MISSISSIPPI LEGISLATURE REGULAR SESSION 1999

By: Senator(s) Gordon

To: Public Health and Welfare; Appropriations

COMMITTEE SUBSTITUTE
FOR
SENATE BILL NO. 2945

1 AN ACT TO AMEND SECTION 43-13-107, MISSISSIPPI CODE OF 1972,
2 TO ESTABLISH AN ADVISORY COMMITTEE TO THE DIVISION OF MEDICAID; TO
3 AMEND SECTION 43-13-113, MISSISSIPPI CODE OF 1972, TO REVISE THE
4 PROCEDURES FOR THE DISBURSEMENT OF MEDICAID REIMBURSEMENT FUNDS TO
5 PROVIDERS; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
6 TO INCREASE THE RATE FOR MEDICAID REIMBURSEMENT FOR PHYSICIANS
7 SERVICES; AND FOR RELATED PURPOSES. BE IT ENACTED BY THE
8 LEGISLATURE OF THE STATE OF MISSISSIPPI:
9
10 SECTION 1. Section 43-13-107, Mississippi Code of 1972, is
11 amended as follows:
12 43-13-107. (1) The Division of Medicaid is hereby created
13 in the Office of the Governor and established to administer this
14 article and perform such other duties as are prescribed by law.
15 (2) The Governor shall appoint a full-time director, with
16 the advice and consent of the Senate, who shall be either a
17 physician with administrative experience in a medical care or
18 health program or a person holding a graduate degree in medical
19 care administration, public health, hospital administration, or
20 the equivalent, and who shall serve at the will and pleasure of
21 the Governor. The director shall be the official secretary and
22 legal custodian of the records of the division; shall be the agent
23 of the division for the purpose of receiving all service of
24 process, summons and notices directed to the division; and shall
25 perform such other duties as the Governor shall, from time to
26 time, prescribe. The director, with the approval of the Governor
27 and the rules and regulations of the State Personnel Board, shall
28 employ such professional, administrative, stenographic,
29 secretarial, clerical and technical assistance as may be necessary
30 to perform the duties required in administering this article and

31 fix the compensation therefor, all in accordance with a state
32 merit system meeting federal requirements, except that when the
33 salary of the director is not set by law, such salary shall be set
34 by the State Personnel Board. No employees of the Division of
35 Medicaid shall be considered to be staff members of the immediate
36 Office of the Governor; however, the provisions of Section
37 25-9-107(xv), Mississippi Code of 1972, shall apply to the
38 director and other administrative heads of the division.
39 (3) A Medical Advisory Committee shall be established to
40 advise the Division of Medicaid. The committees shall be composed
41 of the respective Chairmen of the Senate Public Health and Welfare
42 Committee, the Senate Appropriations Committee, the House Public
43 Health and Welfare Committee, the House Appropriations Committee,
44 four (4) members appointed by the Speaker of the House of
45 Representatives and four (4) members appointed by the Lieutenant
46 Governor. At least two (2) members of the committee appointed by
47 the Speaker of the House and Lieutenant Governor shall be
48 physicians. The division may, at its discretion, make
49 appointments to the committee, but the committee shall not consist
50 of more than nine (9) members who shall serve not less than two-
51 nor more than four-year terms and may be reappointed. The
52 chairmanship of the committee shall alternate for twelve-month
53 periods between the Senate members and the House members with the
54 Chairman of the Senate Public Health and Welfare Committee serving
55 as the first chairman. Members of the committee who are not
56 legislators shall serve without compensation but expenses to
57 defray actual expenses incurred in the performance of travel,
58 lodging and subsistence may be authorized. Members of the
59 committee who are legislators shall receive the same per diem and
60 expense reimbursement authorized for legislators when attending
61 committee meetings when the Legislature is not in session. The
62 committee shall meet not less than twice annually and shall be
63 furnished written notice of the meetings at least ten (10) days
64 prior to the date of the meeting. The committee, among its duties
65 and responsibilities prescribed and agreed to, shall:
66 (a) Advise the division with respect to issues
67 concerning receipt and disbursement of funds and eligibility for
68 medical assistance;

69 (b) Advise the division with respect to determining the
70 quantity, quality and extent of medical care provided under this
71 article;
72 (c) Communicate the views of the medical care
73 professions to the division and communicate the views of the
74 division to the medical care community;
75 (d) Advise the division with respect to encouraging
76 physicians and other medical care personnel to participate in
77 division programs;
78 (e) Provide a written report on or before November 30
79 of each year to the Lieutenant Governor and Speaker of the House
80 of Representatives.
81 SECTION 2. Section 43-13-113, Mississippi Code of 1972, is
82 amended as follows:
83 43-13-113. (1) The State Treasurer is hereby authorized and
84 directed to receive on behalf of the state, and to execute all
85 instruments incidental thereto, federal and other funds to be used
86 for financing the medical assistance plan or program adopted
87 pursuant to this article, and to place all such funds in a special
88 account to the credit of the Governor's Office-Division of
89 Medicaid, which said funds shall be expended by the division for
90 the purposes and under the provisions of this article, and shall
91 be paid out by the State Treasurer as funds appropriated to carry
92 out the provisions of this article are paid out by him.
93 The division shall issue all checks or electronic transfers
94 for administrative expenses, and for medical assistance under the
95 provisions of this article. All such checks or electronic
96 transfers shall be drawn upon funds made available to the division
97 by the State Auditor, upon requisition of the director. It is the
98 purpose of this section to provide that the State Auditor shall
99 transfer, in lump sums, amounts to the division for disbursement
100 under the regulations which shall be made by the director with the
101 approval of the Governor; provided, however, that the division, or
102 its fiscal agent in behalf of the division, shall be authorized in

103 maintaining separate accounts with a Mississippi bank to handle
104 claim payments, refund recoveries and related Medicaid program
105 financial transactions, to aggressively manage the float in these
106 accounts while awaiting clearance of checks or electronic
107 transfers and/or other disposition so as to accrue maximum
108 interest advantage of the funds in the account, and to retain all
109 earned interest on these funds to be applied to match federal
110 funds for Medicaid program operations.
111 (2) Disbursement of funds to providers shall be made as
112 follows:
113 (a) All providers must submit all claims to the
114 Division of Medicaid's fiscal agent no later than twelve (12)
115 months from the date of service.
116 (b) The Division of Medicaid's fiscal agent must
117 pay *** * *** all clean claims within forty-five (45) days of the date
118 of receipt.
119 *** * ***
120 (c) The Division of Medicaid's fiscal agent must pay
121 all other claims within three (3) months of the date of receipt.
122 (d) If a claim is neither paid nor denied for valid and
123 proper reasons by the end of the time periods as specified above,
124 the Division of Medicaid's fiscal agent must pay the provider
125 interest on the claim at the rate of one and one-half percent
126 (1-1/2%) per month on the amount of such claim until it is finally
127 settled or adjudicated.
128 (3) The date of receipt is the date the fiscal agent
129 receives the claim as indicated by its date stamp on the claim or,
130 for those claims filed electronically, the date of receipt is the
131 date of transmission.
132 (4) The date of payment is the date of the check or, for
133 those claims paid by electronic funds transfer, the date of the
134 transfer.
135 (5) The above specified time limitations do not apply in the
136 following circumstances:

137 (a) Retroactive adjustments paid to providers
138 reimbursed under a retrospective payment system;
139 (b) If a claim for payment under Medicare has been
140 filed in a timely manner, the fiscal agent may pay a Medicaid
141 claim relating to the same services within six (6) months after
142 it, or the provider, receives notice of the disposition of the
143 Medicare claim;
144 (c) Claims from providers under investigation for fraud
145 or abuse; and
146 (d) The Division of Medicaid and/or its fiscal agent
147 may make payments at any time in accordance with a court order, to
148 carry out hearing decisions or corrective actions taken to resolve
149 a dispute, or to extend the benefits of a hearing decision,
150 corrective action, or court order to others in the same situation
151 as those directly affected by it.
152 (6) If sufficient funds are appropriated therefor by the
153 Legislature, the Division of Medicaid may contract with the
154 Mississippi Dental Association, or an approved designee, to
155 develop and operate a Donated Dental Services (DDS) program
156 through which volunteer dentists will treat needy disabled, aged,
157 and medically-compromised individuals who are non-Medicaid
158 eligible recipients.
159 SECTION 3. Section 43-13-117, Mississippi Code of 1972, is
160 amended as follows:
161 43-13-117. Medical assistance as authorized by this article
162 shall include payment of part or all of the costs, at the
163 discretion of the division or its successor, with approval of the
164 Governor, of the following types of care and services rendered to
165 eligible applicants who shall have been determined to be eligible
166 for such care and services, within the limits of state
167 appropriations and federal matching funds:
168 (1) Inpatient hospital services.
169 (a) The division shall allow thirty (30) days of
170 inpatient hospital care annually for all Medicaid recipients;

171 however, before any recipient will be allowed more than fifteen
172 (15) days of inpatient hospital care in any one (1) year, he must
173 obtain prior approval therefor from the division. The division
174 shall be authorized to allow unlimited days in disproportionate
175 hospitals as defined by the division for eligible infants under
176 the age of six (6) years.
177 (b) From and after July 1, 1994, the Executive Director
178 of the Division of Medicaid shall amend the Mississippi Title XIX
179 Inpatient Hospital Reimbursement Plan to remove the occupancy rate
180 penalty from the calculation of the Medicaid Capital Cost
181 Component utilized to determine total hospital costs allocated to
182 the Medicaid Program.
183 (2) Outpatient hospital services. Provided that where the
184 same services are reimbursed as clinic services, the division may
185 revise the rate or methodology of outpatient reimbursement to
186 maintain consistency, efficiency, economy and quality of care.
187 (3) Laboratory and X-ray services.
188 (4) Nursing facility services.
189 (a) The division shall make full payment to nursing
190 facilities for each day, not exceeding thirty-six (36) days per
191 year, that a patient is absent from the facility on home leave.
192 However, before payment may be made for more than eighteen (18)
193 home leave days in a year for a patient, the patient must have
194 written authorization from a physician stating that the patient is
195 physically and mentally able to be away from the facility on home
196 leave. Such authorization must be filed with the division before
197 it will be effective and the authorization shall be effective for
198 three (3) months from the date it is received by the division,
199 unless it is revoked earlier by the physician because of a change
200 in the condition of the patient.
201 (b) From and after July 1, 1993, the division shall
202 implement the integrated case-mix payment and quality monitoring
203 system developed pursuant to Section 43-13-122, which includes the
204 fair rental system for property costs and in which recapture of

205 depreciation is eliminated. The division may revise the
206 reimbursement methodology for the case-mix payment system by
207 reducing payment for hospital leave and therapeutic home leave
208 days to the lowest case-mix category for nursing facilities,
209 modifying the current method of scoring residents so that only
210 services provided at the nursing facility are considered in
211 calculating a facility's per diem, and the division may limit
212 administrative and operating costs, but in no case shall these
213 costs be less than one hundred nine percent (109%) of the median
214 administrative and operating costs for each class of facility, not
215 to exceed the median used to calculate the nursing facility
216 reimbursement for Fiscal Year 1996, to be applied uniformly to all
217 long-term care facilities. This paragraph (b) shall stand
218 repealed on July 1, 1997.
219 (c) From and after July 1, 1997, all state-owned
220 nursing facilities shall be reimbursed on a full reasonable costs
221 basis. From and after July 1, 1997, payments by the division to
222 nursing facilities for return on equity capital shall be made at
223 the rate paid under Medicare (Title XVIII of the Social Security
224 Act), but shall be no less than seven and one-half percent (7.5%)
225 nor greater than ten percent (10%).
226 (d) A Review Board for nursing facilities is
227 established to conduct reviews of the Division of Medicaid's
228 decision in the areas set forth below:
229 (i) Review shall be heard in the following areas:
230 (A) Matters relating to cost reports
231 including, but not limited to, allowable costs and cost
232 adjustments resulting from desk reviews and audits.
233 (B) Matters relating to the Minimum Data Set
234 Plus (MDS +) or successor assessment formats including, but not
235 limited to, audits, classifications and submissions.
236 (ii) The Review Board shall be composed of six (6)
237 members, three (3) having expertise in one (1) of the two (2)
238 areas set forth above and three (3) having expertise in the other

239 area set forth above. Each panel of three (3) shall only review
240 appeals arising in its area of expertise. The members shall be
241 appointed as follows:
242 (A) In each of the areas of expertise defined
243 under subparagraphs (i)(A) and (i)(B), the Executive Director of
244 the Division of Medicaid shall appoint one (1) person chosen from
245 the private sector nursing home industry in the state, which may
246 include independent accountants and consultants serving the
247 industry;
248 (B) In each of the areas of expertise defined
249 under subparagraphs (i)(A) and (i)(B), the Executive Director of
250 the Division of Medicaid shall appoint one (1) person who is
251 employed by the state who does not participate directly in desk
252 reviews or audits of nursing facilities in the two (2) areas of
253 review;
254 (C) The two (2) members appointed by the
255 Executive Director of the Division of Medicaid in each area of
256 expertise shall appoint a third member in the same area of
257 expertise.
258 In the event of a conflict of interest on the part of any
259 Review Board members, the Executive Director of the Division of
260 Medicaid or the other two (2) panel members, as applicable, shall
261 appoint a substitute member for conducting a specific review.
262 (iii) The Review Board panels shall have the power
263 to preserve and enforce order during hearings; to issue subpoenas;
264 to administer oaths; to compel attendance and testimony of
265 witnesses; or to compel the production of books, papers, documents
266 and other evidence; or the taking of depositions before any
267 designated individual competent to administer oaths; to examine
268 witnesses; and to do all things conformable to law that may be
269 necessary to enable it effectively to discharge its duties. The
270 Review Board panels may appoint such person or persons as they
271 shall deem proper to execute and return process in connection
272 therewith.

273 (iv) The Review Board shall promulgate, publish
274 and disseminate to nursing facility providers rules of procedure
275 for the efficient conduct of proceedings, subject to the approval
276 of the Executive Director of the Division of Medicaid and in
277 accordance with federal and state administrative hearing laws and
278 regulations.

279 (v) Proceedings of the Review Board shall be of
280 record.

281 (vi) Appeals to the Review Board shall be in
282 writing and shall set out the issues, a statement of alleged facts
283 and reasons supporting the provider's position. Relevant
284 documents may also be attached. The appeal shall be filed within
285 thirty (30) days from the date the provider is notified of the
286 action being appealed or, if informal review procedures are taken,
287 as provided by administrative regulations of the Division of
288 Medicaid, within thirty (30) days after a decision has been
289 rendered through informal hearing procedures.

290 (vii) The provider shall be notified of the
291 hearing date by certified mail within thirty (30) days from the
292 date the Division of Medicaid receives the request for appeal.
293 Notification of the hearing date shall in no event be less than
294 thirty (30) days before the scheduled hearing date. The appeal
295 may be heard on shorter notice by written agreement between the
296 provider and the Division of Medicaid.

297 (viii) Within thirty (30) days from the date of
298 the hearing, the Review Board panel shall render a written
299 recommendation to the Executive Director of the Division of
300 Medicaid setting forth the issues, findings of fact and applicable
301 law, regulations or provisions.

302 (ix) The Executive Director of the Division of
303 Medicaid shall, upon review of the recommendation, the proceedings
304 and the record, prepare a written decision which shall be mailed
305 to the nursing facility provider no later than twenty (20) days
306 after the submission of the recommendation by the panel. The

307 decision of the executive director is final, subject only to
308 judicial review.
309 (x) Appeals from a final decision shall be made to
310 the Chancery Court of Hinds County. The appeal shall be filed
311 with the court within thirty (30) days from the date the decision
312 of the Executive Director of the Division of Medicaid becomes
313 final.
314 (xi) The action of the Division of Medicaid under
315 review shall be stayed until all administrative proceedings have
316 been exhausted.
317 (xii) Appeals by nursing facility providers
318 involving any issues other than those two (2) specified in
319 subparagraphs (i)(A) and (ii)(B) shall be taken in accordance with
320 the administrative hearing procedures established by the Division
321 of Medicaid.
322 (e) When a facility of a category that does not require
323 a certificate of need for construction and that could not be
324 eligible for Medicaid reimbursement is constructed to nursing
325 facility specifications for licensure and certification, and the
326 facility is subsequently converted to a nursing facility pursuant
327 to a certificate of need that authorizes conversion only and the
328 applicant for the certificate of need was assessed an application
329 review fee based on capital expenditures incurred in constructing
330 the facility, the division shall allow reimbursement for capital
331 expenditures necessary for construction of the facility that were
332 incurred within the twenty-four (24) consecutive calendar months
333 immediately preceding the date that the certificate of need
334 authorizing such conversion was issued, to the same extent that
335 reimbursement would be allowed for construction of a new nursing
336 facility pursuant to a certificate of need that authorizes such
337 construction. The reimbursement authorized in this subparagraph
338 (e) may be made only to facilities the construction of which was
339 completed after June 30, 1989. Before the division shall be
340 authorized to make the reimbursement authorized in this

341 subparagraph (e), the division first must have received approval
342 from the Health Care Financing Administration of the United States
343 Department of Health and Human Services of the change in the state
344 Medicaid plan providing for such reimbursement.
345 (5) Periodic screening and diagnostic services for
346 individuals under age twenty-one (21) years as are needed to
347 identify physical and mental defects and to provide health care
348 treatment and other measures designed to correct or ameliorate
349 defects and physical and mental illness and conditions discovered
350 by the screening services regardless of whether these services are
351 included in the state plan. The division may include in its
352 periodic screening and diagnostic program those discretionary
353 services authorized under the federal regulations adopted to
354 implement Title XIX of the federal Social Security Act, as
355 amended. The division, in obtaining physical therapy services,
356 occupational therapy services, and services for individuals with
357 speech, hearing and language disorders, may enter into a
358 cooperative agreement with the State Department of Education for
359 the provision of such services to handicapped students by public
360 school districts using state funds which are provided from the
361 appropriation to the Department of Education to obtain federal
362 matching funds through the division. The division, in obtaining
363 medical and psychological evaluations for children in the custody
364 of the State Department of Human Services may enter into a
365 cooperative agreement with the State Department of Human Services
366 for the provision of such services using state funds which are
367 provided from the appropriation to the Department of Human
368 Services to obtain federal matching funds through the division.
369 On July 1, 1993, all fees for periodic screening and
370 diagnostic services under this paragraph (5) shall be increased by
371 twenty-five percent (25%) of the reimbursement rate in effect on
372 June 30, 1993.
373 (6) Physicians' services. *** * *** All fees for physicians'
374 services shall be reimbursed at <u>not less than ninety percent (90%)</u>

375 of the rate established on January 1, <u>1999</u>, under Medicare (Title
376 XVIII of the Social Security Act), as amended, and <u>which shall, in</u>
377 <u>no event, be less than seventy percent (70%) of the rate</u>
378 <u>established on January 1, 1994.</u> The division <u>shall pay ten</u>
379 <u>percent (10%) of any co-payment for</u> physician's <u>services rendered</u>
380 <u>to a person dually eligible for</u> Medicaid and Medicare.
381 (7) (a) Home health services for eligible persons, not to
382 exceed in cost the prevailing cost of nursing facility services,
383 not to exceed sixty (60) visits per year.
384 (b) The division may revise reimbursement for home
385 health services in order to establish equity between reimbursement
386 for home health services and reimbursement for institutional
387 services within the Medicaid program. This paragraph (b) shall
388 stand repealed on July 1, 1997.
389 (8) Emergency medical transportation services. On January
390 1, 1994, emergency medical transportation services shall be
391 reimbursed at seventy percent (70%) of the rate established under
392 Medicare (Title XVIII of the Social Security Act), as amended.
393 "Emergency medical transportation services" shall mean, but shall
394 not be limited to, the following services by a properly permitted
395 ambulance operated by a properly licensed provider in accordance
396 with the Emergency Medical Services Act of 1974 (Section 41-59-1
397 et seq.): (i) basic life support, (ii) advanced life support,
398 (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi)
399 disposable supplies, (vii) similar services.
400 (9) Legend and other drugs as may be determined by the
401 division. The division may implement a program of prior approval
402 for drugs to the extent permitted by law. Payment by the division
403 for covered multiple source drugs shall be limited to the lower of
404 the upper limits established and published by the Health Care
405 Financing Administration (HCFA) plus a dispensing fee of Four
406 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
407 cost (EAC) as determined by the division plus a dispensing fee of
408 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual

409 and customary charge to the general public. The division shall
410 allow five (5) prescriptions per month for noninstitutionalized
411 Medicaid recipients.
412 Payment for other covered drugs, other than multiple source
413 drugs with HCFA upper limits, shall not exceed the lower of the
414 estimated acquisition cost as determined by the division plus a
415 dispensing fee of Four Dollars and Ninety-one Cents ($4.91) or the
416 providers' usual and customary charge to the general public.
417 Payment for nonlegend or over-the-counter drugs covered on
418 the division's formulary shall be reimbursed at the lower of the
419 division's estimated shelf price or the providers' usual and
420 customary charge to the general public. No dispensing fee shall
421 be paid.
422 The division shall develop and implement a program of payment
423 for additional pharmacist services, with payment to be based on
424 demonstrated savings, but in no case shall the total payment
425 exceed twice the amount of the dispensing fee.
426 As used in this paragraph (9), "estimated acquisition cost"
427 means the division's best estimate of what price providers
428 generally are paying for a drug in the package size that providers
429 buy most frequently. Product selection shall be made in
430 compliance with existing state law; however, the division may
431 reimburse as if the prescription had been filled under the generic
432 name. The division may provide otherwise in the case of specified
433 drugs when the consensus of competent medical advice is that
434 trademarked drugs are substantially more effective.
435 (10) Dental care that is an adjunct to treatment of an acute
436 medical or surgical condition; services of oral surgeons and
437 dentists in connection with surgery related to the jaw or any
438 structure contiguous to the jaw or the reduction of any fracture
439 of the jaw or any facial bone; and emergency dental extractions
440 and treatment related thereto. On January 1, 1994, all fees for
441 dental care and surgery under authority of this paragraph (10)
442 shall be increased by twenty percent (20%) of the reimbursement

443 rate as provided in the Dental Services Provider Manual in effect
444 on December 31, 1993.
445 (11) Eyeglasses necessitated by reason of eye surgery, and
446 as prescribed by a physician skilled in diseases of the eye or an
447 optometrist, whichever the patient may select.
448 (12) Intermediate care facility services.
449 (a) The division shall make full payment to all
450 intermediate care facilities for the mentally retarded for each
451 day, not exceeding thirty-six (36) days per year, that a patient
452 is absent from the facility on home leave. However, before
453 payment may be made for more than eighteen (18) home leave days in
454 a year for a patient, the patient must have written authorization
455 from a physician stating that the patient is physically and
456 mentally able to be away from the facility on home leave. Such
457 authorization must be filed with the division before it will be
458 effective, and the authorization shall be effective for three (3)
459 months from the date it is received by the division, unless it is
460 revoked earlier by the physician because of a change in the
461 condition of the patient.
462 (b) All state-owned intermediate care facilities for
463 the mentally retarded shall be reimbursed on a full reasonable
464 cost basis.
465 (13) Family planning services, including drugs, supplies and
466 devices, when such services are under the supervision of a
467 physician.
468 (14) Clinic services. Such diagnostic, preventive,
469 therapeutic, rehabilitative or palliative services furnished to an
470 outpatient by or under the supervision of a physician or dentist
471 in a facility which is not a part of a hospital but which is
472 organized and operated to provide medical care to outpatients.
473 Clinic services shall include any services reimbursed as
474 outpatient hospital services which may be rendered in such a
475 facility, including those that become so after July 1, 1991. On
476 January 1, 1994, all fees for physicians' services reimbursed

477 under authority of this paragraph (14) shall be reimbursed at
478 seventy percent (70%) of the rate established on January 1, 1993,
479 under Medicare (Title XVIII of the Social Security Act), as
480 amended, or the amount that would have been paid under the
481 division's fee schedule that was in effect on December 31, 1993,
482 whichever is greater, and the division may adjust the physicians'
483 reimbursement schedule to reflect the differences in relative
484 value between Medicaid and Medicare. However, on January 1, 1994,
485 the division may increase any fee for physicians' services in the
486 division's fee schedule on December 31, 1993, that was greater
487 than seventy percent (70%) of the rate established under Medicare
488 by no more than ten percent (10%). On January 1, 1994, all fees
489 for dentists' services reimbursed under authority of this
490 paragraph (14) shall be increased by twenty percent (20%) of the
491 amount the reimbursement rate as provided in the Dental Services
492 Provider Manual in effect on December 31, 1993.
493 (15) Home- and community-based services, as provided under
494 Title XIX of the federal Social Security Act, as amended, under
495 waivers, subject to the availability of funds specifically
496 appropriated therefor by the Legislature. Payment for such
497 services shall be limited to individuals who would be eligible for
498 and would otherwise require the level of care provided in a
499 nursing facility. The division shall certify case management
500 agencies to provide case management services and provide for home-
501 and community-based services for eligible individuals under this
502 paragraph. The home- and community-based services under this
503 paragraph and the activities performed by certified case
504 management agencies under this paragraph shall be funded using
505 state funds that are provided from the appropriation to the
506 Division of Medicaid and used to match federal funds under a
507 cooperative agreement between the division and the Department of
508 Human Services.
509 (16) Mental health services. Approved therapeutic and case
510 management services provided by (a) an approved regional mental

511 health/retardation center established under Sections 41-19-31
512 through 41-19-39, or by another community mental health service
513 provider meeting the requirements of the Department of Mental
514 Health to be an approved mental health/retardation center if
515 determined necessary by the Department of Mental Health, using
516 state funds which are provided from the appropriation to the State
517 Department of Mental Health and used to match federal funds under
518 a cooperative agreement between the division and the department,
519 or (b) a facility which is certified by the State Department of
520 Mental Health to provide therapeutic and case management services,
521 to be reimbursed on a fee for service basis. Any such services
522 provided by a facility described in paragraph (b) must have the
523 prior approval of the division to be reimbursable under this
524 section. After June 30, 1997, mental health services provided by
525 regional mental health/retardation centers established under
526 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
527 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
528 psychiatric residential treatment facilities as defined in Section
529 43-11-1, or by another community mental health service provider
530 meeting the requirements of the Department of Mental Health to be
531 an approved mental health/retardation center if determined
532 necessary by the Department of Mental Health, shall not be
533 included in or provided under any capitated managed care pilot
534 program provided for under paragraph (24) of this section.
535 (17) Durable medical equipment services and medical supplies
536 restricted to patients receiving home health services unless
537 waived on an individual basis by the division. The division shall
538 not expend more than Three Hundred Thousand Dollars ($300,000.00)
539 of state funds annually to pay for medical supplies authorized
540 under this paragraph.
541 (18) Notwithstanding any other provision of this section to
542 the contrary, the division shall make additional reimbursement to
543 hospitals which serve a disproportionate share of low-income
544 patients and which meet the federal requirements for such payments

545 as provided in Section 1923 of the federal Social Security Act and
546 any applicable regulations.

547 (19) (a) Perinatal risk management services. The division
548 shall promulgate regulations to be effective from and after
549 October 1, 1988, to establish a comprehensive perinatal system for
550 risk assessment of all pregnant and infant Medicaid recipients and
551 for management, education and follow-up for those who are
552 determined to be at risk. Services to be performed include case
553 management, nutrition assessment/counseling, psychosocial
554 assessment/counseling and health education. The division shall
555 set reimbursement rates for providers in conjunction with the
556 State Department of Health.

557 (b) Early intervention system services. The division
558 shall cooperate with the State Department of Health, acting as
559 lead agency, in the development and implementation of a statewide
560 system of delivery of early intervention services, pursuant to
561 Part H of the Individuals with Disabilities Education Act (IDEA).
562 The State Department of Health shall certify annually in writing
563 to the director of the division the dollar amount of state early
564 intervention funds available which shall be utilized as a
565 certified match for Medicaid matching funds. Those funds then
566 shall be used to provide expanded targeted case management
567 services for Medicaid eligible children with special needs who are
568 eligible for the state's early intervention system.
569 Qualifications for persons providing service coordination shall be
570 determined by the State Department of Health and the Division of
571 Medicaid.

572 (20) Home- and community-based services for physically
573 disabled approved services as allowed by a waiver from the U.S.
574 Department of Health and Human Services for home- and
575 community-based services for physically disabled people using
576 state funds which are provided from the appropriation to the State
577 Department of Rehabilitation Services and used to match federal
578 funds under a cooperative agreement between the division and the

579 department, provided that funds for these services are
580 specifically appropriated to the Department of Rehabilitation
581 Services.
582 (21) Nurse practitioner services. Services furnished by a
583 registered nurse who is licensed and certified by the Mississippi
584 Board of Nursing as a nurse practitioner including, but not
585 limited to, nurse anesthetists, nurse midwives, family nurse
586 practitioners, family planning nurse practitioners, pediatric
587 nurse practitioners, obstetrics-gynecology nurse practitioners and
588 neonatal nurse practitioners, under regulations adopted by the
589 division. Reimbursement for such services shall not exceed ninety
590 percent (90%) of the reimbursement rate for comparable services
591 rendered by a physician.
592 (22) Ambulatory services delivered in federally qualified
593 health centers and in clinics of the local health departments of
594 the State Department of Health for individuals eligible for
595 medical assistance under this article based on reasonable costs as
596 determined by the division.
597 (23) Inpatient psychiatric services. Inpatient psychiatric
598 services to be determined by the division for recipients under age
599 twenty-one (21) which are provided under the direction of a
600 physician in an inpatient program in a licensed acute care
601 psychiatric facility or in a licensed psychiatric residential
602 treatment facility, before the recipient reaches age twenty-one
603 (21) or, if the recipient was receiving the services immediately
604 before he reached age twenty-one (21), before the earlier of the
605 date he no longer requires the services or the date he reaches age
606 twenty-two (22), as provided by federal regulations. Recipients
607 shall be allowed forty-five (45) days per year of psychiatric
608 services provided in acute care psychiatric facilities, and shall
609 be allowed unlimited days of psychiatric services provided in
610 licensed psychiatric residential treatment facilities.
611 (24) Managed care services in a program to be developed by
612 the division by a public or private provider. Notwithstanding any

613 other provision in this article to the contrary, the division
614 shall establish rates of reimbursement to providers rendering care
615 and services authorized under this section, and may revise such
616 rates of reimbursement without amendment to this section by the
617 Legislature for the purpose of achieving effective and accessible
618 health services, and for responsible containment of costs. This
619 shall include, but not be limited to, one (1) module of capitated
620 managed care in a rural area, and one (1) module of capitated
621 managed care in an urban area.
622 (25) Birthing center services.
623 (26) Hospice care. As used in this paragraph, the term
624 "hospice care" means a coordinated program of active professional
625 medical attention within the home and outpatient and inpatient
626 care which treats the terminally ill patient and family as a unit,
627 employing a medically directed interdisciplinary team. The
628 program provides relief of severe pain or other physical symptoms
629 and supportive care to meet the special needs arising out of
630 physical, psychological, spiritual, social and economic stresses
631 which are experienced during the final stages of illness and
632 during dying and bereavement and meets the Medicare requirements
633 for participation as a hospice as provided in 42 CFR Part 418.
634 (27) Group health plan premiums and cost sharing if it is
635 cost effective as defined by the Secretary of Health and Human
636 Services.
637 (28) Other health insurance premiums which are cost
638 effective as defined by the Secretary of Health and Human
639 Services. Medicare eligible must have Medicare Part B before
640 other insurance premiums can be paid.
641 (29) The Division of Medicaid may apply for a waiver from
642 the Department of Health and Human Services for home- and
643 community-based services for developmentally disabled people using
644 state funds which are provided from the appropriation to the State
645 Department of Mental Health and used to match federal funds under
646 a cooperative agreement between the division and the department,

647 provided that funds for these services are specifically
648 appropriated to the Department of Mental Health.
649 (30) Pediatric skilled nursing services for eligible persons
650 under twenty-one (21) years of age.
651 (31) Targeted case management services for children with
652 special needs, under waivers from the U.S. Department of Health
653 and Human Services, using state funds that are provided from the
654 appropriation to the Mississippi Department of Human Services and
655 used to match federal funds under a cooperative agreement between
656 the division and the department.
657 (32) Care and services provided in Christian Science
658 Sanatoria operated by or listed and certified by The First Church
659 of Christ Scientist, Boston, Massachusetts, rendered in connection
660 with treatment by prayer or spiritual means to the extent that
661 such services are subject to reimbursement under Section 1903 of
662 the Social Security Act.
663 (33) Podiatrist services.
664 (34) Personal care services provided in a pilot program to
665 not more than forty (40) residents at a location or locations to
666 be determined by the division and delivered by individuals
667 qualified to provide such services, as allowed by waivers under
668 Title XIX of the Social Security Act, as amended. The division
669 shall not expend more than Three Hundred Thousand Dollars
670 ($300,000.00) annually to provide such personal care services.
671 The division shall develop recommendations for the effective
672 regulation of any facilities that would provide personal care
673 services which may become eligible for Medicaid reimbursement
674 under this section, and shall present such recommendations with
675 any proposed legislation to the 1996 Regular Session of the
676 Legislature on or before January 1, 1996.
677 (35) Services and activities authorized in Sections
678 43-27-101 and 43-27-103, using state funds that are provided from
679 the appropriation to the State Department of Human Services and
680 used to match federal funds under a cooperative agreement between

681 the division and the department.

682 (36) Nonemergency transportation services for
683 Medicaid-eligible persons, to be provided by the Department of
684 Human Services. The division may contract with additional
685 entities to administer nonemergency transportation services as it
686 deems necessary. All providers shall have a valid driver's
687 license, vehicle inspection sticker and a standard liability
688 insurance policy covering the vehicle.

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

696 (38) Chiropractic services: a chiropractor's manual
697 manipulation of the spine to correct a subluxation, if x-ray
698 demonstrates that a subluxation exists and if the subluxation has
699 resulted in a neuromusculoskeletal condition for which
700 manipulation is appropriate treatment. Reimbursement for
701 chiropractic services shall not exceed Seven Hundred Dollars
702 ($700.00) per year per recipient.

703 Notwithstanding any provision of this article, except as
704 authorized in the following paragraph and in Section 43-13-139,
705 neither (a) the limitations on quantity or frequency of use of or
706 the fees or charges for any of the care or services available to
707 recipients under this section, nor (b) the payments or rates of
708 reimbursement to providers rendering care or services authorized
709 under this section to recipients, may be increased, decreased or
710 otherwise changed from the levels in effect on July 1, 1986,
711 unless such is authorized by an amendment to this section by the
712 Legislature. However, the restriction in this paragraph shall not
713 prevent the division from changing the payments or rates of
714 reimbursement to providers without an amendment to this section

715 whenever such changes are required by federal law or regulation,
716 or whenever such changes are necessary to correct administrative
717 errors or omissions in calculating such payments or rates of
718 reimbursement.

719 Notwithstanding any provision of this article, no new groups
720 or categories of recipients and new types of care and services may
721 be added without enabling legislation from the Mississippi
722 Legislature, except that the division may authorize such changes
723 without enabling legislation when such addition of recipients or
724 services is ordered by a court of proper authority. The director
725 shall keep the Governor advised on a timely basis of the funds
726 available for expenditure and the projected expenditures. In the
727 event current or projected expenditures can be reasonably
728 anticipated to exceed the amounts appropriated for any fiscal
729 year, the Governor, after consultation with the director, shall
730 discontinue any or all of the payment of the types of care and
731 services as provided herein which are deemed to be optional
732 services under Title XIX of the federal Social Security Act, as
733 amended, for any period necessary to not exceed appropriated
734 funds, and when necessary shall institute any other cost
735 containment measures on any program or programs authorized under
736 the article to the extent allowed under the federal law governing
737 such program or programs, it being the intent of the Legislature
738 that expenditures during any fiscal year shall not exceed the
739 amounts appropriated for such fiscal year.

740 SECTION 4. This act shall take effect and be in force from
741 and after July 1, 1999.