Pending
AMENDMENT No. 1 PROPOSED TO

House Bill NO. 1067

By Senator(s) Committee

Amend by striking all after the enacting clause and inserting in lieu thereof the following:

13 SECTION 1. Every hospital, health or medical expenses
14 insurance policy, hospital or medical service contract, health
15 maintenance organization and preferred provider organization that
16 is delivered or issued for delivery in this state and otherwise
17 provides anesthesia benefits shall provide benefits for anesthesia
18 and for associated facility charges when the mental or physical
19 condition of the child or mentally handicapped adult requires
20 dental treatment to be rendered under physician-supervised general
21 anesthesia in a hospital setting, surgical center or dental
22 office. The requirements of this section shall be fully
23 applicable to the State Employees Health Insurance Plan, the
24 Public School Employees Health Insurance Plan, the State Medicaid
25 Program and the Children's Health Insurance Program. Excluded
26 herefrom are limited benefit or supplemental health insurance
27 policies.
28 An insurer may require prior authorization for the anesthesia
29 and associated facility charges for dental care procedures in the
30 same manner that prior authorization is required for treatment of
31 other medical conditions under general anesthesia. An insurer may
32 require review for medical necessity and may limit payment of
33 facility charges to certified facilities in the same manner that

34 medical review is required and payment of facility charges is
35 limited for other services. The benefit provided by this coverage
36 shall be subject to the same annual deductibles or coinsurance
37 established for all other covered benefits within a given policy,
38 plan or contract. Private third party payers may not reduce or
39 eliminate coverage due to these requirements.

40 A dentist shall consider the Indications for General
41 Anesthesia as published in the reference manual of the American
42 Academy of Pediatric Dentistry as utilization standards for
43 determining whether performing dental procedures necessary to
44 treat the particular condition or conditions of the patient under
45 general anesthesia constitutes appropriate treatment.

46 The provisions of this section shall apply to anesthesia
47 services provided by oral and maxillofacial surgeons as permitted
48 by the Mississippi State Board of Dental Examiners.

49 The provisions of this section shall not apply to treatment
50 rendered for temporal mandibular joint (TMJ) disorders.

51 SECTION 2. Section 83-41-211, Mississippi Code of 1972, is
52 amended as follows:

53 83-41-211. Whenever any policy of insurance or any medical
54 service plan or hospital service contract or hospital and medical
55 service contract issued in this state provides for reimbursement
56 for any diagnosis and treatment of mental, nervous or emotional
57 disorders only which are within the lawful scope of practice of a
58 duly licensed psychologist as defined in Section 73-31-3, within
59 the lawful scope of practice of a duly licensed professional
60 counselor as defined in Section 73-30-3, or within the lawful
61 scope of practice of a duly licensed clinical social worker as
62 defined in Section 73-53-3, the insured or other person entitled
63 to benefits under such policy shall be entitled to reimbursement
64 for such services, whether such services are performed by a duly
65 licensed physician or by a duly licensed psychologist, by a duly
66 licensed professional counselor or by a duly licensed clinical

67 social worker, notwithstanding any provision to the contrary in
68 any statute or in such policy, plan or contract. Duly licensed
69 psychologists shall be entitled to participate in such policies,
70 plans or contracts providing for the diagnosis and treatment of
71 mental, nervous or emotional disorders only as authorized by
72 Section 73-31-3. A duly licensed professional counselor shall be
73 entitled to participate in such policies, plans or contracts
74 providing for the diagnosis and treatment of mental, nervous or
75 emotional disorders only as authorized by Section 73-30-3. <u>The</u>
76 <u>requirements of this section relative to mental health counseling</u>
77 <u>services provided by a duly licensed professional counselor shall</u>
78 <u>be fully applicable to the State Employees Health Insurance Plan</u>
79 <u>and the Public School Employees Health Insurance Plan.</u> A duly
80 licensed clinical social worker shall be entitled to participate
81 in such policies, plans or contracts providing for the diagnosis
82 and treatment of mental, nervous or emotional disorders only as
83 authorized by Section 73-53-3.

84 SECTION 3. Section 25-15-9, Mississippi Code of 1972, is
85 amended as follows:

86 25-15-9. (1) (a) The department shall design a plan of
87 health insurance for state employees which provides benefits for
88 semiprivate rooms in addition to other incidental coverages which
89 the department deems necessary. The amount of the coverages shall
90 be in such reasonable amount as may be determined by the
91 department to be adequate, after due consideration of current
92 health costs in Mississippi. The plan shall also include major
93 medical benefits in such amounts as the department shall
94 determine. <u>The plan shall provide benefits for anesthesia and</u>
95 <u>associated facility charges for certain dental care procedures as</u>
96 <u>required in Section 1 of House Bill No. 1067, 1999 Regular</u>
97 <u>Session, and benefits for mental health counseling services</u>
98 <u>provided by a duly licensed professional counselor as required in</u>
99 <u>Section 83-41-211.</u> The department is also authorized to accept

100 bids for such alternate coverage and optional benefits as the
101 department shall deem proper. The department may employ or
102 contract for such consulting or actuarial services as may be
103 necessary to formulate the State Employees Health Insurance Plan,
104 and to assist the department in the preparation of specifications
105 and in the process of advertising for the bids for the plan. The
106 department is authorized to promulgate rules and regulations to
107 implement the provisions of this subsection.

108 The department shall develop plans for the insurance plan
109 authorized by this section in accordance with the provisions of
110 Section 25-15-5.

111 (b) There is created an advisory council to advise the
112 department in the formulation of the State Employees Health
113 Insurance Plan. The council shall be composed of the State
114 Insurance Commissioner or his designee, an employee-representative
115 of the institutions of higher learning appointed by the board of
116 trustees thereof, an employee-representative of the Department of
117 Transportation appointed by the director thereof, an
118 employee-representative of the State Tax Commission appointed by
119 the Commissioner of Revenue, an employee-representative of the
120 Mississippi Department of Health appointed by the State Health
121 Officer, an employee-representative of the Mississippi Department
122 of Corrections appointed by the Commissioner of Corrections, and
123 an employee-representative of the Department of Human Services
124 appointed by the Executive Director of Human Services.

125 The Lieutenant Governor may designate the Secretary of the
126 Senate, the Chairman of the Senate Appropriations Committee and
127 the Chairman of the Senate Insurance Committee, and the Speaker of
128 the House of Representatives may designate the Clerk of the House,
129 the Chairman of the House Appropriations Committee and the
130 Chairman of the House Insurance Committee, to attend any meeting
131 of the State Employees Insurance Advisory Council. The appointing
132 authorities may designate an alternate member from their

133 respective houses to serve when the regular designee is unable to
134 attend such meetings of the council. Such designees shall have
135 no jurisdiction or vote on any matter within the jurisdiction of
136 the council. For attending meetings of the council, such
137 legislators shall receive per diem and expenses which shall be
138 paid from the contingent expense funds of their respective houses
139 in the same amounts as provided for committee meetings when the
140 Legislature is not in session; however, no per diem and expenses
141 for attending meetings of the council will be paid while the
142 Legislature is in session. No per diem and expenses will be paid
143 except for attending meetings of the council without prior
144 approval of the proper committee in their respective houses.

145 (c) No change in the terms of the State Employees
146 Health Insurance Plan may be made effective unless the Executive
147 Director of the Department of Finance and Administration or his
148 designee, has provided notice to the State Employees Health
149 Insurance Advisory Council and has called a meeting of the council
150 at least fifteen (15) days before the effective date of such
151 change. In the event that the State Employees Health Insurance
152 Council does not meet to advise the department on the proposed
153 changes, the changes to the plan shall become effective at such
154 time as the department has informed the council that the changes
155 shall become effective.

156 (d) **Medical benefits for retired employees and**
157 **dependents under age sixty-five (65) years.** The same health
158 insurance coverage as for all other active employees and their
159 dependents shall be available to retired employees and all
160 dependents under age sixty-five (65) years, the level of benefits
161 to be the same level as for all other active participants. This
162 section will apply to those employees who retire due to one
163 hundred percent (100%) medical disability as well as those
164 employees electing early retirement.

165 (e) **Medical benefits for retired employees over age**

166 **sixty-five (65) years.** The health insurance coverage available to
167 retired employees over age sixty-five (65) years, and all
168 dependents over age sixty-five (65) years, shall be the major
169 medical coverage with the lifetime maximum of One Million Dollars
170 ($1,000,000.00). Benefits shall be reduced by Medicare benefits
171 as though such Medicare benefits were the base plan.
172 All covered individuals shall be assumed to have full
173 Medicare coverage, Parts A and B; and any Medicare payments under
174 both Parts A and B shall be computed to reduce benefits payable
175 under this plan.
176 (2) Nonduplication of benefits--reduction of benefits by
177 Title XIX benefits: When benefits would be payable under more
178 than one (1) group plan, benefits under those plans will be
179 coordinated to the extent that the total benefits under all plans
180 will not exceed the total expenses incurred.
181 Benefits for hospital or surgical or medical benefits shall
182 be reduced by any similar benefits payable in accordance with
183 Title XIX of the Social Security Act or under any amendments
184 thereto, or any implementing legislation.
185 Benefits for hospital or surgical or medical benefits shall be
186 reduced by any similar benefits payable by workers' compensation.
187 (3) Schedule of life insurance benefits--group term: The
188 amount of term life insurance for each active employee shall not be
189 in excess of One Hundred Fifty Thousand Dollars ($150,000.00), or
190 four (4) times the amount of the employee's annual wage to the next
191 highest One Thousand Dollars ($1,000.00), whichever may be less, but
192 in no case less than Fifty Thousand Dollars ($50,000.00), with a
193 like amount for accidental death and dismemberment on a
194 twenty-four-hour basis. The plan will further contain a premium
195 waiver provision if a covered employee becomes totally and
196 permanently disabled prior to age sixty-five (65) years. ***
197 Employees retiring after June 30, 1999, shall be eligible to
198 continue life insurance coverage in an amount of Ten Thousand

199 Dollars ($10,000.00), Twenty Thousand Dollars ($20,000.00) or Fifty
200 Thousand Dollars ($50,000.00) into retirement. * * *
201 (4) Any eligible employee who on March 1, 1971, was
202 participating in a group life insurance program which has provisions
203 different from those included herein and for which the State of
204 Mississippi was paying a part of the premium may, at his discretion,
205 continue to participate in such plan. Such employee shall pay in
206 full all additional costs, if any, above the minimum program
207 established by this article. Under no circumstances shall any
208 individual who begins employment with the state after March 1, 1971,
209 be eligible for the provisions of this paragraph.
210 (5) Any participant of the State Employees Health Insurance
211 Plan who otherwise would lose coverage and who would be eligible as
212 a dependent under an existing Public School Employees Health
213 Insurance Plan contract may transfer to the Public School Employees
214 Health Insurance Plan as a dependent under the existing contract.
215 Any participant of the Public School Employees Health Insurance Plan
216 who otherwise would lose coverage and who would be eligible as a
217 dependent under an existing State Employees Health Insurance Plan
218 contract may transfer to the State Employees Health Insurance Plan
219 as a dependent under the existing contract. A transfer pursuant to
220 this subsection must occur within thirty-one (31) days of losing
221 coverage. Credit shall be given for any deductible amount
222 satisfied, out-of-pocket expenses and time served toward the
223 twelve-month pre-existing waiting period.
224 (6) If both spouses are eligible employees who participate in
225 the plan, the benefits shall apply individually to each spouse by
226 virtue of his or her participation in the plan. If those spouses
227 also have one or more eligible dependents participating in the plan,
228 the cost of their dependents shall be calculated at a special family
229 plan rate. The cost for participation by the dependents shall be
230 paid by the spouse who elects to carry such dependents under his or
231 her coverage. The special family plan rate shall also apply if the

232 state employee's spouse is a covered eligible employee under the
233 Public School Employees Health Insurance Plan.
234 (7) (a) The department may offer medical savings accounts as
235 defined in Section 71-9-3 as a plan option. Provided, however, that
236 prior to offering such accounts as a plan option, the Department of
237 Finance and Administration shall prepare and present to the Senate
238 and House Insurance Committees by December 15, 1996, a comprehensive
239 study of medical savings accounts to include a proposed
240 implementation timetable and potential actuarial effects of such
241 accounts on the existing state employee health plan. The
242 department's study shall also include, but not be limited to,
243 recommended employer contribution levels, recommended employee
244 contribution levels, recommendations on annual rollover of balances
245 or withdrawals for nonmedical purposes, and recommendations on
246 medical coverage for persons who expend their account balances. The
247 department shall use existing staff resources and those of other
248 agencies to conduct this study. In no case shall the department
249 employ a consultant or contractor other than an actuary to conduct
250 this study. No later than July 15, 1996, the Department of Finance
251 and Administration shall meet with the staff of the PEER Committee
252 and the Legislative Budget Office to receive recommendations on the
253 issues and methods which the department shall consider in preparing
254 its report. No later than October 15, 1996, the Department of
255 Finance and Administration shall submit a copy of its draft report
256 to the PEER Committee and the Legislative Budget Office which shall
257 analyze the report and prepare comments for publication in the final
258 report to be submitted to the House and Senate Insurance Committees
259 on December 15, 1996.
260 (b) In no case shall the department offer medical savings
261 accounts as an option to health plan participants prior to January
262 1, 1998.
263 (8) Any premium differentials, differences in coverages,
264 discounts determined by risk or by any other factors shall be

265 uniformly applied to all active employees participating in the
266 insurance plan. It is the intent of the Legislature that the state
267 contribution to the plan be the same for each employee throughout
268 the state.

269 SECTION 4. Section 25-15-255, Mississippi Code of 1972, is
270 amended as follows:

271 25-15-255. (1) (a) The Department of Finance and
272 Administration shall design a plan of health insurance for employees
273 which provides benefits for semiprivate rooms in addition to other
274 incidental coverages which the department deems necessary.

275 The amount of the coverages shall be in such reasonable amount
276 as may be determined by the department to be adequate, after due
277 consideration of current health costs in Mississippi. The plan
278 shall also include major medical benefits in such amounts as the
279 department shall determine. The plan shall provide benefits for
280 anesthesia and associated facility charges for certain dental care
281 procedures as required in Section 1 of House Bill No. 1067, 1999
282 Regular Session, and benefits for mental health counseling services
283 provided by a duly licensed professional counselor as required in
284 Section 83-41-211. The department is also authorized to accept bids
285 for alternate coverage and optional benefits. Any contract for
286 alternative coverage and optional benefits shall be awarded by the
287 department after it has carefully studied and evaluated the bids and
288 selected the best and most cost-effective bid. The department may
289 reject all such bids; however, the department shall notify all
290 bidders of the rejection and shall actively solicit new bids if all
291 bids are rejected.

292 It is the intent of the Legislature that coverage under this
293 plan may be self-insured by the State of Mississippi and the same as
294 coverage provided state employees under the Public Employees Health
295 Insurance Plan created in Section 25-15-3 et seq. The department
296 may contract the administration and service of the self-insured
297 program to a third party; however, before executing any contract,

298 the department shall actively solicit bids for the administration
299 and service of the program.
300 The department shall conduct the solicitation and contracting
301 process in strict accordance with Section 25-15-301.
302 Beginning on January 1, 1996, any contract entered into between
303 the department for the administration and/or service of the
304 self-insured plan and a third party shall be for the calendar year
305 that begins on the first day of January and expires on the following
306 thirty-first day of December.
307 The department may employ or contract for such consulting or
308 actuarial services as may be necessary to formulate the Public
309 School Employees Health Insurance Plan, and to assist the department
310 in the preparation of specifications and in the process of
311 advertising for the bids for the plan. Such contracts shall be
312 solicited and entered into in accordance with Section 25-15-5. The
313 department shall keep a record of all persons, agents and
314 corporations who contract with or assist the department in preparing
315 and developing the plan. The department, in a timely manner, shall
316 provide copies of this record to the members of the advisory council
317 created in paragraph (b) of this subsection and those legislators,
318 or their designees, who may attend meetings of the advisory council.
319 The department shall provide copies of this record in the
320 solicitation of bids for the administration and servicing of the
321 self-insured program. Each person, agent or corporation which,
322 during the previous fiscal year, has assisted in the development of
323 the plan or employed or compensated any person who assisted in the
324 development of the plan, and which bids on the administration or
325 servicing of the plan, shall submit to the department a statement
326 accompanying the bid explaining in detail its participation with the
327 development of the plan. This statement shall include the amount of
328 compensation paid by the bidder to any such employee during the
329 previous fiscal year. The department shall make all such
330 information available to the members of the advisory council and

331 those legislators, or their designees, who may attend meetings of
332 the advisory council before any action is taken by the department on
333 the bids submitted. The failure of any bidder to fully and
334 accurately comply with this paragraph shall result in the rejection
335 of any bid submitted by that bidder or the cancellation of any
336 contract executed when the failure is discovered after the
337 acceptance of that bid.

338 The department is authorized to promulgate rules and
339 regulations to implement the provisions of this subsection. After
340 expiration or termination of the contract between the state and the
341 administering corporation existing immediately before the date on
342 which the plan becomes self-insured by the State of Mississippi, the
343 remainder of funds in the Premium Stabilization Fund shall revert to
344 the Public School Employees Insurance Fund and shall be used
345 exclusively for payment of future premiums.

346 Any corporation, association, company or individual that
347 contracts with the department for the third-party claims
348 administration of the self-insured plan shall prepare and keep on
349 file an explanation of benefits for each claim processed. The
350 explanation of benefits shall contain such information relative to
351 each processed claim which the department deems necessary, and at a
352 minimum, each explanation shall provide the claimant's name, claim
353 number, provider number, provider name, service dates, type of
354 services, amount of charges, amount allowed to the claimant and
355 reason codes.

356 The information contained in the explanation of benefits shall
357 be available for inspection upon request by the department. The
358 department shall have access to all claims information utilized in
359 the issuance of payments to employees and providers. Any
360 corporation, association, company or individual that contracts with
361 the department for the administration and/or service of the
362 self-insured plan shall remit one hundred percent (100%) of all
363 savings or discounts resulting from any contract to the department

364 and/or participant. Any corporation, association, company or
365 individual that contracts with the department for the administration
366 and/or service of the self-insured plan shall allow, upon notice by
367 the department, the department or its designee to audit records of
368 the corporation, association, company or individual relative to the
369 corporation, association, company or individual's performance under
370 any contract with the department. The information maintained by any
371 corporation, association, company or individual, relating to such
372 contracts, shall be available for inspection upon request by the
373 department and such information shall be compiled in a manner that
374 will provide a clear audit trail.

375 (b) There is created an advisory council to the
376 department to advise the department in the formulation of the Public
377 School Employees Health Insurance Plan. The advisory council and
378 those legislators, or their designees, authorized to attend meetings
379 of the advisory council pursuant to this subsection shall be
380 informed in a timely manner concerning each aspect of the
381 formulation and development of the plan. No change in the terms of
382 the Public School Employees Health Insurance Plan may be made
383 effective unless the Executive Director of the Department of Finance
384 and Administration, or his designee, has provided notice to the
385 Public School Employees Health Insurance Advisory Council and has
386 called a meeting of the council at least fifteen (15) days before
387 the effective date of such change. In the event that the Public
388 School Employees Health Insurance Advisory Council does not meet to
389 advise the department on the proposed changes, the changes to the
390 plan shall become effective at such times as the department has
391 informed the council that the changes shall become effective.

392 The council shall be composed of the State Insurance
393 Commissioner or his designee, two (2) certificated public school
394 administrators appointed by the State Board of Education, two (2)
395 certificated classroom teachers appointed by the State Board of
396 Education, a noncertificated school employee appointed by the State

397 Board of Education, and a community/junior college employee
398 appointed by the State Board for Community and Junior Colleges.
399 Members of the council shall serve at the will and pleasure of the
400 appointing authorities; however, no member shall serve for a period
401 of less than one (1) year. The members of the council shall serve
402 without compensation, per diem or expense reimbursement.
403 The Chairman of the Senate Insurance Committee, the Chairman of
404 the Senate Education Committee, the Chairman of the House of
405 Representatives Insurance Committee and the Chairman of the House of
406 Representatives Education Committee, and/or their designees from
407 their respective houses, may attend any meeting of the advisory
408 council. The legislators, or their designees, shall have no
409 jurisdiction or vote on any matter within the jurisdiction of the
410 council. For attending meetings of the council, the legislators
411 shall receive per diem and expenses which shall be paid from the
412 contingent expense funds of their respective houses in the same
413 amounts as provided for committee meetings when the Legislature is
414 not in session; however, no per diem and expenses for attending
415 meetings of the council will be paid while the Legislature is in
416 session. No per diem and expenses will be paid except for attending
417 meetings of the council without prior approval of the proper
418 committee in their respective houses.
419 (c) **Medical benefits for retired employees and dependents**
420 **under age sixty-five (65) years.** The same health insurance coverage
421 as for all other active employees and their dependents shall be
422 available to retired employees and all dependents under age
423 sixty-five (65) years, the level of benefits to be the same level as
424 for all other active participants. This section will apply to those
425 employees who retire due to one hundred percent (100%) medical
426 disability as well as those employees electing early retirement.
427 (d) **Medical benefits for retired employees over age**
428 **sixty-five (65)**. The health insurance coverage available to retired
429 employees over age sixty-five (65) years, and all dependents over

430 age sixty-five (65) years, shall be the major medical coverage with
431 the lifetime maximum of One Million Dollars ($1,000,000.00).
432 Benefits shall be reduced by Medicare benefits as though such
433 Medicare benefits were the base plan.
434 All covered individuals shall be assumed to have full Medicare
435 coverage, Parts A and B; and any Medicare payments under both Parts
436 A and B shall be computed to reduce benefits payable under this
437 plan.
438 (2) **Nonduplication of benefits-reduction of benefits by Title**
439 **XIX benefits.** When benefits would be payable under more than one
440 group plan, benefits under those plans will be coordinated to the
441 extent that the total benefits under all plans will not exceed the
442 total expenses incurred.
443 Benefits for hospital or surgical or medical benefits shall be
444 reduced by any similar benefits payable in accordance with Title XIX
445 of the Social Security Act or under any amendments thereto, or any
446 implementing legislation.
447 Benefits for hospital or surgical or medical benefits shall be
448 reduced by any similar benefits payable by workers' compensation.
449 (3) The department is hereby authorized to determine the
450 manner in which premiums and contributions by the state and local
451 school districts shall be collected to provide the self-insured
452 health insurance program for school employees and community/junior
453 college employees as provided under this article.
454 (4) Any premium differentials, differences in coverages,
455 discounts determined by risk or by any other factors shall be
456 uniformly applied to all active employees participating in the
457 insurance plan. It is the intent of the Legislature that the state
458 contribution to the plan be the same for each employee throughout
459 the state.
460 (5) Any participant of the State Employees Health Insurance
461 Plan who otherwise would lose coverage and who would be eligible as
462 a dependent under an existing Public School Employees Health

463 Insurance Plan contract may transfer to the Public School Employees
464 Health Insurance Plan as a dependent under the existing contract.
465 Any participant of the Public School Employees Health Insurance Plan
466 who otherwise would lose coverage and who would be eligible as a
467 dependent under an existing State Employees Health Insurance Plan
468 contract may transfer to the State Employees Health Insurance Plan
469 as a dependent under the existing contract. A transfer pursuant to
470 this subsection must occur within thirty-one (31) days of losing
471 coverage. Credit shall be given for any deductible amount
472 satisfied, out-of-pocket expenses and time served toward the
473 twelve-month pre-existing waiting period.
474 (6) The Department of Finance and Administration shall
475 annually report to the Joint Legislative Budget Committee the
476 condition of the Public School Employees Health Insurance Plan.
477 Such report shall contain, but not be limited to, a report of the
478 plan's financial condition at the close of the most recent complete
479 calendar year. The report shall also include all recommendations
480 made to the department by consultants regarding the plan and its
481 administration, including a complete departmental response to each
482 recommendation. The department shall also list the history of
483 yearly claims paid and premiums received for each employee subgroup,
484 including, but not limited to, active employees, dependents and
485 retirees and shall also publish the loss ratios for these subgroups.
486 For purposes of this subsection, the term "loss ratios" shall mean
487 claims paid by the plan for each subgroup divided by premiums
488 received by the plan for the insurance coverage of the members in
489 that subgroup. Any plan revisions made during the previous year
490 shall also be listed in the report and fully described in the
491 report. The department shall also provide the Joint Legislative
492 Budget Committee with a monthly statement of plan utilization.
493 In addition to the information provided for herein, the
494 department shall provide to the Joint Legislative Budget Committee
495 budgetary information on the Public School Employees Health

496 Insurance Plan. All information shall be provided to the Joint
497 Legislative Budget Committee in a format designated by the
498 committee. The information shall be provided in September of each
499 year, and at such times throughout the year as the committee deems
500 necessary. The information shall include, but not be limited to:
501 (a) A detailed breakdown of all expenditures of the plan,
502 administrative and otherwise, for the most recently completed fiscal
503 year and projected expenditures for the current fiscal year;
504 (b) A schedule of all contracts, administrative and
505 otherwise, executed for the benefit of the plan during the most
506 recent completed fiscal year, and those executed and anticipated for
507 the current fiscal year;
508 (c) Anticipated plan expenditures, administrative and
509 otherwise, for the next fiscal year.
510 The department shall also provide to the Joint Legislative
511 Committee on Performance Evaluation and Expenditure Review (PEER)
512 all information described in paragraph (b) in this subsection. The
513 PEER Committee shall prepare a report by January 1 of each year on
514 all contractors utilized by the department for the health plans,
515 excluding the third-party administrator contract. The committee's
516 report shall address the processes by which the department procured
517 the contractors, the contractors' work products and contract
518 expenditures. The review provided for herein shall be supplemental
519 to the review provided for in Section 25-15-301.
520 (7) (a) The department may offer medical savings accounts as
521 defined in Section 71-9-3 as a plan option. Provided, however, that
522 prior to offering such accounts as a plan option, the Department of
523 Finance and Administration shall prepare and present to the
524 Legislature by December 15, 1996, a comprehensive study of medical
525 savings accounts to include a proposed implementation timetable and
526 potential actuarial effects of such accounts on the existing public
527 school employees' health plan. The department's study shall also
528 include, but not be limited to, recommended employer contribution

529 levels, recommended employee contribution levels, recommendations on
530 annual rollover of balances or withdrawals for nonmedical purposes,
531 and, recommendations on medical coverage for persons who expend
532 their account balances. The department shall use existing staff
533 resources and those of other agencies to conduct this study. In no
534 case shall the department employ a consultant or contractor other
535 than an actuary to conduct this study. No later than July 15, 1996,
536 the Department of Finance and Administration shall meet with the
537 staff of the PEER Committee and the Legislative Budget Office to
538 receive recommendations on the issues and methods which the
539 department shall consider in preparing its report. No later than
540 October 15, 1996, the Department of Finance and Administration shall
541 submit a copy of its draft report to the PEER Committee and the
542 Legislative Budget Office which shall analyze the report and prepare
543 comments for publication in the final report to be submitted to the
544 House and Senate Insurance Committees on December 15, 1996.
545 (b) In no case shall the department offer medical savings
546 accounts as an option to health plan participants prior to January
547 1, 1998.
548 SECTION 5. Section 41-86-17, Mississippi Code of 1972, is
549 amended as follows:
550 41-86-17. The covered benefits under the program shall include
551 all health care benefits and services required to be included as
552 covered benefits under Title XXI of the federal Social Security Act,
553 as amended, and shall include early and periodic screening and
554 diagnosis services at least equal to those provided under the
555 Medicaid program. The benefits and services offered and available
556 to state employees under the State Employees Health Insurance Plan
557 shall be used as the benchmark for benefits and services under the
558 program, with an emphasis on preventive and primary care. Benefits
559 and services to be provided under the program shall include: vision
560 and hearing screening, eyeglasses and hearing aids, preventive
561 dental care and routine dental fillings<u>, anesthesia and associated</u>

562 facility charges for certain dental care procedures as required in
563 Section 1 of House Bill No. 1067, 1999 Regular Session. No
564 deductibles, coinsurance or any other cost-sharing shall be allowed
565 for any of the benefits and services named in the preceding
566 sentence.

567 SECTION 6. Section 43-13-117, Mississippi Code of 1972, is
568 amended as follows:

569 43-13-117. Medical assistance as authorized by this article
570 shall include payment of part or all of the costs, at the discretion
571 of the division or its successor, with approval of the Governor, of
572 the following types of care and services rendered to eligible
573 applicants who shall have been determined to be eligible for such
574 care and services, within the limits of state appropriations and
575 federal matching funds:

576 (1) Inpatient hospital services.

577 (a) The division shall allow thirty (30) days of
578 inpatient hospital care annually for all Medicaid recipients;
579 however, before any recipient will be allowed more than fifteen (15)
580 days of inpatient hospital care in any one (1) year, he must obtain
581 prior approval therefor from the division. The division shall be
582 authorized to allow unlimited days in disproportionate hospitals as
583 defined by the division for eligible infants under the age of six
584 (6) years.

585 (b) From and after July 1, 1994, the Executive Director
586 of the Division of Medicaid shall amend the Mississippi Title XIX
587 Inpatient Hospital Reimbursement Plan to remove the occupancy rate
588 penalty from the calculation of the Medicaid Capital Cost Component
589 utilized to determine total hospital costs allocated to the Medicaid
590 Program.

591 (2) Outpatient hospital services. Provided that where the
592 same services are reimbursed as clinic services, the division may
593 revise the rate or methodology of outpatient reimbursement to
594 maintain consistency, efficiency, economy and quality of care.

595 (3) Laboratory and X-ray services.
596 (4) Nursing facility services.
597 (a) The division shall make full payment to nursing
598 facilities for each day, not exceeding thirty-six (36) days per
599 year, that a patient is absent from the facility on home leave.
600 However, before payment may be made for more than eighteen (18) home
601 leave days in a year for a patient, the patient must have written
602 authorization from a physician stating that the patient is
603 physically and mentally able to be away from the facility on home
604 leave. Such authorization must be filed with the division before it
605 will be effective and the authorization shall be effective for three
606 (3) months from the date it is received by the division, unless it
607 is revoked earlier by the physician because of a change in the
608 condition of the patient.
609 (b) From and after July 1, 1993, the division shall
610 implement the integrated case-mix payment and quality monitoring
611 system developed pursuant to Section 43-13-122, which includes the
612 fair rental system for property costs and in which recapture of
613 depreciation is eliminated. The division may revise the
614 reimbursement methodology for the case-mix payment system by
615 reducing payment for hospital leave and therapeutic home leave days
616 to the lowest case-mix category for nursing facilities, modifying
617 the current method of scoring residents so that only services
618 provided at the nursing facility are considered in calculating a
619 facility's per diem, and the division may limit administrative and
620 operating costs, but in no case shall these costs be less than one
621 hundred nine percent (109%) of the median administrative and
622 operating costs for each class of facility, not to exceed the median
623 used to calculate the nursing facility reimbursement for Fiscal Year
624 1996, to be applied uniformly to all long-term care facilities.
625 This paragraph (b) shall stand repealed on July 1, 1997.
626 (c) From and after July 1, 1997, all state-owned nursing
627 facilities shall be reimbursed on a full reasonable costs basis.

628 From and after July 1, 1997, payments by the division to nursing
629 facilities for return on equity capital shall be made at the rate
630 paid under Medicare (Title XVIII of the Social Security Act), but
631 shall be no less than seven and one-half percent (7.5%) nor greater
632 than ten percent (10%).
633 (d) A Review Board for nursing facilities is established
634 to conduct reviews of the Division of Medicaid's decision in the
635 areas set forth below:
636 (i) Review shall be heard in the following areas:
637 (A) Matters relating to cost reports including,
638 but not limited to, allowable costs and cost adjustments resulting
639 from desk reviews and audits.
640 (B) Matters relating to the Minimum Data Set
641 Plus (MDS +) or successor assessment formats including, but not
642 limited to, audits, classifications and submissions.
643 (ii) The Review Board shall be composed of six (6)
644 members, three (3) having expertise in one (1) of the two (2) areas
645 set forth above and three (3) having expertise in the other area set
646 forth above. Each panel of three (3) shall only review appeals
647 arising in its area of expertise. The members shall be appointed as
648 follows:
649 (A) In each of the areas of expertise defined
650 under subparagraphs (i)(A) and (i)(B), the Executive Director of the
651 Division of Medicaid shall appoint one (1) person chosen from the
652 private sector nursing home industry in the state, which may include
653 independent accountants and consultants serving the industry;
654 (B) In each of the areas of expertise defined
655 under subparagraphs (i)(A) and (i)(B), the Executive Director of the
656 Division of Medicaid shall appoint one (1) person who is employed by
657 the state who does not participate directly in desk reviews or
658 audits of nursing facilities in the two (2) areas of review;
659 (C) The two (2) members appointed by the
660 Executive Director of the Division of Medicaid in each area of

661 expertise shall appoint a third member in the same area of
662 expertise.
663 In the event of a conflict of interest on the part of any
664 Review Board members, the Executive Director of the Division of
665 Medicaid or the other two (2) panel members, as applicable, shall
666 appoint a substitute member for conducting a specific review.
667 (iii) The Review Board panels shall have the power
668 to preserve and enforce order during hearings; to issue subpoenas;
669 to administer oaths; to compel attendance and testimony of
670 witnesses; or to compel the production of books, papers, documents
671 and other evidence; or the taking of depositions before any
672 designated individual competent to administer oaths; to examine
673 witnesses; and to do all things conformable to law that may be
674 necessary to enable it effectively to discharge its duties. The
675 Review Board panels may appoint such person or persons as they shall
676 deem proper to execute and return process in connection therewith.
677 (iv) The Review Board shall promulgate, publish and
678 disseminate to nursing facility providers rules of procedure for the
679 efficient conduct of proceedings, subject to the approval of the
680 Executive Director of the Division of Medicaid and in accordance
681 with federal and state administrative hearing laws and regulations.
682 (v) Proceedings of the Review Board shall be of
683 record.
684 (vi) Appeals to the Review Board shall be in writing
685 and shall set out the issues, a statement of alleged facts and
686 reasons supporting the provider's position. Relevant documents may
687 also be attached. The appeal shall be filed within thirty (30) days
688 from the date the provider is notified of the action being appealed
689 or, if informal review procedures are taken, as provided by
690 administrative regulations of the Division of Medicaid, within
691 thirty (30) days after a decision has been rendered through informal
692 hearing procedures.
693 (vii) The provider shall be notified of the hearing

694 date by certified mail within thirty (30) days from the date the
695 Division of Medicaid receives the request for appeal. Notification
696 of the hearing date shall in no event be less than thirty (30) days
697 before the scheduled hearing date. The appeal may be heard on
698 shorter notice by written agreement between the provider and the
699 Division of Medicaid.
700 (viii) Within thirty (30) days from the date of the
701 hearing, the Review Board panel shall render a written
702 recommendation to the Executive Director of the Division of Medicaid
703 setting forth the issues, findings of fact and applicable law,
704 regulations or provisions.
705 (ix) The Executive Director of the Division of
706 Medicaid shall, upon review of the recommendation, the proceedings
707 and the record, prepare a written decision which shall be mailed to
708 the nursing facility provider no later than twenty (20) days after
709 the submission of the recommendation by the panel. The decision of
710 the executive director is final, subject only to judicial review.
711 (x) Appeals from a final decision shall be made to
712 the Chancery Court of Hinds County. The appeal shall be filed with
713 the court within thirty (30) days from the date the decision of the
714 Executive Director of the Division of Medicaid becomes final.
715 (xi) The action of the Division of Medicaid under
716 review shall be stayed until all administrative proceedings have
717 been exhausted.
718 (xii) Appeals by nursing facility providers
719 involving any issues other than those two (2) specified in
720 subparagraphs (i)(A) and (ii)(B) shall be taken in accordance with
721 the administrative hearing procedures established by the Division of
722 Medicaid.
723 (e) When a facility of a category that does not require a
724 certificate of need for construction and that could not be eligible
725 for Medicaid reimbursement is constructed to nursing facility
726 specifications for licensure and certification, and the facility is

727 subsequently converted to a nursing facility pursuant to a
728 certificate of need that authorizes conversion only and the
729 applicant for the certificate of need was assessed an application
730 review fee based on capital expenditures incurred in constructing
731 the facility, the division shall allow reimbursement for capital
732 expenditures necessary for construction of the facility that were
733 incurred within the twenty-four (24) consecutive calendar months
734 immediately preceding the date that the certificate of need
735 authorizing such conversion was issued, to the same extent that
736 reimbursement would be allowed for construction of a new nursing
737 facility pursuant to a certificate of need that authorizes such
738 construction. The reimbursement authorized in this subparagraph (e)
739 may be made only to facilities the construction of which was
740 completed after June 30, 1989. Before the division shall be
741 authorized to make the reimbursement authorized in this subparagraph
742 (e), the division first must have received approval from the Health
743 Care Financing Administration of the United States Department of
744 Health and Human Services of the change in the state Medicaid plan
745 providing for such reimbursement.
746 (5) Periodic screening and diagnostic services for individuals
747 under age twenty-one (21) years as are needed to identify physical
748 and mental defects and to provide health care treatment and other
749 measures designed to correct or ameliorate defects and physical and
750 mental illness and conditions discovered by the screening services
751 regardless of whether these services are included in the state plan.
752 The division may include in its periodic screening and diagnostic
753 program those discretionary services authorized under the federal
754 regulations adopted to implement Title XIX of the federal Social
755 Security Act, as amended. The division, in obtaining physical
756 therapy services, occupational therapy services, and services for
757 individuals with speech, hearing and language disorders, may enter
758 into a cooperative agreement with the State Department of Education
759 for the provision of such services to handicapped students by public

760 school districts using state funds which are provided from the
761 appropriation to the Department of Education to obtain federal
762 matching funds through the division. The division, in obtaining
763 medical and psychological evaluations for children in the custody of
764 the State Department of Human Services may enter into a cooperative
765 agreement with the State Department of Human Services for the
766 provision of such services using state funds which are provided from
767 the appropriation to the Department of Human Services to obtain
768 federal matching funds through the division.
769 On July 1, 1993, all fees for periodic screening and diagnostic
770 services under this paragraph (5) shall be increased by twenty-five
771 percent (25%) of the reimbursement rate in effect on June 30, 1993.
772 (6) Physicians' services. On January 1, 1996, all fees for
773 physicians' services shall be reimbursed at seventy percent (70%) of
774 the rate established on January 1, 1994, under Medicare (Title XVIII
775 of the Social Security Act), as amended, and the division may adjust
776 the physicians' reimbursement schedule to reflect the differences in
777 relative value between Medicaid and Medicare.
778 (7) (a) Home health services for eligible persons, not to
779 exceed in cost the prevailing cost of nursing facility services, not
780 to exceed sixty (60) visits per year.
781 (b) The division may revise reimbursement for home health
782 services in order to establish equity between reimbursement for home
783 health services and reimbursement for institutional services within
784 the Medicaid program. This paragraph (b) shall stand repealed on
785 July 1, 1997.
786 (8) Emergency medical transportation services. On January 1,
787 1994, emergency medical transportation services shall be reimbursed
788 at seventy percent (70%) of the rate established under Medicare
789 (Title XVIII of the Social Security Act), as amended. "Emergency
790 medical transportation services" shall mean, but shall not be
791 limited to, the following services by a properly permitted ambulance
792 operated by a properly licensed provider in accordance with the

793 Emergency Medical Services Act of 1974 (Section 41-59-1 et seq.):
794 (i) basic life support, (ii) advanced life support, (iii) mileage,
795 (iv) oxygen, (v) intravenous fluids, (vi) disposable supplies, (vii)
796 similar services.
797 (9) Legend and other drugs as may be determined by the
798 division. The division may implement a program of prior approval
799 for drugs to the extent permitted by law. Payment by the division
800 for covered multiple source drugs shall be limited to the lower of
801 the upper limits established and published by the Health Care
802 Financing Administration (HCFA) plus a dispensing fee of Four
803 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
804 cost (EAC) as determined by the division plus a dispensing fee of
805 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual
806 and customary charge to the general public. The division shall
807 allow five (5) prescriptions per month for noninstitutionalized
808 Medicaid recipients.
809 Payment for other covered drugs, other than multiple source
810 drugs with HCFA upper limits, shall not exceed the lower of the
811 estimated acquisition cost as determined by the division plus a
812 dispensing fee of Four Dollars and Ninety-one Cents ($4.91) or the
813 providers' usual and customary charge to the general public.
814 Payment for nonlegend or over-the-counter drugs covered on the
815 division's formulary shall be reimbursed at the lower of the
816 division's estimated shelf price or the providers' usual and
817 customary charge to the general public. No dispensing fee shall be
818 paid.
819 The division shall develop and implement a program of payment
820 for additional pharmacist services, with payment to be based on
821 demonstrated savings, but in no case shall the total payment exceed
822 twice the amount of the dispensing fee.
823 As used in this paragraph (9), "estimated acquisition cost"
824 means the division's best estimate of what price providers generally
825 are paying for a drug in the package size that providers buy most

826 frequently. Product selection shall be made in compliance with
827 existing state law; however, the division may reimburse as if the
828 prescription had been filled under the generic name. The division
829 may provide otherwise in the case of specified drugs when the
830 consensus of competent medical advice is that trademarked drugs are
831 substantially more effective.
832 (10) Dental care that is an adjunct to treatment of an acute
833 medical or surgical condition; services of oral surgeons and
834 dentists in connection with surgery related to the jaw or any
835 structure contiguous to the jaw or the reduction of any fracture of
836 the jaw or any facial bone; and emergency dental extractions and
837 treatment related thereto. On January 1, 1994, all fees for dental
838 care and surgery under authority of this paragraph (10) shall be
839 increased by twenty percent (20%) of the reimbursement rate as
840 provided in the Dental Services Provider Manual in effect on
841 December 31, 1993.
842 (11) Eyeglasses necessitated by reason of eye surgery, and as
843 prescribed by a physician skilled in diseases of the eye or an
844 optometrist, whichever the patient may select.
845 (12) Intermediate care facility services.
846 (a) The division shall make full payment to all
847 intermediate care facilities for the mentally retarded for each day,
848 not exceeding thirty-six (36) days per year, that a patient is
849 absent from the facility on home leave. However, before payment may
850 be made for more than eighteen (18) home leave days in a year for a
851 patient, the patient must have written authorization from a
852 physician stating that the patient is physically and mentally able
853 to be away from the facility on home leave. Such authorization must
854 be filed with the division before it will be effective, and the
855 authorization shall be effective for three (3) months from the date
856 it is received by the division, unless it is revoked earlier by the
857 physician because of a change in the condition of the patient.
858 (b) All state-owned intermediate care facilities for the

859 mentally retarded shall be reimbursed on a full reasonable cost
860 basis.
861 (13) Family planning services, including drugs, supplies and
862 devices, when such services are under the supervision of a
863 physician.
864 (14) Clinic services. Such diagnostic, preventive,
865 therapeutic, rehabilitative or palliative services furnished to an
866 outpatient by or under the supervision of a physician or dentist in
867 a facility which is not a part of a hospital but which is organized
868 and operated to provide medical care to outpatients. Clinic
869 services shall include any services reimbursed as outpatient
870 hospital services which may be rendered in such a facility,
871 including those that become so after July 1, 1991. On January 1,
872 1994, all fees for physicians' services reimbursed under authority
873 of this paragraph (14) shall be reimbursed at seventy percent (70%)
874 of the rate established on January 1, 1993, under Medicare (Title
875 XVIII of the Social Security Act), as amended, or the amount that
876 would have been paid under the division's fee schedule that was in
877 effect on December 31, 1993, whichever is greater, and the division
878 may adjust the physicians' reimbursement schedule to reflect the
879 differences in relative value between Medicaid and Medicare.
880 However, on January 1, 1994, the division may increase any fee for
881 physicians' services in the division's fee schedule on December 31,
882 1993, that was greater than seventy percent (70%) of the rate
883 established under Medicare by no more than ten percent (10%). On
884 January 1, 1994, all fees for dentists' services reimbursed under
885 authority of this paragraph (14) shall be increased by twenty
886 percent (20%) of the reimbursement rate as provided in the Dental
887 Services Provider Manual in effect on December 31, 1993.
888 (15) Home- and community-based services, as provided under
889 Title XIX of the federal Social Security Act, as amended, under
890 waivers, subject to the availability of funds specifically
891 appropriated therefor by the Legislature. Payment for such services

892 shall be limited to individuals who would be eligible for and would
893 otherwise require the level of care provided in a nursing facility.
894 The division shall certify case management agencies to provide case
895 management services and provide for home- and community-based
896 services for eligible individuals under this paragraph. The home-
897 and community-based services under this paragraph and the activities
898 performed by certified case management agencies under this paragraph
899 shall be funded using state funds that are provided from the
900 appropriation to the Division of Medicaid and used to match federal
901 funds under a cooperative agreement between the division and the
902 Department of Human Services.
903 (16) Mental health services. Approved therapeutic and case
904 management services provided by (a) an approved regional mental
905 health/retardation center established under Sections 41-19-31
906 through 41-19-39, or by another community mental health service
907 provider meeting the requirements of the Department of Mental Health
908 to be an approved mental health/retardation center if determined
909 necessary by the Department of Mental Health, using state funds
910 which are provided from the appropriation to the State Department of
911 Mental Health and used to match federal funds under a cooperative
912 agreement between the division and the department, or (b) a facility
913 which is certified by the State Department of Mental Health to
914 provide therapeutic and case management services, to be reimbursed
915 on a fee for service basis. Any such services provided by a
916 facility described in paragraph (b) must have the prior approval of
917 the division to be reimbursable under this section. After June 30,
918 1997, mental health services provided by regional mental
919 health/retardation centers established under Sections 41-19-31
920 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
921 and/or their subsidiaries and divisions, or by psychiatric
922 residential treatment facilities as defined in Section 43-11-1, or
923 by another community mental health service provider meeting the
924 requirements of the Department of Mental Health to be an approved

925 mental health/retardation center if determined necessary by the
926 Department of Mental Health, shall not be included in or provided
927 under any capitated managed care pilot program provided for under
928 paragraph (24) of this section.

929 (17) Durable medical equipment services and medical supplies
930 restricted to patients receiving home health services unless waived
931 on an individual basis by the division. The division shall not
932 expend more than Three Hundred Thousand Dollars ($300,000.00) of
933 state funds annually to pay for medical supplies authorized under
934 this paragraph.

935 (18) Notwithstanding any other provision of this section to
936 the contrary, the division shall make additional reimbursement to
937 hospitals which serve a disproportionate share of low-income
938 patients and which meet the federal requirements for such payments
939 as provided in Section 1923 of the federal Social Security Act and
940 any applicable regulations.

941 (19) (a) Perinatal risk management services. The division
942 shall promulgate regulations to be effective from and after October
943 1, 1988, to establish a comprehensive perinatal system for risk
944 assessment of all pregnant and infant Medicaid recipients and for
945 management, education and follow-up for those who are determined to
946 be at risk. Services to be performed include case management,
947 nutrition assessment/counseling, psychosocial assessment/counseling
948 and health education. The division shall set reimbursement rates
949 for providers in conjunction with the State Department of Health.

950 (b) Early intervention system services. The division
951 shall cooperate with the State Department of Health, acting as lead
952 agency, in the development and implementation of a statewide system
953 of delivery of early intervention services, pursuant to Part H of
954 the Individuals with Disabilities Education Act (IDEA). The State
955 Department of Health shall certify annually in writing to the
956 director of the division the dollar amount of state early
957 intervention funds available which shall be utilized as a certified

958 match for Medicaid matching funds. Those funds then shall be used
959 to provide expanded targeted case management services for Medicaid
960 eligible children with special needs who are eligible for the
961 state's early intervention system. Qualifications for persons
962 providing service coordination shall be determined by the State
963 Department of Health and the Division of Medicaid.
964 (20) Home- and community-based services for physically
965 disabled approved services as allowed by a waiver from the U.S.
966 Department of Health and Human Services for home- and
967 community-based services for physically disabled people using state
968 funds which are provided from the appropriation to the State
969 Department of Rehabilitation Services and used to match federal
970 funds under a cooperative agreement between the division and the
971 department, provided that funds for these services are specifically
972 appropriated to the Department of Rehabilitation Services.
973 (21) Nurse practitioner services. Services furnished by a
974 registered nurse who is licensed and certified by the Mississippi
975 Board of Nursing as a nurse practitioner including, but not limited
976 to, nurse anesthetists, nurse midwives, family nurse practitioners,
977 family planning nurse practitioners, pediatric nurse practitioners,
978 obstetrics-gynecology nurse practitioners and neonatal nurse
979 practitioners, under regulations adopted by the division.
980 Reimbursement for such services shall not exceed ninety percent
981 (90%) of the reimbursement rate for comparable services rendered by
982 a physician.
983 (22) Ambulatory services delivered in federally qualified
984 health centers and in clinics of the local health departments of the
985 State Department of Health for individuals eligible for medical
986 assistance under this article based on reasonable costs as
987 determined by the division.
988 (23) Inpatient psychiatric services. Inpatient psychiatric
989 services to be determined by the division for recipients under age
990 twenty-one (21) which are provided under the direction of a

991 physician in an inpatient program in a licensed acute care
992 psychiatric facility or in a licensed psychiatric residential
993 treatment facility, before the recipient reaches age twenty-one (21)
994 or, if the recipient was receiving the services immediately before
995 he reached age twenty-one (21), before the earlier of the date he no
996 longer requires the services or the date he reaches age twenty-two
997 (22), as provided by federal regulations. Recipients shall be
998 allowed forty-five (45) days per year of psychiatric services
999 provided in acute care psychiatric facilities, and shall be allowed
1000 unlimited days of psychiatric services provided in licensed
1001 psychiatric residential treatment facilities.
1002 (24) Managed care services in a program to be developed by the
1003 division by a public or private provider. Notwithstanding any other
1004 provision in this article to the contrary, the division shall
1005 establish rates of reimbursement to providers rendering care and
1006 services authorized under this section, and may revise such rates of
1007 reimbursement without amendment to this section by the Legislature
1008 for the purpose of achieving effective and accessible health
1009 services, and for responsible containment of costs. This shall
1010 include, but not be limited to, one (1) module of capitated managed
1011 care in a rural area, and one (1) module of capitated managed care
1012 in an urban area.
1013 (25) Birthing center services.
1014 (26) Hospice care. As used in this paragraph, the term
1015 "hospice care" means a coordinated program of active professional
1016 medical attention within the home and outpatient and inpatient care
1017 which treats the terminally ill patient and family as a unit,
1018 employing a medically directed interdisciplinary team. The program
1019 provides relief of severe pain or other physical symptoms and
1020 supportive care to meet the special needs arising out of physical,
1021 psychological, spiritual, social and economic stresses which are
1022 experienced during the final stages of illness and during dying and
1023 bereavement and meets the Medicare requirements for participation as

1024 a hospice as provided in 42 CFR Part 418.
1025 (27) Group health plan premiums and cost sharing if it is cost
1026 effective as defined by the Secretary of Health and Human Services.
1027 (28) Other health insurance premiums which are cost effective
1028 as defined by the Secretary of Health and Human Services. Medicare
1029 eligible must have Medicare Part B before other insurance premiums
1030 can be paid.
1031 (29) The Division of Medicaid may apply for a waiver from the
1032 Department of Health and Human Services for home- and
1033 community-based services for developmentally disabled people using
1034 state funds which are provided from the appropriation to the State
1035 Department of Mental Health and used to match federal funds under a
1036 cooperative agreement between the division and the department,
1037 provided that funds for these services are specifically appropriated
1038 to the Department of Mental Health.
1039 (30) Pediatric skilled nursing services for eligible persons
1040 under twenty-one (21) years of age.
1041 (31) Targeted case management services for children with
1042 special needs, under waivers from the U.S. Department of Health and
1043 Human Services, using state funds that are provided from the
1044 appropriation to the Mississippi Department of Human Services and
1045 used to match federal funds under a cooperative agreement between
1046 the division and the department.
1047 (32) Care and services provided in Christian Science Sanatoria
1048 operated by or listed and certified by The First Church of Christ
1049 Scientist, Boston, Massachusetts, rendered in connection with
1050 treatment by prayer or spiritual means to the extent that such
1051 services are subject to reimbursement under Section 1903 of the
1052 Social Security Act.
1053 (33) Podiatrist services.
1054 (34) Personal care services provided in a pilot program to not
1055 more than forty (40) residents at a location or locations to be
1056 determined by the division and delivered by individuals qualified to

1057 provide such services, as allowed by waivers under Title XIX of the
1058 Social Security Act, as amended. The division shall not expend more
1059 than Three Hundred Thousand Dollars ($300,000.00) annually to
1060 provide such personal care services. The division shall develop
1061 recommendations for the effective regulation of any facilities that
1062 would provide personal care services which may become eligible for
1063 Medicaid reimbursement under this section, and shall present such
1064 recommendations with any proposed legislation to the 1996 Regular
1065 Session of the Legislature on or before January 1, 1996.
1066 (35) Services and activities authorized in Sections 43-27-101
1067 and 43-27-103, using state funds that are provided from the
1068 appropriation to the State Department of Human Services and used to
1069 match federal funds under a cooperative agreement between the
1070 division and the department.
1071 (36) Nonemergency transportation services for
1072 Medicaid-eligible persons, to be provided by the Department of Human
1073 Services. The division may contract with additional entities to
1074 administer nonemergency transportation services as it deems
1075 necessary. All providers shall have a valid driver's license,
1076 vehicle inspection sticker and a standard liability insurance policy
1077 covering the vehicle.
1078 (37) Targeted case management services for individuals with
1079 chronic diseases, with expanded eligibility to cover services to
1080 uninsured recipients, on a pilot program basis. This paragraph (37)
1081 shall be contingent upon continued receipt of special funds from the
1082 Health Care Financing Authority and private foundations who have
1083 granted funds for planning these services. No funding for these
1084 services shall be provided from State General Funds.
1085 (38) Chiropractic services: a chiropractor's manual
1086 manipulation of the spine to correct a subluxation, if x-ray
1087 demonstrates that a subluxation exists and if the subluxation has
1088 resulted in a neuromusculoskeletal condition for which manipulation
1089 is appropriate treatment. Reimbursement for chiropractic services

1090 shall not exceed Seven Hundred Dollars ($700.00) per year per
1091 recipient.
1092 (39) Anesthesia services and associated facility charges for
1093 certain dental care procedures as required in Section 1 of House
1094 Bill No. 1067, 1999 Regular Session.
1095 Notwithstanding any provision of this article, except as
1096 authorized in the following paragraph and in Section 43-13-139,
1097 neither (a) the limitations on quantity or frequency of use of or
1098 the fees or charges for any of the care or services available to
1099 recipients under this section, nor (b) the payments or rates of
1100 reimbursement to providers rendering care or services authorized
1101 under this section to recipients, may be increased, decreased or
1102 otherwise changed from the levels in effect on July 1, 1986, unless
1103 such is authorized by an amendment to this section by the
1104 Legislature. However, the restriction in this paragraph shall not
1105 prevent the division from changing the payments or rates of
1106 reimbursement to providers without an amendment to this section
1107 whenever such changes are required by federal law or regulation, or
1108 whenever such changes are necessary to correct administrative errors
1109 or omissions in calculating such payments or rates of reimbursement.
1110 Notwithstanding any provision of this article, no new groups or
1111 categories of recipients and new types of care and services may be
1112 added without enabling legislation from the Mississippi Legislature,
1113 except that the division may authorize such changes without enabling
1114 legislation when such addition of recipients or services is ordered
1115 by a court of proper authority. The director shall keep the
1116 Governor advised on a timely basis of the funds available for
1117 expenditure and the projected expenditures. In the event current or
1118 projected expenditures can be reasonably anticipated to exceed the
1119 amounts appropriated for any fiscal year, the Governor, after
1120 consultation with the director, shall discontinue any or all of the
1121 payment of the types of care and services as provided herein which
1122 are deemed to be optional services under Title XIX of the federal

1123 Social Security Act, as amended, for any period necessary to not
1124 exceed appropriated funds, and when necessary shall institute any
1125 other cost containment measures on any program or programs
1126 authorized under the article to the extent allowed under the federal
1127 law governing such program or programs, it being the intent of the
1128 Legislature that expenditures during any fiscal year shall not
1129 exceed the amounts appropriated for such fiscal year.
1130 SECTION 7. This act shall take effect and be in force from and
1131 after July 1, 1999.

Further, amend by striking the title in its entirety and inserting in lieu thereof the following:

1 AN ACT TO REQUIRE THAT CERTAIN INSURANCE POLICIES AND PLANS
2 PROVIDE MEDICAL BENEFITS WHEN DENTAL CARE IS PROVIDED UNDER
3 PHYSICIAN-SUPERVISED GENERAL ANESTHESIA; TO AMEND SECTION 83-41-211,
4 MISSISSIPPI CODE OF 1972, TO REQUIRE MENTAL HEALTH COUNSELING
5 SERVICES PROVIDED BY A DULY LICENSED PROFESSIONAL COUNSELOR TO BE
6 INCLUDED COVERAGE UNDER THE STATE EMPLOYEES HEALTH INSURANCE PLAN
7 AND THE PUBLIC SCHOOL EMPLOYEES HEALTH INSURANCE PLAN; TO INCREASE
8 THE AUTHORIZED FACE VALUE OF LIFE INSURANCE POLICIES UNDER THE STATE
9 EMPLOYEES HEALTH INSURANCE PLAN; TO AMEND SECTIONS 25-15-9,
10 25-15-255, 41-86-17 AND 43-13-117, MISSISSIPPI CODE OF 1972, IN
11 CONFORMITY THERETO; AND FOR RELATED PURPOSES.