MISSISSIPPI LEGISLATURE REGULAR SESSION 1999

By: Representatives Moody, Scott (80th)

To: Public Health and Welfare; Appropriations

COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 1332

1 AN ACT TO AMEND SECTION 43-13-107, MISSISSIPPI CODE OF 1972,
2 TO CREATE A MEDICAL CARE ADVISORY COMMITTEE TO THE DIVISION OF
3 MEDICAID; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO
4 REVISE THE MEDICAID REIMBURSEMENT RATE FOR PHYSICIAN'S SERVICES;
5 TO DELETE THE REQUIREMENT THAT THE DIVISION OF MEDICAID OPERATE
6 CAPITATED MANAGED CARE PROGRAMS IN URBAN AND RURAL AREAS IN THE
7 STATE; AND FOR RELATED PURPOSES.

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

9 SECTION 1. Section 43-13-107, Mississippi Code of 1972, is
10 amended as follows:

11 43-13-107. (1) The Division of Medicaid is *** * *** created in
12 the Office of the Governor and established to administer this
13 article and perform such other duties as are prescribed by law.

14 (2) The Governor shall appoint a full-time director, with
15 the advice and consent of the Senate, who shall be either a
16 physician with administrative experience in a medical care or
17 health program or a person holding a graduate degree in medical
18 care administration, public health, hospital administration, or
19 the equivalent, and who shall serve at the will and pleasure of
20 the Governor. The director shall be the official secretary and
21 legal custodian of the records of the division; shall be the agent
22 of the division for the purpose of receiving all service of
23 process, summons and notices directed to the division; and shall
24 perform such other duties as the Governor shall, from time to
25 time, prescribe. The director, with the approval of the Governor
26 and the rules and regulations of the State Personnel Board, shall
27 employ such professional, administrative, stenographic,
28 secretarial, clerical and technical assistance as may be necessary
29 to perform the duties required in administering this article and

30 fix the compensation therefor, all in accordance with a state
31 merit system meeting federal requirements, except that when the
32 salary of the director is not set by law, such salary shall be set
33 by the State Personnel Board. No employees of the Division of
34 Medicaid shall be considered to be staff members of the immediate
35 Office of the Governor; however, the provisions of Section
36 25-9-107(xv) shall apply to the director and other administrative
37 heads of the Division.
38 (3) (a) There is established a Medical Care Advisory
39 Committee, which shall be the committee that is required by
40 federal regulation to advise the Division of Medicaid about health
41 and medical care services.
42 (b) The committee shall consist of not less than
43 thirteen (13) members, as follows:
44 (i) The Speaker of the House of Representatives
45 and the Lieutenant Governor each shall appoint three (3) members
46 of the committee who are health care providers familiar with the
47 Medicaid program.
48 (ii) The Speaker of the House of Representatives
49 shall appoint one (1) member of the committee who is a member of
50 the House of Representatives, and the Lieutenant Governor shall
51 appoint one (1) member of the committee who is a member of the
52 Senate.
53 (iii) The respective chairmen of the House Public
54 Health and Welfare Committee, the House Appropriations Committee,
55 the Senate Public Health and Welfare Committee and the Senate
56 Appropriations Committee, or their designees, shall be members of
57 the committee.
58 (iv) The Division of Medicaid shall appoint one (1)
59 member of the committee.
60 (c) In addition to the committee members required by
61 paragraph (b), the committee shall consist of such other members
62 as are necessary to meet the requirements of the federal
63 regulation applicable to the Medical Care Advisory Committee, who
64 shall be appointed as provided in the federal regulation.
65 (d) The chairmanship of the committee shall alternate
66 for twelve-month periods between the chairmen of the House and
67 Senate Public Health and Welfare Committees, with the Chairman of

68 the House Public Health and Welfare Committee serving as the first
69 chairman.
70 (e) The members of the committee specified in paragraph
71 (b) shall serve for terms that are concurrent with the terms of
72 members of the Legislature, and any member appointed under
73 paragraph (b) may be reappointed to the committee. The members of
74 the committee specified in paragraph (b) shall serve without
75 compensation, but expenses to defray actual expenses incurred in
76 the performance of travel, lodging and subsistence may be
77 authorized.
78 (f) The committee shall meet not less than quarterly,
79 and committee members shall be furnished written notice of the
80 meetings at least ten (10) days before the date of the meeting.
81 (g) The Executive Director of the Division of Medicaid
82 shall submit to the committee all amendments, modifications and
83 changes to the state plan for the operation of the Medicaid
84 program, for review by the committee before the amendments,
85 modifications or changes may be implemented by the division.
86 (h) The committee, among its duties and
87 responsibilities, shall:
88 (i) Advise the division with respect to
89 amendments, modifications and changes to the state plan for the
90 operation of the Medicaid program;
91 (ii) Advise the division with respect to issues
92 concerning receipt and disbursement of funds and eligibility for
93 medical assistance;
94 (iii) Advise the division with respect to
95 determining the quantity, quality and extent of medical care
96 provided under this article;
97 (iv) Communicate the views of the medical care
98 professions to the division and communicate the views of the
99 division to the medical care professions;
100 (v) Gather information on reasons that medical
101 care providers do not participate in the Medicaid program and

102 changes that could be made in the program to encourage more
103 providers to participate in the Medicaid program, and advise the
104 division with respect to encouraging physicians and other medical
105 care providers to participate in the Medicaid program;
106 (vi) Provide a written report on or before
107 November 30 of each year to the Governor, Lieutenant Governor and
108 Speaker of the House of Representatives.
109 SECTION 2. Section 43-13-117, Mississippi Code of 1972, is
110 amended as follows:
111 43-13-117. Medical assistance as authorized by this article
112 shall include payment of part or all of the costs, at the
113 discretion of the division or its successor, with approval of the
114 Governor, of the following types of care and services rendered to
115 eligible applicants who shall have been determined to be eligible
116 for such care and services, within the limits of state
117 appropriations and federal matching funds:
118 (1) Inpatient hospital services.
119 (a) The division shall allow thirty (30) days of
120 inpatient hospital care annually for all Medicaid recipients;
121 however, before any recipient will be allowed more than fifteen
122 (15) days of inpatient hospital care in any one (1) year, he must
123 obtain prior approval therefor from the division. The division
124 shall be authorized to allow unlimited days in disproportionate
125 hospitals as defined by the division for eligible infants under
126 the age of six (6) years.
127 (b) From and after July 1, 1994, the Executive Director
128 of the Division of Medicaid shall amend the Mississippi Title XIX
129 Inpatient Hospital Reimbursement Plan to remove the occupancy rate
130 penalty from the calculation of the Medicaid Capital Cost
131 Component utilized to determine total hospital costs allocated to
132 the Medicaid Program.
133 (2) Outpatient hospital services. Provided that where the
134 same services are reimbursed as clinic services, the division may
135 revise the rate or methodology of outpatient reimbursement to

136 maintain consistency, efficiency, economy and quality of care.

137 (3) Laboratory and x-ray services.

138 (4) Nursing facility services.

139 (a) The division shall make full payment to nursing
140 facilities for each day, not exceeding thirty-six (36) days per
141 year, that a patient is absent from the facility on home leave.
142 However, before payment may be made for more than eighteen (18)
143 home leave days in a year for a patient, the patient must have
144 written authorization from a physician stating that the patient is
145 physically and mentally able to be away from the facility on home
146 leave. Such authorization must be filed with the division before
147 it will be effective and the authorization shall be effective for
148 three (3) months from the date it is received by the division,
149 unless it is revoked earlier by the physician because of a change
150 in the condition of the patient.

151 (b) Repealed.

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

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

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

163 (A) Matters relating to cost reports
164 including, but not limited to, allowable costs and cost
165 adjustments resulting from desk reviews and audits.

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

169 (ii) The Review Board shall be composed of six (6)

170 members, three (3) having expertise in one (1) of the two (2)
171 areas set forth above and three (3) having expertise in the other
172 area set forth above. Each panel of three (3) shall only review
173 appeals arising in its area of expertise. The members shall be
174 appointed as follows:
175 (A) In each of the areas of expertise defined
176 under subparagraphs (i)(A) and (i)(B), the Executive Director of
177 the Division of Medicaid shall appoint one (1) person chosen from
178 the private sector nursing home industry in the state, which may
179 include independent accountants and consultants serving the
180 industry;
181 (B) In each of the areas of expertise defined
182 under subparagraphs (i)(A) and (i)(B), the Executive Director of
183 the Division of Medicaid shall appoint one (1) person who is
184 employed by the state who does not participate directly in desk
185 reviews or audits of nursing facilities in the two (2) areas of
186 review;
187 (C) The two (2) members appointed by the
188 Executive Director of the Division of Medicaid in each area of
189 expertise shall appoint a third member in the same area of
190 expertise.
191 In the event of a conflict of interest on the part of any
192 Review Board members, the Executive Director of the Division of
193 Medicaid or the other two (2) panel members, as applicable, shall
194 appoint a substitute member for conducting a specific review.
195 (iii) The Review Board panels shall have the power
196 to preserve and enforce order during hearings; to issue subpoenas;
197 to administer oaths; to compel attendance and testimony of
198 witnesses; or to compel the production of books, papers, documents
199 and other evidence; or the taking of depositions before any
200 designated individual competent to administer oaths; to examine
201 witnesses; and to do all things conformable to law that may be
202 necessary to enable it effectively to discharge its duties. The
203 Review Board panels may appoint such person or persons as they

204 shall deem proper to execute and return process in connection
205 therewith.
206 (iv) The Review Board shall promulgate, publish
207 and disseminate to nursing facility providers rules of procedure
208 for the efficient conduct of proceedings, subject to the approval
209 of the Executive Director of the Division of Medicaid and in
210 accordance with federal and state administrative hearing laws and
211 regulations.
212 (v) Proceedings of the Review Board shall be of
213 record.
214 (vi) Appeals to the Review Board shall be in
215 writing and shall set out the issues, a statement of alleged facts
216 and reasons supporting the provider's position. Relevant
217 documents may also be attached. The appeal shall be filed within
218 thirty (30) days from the date the provider is notified of the
219 action being appealed or, if informal review procedures are taken,
220 as provided by administrative regulations of the Division of
221 Medicaid, within thirty (30) days after a decision has been
222 rendered through informal hearing procedures.
223 (vii) The provider shall be notified of the
224 hearing date by certified mail within thirty (30) days from the
225 date the Division of Medicaid receives the request for appeal.
226 Notification of the hearing date shall in no event be less than
227 thirty (30) days before the scheduled hearing date. The appeal
228 may be heard on shorter notice by written agreement between the
229 provider and the Division of Medicaid.
230 (viii) Within thirty (30) days from the date of
231 the hearing, the Review Board panel shall render a written
232 recommendation to the Executive Director of the Division of
233 Medicaid setting forth the issues, findings of fact and applicable
234 law, regulations or provisions.
235 (ix) The Executive Director of the Division of
236 Medicaid shall, upon review of the recommendation, the proceedings
237 and the record, prepare a written decision which shall be mailed

238 to the nursing facility provider no later than twenty (20) days
239 after the submission of the recommendation by the panel. The
240 decision of the executive director is final, subject only to
241 judicial review.

242 (x) Appeals from a final decision shall be made to
243 the Chancery Court of Hinds County. The appeal shall be filed
244 with the court within thirty (30) days from the date the decision
245 of the Executive Director of the Division of Medicaid becomes
246 final.

247 (xi) The action of the Division of Medicaid under
248 review shall be stayed until all administrative proceedings have
249 been exhausted.

250 (xii) Appeals by nursing facility providers
251 involving any issues other than those two (2) specified in
252 subparagraphs (i)(A) and (ii)(B) shall be taken in accordance with
253 the administrative hearing procedures established by the Division
254 of Medicaid.

255 (e) When a facility of a category that does not require
256 a certificate of need for construction and that could not be
257 eligible for Medicaid reimbursement is constructed to nursing
258 facility specifications for licensure and certification, and the
259 facility is subsequently converted to a nursing facility pursuant
260 to a certificate of need that authorizes conversion only and the
261 applicant for the certificate of need was assessed an application
262 review fee based on capital expenditures incurred in constructing
263 the facility, the division shall allow reimbursement for capital
264 expenditures necessary for construction of the facility that were
265 incurred within the twenty-four (24) consecutive calendar months
266 immediately preceding the date that the certificate of need
267 authorizing such conversion was issued, to the same extent that
268 reimbursement would be allowed for construction of a new nursing
269 facility pursuant to a certificate of need that authorizes such
270 construction. The reimbursement authorized in this subparagraph
271 (e) may be made only to facilities the construction of which was

272 completed after June 30, 1989. Before the division shall be
273 authorized to make the reimbursement authorized in this
274 subparagraph (e), the division first must have received approval
275 from the Health Care Financing Administration of the United States
276 Department of Health and Human Services of the change in the state
277 Medicaid plan providing for such reimbursement.

278 (5) Periodic screening and diagnostic services for
279 individuals under age twenty-one (21) years as are needed to
280 identify physical and mental defects and to provide health care
281 treatment and other measures designed to correct or ameliorate
282 defects and physical and mental illness and conditions discovered
283 by the screening services regardless of whether these services are
284 included in the state plan. The division may include in its
285 periodic screening and diagnostic program those discretionary
286 services authorized under the federal regulations adopted to
287 implement Title XIX of the federal Social Security Act, as
288 amended. The division, in obtaining physical therapy services,
289 occupational therapy services, and services for individuals with
290 speech, hearing and language disorders, may enter into a
291 cooperative agreement with the State Department of Education for
292 the provision of such services to handicapped students by public
293 school districts using state funds which are provided from the
294 appropriation to the Department of Education to obtain federal
295 matching funds through the division. The division, in obtaining
296 medical and psychological evaluations for children in the custody
297 of the State Department of Human Services may enter into a
298 cooperative agreement with the State Department of Human Services
299 for the provision of such services using state funds which are
300 provided from the appropriation to the Department of Human
301 Services to obtain federal matching funds through the division.

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

306 (6) Physician's services. * * * All fees for
307 physicians' services that are covered only by Medicaid shall be
308 reimbursed at ninety percent (90%) of the rate established on
309 January 1, 1999, and as adjusted each January thereafter, under
310 Medicare (Title XVIII of the Social Security Act), as amended, and
311 which shall in no event be less than seventy percent (70%) of the
312 rate established on January 1, 1994. All fees for physicians'
313 services that are covered by both Medicare and Medicaid shall be
314 reimbursed at ten percent (10%) of the adjusted Medicare payment
315 established on January 1, 1999, and as adjusted each January
316 thereafter, under Medicare (Title XVIII of the Social Security
317 Act), as amended, and which shall in no event be less than seven
318 percent (7%) of the adjusted Medicare payment established on
319 January 1, 1994.
320 (7) (a) Home health services for eligible persons, not to
321 exceed in cost the prevailing cost of nursing facility services,
322 not to exceed sixty (60) visits per year.
323 (b) Repealed.
324 (8) Emergency medical transportation services. On January
325 1, 1994, emergency medical transportation services shall be
326 reimbursed at seventy percent (70%) of the rate established under
327 Medicare (Title XVIII of the Social Security Act), as amended.
328 "Emergency medical transportation services" shall mean, but shall
329 not be limited to, the following services by a properly permitted
330 ambulance operated by a properly licensed provider in accordance
331 with the Emergency Medical Services Act of 1974 (Section 41-59-1
332 et seq.): (i) basic life support, (ii) advanced life support,
333 (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi)
334 disposable supplies, (vii) similar services.
335 (9) Legend and other drugs as may be determined by the
336 division. The division may implement a program of prior approval
337 for drugs to the extent permitted by law. Payment by the division
338 for covered multiple source drugs shall be limited to the lower of
339 the upper limits established and published by the Health Care

340 Financing Administration (HCFA) plus a dispensing fee of Four
341 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
342 cost (EAC) as determined by the division plus a dispensing fee of
343 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual
344 and customary charge to the general public. The division shall
345 allow five (5) prescriptions per month for noninstitutionalized
346 Medicaid recipients.
347 Payment for other covered drugs, other than multiple source
348 drugs with HCFA upper limits, shall not exceed the lower of the
349 estimated acquisition cost as determined by the division plus a
350 dispensing fee of Four Dollars and Ninety-one Cents ($4.91) or the
351 providers' usual and customary charge to the general public.
352 Payment for nonlegend or over-the-counter drugs covered on
353 the division's formulary shall be reimbursed at the lower of the
354 division's estimated shelf price or the providers' usual and
355 customary charge to the general public. No dispensing fee shall
356 be paid.
357 The division shall develop and implement a program of payment
358 for additional pharmacist services, with payment to be based on
359 demonstrated savings, but in no case shall the total payment
360 exceed twice the amount of the dispensing fee.
361 As used in this paragraph (9), "estimated acquisition cost"
362 means the division's best estimate of what price providers
363 generally are paying for a drug in the package size that providers
364 buy most frequently. Product selection shall be made in
365 compliance with existing state law; however, the division may
366 reimburse as if the prescription had been filled under the generic
367 name. The division may provide otherwise in the case of specified
368 drugs when the consensus of competent medical advice is that
369 trademarked drugs are substantially more effective.
370 (10) Dental care that is an adjunct to treatment of an acute
371 medical or surgical condition; services of oral surgeons and
372 dentists in connection with surgery related to the jaw or any
373 structure contiguous to the jaw or the reduction of any fracture

374 of the jaw or any facial bone; and emergency dental extractions
375 and treatment related thereto. On January 1, 1994, all fees for
376 dental care and surgery under authority of this paragraph (10)
377 shall be increased by twenty percent (20%) of the reimbursement
378 rate as provided in the Dental Services Provider Manual in effect
379 on December 31, 1993.

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

383 (12) Intermediate care facility services.

384 (a) The division shall make full payment to all
385 intermediate care facilities for the mentally retarded for each
386 day, not exceeding thirty-six (36) days per year, that a patient
387 is absent from the facility on home leave. However, before
388 payment may be made for more than eighteen (18) home leave days in
389 a year for a patient, the patient must have written authorization
390 from a physician stating that the patient is physically and
391 mentally able to be away from the facility on home leave. Such
392 authorization must be filed with the division before it will be
393 effective, and the authorization shall be effective for three (3)
394 months from the date it is received by the division, unless it is
395 revoked earlier by the physician because of a change in the
396 condition of the patient.

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

400 (13) Family planning services, including drugs, supplies and
401 devices, when such services are under the supervision of a
402 physician.

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

408 Clinic services shall include any services reimbursed as
409 outpatient hospital services which may be rendered in such a
410 facility, including those that become so after July 1, 1991. On
411 January 1, 1994, all fees for physicians' services reimbursed
412 under authority of this paragraph (14) shall be reimbursed at
413 seventy percent (70%) of the rate established on January 1, 1993,
414 under Medicare (Title XVIII of the Social Security Act), as
415 amended, or the amount that would have been paid under the
416 division's fee schedule that was in effect on December 31, 1993,
417 whichever is greater, and the division may adjust the physicians'
418 reimbursement schedule to reflect the differences in relative
419 value between Medicaid and Medicare. However, on January 1, 1994,
420 the division may increase any fee for physicians' services in the
421 division's fee schedule on December 31, 1993, that was greater
422 than seventy percent (70%) of the rate established under Medicare
423 by no more than ten percent (10%). On January 1, 1994, all fees
424 for dentists' services reimbursed under authority of this
425 paragraph (14) shall be increased by twenty percent (20%) of the
426 reimbursement rate as provided in the Dental Services Provider
427 Manual in effect on December 31, 1993.
428 (15) Home- and community-based services, as provided under
429 Title XIX of the federal Social Security Act, as amended, under
430 waivers, subject to the availability of funds specifically
431 appropriated therefor by the Legislature. Payment for such
432 services shall be limited to individuals who would be eligible for
433 and would otherwise require the level of care provided in a
434 nursing facility. The division shall certify case management
435 agencies to provide case management services and provide for home-
436 and community-based services for eligible individuals under this
437 paragraph. The home- and community-based services under this
438 paragraph and the activities performed by certified case
439 management agencies under this paragraph shall be funded using
440 state funds that are provided from the appropriation to the
441 Division of Medicaid and used to match federal funds under a

442 cooperative agreement between the division and the Department of
443 Human Services.
444 (16) Mental health services. Approved therapeutic and case
445 management services provided by (a) an approved regional mental
446 health/retardation center established under Sections 41-19-31
447 through 41-19-39, or by another community mental health service
448 provider meeting the requirements of the Department of Mental
449 Health to be an approved mental health/retardation center if
450 determined necessary by the Department of Mental Health, using
451 state funds which are provided from the appropriation to the State
452 Department of Mental Health and used to match federal funds under
453 a cooperative agreement between the division and the department,
454 or (b) a facility which is certified by the State Department of
455 Mental Health to provide therapeutic and case management services,
456 to be reimbursed on a fee for service basis. Any such services
457 provided by a facility described in paragraph (b) must have the
458 prior approval of the division to be reimbursable under this
459 section. After June 30, 1997, mental health services provided by
460 regional mental health/retardation centers established under
461 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
462 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
463 psychiatric residential treatment facilities as defined in Section
464 43-11-1, or by another community mental health service provider
465 meeting the requirements of the Department of Mental Health to be
466 an approved mental health/retardation center if determined
467 necessary by the Department of Mental Health, shall not be
468 included in or provided under any capitated managed care pilot
469 program provided for under paragraph (24) of this section.
470 (17) Durable medical equipment services and medical supplies
471 restricted to patients receiving home health services unless
472 waived on an individual basis by the division. The division shall
473 not expend more than Three Hundred Thousand Dollars ($300,000.00)
474 of state funds annually to pay for medical supplies authorized
475 under this paragraph.

476 (18) Notwithstanding any other provision of this section to
477 the contrary, the division shall make additional reimbursement to
478 hospitals which serve a disproportionate share of low-income
479 patients and which meet the federal requirements for such payments
480 as provided in Section 1923 of the federal Social Security Act and
481 any applicable regulations.
482 (19) (a) Perinatal risk management services. The division
483 shall promulgate regulations to be effective from and after
484 October 1, 1988, to establish a comprehensive perinatal system for
485 risk assessment of all pregnant and infant Medicaid recipients and
486 for management, education and follow-up for those who are
487 determined to be at risk. Services to be performed include case
488 management, nutrition assessment/counseling, psychosocial
489 assessment/counseling and health education. The division shall
490 set reimbursement rates for providers in conjunction with the
491 State Department of Health.
492 (b) Early intervention system services. The division
493 shall cooperate with the State Department of Health, acting as
494 lead agency, in the development and implementation of a statewide
495 system of delivery of early intervention services, pursuant to
496 Part H of the Individuals with Disabilities Education Act (IDEA).
497 The State Department of Health shall certify annually in writing
498 to the director of the division the dollar amount of state early
499 intervention funds available which shall be utilized as a
500 certified match for Medicaid matching funds. Those funds then
501 shall be used to provide expanded targeted case management
502 services for Medicaid eligible children with special needs who are
503 eligible for the state's early intervention system.
504 Qualifications for persons providing service coordination shall be
505 determined by the State Department of Health and the Division of
506 Medicaid.
507 (20) Home- and community-based services for physically
508 disabled approved services as allowed by a waiver from the U.S.
509 Department of Health and Human Services for home- and

510 community-based services for physically disabled people using
511 state funds which are provided from the appropriation to the State
512 Department of Rehabilitation Services and used to match federal
513 funds under a cooperative agreement between the division and the
514 department, provided that funds for these services are
515 specifically appropriated to the Department of Rehabilitation
516 Services.
517 (21) Nurse practitioner services. Services furnished by a
518 registered nurse who is licensed and certified by the Mississippi
519 Board of Nursing as a nurse practitioner including, but not
520 limited to, nurse anesthetists, nurse midwives, family nurse
521 practitioners, family planning nurse practitioners, pediatric
522 nurse practitioners, obstetrics-gynecology nurse practitioners and
523 neonatal nurse practitioners, under regulations adopted by the
524 division. Reimbursement for such services shall not exceed ninety
525 percent (90%) of the reimbursement rate for comparable services
526 rendered by a physician.
527 (22) Ambulatory services delivered in federally qualified
528 health centers and in clinics of the local health departments of
529 the State Department of Health for individuals eligible for
530 medical assistance under this article based on reasonable costs as
531 determined by the division.
532 (23) Inpatient psychiatric services. Inpatient psychiatric
533 services to be determined by the division for recipients under age
534 twenty-one (21) which are provided under the direction of a
535 physician in an inpatient program in a licensed acute care
536 psychiatric facility or in a licensed psychiatric residential
537 treatment facility, before the recipient reaches age twenty-one
538 (21) or, if the recipient was receiving the services immediately
539 before he reached age twenty-one (21), before the earlier of the
540 date he no longer requires the services or the date he reaches age
541 twenty-two (22), as provided by federal regulations. Recipients
542 shall be allowed forty-five (45) days per year of psychiatric
543 services provided in acute care psychiatric facilities, and shall

544 be allowed unlimited days of psychiatric services provided in
545 licensed psychiatric residential treatment facilities.
546 (24) Managed care services in a program to be developed by
547 the division by a public or private provider. Notwithstanding any
548 other provision in this article to the contrary, the division
549 shall establish rates of reimbursement to providers rendering care
550 and services authorized under this section, and may revise such
551 rates of reimbursement without amendment to this section by the
552 Legislature for the purpose of achieving effective and accessible
553 health services, and for responsible containment of costs. *** * * ***
554 (25) Birthing center services.
555 (26) Hospice care. As used in this paragraph, the term
556 "hospice care" means a coordinated program of active professional
557 medical attention within the home and outpatient and inpatient
558 care which treats the terminally ill patient and family as a unit,
559 employing a medically directed interdisciplinary team. The
560 program provides relief of severe pain or other physical symptoms
561 and supportive care to meet the special needs arising out of
562 physical, psychological, spiritual, social and economic stresses
563 which are experienced during the final stages of illness and
564 during dying and bereavement and meets the Medicare requirements
565 for participation as a hospice as provided in 42 CFR Part 418.
566 (27) Group health plan premiums and cost sharing if it is
567 cost effective as defined by the Secretary of Health and Human
568 Services.
569 (28) Other health insurance premiums which are cost
570 effective as defined by the Secretary of Health and Human
571 Services. Medicare eligible must have Medicare Part B before
572 other insurance premiums can be paid.
573 (29) The Division of Medicaid may apply for a waiver from
574 the Department of Health and Human Services for home- and
575 community-based services for developmentally disabled people using
576 state funds which are provided from the appropriation to the State
577 Department of Mental Health and used to match federal funds under

578 a cooperative agreement between the division and the department,
579 provided that funds for these services are specifically
580 appropriated to the Department of Mental Health.
581 (30) Pediatric skilled nursing services for eligible persons
582 under twenty-one (21) years of age.
583 (31) Targeted case management services for children with
584 special needs, under waivers from the U.S. Department of Health
585 and Human Services, using state funds that are provided from the
586 appropriation to the Mississippi Department of Human Services and
587 used to match federal funds under a cooperative agreement between
588 the division and the department.
589 (32) Care and services provided in Christian Science
590 Sanatoria operated by or listed and certified by The First Church
591 of Christ Scientist, Boston, Massachusetts, rendered in connection
592 with treatment by prayer or spiritual means to the extent that
593 such services are subject to reimbursement under Section 1903 of
594 the Social Security Act.
595 (33) Podiatrist services.
596 (34) Personal care services provided in a pilot program to
597 not more than forty (40) residents at a location or locations to
598 be determined by the division and delivered by individuals
599 qualified to provide such services, as allowed by waivers under
600 Title XIX of the Social Security Act, as amended. The division
601 shall not expend more than Three Hundred Thousand Dollars
602 ($300,000.00) annually to provide such personal care services.
603 The division shall develop recommendations for the effective
604 regulation of any facilities that would provide personal care
605 services which may become eligible for Medicaid reimbursement
606 under this section, and shall present such recommendations with
607 any proposed legislation to the 1996 Regular Session of the
608 Legislature on or before January 1, 1996.
609 (35) Services and activities authorized in Sections
610 43-27-101 and 43-27-103, using state funds that are provided from
611 the appropriation to the State Department of Human Services and

612 used to match federal funds under a cooperative agreement between
613 the division and the department.
614 (36) Nonemergency transportation services for
615 Medicaid-eligible persons, to be provided by the Department of
616 Human Services. The division may contract with additional
617 entities to administer nonemergency transportation services as it
618 deems necessary. All providers shall have a valid driver's
619 license, vehicle inspection sticker and a standard liability
620 insurance policy covering the vehicle.
621 (37) Targeted case management services for individuals with
622 chronic diseases, with expanded eligibility to cover services to
623 uninsured recipients, on a pilot program basis. This paragraph
624 (37) shall be contingent upon continued receipt of special funds
625 from the Health Care Financing Authority and private foundations
626 who have granted funds for planning these services. No funding
627 for these services shall be provided from State General Funds.
628 (38) Chiropractic services: a chiropractor's manual
629 manipulation of the spine to correct a subluxation, if x-ray
630 demonstrates that a subluxation exists and if the subluxation has
631 resulted in a neuromusculoskeletal condition for which
632 manipulation is appropriate treatment. Reimbursement for
633 chiropractic services shall not exceed Seven Hundred Dollars
634 ($700.00) per year per recipient.
635 Notwithstanding any provision of this article, except as
636 authorized in the following paragraph and in Section 43-13-139,
637 neither (a) the limitations on quantity or frequency of use of or
638 the fees or charges for any of the care or services available to
639 recipients under this section, nor (b) the payments or rates of
640 reimbursement to providers rendering care or services authorized
641 under this section to recipients, may be increased, decreased or
642 otherwise changed from the levels in effect on July 1, 1986,
643 unless such is authorized by an amendment to this section by the
644 Legislature. However, the restriction in this paragraph shall not
645 prevent the division from changing the payments or rates of

646 reimbursement to providers without an amendment to this section
647 whenever such changes are required by federal law or regulation,
648 or whenever such changes are necessary to correct administrative
649 errors or omissions in calculating such payments or rates of
650 reimbursement.

651 Notwithstanding any provision of this article, no new groups
652 or categories of recipients and new types of care and services may
653 be added without enabling legislation from the Mississippi
654 Legislature, except that the division may authorize such changes
655 without enabling legislation when such addition of recipients or
656 services is ordered by a court of proper authority. The director
657 shall keep the Governor advised on a timely basis of the funds
658 available for expenditure and the projected expenditures. In the
659 event current or projected expenditures can be reasonably
660 anticipated to exceed the amounts appropriated for any fiscal
661 year, the Governor, after consultation with the director, shall
662 discontinue any or all of the payment of the types of care and
663 services as provided herein which are deemed to be optional
664 services under Title XIX of the federal Social Security Act, as
665 amended, for any period necessary to not exceed appropriated
666 funds, and when necessary shall institute any other cost
667 containment measures on any program or programs authorized under
668 the article to the extent allowed under the federal law governing
669 such program or programs, it being the intent of the Legislature
670 that expenditures during any fiscal year shall not exceed the
671 amounts appropriated for such fiscal year.

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