MISSISSIPPI LEGISLATURE REGULAR SESSION 1999

By: Senator(s) Dearing To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2249

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO REQUIRE THE DIVISION OF MEDICAID TO DEVELOP AND IMPLEMENT A
3 REIMBURSEMENT PROGRAM FOR SPECIAL EDUCATION HEALTH RELATED
4 SERVICES; TO PLACE RESTRICTIONS ON PRIOR APPROVAL; TO PROHIBIT
5 PARTICIPATION IN SUCH SPECIAL EDUCATION HEALTH SERVICES BY
6 CAPITATED MANAGED CARE PROGRAMS; AND FOR RELATED PURPOSES.

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

8 SECTION 1. Section 43-13-117, Mississippi Code of 1972, is
9 amended as follows:

10 43-13-117. Medical assistance as authorized by this article
11 shall include payment of part or all of the costs, at the
12 discretion of the division or its successor, with approval of the
13 Governor, of the following types of care and services rendered to
14 eligible applicants who shall have been determined to be eligible
15 for such care and services, within the limits of state
16 appropriations and federal matching funds:

17 (1) Inpatient hospital services.

18 (a) The division shall allow thirty (30) days of
19 inpatient hospital care annually for all Medicaid recipients;
20 however, before any recipient will be allowed more than fifteen
21 (15) days of inpatient hospital care in any one (1) year, he must
22 obtain prior approval therefor from the division. The division
23 shall be authorized to allow unlimited days in disproportionate
24 hospitals as defined by the division for eligible infants under
25 the age of six (6) years.

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

30 Component utilized to determine total hospital costs allocated to
31 the Medicaid Program.
32 (2) Outpatient hospital services. Provided that where the
33 same services are reimbursed as clinic services, the division may
34 revise the rate or methodology of outpatient reimbursement to
35 maintain consistency, efficiency, economy and quality of care.
36 (3) Laboratory and X-ray services.
37 (4) Nursing facility services.
38 (a) The division shall make full payment to nursing
39 facilities for each day, not exceeding thirty-six (36) days per
40 year, that a patient is absent from the facility on home leave.
41 However, before payment may be made for more than eighteen (18)
42 home leave days in a year for a patient, the patient must have
43 written authorization from a physician stating that the patient is
44 physically and mentally able to be away from the facility on home
45 leave. Such authorization must be filed with the division before
46 it will be effective and the authorization shall be effective for
47 three (3) months from the date it is received by the division,
48 unless it is revoked earlier by the physician because of a change
49 in the condition of the patient.
50 (b) From and after July 1, 1993, the division shall
51 implement the integrated case-mix payment and quality monitoring
52 system developed pursuant to Section 43-13-122, which includes the
53 fair rental system for property costs and in which recapture of
54 depreciation is eliminated. The division may revise the
55 reimbursement methodology for the case-mix payment system by
56 reducing payment for hospital leave and therapeutic home leave
57 days to the lowest case-mix category for nursing facilities,
58 modifying the current method of scoring residents so that only
59 services provided at the nursing facility are considered in
60 calculating a facility's per diem, and the division may limit
61 administrative and operating costs, but in no case shall these
62 costs be less than one hundred nine percent (109%) of the median
63 administrative and operating costs for each class of facility, not
64 to exceed the median used to calculate the nursing facility
65 reimbursement for Fiscal Year 1996, to be applied uniformly to all
66 long-term care facilities. This paragraph (b) shall stand
67 repealed on July 1, 1997.

68 (c) From and after July 1, 1997, all state-owned
69 nursing facilities shall be reimbursed on a full reasonable costs
70 basis. From and after July 1, 1997, payments by the division to
71 nursing facilities for return on equity capital shall be made at
72 the rate paid under Medicare (Title XVIII of the Social Security
73 Act), but shall be no less than seven and one-half percent (7.5%)
74 nor greater than ten percent (10%).
75 (d) A Review Board for nursing facilities is
76 established to conduct reviews of the Division of Medicaid's
77 decision in the areas set forth below:
78 (i) Review shall be heard in the following areas:
79 (A) Matters relating to cost reports
80 including, but not limited to, allowable costs and cost
81 adjustments resulting from desk reviews and audits.
82 (B) Matters relating to the Minimum Data Set
83 Plus (MDS +) or successor assessment formats including, but not
84 limited to, audits, classifications and submissions.
85 (ii) The Review Board shall be composed of six (6)
86 members, three (3) having expertise in one (1) of the two (2)
87 areas set forth above and three (3) having expertise in the other
88 area set forth above. Each panel of three (3) shall only review
89 appeals arising in its area of expertise. The members shall be
90 appointed as follows:
91 (A) In each of the areas of expertise defined
92 under subparagraphs (i)(A) and (i)(B), the Executive Director of
93 the Division of Medicaid shall appoint one (1) person chosen from
94 the private sector nursing home industry in the state, which may
95 include independent accountants and consultants serving the
96 industry;
97 (B) In each of the areas of expertise defined
98 under subparagraphs (i)(A) and (i)(B), the Executive Director of
99 the Division of Medicaid shall appoint one (1) person who is
100 employed by the state who does not participate directly in desk
101 reviews or audits of nursing facilities in the two (2) areas of

102 review;

103 (C) The two (2) members appointed by the

104 Executive Director of the Division of Medicaid in each area of

105 expertise shall appoint a third member in the same area of

106 expertise.

107 In the event of a conflict of interest on the part of any

108 Review Board members, the Executive Director of the Division of

109 Medicaid or the other two (2) panel members, as applicable, shall

110 appoint a substitute member for conducting a specific review.

111 (iii) The Review Board panels shall have the power

112 to preserve and enforce order during hearings; to issue subpoenas;

113 to administer oaths; to compel attendance and testimony of

114 witnesses; or to compel the production of books, papers, documents

115 and other evidence; or the taking of depositions before any

116 designated individual competent to administer oaths; to examine

117 witnesses; and to do all things conformable to law that may be

118 necessary to enable it effectively to discharge its duties. The

119 Review Board panels may appoint such person or persons as they

120 shall deem proper to execute and return process in connection

121 therewith.

122 (iv) The Review Board shall promulgate, publish

123 and disseminate to nursing facility providers rules of procedure

124 for the efficient conduct of proceedings, subject to the approval

125 of the Executive Director of the Division of Medicaid and in

126 accordance with federal and state administrative hearing laws and

127 regulations.

128 (v) Proceedings of the Review Board shall be of

129 record.

130 (vi) Appeals to the Review Board shall be in

131 writing and shall set out the issues, a statement of alleged facts

132 and reasons supporting the provider's position. Relevant

133 documents may also be attached. The appeal shall be filed within

134 thirty (30) days from the date the provider is notified of the

135 action being appealed or, if informal review procedures are taken,

136 as provided by administrative regulations of the Division of
137 Medicaid, within thirty (30) days after a decision has been
138 rendered through informal hearing procedures.
139 (vii) The provider shall be notified of the
140 hearing date by certified mail within thirty (30) days from the
141 date the Division of Medicaid receives the request for appeal.
142 Notification of the hearing date shall in no event be less than
143 thirty (30) days before the scheduled hearing date. The appeal
144 may be heard on shorter notice by written agreement between the
145 provider and the Division of Medicaid.
146 (viii) Within thirty (30) days from the date of
147 the hearing, the Review Board panel shall render a written
148 recommendation to the Executive Director of the Division of
149 Medicaid setting forth the issues, findings of fact and applicable
150 law, regulations or provisions.
151 (ix) The Executive Director of the Division of
152 Medicaid shall, upon review of the recommendation, the proceedings
153 and the record, prepare a written decision which shall be mailed
154 to the nursing facility provider no later than twenty (20) days
155 after the submission of the recommendation by the panel. The
156 decision of the executive director is final, subject only to
157 judicial review.
158 (x) Appeals from a final decision shall be made to
159 the Chancery Court of Hinds County. The appeal shall be filed
160 with the court within thirty (30) days from the date the decision
161 of the Executive Director of the Division of Medicaid becomes
162 final.
163 (xi) The action of the Division of Medicaid under
164 review shall be stayed until all administrative proceedings have
165 been exhausted.
166 (xii) Appeals by nursing facility providers
167 involving any issues other than those two (2) specified in
168 subparagraphs (i)(A) and (ii)(B) shall be taken in accordance with
169 the administrative hearing procedures established by the Division

170 of Medicaid.
171 (e) When a facility of a category that does not require
172 a certificate of need for construction and that could not be
173 eligible for Medicaid reimbursement is constructed to nursing
174 facility specifications for licensure and certification, and the
175 facility is subsequently converted to a nursing facility pursuant
176 to a certificate of need that authorizes conversion only and the
177 applicant for the certificate of need was assessed an application
178 review fee based on capital expenditures incurred in constructing
179 the facility, the division shall allow reimbursement for capital
180 expenditures necessary for construction of the facility that were
181 incurred within the twenty-four (24) consecutive calendar months
182 immediately preceding the date that the certificate of need
183 authorizing such conversion was issued, to the same extent that
184 reimbursement would be allowed for construction of a new nursing
185 facility pursuant to a certificate of need that authorizes such
186 construction. The reimbursement authorized in this subparagraph
187 (e) may be made only to facilities the construction of which was
188 completed after June 30, 1989. Before the division shall be
189 authorized to make the reimbursement authorized in this
190 subparagraph (e), the division first must have received approval
191 from the Health Care Financing Administration of the United States
192 Department of Health and Human Services of the change in the state
193 Medicaid plan providing for such reimbursement.
194 (5) Periodic screening and diagnostic services for
195 individuals under age twenty-one (21) years as are needed to
196 identify physical and mental defects and to provide health care
197 treatment and other measures designed to correct or ameliorate
198 defects and physical and mental illness and conditions discovered
199 by the screening services regardless of whether these services are
200 included in the state plan. The division may include in its
201 periodic screening and diagnostic program those discretionary
202 services authorized under the federal regulations adopted to
203 implement Title XIX of the federal Social Security Act, as

204 amended. The division, in obtaining physical therapy services,
205 occupational therapy services, and services for individuals with
206 speech, hearing and language disorders, may enter into a
207 cooperative agreement with the State Department of Education for
208 the provision of such services to handicapped students by public
209 school districts using state funds which are provided from the
210 appropriation to the Department of Education to obtain federal
211 matching funds through the division. The division, in obtaining
212 medical and psychological evaluations for children in the custody
213 of the State Department of Human Services may enter into a
214 cooperative agreement with the State Department of Human Services
215 for the provision of such services using state funds which are
216 provided from the appropriation to the Department of Human
217 Services to obtain federal matching funds through the division.
218 On July 1, 1993, all fees for periodic screening and
219 diagnostic services under this paragraph (5) shall be increased by
220 twenty-five percent (25%) of the reimbursement rate in effect on
221 June 30, 1993.
222 The Division of Medicaid shall develop and implement an
223 effective Medicaid reimbursement program for special education
224 related services. It is the intent of the Legislature that the
225 Division of Medicaid coordinate the development of policy to
226 ensure that federal funding of health related services provided
227 through special education programs under the Medicaid Act will be
228 maximized and that revenue received will be made available to
229 special education programs at the local district level.
230 The Division of Medicaid shall simplify access and facilitate
231 the development of billing and reimbursement systems. The
232 Division of Medicaid to the greatest extent possible shall:
233 (a) Provide efficient, effective verification of
234 eligibility information for the determination of eligibility of
235 student recipients to the local school districts;
236 (b) Integrate health related documentation requirements
237 with current education processes and documentation to the maximum

238 extent allowable under federal law and eliminate prior approval
239 requirements;
240 (c) Recognize existing licensing, certifications and
241 exemptions for educational professionals for provider
242 certification to the maximum extent allowable under federal law;
243 (d) Require the local school district(s) electing to
244 participate to fund the state financial participation. No new
245 state funding shall be expended.
246 (e) Distribute the federal financial participation
247 funds to the local school districts.
248 (f) Should the federal financial participation funds be
249 limited by block grants or for any other reason the Division of
250 Medicaid shall distribute to local school districts only that
251 portion of the federal financial funds specifically allocated to
252 local school districts by the federal government.
253 (g) Any special education health related services
254 included in the program established by the Division of Medicaid
255 shall not be included in or provided under any capitated managed
256 care program. Services provided under the special education
257 health program shall not require prior approval of the division to
258 be reimbursable under this section.
259 (6) Physicians' services. On January 1, 1996, all fees for
260 physicians' services shall be reimbursed at seventy percent (70%)
261 of the rate established on January 1, 1994, under Medicare (Title
262 XVIII of the Social Security Act), as amended, and the division
263 may adjust the physicians' reimbursement schedule to reflect the
264 differences in relative value between Medicaid and Medicare.
265 (7) (a) Home health services for eligible persons, not to
266 exceed in cost the prevailing cost of nursing facility services,
267 not to exceed sixty (60) visits per year.
268 (b) The division may revise reimbursement for home
269 health services in order to establish equity between reimbursement
270 for home health services and reimbursement for institutional
271 services within the Medicaid program. This paragraph (b) shall

272 stand repealed on July 1, 1997.
273 (8) Emergency medical transportation services. On January
274 1, 1994, emergency medical transportation services shall be
275 reimbursed at seventy percent (70%) of the rate established under
276 Medicare (Title XVIII of the Social Security Act), as amended.
277 "Emergency medical transportation services" shall mean, but shall
278 not be limited to, the following services by a properly permitted
279 ambulance operated by a properly licensed provider in accordance
280 with the Emergency Medical Services Act of 1974 (Section 41-59-1
281 et seq.): (i) basic life support, (ii) advanced life support,
282 (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi)
283 disposable supplies, (vii) similar services.
284 (9) Legend and other drugs as may be determined by the
285 division. The division may implement a program of prior approval
286 for drugs to the extent permitted by law. Payment by the division
287 for covered multiple source drugs shall be limited to the lower of
288 the upper limits established and published by the Health Care
289 Financing Administration (HCFA) plus a dispensing fee of Four
290 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
291 cost (EAC) as determined by the division plus a dispensing fee of
292 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual
293 and customary charge to the general public. The division shall
294 allow five (5) prescriptions per month for noninstitutionalized
295 Medicaid recipients.
296 Payment for other covered drugs, other than multiple source
297 drugs with HCFA upper limits, shall not exceed the lower of the
298 estimated acquisition cost as determined by the division plus a
299 dispensing fee of Four Dollars and Ninety-one Cents ($4.91) or the
300 providers' usual and customary charge to the general public.
301 Payment for nonlegend or over-the-counter drugs covered on
302 the division's formulary shall be reimbursed at the lower of the
303 division's estimated shelf price or the providers' usual and
304 customary charge to the general public. No dispensing fee shall
305 be paid.

306 The division shall develop and implement a program of payment
307 for additional pharmacist services, with payment to be based on
308 demonstrated savings, but in no case shall the total payment
309 exceed twice the amount of the dispensing fee.
310 As used in this paragraph (9), "estimated acquisition cost"
311 means the division's best estimate of what price providers
312 generally are paying for a drug in the package size that providers
313 buy most frequently. Product selection shall be made in
314 compliance with existing state law; however, the division may
315 reimburse as if the prescription had been filled under the generic
316 name. The division may provide otherwise in the case of specified
317 drugs when the consensus of competent medical advice is that
318 trademarked drugs are substantially more effective.
319 (10) Dental care that is an adjunct to treatment of an acute
320 medical or surgical condition; services of oral surgeons and
321 dentists in connection with surgery related to the jaw or any
322 structure contiguous to the jaw or the reduction of any fracture
323 of the jaw or any facial bone; and emergency dental extractions
324 and treatment related thereto. On January 1, 1994, all fees for
325 dental care and surgery under authority of this paragraph (10)
326 shall be increased by twenty percent (20%) of the reimbursement
327 rate as provided in the Dental Services Provider Manual in effect
328 on December 31, 1993.
329 (11) Eyeglasses necessitated by reason of eye surgery, and
330 as prescribed by a physician skilled in diseases of the eye or an
331 optometrist, whichever the patient may select.
332 (12) Intermediate care facility services.
333 (a) The division shall make full payment to all
334 intermediate care facilities for the mentally retarded for each
335 day, not exceeding thirty-six (36) days per year, that a patient
336 is absent from the facility on home leave. However, before
337 payment may be made for more than eighteen (18) home leave days in
338 a year for a patient, the patient must have written authorization
339 from a physician stating that the patient is physically and

340 mentally able to be away from the facility on home leave. Such
341 authorization must be filed with the division before it will be
342 effective, and the authorization shall be effective for three (3)
343 months from the date it is received by the division, unless it is
344 revoked earlier by the physician because of a change in the
345 condition of the patient.
346 (b) All state-owned intermediate care facilities for
347 the mentally retarded shall be reimbursed on a full reasonable
348 cost basis.
349 (13) Family planning services, including drugs, supplies and
350 devices, when such services are under the supervision of a
351 physician.
352 (14) Clinic services. Such diagnostic, preventive,
353 therapeutic, rehabilitative or palliative services furnished to an
354 outpatient by or under the supervision of a physician or dentist
355 in a facility which is not a part of a hospital but which is
356 organized and operated to provide medical care to outpatients.
357 Clinic services shall include any services reimbursed as
358 outpatient hospital services which may be rendered in such a
359 facility, including those that become so after July 1, 1991. On
360 January 1, 1994, all fees for physicians' services reimbursed
361 under authority of this paragraph (14) shall be reimbursed at
362 seventy percent (70%) of the rate established on January 1, 1993,
363 under Medicare (Title XVIII of the Social Security Act), as
364 amended, or the amount that would have been paid under the
365 division's fee schedule that was in effect on December 31, 1993,
366 whichever is greater, and the division may adjust the physicians'
367 reimbursement schedule to reflect the differences in relative
368 value between Medicaid and Medicare. However, on January 1, 1994,
369 the division may increase any fee for physicians' services in the
370 division's fee schedule on December 31, 1993, that was greater
371 than seventy percent (70%) of the rate established under Medicare
372 by no more than ten percent (10%). On January 1, 1994, all fees
373 for dentists' services reimbursed under authority of this

374 paragraph (14) shall be increased by twenty percent (20%) of the
375 reimbursement rate as provided in the Dental Services Provider
376 Manual in effect on December 31, 1993.

377 (15) Home- and community-based services, as provided under
378 Title XIX of the federal Social Security Act, as amended, under
379 waivers, subject to the availability of funds specifically
380 appropriated therefor by the Legislature. Payment for such
381 services shall be limited to individuals who would be eligible for
382 and would otherwise require the level of care provided in a
383 nursing facility. The division shall certify case management
384 agencies to provide case management services and provide for home-
385 and community-based services for eligible individuals under this
386 paragraph. The home- and community-based services under this
387 paragraph and the activities performed by certified case
388 management agencies under this paragraph shall be funded using
389 state funds that are provided from the appropriation to the
390 Division of Medicaid and used to match federal funds under a
391 cooperative agreement between the division and the Department of
392 Human Services.

393 (16) Mental health services. Approved therapeutic and case
394 management services provided by (a) an approved regional mental
395 health/retardation center established under Sections 41-19-31
396 through 41-19-39, or by another community mental health service
397 provider meeting the requirements of the Department of Mental
398 Health to be an approved mental health/retardation center if
399 determined necessary by the Department of Mental Health, using
400 state funds which are provided from the appropriation to the State
401 Department of Mental Health and used to match federal funds under
402 a cooperative agreement between the division and the department,
403 or (b) a facility which is certified by the State Department of
404 Mental Health to provide therapeutic and case management services,
405 to be reimbursed on a fee for service basis. Any such services
406 provided by a facility described in paragraph (b) must have the
407 prior approval of the division to be reimbursable under this

408 section. After June 30, 1997, mental health services provided by
409 regional mental health/retardation centers established under
410 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
411 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
412 psychiatric residential treatment facilities as defined in Section
413 43-11-1, or by another community mental health service provider
414 meeting the requirements of the Department of Mental Health to be
415 an approved mental health/retardation center if determined
416 necessary by the Department of Mental Health, shall not be
417 included in or provided under any capitated managed care pilot
418 program provided for under paragraph (24) of this section.
419 (17) Durable medical equipment services and medical supplies
420 restricted to patients receiving home health services unless
421 waived on an individual basis by the division. The division shall
422 not expend more than Three Hundred Thousand Dollars ($300,000.00)
423 of state funds annually to pay for medical supplies authorized
424 under this paragraph.
425 (18) Notwithstanding any other provision of this section to
426 the contrary, the division shall make additional reimbursement to
427 hospitals which serve a disproportionate share of low-income
428 patients and which meet the federal requirements for such payments
429 as provided in Section 1923 of the federal Social Security Act and
430 any applicable regulations.
431 (19) (a) Perinatal risk management services. The division
432 shall promulgate regulations to be effective from and after
433 October 1, 1988, to establish a comprehensive perinatal system for
434 risk assessment of all pregnant and infant Medicaid recipients and
435 for management, education and follow-up for those who are
436 determined to be at risk. Services to be performed include case
437 management, nutrition assessment/counseling, psychosocial
438 assessment/counseling and health education. The division shall
439 set reimbursement rates for providers in conjunction with the
440 State Department of Health.
441 (b) Early intervention system services. The division

442 shall cooperate with the State Department of Health, acting as
443 lead agency, in the development and implementation of a statewide
444 system of delivery of early intervention services, pursuant to
445 Part H of the Individuals with Disabilities Education Act (IDEA).
446 The State Department of Health shall certify annually in writing
447 to the director of the division the dollar amount of state early
448 intervention funds available which shall be utilized as a
449 certified match for Medicaid matching funds. Those funds then
450 shall be used to provide expanded targeted case management
451 services for Medicaid eligible children with special needs who are
452 eligible for the state's early intervention system.
453 Qualifications for persons providing service coordination shall be
454 determined by the State Department of Health and the Division of
455 Medicaid.
456 (20) Home- and community-based services for physically
457 disabled approved services as allowed by a waiver from the U.S.
458 Department of Health and Human Services for home- and
459 community-based services for physically disabled people using
460 state funds which are provided from the appropriation to the State
461 Department of Rehabilitation Services and used to match federal
462 funds under a cooperative agreement between the division and the
463 department, provided that funds for these services are
464 specifically appropriated to the Department of Rehabilitation
465 Services.
466 (21) Nurse practitioner services. Services furnished by a
467 registered nurse who is licensed and certified by the Mississippi
468 Board of Nursing as a nurse practitioner including, but not
469 limited to, nurse anesthetists, nurse midwives, family nurse
470 practitioners, family planning nurse practitioners, pediatric
471 nurse practitioners, obstetrics-gynecology nurse practitioners and
472 neonatal nurse practitioners, under regulations adopted by the
473 division. Reimbursement for such services shall not exceed ninety
474 percent (90%) of the reimbursement rate for comparable services
475 rendered by a physician.

476 (22) Ambulatory services delivered in federally qualified
477 health centers and in clinics of the local health departments of
478 the State Department of Health for individuals eligible for
479 medical assistance under this article based on reasonable costs as
480 determined by the division.
481 (23) Inpatient psychiatric services. Inpatient psychiatric
482 services to be determined by the division for recipients under age
483 twenty-one (21) which are provided under the direction of a
484 physician in an inpatient program in a licensed acute care
485 psychiatric facility or in a licensed psychiatric residential
486 treatment facility, before the recipient reaches age twenty-one
487 (21) or, if the recipient was receiving the services immediately
488 before he reached age twenty-one (21), before the earlier of the
489 date he no longer requires the services or the date he reaches age
490 twenty-two (22), as provided by federal regulations. Recipients
491 shall be allowed forty-five (45) days per year of psychiatric
492 services provided in acute care psychiatric facilities, and shall
493 be allowed unlimited days of psychiatric services provided in
494 licensed psychiatric residential treatment facilities.
495 (24) Managed care services in a program to be developed by
496 the division by a public or private provider. Notwithstanding any
497 other provision in this article to the contrary, the division
498 shall establish rates of reimbursement to providers rendering care
499 and services authorized under this section, and may revise such
500 rates of reimbursement without amendment to this section by the
501 Legislature for the purpose of achieving effective and accessible
502 health services, and for responsible containment of costs. This
503 shall include, but not be limited to, one (1) module of capitated
504 managed care in a rural area, and one (1) module of capitated
505 managed care in an urban area.
506 (25) Birthing center services.
507 (26) Hospice care. As used in this paragraph, the term
508 "hospice care" means a coordinated program of active professional
509 medical attention within the home and outpatient and inpatient

510 care which treats the terminally ill patient and family as a unit,
511 employing a medically directed interdisciplinary team. The
512 program provides relief of severe pain or other physical symptoms
513 and supportive care to meet the special needs arising out of
514 physical, psychological, spiritual, social and economic stresses
515 which are experienced during the final stages of illness and
516 during dying and bereavement and meets the Medicare requirements
517 for participation as a hospice as provided in 42 CFR Part 418.
518 (27) Group health plan premiums and cost sharing if it is
519 cost effective as defined by the Secretary of Health and Human
520 Services.
521 (28) Other health insurance premiums which are cost
522 effective as defined by the Secretary of Health and Human
523 Services. Medicare eligible must have Medicare Part B before
524 other insurance premiums can be paid.
525 (29) The Division of Medicaid may apply for a waiver from
526 the Department of Health and Human Services for home- and
527 community-based services for developmentally disabled people using
528 state funds which are provided from the appropriation to the State
529 Department of Mental Health and used to match federal funds under
530 a cooperative agreement between the division and the department,
531 provided that funds for these services are specifically
532 appropriated to the Department of Mental Health.
533 (30) Pediatric skilled nursing services for eligible persons
534 under twenty-one (21) years of age.
535 (31) Targeted case management services for children with
536 special needs, under waivers from the U.S. Department of Health
537 and Human Services, using state funds that are provided from the
538 appropriation to the Mississippi Department of Human Services and
539 used to match federal funds under a cooperative agreement between
540 the division and the department.
541 (32) Care and services provided in Christian Science
542 Sanatoria operated by or listed and certified by The First Church
543 of Christ Scientist, Boston, Massachusetts, rendered in connection

544 with treatment by prayer or spiritual means to the extent that
545 such services are subject to reimbursement under Section 1903 of
546 the Social Security Act.
547 (33) Podiatrist services.
548 (34) Personal care services provided in a pilot program to
549 not more than forty (40) residents at a location or locations to
550 be determined by the division and delivered by individuals
551 qualified to provide such services, as allowed by waivers under
552 Title XIX of the Social Security Act, as amended. The division
553 shall not expend more than Three Hundred Thousand Dollars
554 ($300,000.00) annually to provide such personal care services.
555 The division shall develop recommendations for the effective
556 regulation of any facilities that would provide personal care
557 services which may become eligible for Medicaid reimbursement
558 under this section, and shall present such recommendations with
559 any proposed legislation to the 1996 Regular Session of the
560 Legislature on or before January 1, 1996.
561 (35) Services and activities authorized in Sections
562 43-27-101 and 43-27-103, using state funds that are provided from
563 the appropriation to the State Department of Human Services and
564 used to match federal funds under a cooperative agreement between
565 the division and the department.
566 (36) Nonemergency transportation services for
567 Medicaid-eligible persons, to be provided by the Department of
568 Human Services. The division may contract with additional
569 entities to administer nonemergency transportation services as it
570 deems necessary. All providers shall have a valid driver's
571 license, vehicle inspection sticker and a standard liability
572 insurance policy covering the vehicle.
573 (37) Targeted case management services for individuals with
574 chronic diseases, with expanded eligibility to cover services to
575 uninsured recipients, on a pilot program basis. This paragraph
576 (37) shall be contingent upon continued receipt of special funds
577 from the Health Care Financing Authority and private foundations

578 who have granted funds for planning these services. No funding
579 for these services shall be provided from State General Funds.
580 (38) Chiropractic services: a chiropractor's manual
581 manipulation of the spine to correct a subluxation, if x-ray
582 demonstrates that a subluxation exists and if the subluxation has
583 resulted in a neuromusculoskeletal condition for which
584 manipulation is appropriate treatment. Reimbursement for
585 chiropractic services shall not exceed Seven Hundred Dollars
586 ($700.00) per year per recipient.
587 Notwithstanding any provision of this article, except as
588 authorized in the following paragraph and in Section 43-13-139,
589 neither (a) the limitations on quantity or frequency of use of or
590 the fees or charges for any of the care or services available to
591 recipients under this section, nor (b) the payments or rates of
592 reimbursement to providers rendering care or services authorized
593 under this section to recipients, may be increased, decreased or
594 otherwise changed from the levels in effect on July 1, 1986,
595 unless such is authorized by an amendment to this section by the
596 Legislature. However, the restriction in this paragraph shall not
597 prevent the division from changing the payments or rates of
598 reimbursement to providers without an amendment to this section
599 whenever such changes are required by federal law or regulation,
600 or whenever such changes are necessary to correct administrative
601 errors or omissions in calculating such payments or rates of
602 reimbursement.
603 Notwithstanding any provision of this article, no new groups
604 or categories of recipients and new types of care and services may
605 be added without enabling legislation from the Mississippi
606 Legislature, except that the division may authorize such changes
607 without enabling legislation when such addition of recipients or
608 services is ordered by a court of proper authority. The director
609 shall keep the Governor advised on a timely basis of the funds
610 available for expenditure and the projected expenditures. In the
611 event current or projected expenditures can be reasonably

612 anticipated to exceed the amounts appropriated for any fiscal
613 year, the Governor, after consultation with the director, shall
614 discontinue any or all of the payment of the types of care and
615 services as provided herein which are deemed to be optional
616 services under Title XIX of the federal Social Security Act, as
617 amended, for any period necessary to not exceed appropriated
618 funds, and when necessary shall institute any other cost
619 containment measures on any program or programs authorized under
620 the article to the extent allowed under the federal law governing
621 such program or programs, it being the intent of the Legislature
622 that expenditures during any fiscal year shall not exceed the
623 amounts appropriated for such fiscal year.
624 SECTION 2. This act shall take effect and be in force from
625 and after its passage.