty from the calculation of the Medicaid Capital Cost
260 Component utilized to determine total hospital costs allocated to
261 the Medicaid Program.

262 (2) Outpatient hospital services. Provided that where the
263 same services are reimbursed as clinic services, the division may
264 revise the rate or methodology of outpatient reimbursement to
265 maintain consistency, efficiency, economy and quality of care.
266 (3) Laboratory and X-ray services.
267 (4) Nursing facility services.
268 (a) The division shall make full payment to nursing
269 facilities for each day, not exceeding thirty-six (36) days per
270 year, that a patient is absent from the facility on home leave.
271 However, before payment may be made for more than eighteen (18)
272 home leave days in a year for a patient, the patient must have
273 written authorization from a physician stating that the patient is
274 physically and mentally able to be away from the facility on home
275 leave. Such authorization must be filed with the division before
276 it will be effective and the authorization shall be effective for
277 three (3) months from the date it is received by the division,
278 unless it is revoked earlier by the physician because of a change
279 in the condition of the patient.
280 (b) Repealed.
281 (c) From and after July 1, 1997, all state-owned
282 nursing facilities shall be reimbursed on a full reasonable costs
283 basis. From and after July 1, 1997, payments by the division to
284 nursing facilities for return on equity capital shall be made at
285 the rate paid under Medicare (Title XVIII of the Social Security
286 Act), but shall be no less than seven and one-half percent (7.5%)
287 nor greater than ten percent (10%).
288 (d) A Review Board for nursing facilities is
289 established to conduct reviews of the Division of Medicaid's
290 decision in the areas set forth below:

291 (i) Review shall be heard in the following areas:
292 (A) Matters relating to cost reports
293 including, but not limited to, allowable costs and cost
294 adjustments resulting from desk reviews and audits.
295 (B) Matters relating to the Minimum Data Set
296 Plus (MDS +) or successor assessment formats including but not
297 limited to audits, classifications and submissions.
298 (ii) The Review Board shall be composed of six (6)
299 members, three (3) having expertise in one (1) of the two (2)
300 areas set forth above and three (3) having expertise in the other
301 area set forth above. Each panel of three (3) shall only review
302 appeals arising in its area of expertise. The members shall be
303 appointed as follows:
304 (A) In each of the areas of expertise defined
305 under subparagraphs (i)(A) and (i)(B), the Executive Director of
306 the Division of Medicaid shall appoint one (1) person chosen from
307 the private sector nursing home industry in the state, which may
308 include independent accountants and consultants serving the
309 industry;
310 (B) In each of the areas of expertise defined
311 under subparagraphs (i)(A) and (i)(B), the Executive Director of
312 the Division of Medicaid shall appoint one (1) person who is
313 employed by the state who does not participate directly in desk
314 reviews or audits of nursing facilities in the two (2) areas of
315 review;
316 (C) The two (2) members appointed by the
317 Executive Director of the Division of Medicaid in each area of
318 expertise shall appoint a third member in the same area of
319 expertise.

320 In the event of a conflict of interest on the part of any
321 Review Board members, the Executive Director of the Division of
322 Medicaid or the other two (2) panel members, as applicable, shall
323 appoint a substitute member for conducting a specific review.
324 (iii) The Review Board panels shall have the power
325 to preserve and enforce order during hearings; to issue subpoenas;
326 to administer oaths; to compel attendance and testimony of
327 witnesses; or to compel the production of books, papers, documents
328 and other evidence; or the taking of depositions before any
329 designated individual competent to administer oaths; to examine
330 witnesses; and to do all things conformable to law that may be
331 necessary to enable it effectively to discharge its duties. The
332 Review Board panels may appoint such person or persons as they
333 shall deem proper to execute and return process in connection
334 therewith.
335 (iv) The Review Board shall promulgate, publish
336 and disseminate to nursing facility providers rules of procedure
337 for the efficient conduct of proceedings, subject to the approval
338 of the Executive Director of the Division of Medicaid and in
339 accordance with federal and state administrative hearing laws and
340 regulations.
341 (v) Proceedings of the Review Board shall be of
342 record.
343 (vi) Appeals to the Review Board shall be in
344 writing and shall set out the issues, a statement of alleged facts
345 and reasons supporting the provider's position. Relevant
346 documents may also be attached. The appeal shall be filed within
347 thirty (30) days from the date the provider is notified of the
348 action being appealed or, if informal review procedures are taken,

349 as provided by administrative regulations of the Division of
350 Medicaid, within thirty (30) days after a decision has been
351 rendered through informal hearing procedures.
352 (vii) The provider shall be notified of the
353 hearing date by certified mail within thirty (30) days from the
354 date the Division of Medicaid receives the request for appeal.
355 Notification of the hearing date shall in no event be less than
356 thirty (30) days before the scheduled hearing date. The appeal
357 may be heard on shorter notice by written agreement between the
358 provider and the Division of Medicaid.
359 (viii) Within thirty (30) days from the date of
360 the hearing, the Review Board panel shall render a written
361 recommendation to the Executive Director of the Division of
362 Medicaid setting forth the issues, findings of fact and applicable
363 law, regulations or provisions.
364 (ix) The Executive Director of the Division of
365 Medicaid shall, upon review of the recommendation, the proceedings
366 and the record, prepare a written decision which shall be mailed
367 to the nursing facility provider no later than twenty (20) days
368 after the submission of the recommendation by the panel. The
369 decision of the executive director is final, subject only to
370 judicial review.
371 (x) Appeals from a final decision shall be made to
372 the Chancery Court of Hinds County. The appeal shall be filed
373 with the court within thirty (30) days from the date the decision
374 of the Executive Director of the Division of Medicaid becomes
375 final.
376 (xi) The action of the Division of Medicaid under
377 review shall be stayed until all administrative proceedings have

378 been exhausted.

379 (xii) Appeals by nursing facility providers
380 involving any issues other than those two (2) specified in
381 subparagraphs (i)(A) and (ii)(B) shall be taken in accordance with
382 the administrative hearing procedures established by the Division
383 of Medicaid.

384 (e) When a facility of a category that does not require
385 a certificate of need for construction and that could not be
386 eligible for Medicaid reimbursement is constructed to nursing
387 facility specifications for licensure and certification, and the
388 facility is subsequently converted to a nursing facility pursuant
389 to a certificate of need that authorizes conversion only and the
390 applicant for the certificate of need was assessed an application
391 review fee based on capital expenditures incurred in constructing
392 the facility, the division shall allow reimbursement for capital
393 expenditures necessary for construction of the facility that were
394 incurred within the twenty-four (24) consecutive calendar months
395 immediately preceding the date that the certificate of need
396 authorizing such conversion was issued, to the same extent that
397 reimbursement would be allowed for construction of a new nursing
398 facility pursuant to a certificate of need that authorizes such
399 construction. The reimbursement authorized in this subparagraph
400 (e) may be made only to facilities the construction of which was
401 completed after June 30, 1989. Before the division shall be
402 authorized to make the reimbursement authorized in this
403 subparagraph (e), the division first must have received approval
404 from the Health Care Financing Administration of the United States
405 Department of Health and Human Services of the change in the state
406 Medicaid plan providing for such reimbursement.

407 (5) Periodic screening and diagnostic services for
408 individuals under age twenty-one (21) years as are needed to
409 identify physical and mental defects and to provide health care
410 treatment and other measures designed to correct or ameliorate
411 defects and physical and mental illness and conditions discovered
412 by the screening services regardless of whether these services are
413 included in the state plan. The division may include in its
414 periodic screening and diagnostic program those discretionary
415 services authorized under the federal regulations adopted to
416 implement Title XIX of the federal Social Security Act, as
417 amended. The division, in obtaining physical therapy services,
418 occupational therapy services, and services for individuals with
419 speech, hearing and language disorders, may enter into a
420 cooperative agreement with the State Department of Education for
421 the provision of such services to handicapped students by public
422 school districts using state funds which are provided from the
423 appropriation to the Department of Education to obtain federal
424 matching funds through the division. The division, in obtaining
425 medical and psychological evaluations for children in the custody
426 of the State Department of Human Services may enter into a
427 cooperative agreement with the State Department of Human Services
428 for the provision of such services using state funds which are
429 provided from the appropriation to the Department of Human
430 Services to obtain federal matching funds through the division.
431 On July 1, 1993, all fees for periodic screening and
432 diagnostic services under this paragraph (5) shall be increased by
433 twenty-five percent (25%) of the reimbursement rate in effect on
434 June 30, 1993.
435 (6) Physician's services. On January 1, 1996, all fees for

436 physicians' services shall be reimbursed at seventy percent (70%)
437 of the rate established on January 1, 1994, under Medicare (Title
438 XVIII of the Social Security Act), as amended, and the division
439 may adjust the physicians' reimbursement schedule to reflect the
440 differences in relative value between Medicaid and Medicare.
441 (7) (a) Home health services for eligible persons, not to
442 exceed in cost the prevailing cost of nursing facility services,
443 not to exceed sixty (60) visits per year.
444 (b) Repealed.
445 (8) Emergency medical transportation services. On January
446 1, 1994, emergency medical transportation services shall be
447 reimbursed at seventy percent (70%) of the rate established under
448 Medicare (Title XVIII of the Social Security Act), as amended.
449 "Emergency medical transportation services" shall mean, but shall
450 not be limited to, the following services by a properly permitted
451 ambulance operated by a properly licensed provider in accordance
452 with the Emergency Medical Services Act of 1974 (Section 41-59-1
453 et seq.): (i) basic life support, (ii) advanced life support,
454 (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi)
455 disposable supplies, (vii) similar services.
456 (9) Legend and other drugs as may be determined by the
457 division. The division may implement a program of prior approval
458 for drugs to the extent permitted by law. Payment by the division
459 for covered multiple source drugs shall be limited to the lower of
460 the upper limits established and published by the Health Care
461 Financing Administration (HCFA) plus a dispensing fee of Four
462 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
463 cost (EAC) as determined by the division plus a dispensing fee of
464 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual

465 and customary charge to the general public. The division shall
466 allow five (5) prescriptions per month for noninstitutionalized
467 Medicaid recipients; however, exceptions for up to ten (10)
468 prescriptions per month shall be allowed, with the approval of the
469 director.
470 Payment for other covered drugs, other than multiple source
471 drugs with HCFA upper limits, shall not exceed the lower of the
472 estimated acquisition cost as determined by the division plus a
473 dispensing fee of Four Dollars and Ninety-one Cents ($4.91) or the
474 providers' usual and customary charge to the general public.
475 Payment for nonlegend or over-the-counter drugs covered on
476 the division's formulary shall be reimbursed at the lower of the
477 division's estimated shelf price or the providers' usual and
478 customary charge to the general public. No dispensing fee shall
479 be paid.
480 The division shall develop and implement a program of payment
481 for additional pharmacist services, with payment to be based on
482 demonstrated savings, but in no case shall the total payment
483 exceed twice the amount of the dispensing fee.
484 As used in this paragraph (9), "estimated acquisition cost"
485 means the division's best estimate of what price providers
486 generally are paying for a drug in the package size that providers
487 buy most frequently. Product selection shall be made in
488 compliance with existing state law; however, the division may
489 reimburse as if the prescription had been filled under the generic
490 name. The division may provide otherwise in the case of specified
491 drugs when the consensus of competent medical advice is that
492 trademarked drugs are substantially more effective.
493 (10) Dental care that is an adjunct to treatment of an acute

494 medical or surgical condition; services of oral surgeons and
495 dentists in connection with surgery related to the jaw or any
496 structure contiguous to the jaw or the reduction of any fracture
497 of the jaw or any facial bone; and emergency dental extractions
498 and treatment related thereto. On January 1, 1994, all fees for
499 dental care and surgery under authority of this paragraph (10)
500 shall be increased by twenty percent (20%) of the reimbursement
501 rate as provided in the Dental Services Provider Manual in effect
502 on December 31, 1993.

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

506 (12) Intermediate care facility services.

507 (a) The division shall make full payment to all
508 intermediate care facilities for the mentally retarded for each
509 day, not exceeding thirty-six (36) days per year, that a patient
510 is absent from the facility on home leave. However, before
511 payment may be made for more than eighteen (18) home leave days in
512 a year for a patient, the patient must have written authorization
513 from a physician stating that the patient is physically and
514 mentally able to be away from the facility on home leave. Such
515 authorization must be filed with the division before it will be
516 effective, and the authorization shall be effective for three (3)
517 months from the date it is received by the division, unless it is
518 revoked earlier by the physician because of a change in the
519 condition of the patient.

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

523 (13) Family planning services, including drugs, supplies and
524 devices, when such services are under the supervision of a
525 physician.
526 (14) Clinic services. Such diagnostic, preventive,
527 therapeutic, rehabilitative or palliative services furnished to an
528 outpatient by or under the supervision of a physician or dentist
529 in a facility which is not a part of a hospital but which is
530 organized and operated to provide medical care to outpatients.
531 Clinic services shall include any services reimbursed as
532 outpatient hospital services which may be rendered in such a
533 facility, including those that become so after July 1, 1991. On
534 January 1, 1994, all fees for physicians' services reimbursed
535 under authority of this paragraph (14) shall be reimbursed at
536 seventy percent (70%) of the rate established on January 1, 1993,
537 under Medicare (Title XVIII of the Social Security Act), as
538 amended, or the amount that would have been paid under the
539 division's fee schedule that was in effect on December 31, 1993,
540 whichever is greater, and the division may adjust the physicians'
541 reimbursement schedule to reflect the differences in relative
542 value between Medicaid and Medicare. However, on January 1, 1994,
543 the division may increase any fee for physicians' services in the
544 division's fee schedule on December 31, 1993, that was greater
545 than seventy percent (70%) of the rate established under Medicare
546 by no more than ten percent (10%). On January 1, 1994, all fees
547 for dentists' services reimbursed under authority of this
548 paragraph (14) shall be increased by twenty percent (20%) of the
549 reimbursement rate as provided in the Dental Services Provider
550 Manual in effect on December 31, 1993.
551 (15) Home- and community-based services, as provided under

552 Title XIX of the federal Social Security Act, as amended, under
553 waivers, subject to the availability of funds specifically
554 appropriated therefor by the Legislature. Payment for such
555 services shall be limited to individuals who would be eligible for
556 and would otherwise require the level of care provided in a
557 nursing facility. The division shall certify case management
558 agencies to provide case management services and provide for home-
559 and community-based services for eligible individuals under this
560 paragraph. The home- and community-based services under this
561 paragraph and the activities performed by certified case
562 management agencies under this paragraph shall be funded using
563 state funds that are provided from the appropriation to the
564 Division of Medicaid and used to match federal funds under a
565 cooperative agreement between the division and the Department of
566 Human Services.
567 (16) Mental health services. Approved therapeutic and case
568 management services provided by (a) an approved regional mental
569 health/retardation center established under Sections 41-19-31
570 through 41-19-39, or by another community mental health service
571 provider meeting the requirements of the Department of Mental
572 Health to be an approved mental health/retardation center if
573 determined necessary by the Department of Mental Health, using
574 state funds which are provided from the appropriation to the State
575 Department of Mental Health and used to match federal funds under
576 a cooperative agreement between the division and the department,
577 or (b) a facility which is certified by the State Department of
578 Mental Health to provide therapeutic and case management services,
579 to be reimbursed on a fee for service basis. Any such services
580 provided by a facility described in paragraph (b) must have the

581 prior approval of the division to be reimbursable under this
582 section. After June 30, 1997, mental health services provided by
583 regional mental health/retardation centers established under
584 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
585 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
586 psychiatric residential treatment facilities as defined in Section
587 43-11-1, or by another community mental health service provider
588 meeting the requirements of the Department of Mental Health to be
589 an approved mental health/retardation center if determined
590 necessary by the Department of Mental Health, shall not be
591 included in or provided under any capitated managed care pilot
592 program provided for under paragraph (24) of this section.
593 (17) Durable medical equipment services and medical supplies
594 restricted to patients receiving home health services unless
595 waived on an individual basis by the division. The division shall
596 not expend more than Three Hundred Thousand Dollars ($300,000.00)
597 of state funds annually to pay for medical supplies authorized
598 under this paragraph.
599 (18) Notwithstanding any other provision of this section to
600 the contrary, the division shall make additional reimbursement to
601 hospitals which serve a disproportionate share of low-income
602 patients and which meet the federal requirements for such payments
603 as provided in Section 1923 of the federal Social Security Act and
604 any applicable regulations.
605 (19) (a) Perinatal risk management services. The division
606 shall promulgate regulations to be effective from and after
607 October 1, 1988, to establish a comprehensive perinatal system for
608 risk assessment of all pregnant and infant Medicaid recipients and
609 for management, education and follow-up for those who are

610 determined to be at risk. Services to be performed include case
611 management, nutrition assessment/counseling, psychosocial
612 assessment/counseling and health education. The division shall
613 set reimbursement rates for providers in conjunction with the
614 State Department of Health.
615 (b) Early intervention system services. The division
616 shall cooperate with the State Department of Health, acting as
617 lead agency, in the development and implementation of a statewide
618 system of delivery of early intervention services, pursuant to
619 Part H of the Individuals with Disabilities Education Act (IDEA).
620 The State Department of Health shall certify annually in writing
621 to the director of the division the dollar amount of state early
622 intervention funds available which shall be utilized as a
623 certified match for Medicaid matching funds. Those funds then
624 shall be used to provide expanded targeted case management
625 services for Medicaid eligible children with special needs who are
626 eligible for the state's early intervention system.
627 Qualifications for persons providing service coordination shall be
628 determined by the State Department of Health and the Division of
629 Medicaid.
630 (20) Home- and community-based services for physically
631 disabled approved services as allowed by a waiver from the U.S.
632 Department of Health and Human Services for home- and
633 community-based services for physically disabled people using
634 state funds which are provided from the appropriation to the State
635 Department of Rehabilitation Services and used to match federal
636 funds under a cooperative agreement between the division and the
637 department, provided that funds for these services are
638 specifically appropriated to the Department of Rehabilitation

639 Services.

640 (21) Nurse practitioner services. Services furnished by a
641 registered nurse who is licensed and certified by the Mississippi
642 Board of Nursing as a nurse practitioner including, but not
643 limited to, nurse anesthetists, nurse midwives, family nurse
644 practitioners, family planning nurse practitioners, pediatric
645 nurse practitioners, obstetrics-gynecology nurse practitioners and
646 neonatal nurse practitioners, under regulations adopted by the
647 division. Reimbursement for such services shall not exceed ninety
648 percent (90%) of the reimbursement rate for comparable services
649 rendered by a physician.

650 (22) Ambulatory services delivered in federally qualified
651 health centers and in clinics of the local health departments of
652 the State Department of Health for individuals eligible for
653 medical assistance under this article based on reasonable costs as
654 determined by the division.

655 (23) Inpatient psychiatric services. Inpatient psychiatric
656 services to be determined by the division for recipients under age
657 twenty-one (21) which are provided under the direction of a
658 physician in an inpatient program in a licensed acute care
659 psychiatric facility or in a licensed psychiatric residential
660 treatment facility, before the recipient reaches age twenty-one
661 (21) or, if the recipient was receiving the services immediately
662 before he reached age twenty-one (21), before the earlier of the
663 date he no longer requires the services or the date he reaches age
664 twenty-two (22), as provided by federal regulations. Recipients
665 shall be allowed forty-five (45) days per year of psychiatric
666 services provided in acute care psychiatric facilities, and shall
667 be allowed unlimited days of psychiatric services provided in

668 licensed psychiatric residential treatment facilities.

669 (24) Managed care services in a program to be developed by
670 the division by a public or private provider. Notwithstanding any
671 other provision in this article to the contrary, the division
672 shall establish rates of reimbursement to providers rendering care
673 and services authorized under this section, and may revise such
674 rates of reimbursement without amendment to this section by the
675 Legislature for the purpose of achieving effective and accessible
676 health services, and for responsible containment of costs. This
677 shall include, but not be limited to, one (1) module of capitated
678 managed care in a rural area, and one (1) module of capitated
679 managed care in an urban area.

680 (25) Birthing center services.

681 (26) Hospice care. As used in this paragraph, the term
682 "hospice care" means a coordinated program of active professional
683 medical attention within the home and outpatient and inpatient
684 care which treats the terminally ill patient and family as a unit,
685 employing a medically directed interdisciplinary team. The
686 program provides relief of severe pain or other physical symptoms
687 and supportive care to meet the special needs arising out of
688 physical, psychological, spiritual, social and economic stresses
689 which are experienced during the final stages of illness and
690 during dying and bereavement and meets the Medicare requirements
691 for participation as a hospice as provided in 42 CFR Part 418.

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

695 (28) Other health insurance premiums which are cost
696 effective as defined by the Secretary of Health and Human

697 Services. Medicare eligible must have Medicare Part B before
698 other insurance premiums can be paid.
699 (29) The Division of Medicaid may apply for a waiver from
700 the Department of Health and Human Services for home- and
701 community-based services for developmentally disabled people using
702 state funds which are provided from the appropriation to the State
703 Department of Mental Health and used to match federal funds under
704 a cooperative agreement between the division and the department,
705 provided that funds for these services are specifically
706 appropriated to the Department of Mental Health.
707 (30) Pediatric skilled nursing services for eligible persons
708 under twenty-one (21) years of age.
709 (31) Targeted case management services for children with
710 special needs, under waivers from the U.S. Department of Health
711 and Human Services, using state funds that are provided from the
712 appropriation to the Mississippi Department of Human Services and
713 used to match federal funds under a cooperative agreement between
714 the division and the department.
715 (32) Care and services provided in Christian Science
716 Sanatoria operated by or listed and certified by The First Church
717 of Christ Scientist, Boston, Massachusetts, rendered in connection
718 with treatment by prayer or spiritual means to the extent that
719 such services are subject to reimbursement under Section 1903 of
720 the Social Security Act.
721 (33) Podiatrist services.
722 (34) Personal care services provided in a pilot program to
723 not more than forty (40) residents at a location or locations to
724 be determined by the division and delivered by individuals
725 qualified to provide such services, as allowed by waivers under

726 Title XIX of the Social Security Act, as amended. The division
727 shall not expend more than Three Hundred Thousand Dollars
728 ($300,000.00) annually to provide such personal care services.
729 The division shall develop recommendations for the effective
730 regulation of any facilities that would provide personal care
731 services which may become eligible for Medicaid reimbursement
732 under this section, and shall present such recommendations with
733 any proposed legislation to the 1996 Regular Session of the
734 Legislature on or before January 1, 1996.
735 (35) Services and activities authorized in Sections
736 43-27-101 and 43-27-103, using state funds that are provided from
737 the appropriation to the State Department of Human Services and
738 used to match federal funds under a cooperative agreement between
739 the division and the department.
740 (36) Nonemergency transportation services for
741 Medicaid-eligible persons, to be provided by the Department of
742 Human Services. The division may contract with additional
743 entities to administer nonemergency transportation services as it
744 deems necessary. All providers shall have a valid driver's
745 license, vehicle inspection sticker and a standard liability
746 insurance policy covering the vehicle.
747 (37) Targeted case management services for individuals with
748 chronic diseases, with expanded eligibility to cover services to
749 uninsured recipients, on a pilot program basis. This paragraph
750 (37) shall be contingent upon continued receipt of special funds
751 from the Health Care Financing Authority and private foundations
752 who have granted funds for planning these services. No funding
753 for these services shall be provided from State General Funds.
754 (38) Chiropractic services: a chiropractor's manual

755 manipulation of the spine to correct a subluxation, if x-ray
756 demonstrates that a subluxation exists and if the subluxation has
757 resulted in a neuromusculoskeletal condition for which
758 manipulation is appropriate treatment. Reimbursement for
759 chiropractic services shall not exceed Seven Hundred Dollars
760 ($700.00) per year per recipient.

761 Notwithstanding any provision of this article, except as
762 authorized in the following paragraph and in Section 43-13-139,
763 neither (a) the limitations on quantity or frequency of use of or
764 the fees or charges for any of the care or services available to
765 recipients under this section, nor (b) the payments or rates of
766 reimbursement to providers rendering care or services authorized
767 under this section to recipients, may be increased, decreased or
768 otherwise changed from the levels in effect on July 1, 1986,
769 unless such is authorized by an amendment to this section by the
770 Legislature. However, the restriction in this paragraph shall not
771 prevent the division from changing the payments or rates of
772 reimbursement to providers without an amendment to this section
773 whenever such changes are required by federal law or regulation,
774 or whenever such changes are necessary to correct administrative
775 errors or omissions in calculating such payments or rates of
776 reimbursement.

777 Notwithstanding any provision of this article, no new groups
778 or categories of recipients and new types of care and services may
779 be added without enabling legislation from the Mississippi
780 Legislature, except that the division may authorize such changes
781 without enabling legislation when such addition of recipients or
782 services is ordered by a court of proper authority. The director
783 shall keep the Governor advised on a timely basis of the funds

784 available for expenditure and the projected expenditures. In the
785 event current or projected expenditures can be reasonably
786 anticipated to exceed the amounts appropriated for any fiscal
787 year, the Governor, after consultation with the director, shall
788 discontinue any or all of the payment of the types of care and
789 services as provided herein which are deemed to be optional
790 services under Title XIX of the federal Social Security Act, as
791 amended, for any period necessary to not exceed appropriated
792 funds, and when necessary shall institute any other cost
793 containment measures on any program or programs authorized under
794 the article to the extent allowed under the federal law governing
795 such program or programs, it being the intent of the Legislature
796 that expenditures during any fiscal year shall not exceed the
797 amounts appropriated for such fiscal year.

798 SECTION 3. This act shall take effect and be in force from
799 and after July 1, 1999.