

By: Holland

To: Public Health and
Welfare;
Appropriations

HOUSE BILL NO. 1265

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE THAT MENTAL HEALTH COUNSELING SERVICES PROVIDED BY A
3 DULY LICENSED MARRIAGE AND FAMILY THERAPIST SHALL BE REIMBURSABLE
4 UNDER MEDICAID; AND FOR RELATED PURPOSES.

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

6 SECTION 1. Section 43-13-117, Mississippi Code of 1972, is
7 amended as follows:[RF1]

8 43-13-117. Medical assistance as authorized by this article
9 shall include payment of part or all of the costs, at the
10 discretion of the division or its successor, with approval of the
11 Governor, of the following types of care and services rendered to
12 eligible applicants who shall have been determined to be eligible
13 for such care and services, within the limits of state
14 appropriations and federal matching funds:

15 (1) Inpatient hospital services.

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

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

28 Capital Cost Component utilized to determine total hospital costs
29 allocated to the Medicaid program.

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

34 (3) Laboratory and x-ray services.

35 (4) Nursing facility services.

36 (a) The division shall make full payment to
37 nursing facilities for each day, not exceeding fifty-two (52) days
38 per year, that a patient is absent from the facility on home
39 leave. Payment may be made for the following home leave days in
40 addition to the fifty-two-day limitation: Christmas, the day
41 before Christmas, the day after Christmas, Thanksgiving, the day
42 before Thanksgiving and the day after Thanksgiving. However,
43 before payment may be made for more than eighteen (18) home leave
44 days in a year for a patient, the patient must have written
45 authorization from a physician stating that the patient is
46 physically and mentally able to be away from the facility on home
47 leave. Such authorization must be filed with the division before
48 it will be effective and the authorization shall be effective for
49 three (3) months from the date it is received by the division,
50 unless it is revoked earlier by the physician because of a change
51 in the condition of the patient.

52 (b) From and after July 1, 1993, the division
53 shall implement the integrated case-mix payment and quality
54 monitoring system developed pursuant to Section 43-13-122, which
55 includes the fair rental system for property costs and in which
56 recapture of depreciation is eliminated. The division may revise
57 the reimbursement methodology for the case-mix payment system by
58 reducing payment for hospital leave and therapeutic home leave
59 days to the lowest case-mix category for nursing facilities,
60 modifying the current method of scoring residents so that only
61 services provided at the nursing facility are considered in
62 calculating a facility's per diem, and the division may limit
63 administrative and operating costs, but in no case shall these
64 costs be less than one hundred nine percent (109%) of the median

65 administrative and operating costs for each class of facility, not
66 to exceed the median used to calculate the nursing facility
67 reimbursement for fiscal year 1996, to be applied uniformly to all
68 long-term care facilities.

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

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

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

81 (A) Matters relating to cost reports
82 including, but not limited to, allowable costs and cost
83 adjustments resulting from desk reviews and audits.

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

87 (ii) The Review Board shall be composed of
88 six (6) members, three (3) having expertise in one (1) of the two
89 (2) areas set forth above and three (3) having expertise in the
90 other area set forth above. Each panel of three (3) shall only
91 review appeals arising in its area of expertise. The members
92 shall be appointed as follows:

93 (A) In each of the areas of expertise
94 defined under subparagraphs (i)(A) and (i)(B), the Executive
95 Director of the Division of Medicaid shall appoint one (1) person
96 chosen from the private sector nursing home industry in the state,
97 which may include independent accountants and consultants serving

98 the industry;

99 (B) In each of the areas of expertise
100 defined under subparagraphs (i)(A) and (i)(B), the Executive
101 Director of the Division of Medicaid shall appoint one (1) person
102 who is employed by the state who does not participate directly in
103 desk reviews or audits of nursing facilities in the two (2) areas
104 of review;

105 (C) The two (2) members appointed by the
106 Executive Director of the Division of Medicaid in each area of
107 expertise shall appoint a third member in the same area of
108 expertise.

109 In the event of a conflict of interest on the part of any
110 Review Board members, the Executive Director of the Division of
111 Medicaid or the other two (2) panel members, as applicable, shall
112 appoint a substitute member for conducting a specific review.

113 (iii) The Review Board panels shall have the
114 power to preserve and enforce order during hearings; to issue
115 subpoenas; to administer oaths; to compel attendance and testimony
116 of witnesses; or to compel the production of books, papers,
117 documents and other evidence; or the taking of depositions before
118 any designated individual competent to administer oaths; to
119 examine witnesses; and to do all things conformable to law that
120 may be necessary to enable it effectively to discharge its duties.

121 The Review Board panels may appoint such person or persons as
122 they shall deem proper to execute and return process in connection
123 therewith.

124 (iv) The Review Board shall promulgate,
125 publish and disseminate to nursing facility providers rules of
126 procedure for the efficient conduct of proceedings, subject to the
127 approval of the Executive Director of the Division of Medicaid and
128 in accordance with federal and state administrative hearing laws
129 and regulations.

130 (v) Proceedings of the Review Board shall be

131 of record.

132 (vi) Appeals to the Review Board shall be in
133 writing and shall set out the issues, a statement of alleged facts
134 and reasons supporting the provider's position. Relevant
135 documents may also be attached. The appeal shall be filed within
136 thirty (30) days from the date the provider is notified of the
137 action being appealed or, if informal review procedures are taken,
138 as provided by administrative regulations of the Division of
139 Medicaid, within thirty (30) days after a decision has been
140 rendered through informal hearing procedures.

141 (vii) The provider shall be notified of the
142 hearing date by certified mail within thirty (30) days from the
143 date the Division of Medicaid receives the request for appeal.
144 Notification of the hearing date shall in no event be less than
145 thirty (30) days before the scheduled hearing date. The appeal
146 may be heard on shorter notice by written agreement between the
147 provider and the Division of Medicaid.

148 (viii) Within thirty (30) days from the date
149 of the hearing, the Review Board panel shall render a written
150 recommendation to the Executive Director of the Division of
151 Medicaid setting forth the issues, findings of fact and applicable
152 law, regulations or provisions.

153 (ix) The Executive Director of the Division
154 of Medicaid shall, upon review of the recommendation, the
155 proceedings and the record, prepare a written decision which shall
156 be mailed to the nursing facility provider no later than twenty
157 (20) days after the submission of the recommendation by the panel.
158 The decision of the executive director is final, subject only to
159 judicial review.

160 (x) Appeals from a final decision shall be
161 made to the Chancery Court of Hinds County. The appeal shall be
162 filed with the court within thirty (30) days from the date the
163 decision of the Executive Director of the Division of Medicaid

164 becomes final.

165 (xi) The action of the Division of Medicaid
166 under review shall be stayed until all administrative proceedings
167 have been exhausted.

168 (xii) Appeals by nursing facility providers
169 involving any issues other than those two (2) specified in
170 subparagraphs (i)(A) and (i)(B) shall be taken in accordance with
171 the administrative hearing procedures established by the Division
172 of Medicaid.

173 (e) When a facility of a category that does not
174 require a certificate of need for construction and that could not
175 be eligible for Medicaid reimbursement is constructed to nursing
176 facility specifications for licensure and certification, and the
177 facility is subsequently converted to a nursing facility pursuant
178 to a certificate of need that authorizes conversion only and the
179 applicant for the certificate of need was assessed an application
180 review fee based on capital expenditures incurred in constructing
181 the facility, the division shall allow reimbursement for capital
182 expenditures necessary for construction of the facility that were
183 incurred within the twenty-four (24) consecutive calendar months
184 immediately preceding the date that the certificate of need
185 authorizing such conversion was issued, to the same extent that
186 reimbursement would be allowed for construction of a new nursing
187 facility pursuant to a certificate of need that authorizes such
188 construction. The reimbursement authorized in this subparagraph
189 (e) may be made only to facilities the construction of which was
190 completed after June 30, 1989. Before the division shall be
191 authorized to make the reimbursement authorized in this
192 subparagraph (e), the division first must have received approval
193 from the Health Care Financing Administration of the United States
194 Department of Health and Human Services of the change in the state
195 Medicaid plan providing for such reimbursement.

196 (f) The division shall develop and implement a

197 case-mix payment add-on determined by time studies and other valid
198 statistical data which will reimburse a nursing facility for the
199 additional cost of caring for a resident who has a diagnosis of
200 Alzheimer's or other related dementia and exhibits symptoms that
201 require special care. Any such case-mix add-on payment shall be
202 supported by a determination of additional cost. The division
203 shall also develop and implement as part of the fair rental
204 reimbursement system for nursing facility beds, an Alzheimer's
205 resident bed depreciation enhanced reimbursement system which will
206 provide an incentive to encourage nursing facilities to convert or
207 construct beds for residents with Alzheimer's or other related
208 dementia.

209 (g) The Division of Medicaid shall develop and
210 implement a referral process for long-term care alternatives for
211 Medicaid beneficiaries and applicants. No Medicaid beneficiary
212 shall be admitted to a Medicaid-certified nursing facility unless
213 a licensed physician certifies that nursing facility care is
214 appropriate for that person on a standardized form to be prepared
215 and provided to nursing facilities by the Division of Medicaid.
216 The physician shall forward a copy of that certification to the
217 Division of Medicaid within twenty-four (24) hours after it is
218 signed by the physician. Any physician who fails to forward the
219 certification to the Division of Medicaid within the time period
220 specified in this paragraph shall be ineligible for Medicaid
221 reimbursement for any physician's services performed for the
222 applicant. The Division of Medicaid shall determine, through an
223 assessment of the applicant conducted within two (2) business days
224 after receipt of the physician's certification, whether the
225 applicant also could live appropriately and cost-effectively at
226 home or in some other community-based setting if home- or
227 community-based services were available to the applicant. The
228 time limitation prescribed in this paragraph shall be waived in
229 cases of emergency. If the Division of Medicaid determines that a

230 home- or other community-based setting is appropriate and
231 cost-effective, the division shall:

232 (i) Advise the applicant or the applicant's
233 legal representative that a home- or other community-based setting
234 is appropriate;

235 (ii) Provide a proposed care plan and inform
236 the applicant or the applicant's legal representative regarding
237 the degree to which the services in the care plan are available in
238 a home- or in other community-based setting rather than nursing
239 facility care; and

240 (iii) Explain that such plan and services are
241 available only if the applicant or the applicant's legal
242 representative chooses a home- or community-based alternative to
243 nursing facility care, and that the applicant is free to choose
244 nursing facility care.

245 The Division of Medicaid may provide the services described
246 in this paragraph (g) directly or through contract with case
247 managers from the local Area Agencies on Aging, and shall
248 coordinate long-term care alternatives to avoid duplication with
249 hospital discharge planning procedures.

250 Placement in a nursing facility may not be denied by the
251 division if home- or community-based services that would be more
252 appropriate than nursing facility care are not actually available,
253 or if the applicant chooses not to receive the appropriate home-
254 or community-based services.

255 The division shall provide an opportunity for a fair hearing
256 under federal regulations to any applicant who is not given the
257 choice of home- or community-based services as an alternative to
258 institutional care.

259 The division shall make full payment for long-term care
260 alternative services.

261 The division shall apply for necessary federal waivers to
262 assure that additional services providing alternatives to nursing

263 facility care are made available to applicants for nursing
264 facility care.

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

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

293 (6) Physician's services. All fees for physicians'
294 services that are covered only by Medicaid shall be reimbursed at
295 ninety percent (90%) of the rate established on January 1, 1999,

296 and as adjusted each January thereafter, under Medicare (Title
297 XVIII of the Social Security Act), as amended, and which shall in
298 no event be less than seventy percent (70%) of the rate
299 established on January 1, 1994. All fees for physicians' services
300 that are covered by both Medicare and Medicaid shall be reimbursed
301 at ten percent (10%) of the adjusted Medicare payment established
302 on January 1, 1999, and as adjusted each January thereafter, under
303 Medicare (Title XVIII of the Social Security Act), as amended, and
304 which shall in no event be less than seven percent (7%) of the
305 adjusted Medicare payment established on January 1, 1994.

306 (7) (a) Home health services for eligible persons, not
307 to exceed in cost the prevailing cost of nursing facility
308 services, not to exceed sixty (60) visits per year.

309 (b) Repealed.

310 (8) Emergency medical transportation services. On
311 January 1, 1994, emergency medical transportation services shall
312 be reimbursed at seventy percent (70%) of the rate established
313 under Medicare (Title XVIII of the Social Security Act), as
314 amended. "Emergency medical transportation services" shall mean,
315 but shall not be limited to, the following services by a properly
316 permitted ambulance operated by a properly licensed provider in
317 accordance with the Emergency Medical Services Act of 1974
318 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
319 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
320 (vi) disposable supplies, (vii) similar services.

321 (9) Legend and other drugs as may be determined by the
322 division. The division may implement a program of prior approval
323 for drugs to the extent permitted by law. Payment by the division
324 for covered multiple source drugs shall be limited to the lower of
325 the upper limits established and published by the Health Care
326 Financing Administration (HCFA) plus a dispensing fee of Four
327 Dollars and Ninety-one Cents (\$4.91), or the estimated acquisition
328 cost (EAC) as determined by the division plus a dispensing fee of

329 Four Dollars and Ninety-one Cents (\$4.91), or the providers' usual
330 and customary charge to the general public. The division shall
331 allow five (5) prescriptions per month for noninstitutionalized
332 Medicaid recipients; however, exceptions for up to ten (10)
333 prescriptions per month shall be allowed, with the approval of the
334 director.

335 Payment for other covered drugs, other than multiple source
336 drugs with HCFA upper limits, shall not exceed the lower of the
337 estimated acquisition cost as determined by the division plus a
338 dispensing fee of Four Dollars and Ninety-one Cents (\$4.91) or the
339 providers' usual and customary charge to the general public.

340 Payment for nonlegend or over-the-counter drugs covered on
341 the division's formulary shall be reimbursed at the lower of the
342 division's estimated shelf price or the providers' usual and
343 customary charge to the general public. No dispensing fee shall
344 be paid.

345 The division shall develop and implement a program of payment
346 for additional pharmacist services, with payment to be based on
347 demonstrated savings, but in no case shall the total payment
348 exceed twice the amount of the dispensing fee.

349 As used in this paragraph (9), "estimated acquisition cost"
350 means the division's best estimate of what price providers
351 generally are paying for a drug in the package size that providers
352 buy most frequently. Product selection shall be made in
353 compliance with existing state law; however, the division may
354 reimburse as if the prescription had been filled under the generic
355 name. The division may provide otherwise in the case of specified
356 drugs when the consensus of competent medical advice is that
357 trademarked drugs are substantially more effective.

358 (10) Dental care that is an adjunct to treatment of an
359 acute medical or surgical condition; services of oral surgeons and
360 dentists in connection with surgery related to the jaw or any
361 structure contiguous to the jaw or the reduction of any fracture

362 of the jaw or any facial bone; and emergency dental extractions
363 and treatment related thereto. On July 1, 1999, all fees for
364 dental care and surgery under authority of this paragraph (10)
365 shall be increased to one hundred sixty percent (160%) of the
366 amount of the reimbursement rate that was in effect on June 30,
367 1999. It is the intent of the Legislature to encourage more
368 dentists to participate in the Medicaid program.

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

372 (12) Intermediate care facility services.

373 (a) The division shall make full payment to all
374 intermediate care facilities for the mentally retarded for each
375 day, not exceeding eighty-four (84) days per year, that a patient
376 is absent from the facility on home leave. Payment may be made
377 for the following home leave days in addition to the
378 eighty-four-day limitation: Christmas, the day before Christmas,
379 the day after Christmas, Thanksgiving, the day before Thanksgiving
380 and the day after Thanksgiving. However, before payment may be
381 made for more than eighteen (18) home leave days in a year for a
382 patient, the patient must have written authorization from a
383 physician stating that the patient is physically and mentally able
384 to be away from the facility on home leave. Such authorization
385 must be filed with the division before it will be effective, and
386 the authorization shall be effective for three (3) months from the
387 date it is received by the division, unless it is revoked earlier
388 by the physician because of a change in the condition of the
389 patient.

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

393 (13) Family planning services, including drugs,
394 supplies and devices, when such services are under the supervision

395 of a physician.

396 (14) Clinic services. Such diagnostic, preventive,
397 therapeutic, rehabilitative or palliative services furnished to an
398 outpatient by or under the supervision of a physician or dentist
399 in a facility which is not a part of a hospital but which is
400 organized and operated to provide medical care to outpatients.
401 Clinic services shall include any services reimbursed as
402 outpatient hospital services which may be rendered in such a
403 facility, including those that become so after July 1, 1991. On
404 July 1, 1999, all fees for physicians' services reimbursed under
405 authority of this paragraph (14) shall be reimbursed at ninety
406 percent (90%) of the rate established on January 1, 1999, and as
407 adjusted each January thereafter, under Medicare (Title XVIII of
408 the Social Security Act), as amended, and which shall in no event
409 be less than seventy percent (70%) of the rate established on
410 January 1, 1994. All fees for physicians' services that are
411 covered by both Medicare and Medicaid shall be reimbursed at ten
412 percent (10%) of the adjusted Medicare payment established on
413 January 1, 1999, and as adjusted each January thereafter, under
414 Medicare (Title XVIII of the Social Security Act), as amended, and
415 which shall in no event be less than seven percent (7%) of the
416 adjusted Medicare payment established on January 1, 1994. On July
417 1, 1999, all fees for dentists' services reimbursed under
418 authority of this paragraph (14) shall be increased to one hundred
419 sixty percent (160%) of the amount of the reimbursement rate that
420 was in effect on June 30, 1999.

421 (15) Home- and community-based services, as provided
422 under Title XIX of the federal Social Security Act, as amended,
423 under waivers, subject to the availability of funds specifically
424 appropriated therefor by the Legislature. Payment for such
425 services shall be limited to individuals who would be eligible for
426 and would otherwise require the level of care provided in a
427 nursing facility. The home- and community-based services

428 authorized under this paragraph shall be expanded over a five-year
429 period beginning July 1, 1999. The division shall certify case
430 management agencies to provide case management services and
431 provide for home- and community-based services for eligible
432 individuals under this paragraph. The home- and community-based
433 services under this paragraph and the activities performed by
434 certified case management agencies under this paragraph shall be
435 funded using state funds that are provided from the appropriation
436 to the Division of Medicaid and used to match federal funds.

437 (16) Mental health services. Approved therapeutic and
438 case management services provided by (a) an approved regional
439 mental health/retardation center established under Sections
440 41-19-31 through 41-19-39, or by another community mental health
441 service provider meeting the requirements of the Department of
442 Mental Health to be an approved mental health/retardation center
443 if determined necessary by the Department of Mental Health, using
444 state funds which are provided from the appropriation to the State
445 Department of Mental Health and used to match federal funds under
446 a cooperative agreement between the division and the department,
447 or (b) a facility which is certified by the State Department of
448 Mental Health to provide therapeutic and case management services,
449 to be reimbursed on a fee for service basis. Any such services
450 provided by a facility described in paragraph (b) must have the
451 prior approval of the division to be reimbursable under this
452 section. After June 30, 1997, mental health services provided by
453 regional mental health/retardation centers established under
454 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
455 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
456 psychiatric residential treatment facilities as defined in Section
457 43-11-1, or by another community mental health service provider
458 meeting the requirements of the Department of Mental Health to be
459 an approved mental health/retardation center if determined
460 necessary by the Department of Mental Health, shall not be

461 included in or provided under any capitated managed care pilot
462 program provided for under paragraph (24) of this section.

463 (17) Durable medical equipment services and medical
464 supplies restricted to patients receiving home health services
465 unless waived on an individual basis by the division. The
466 division shall not expend more than Three Hundred Thousand Dollars
467 (\$300,000.00) of state funds annually to pay for medical supplies
468 authorized under this paragraph.

469 (18) Notwithstanding any other provision of this
470 section to the contrary, the division shall make additional
471 reimbursement to hospitals which serve a disproportionate share of
472 low-income patients and which meet the federal requirements for
473 such payments as provided in Section 1923 of the federal Social
474 Security Act and any applicable regulations.

475 (19) (a) Perinatal risk management services. The
476 division shall promulgate regulations to be effective from and
477 after October 1, 1988, to establish a comprehensive perinatal
478 system for risk assessment of all pregnant and infant Medicaid
479 recipients and for management, education and follow-up for those
480 who are determined to be at risk. Services to be performed
481 include case management, nutrition assessment/counseling,
482 psychosocial assessment/counseling and health education. The
483 division shall set reimbursement rates for providers in
484 conjunction with the State Department of Health.

485 (b) Early intervention system services. The
486 division shall cooperate with the State Department of Health,
487 acting as lead agency, in the development and implementation of a
488 statewide system of delivery of early intervention services,
489 pursuant to Part H of the Individuals with Disabilities Education
490 Act (IDEA). The State Department of Health shall certify annually
491 in writing to the director of the division the dollar amount of
492 state early intervention funds available which shall be utilized
493 as a certified match for Medicaid matching funds. Those funds

494 then shall be used to provide expanded targeted case management
495 services for Medicaid eligible children with special needs who are
496 eligible for the state's early intervention system.

497 Qualifications for persons providing service coordination shall be
498 determined by the State Department of Health and the Division of
499 Medicaid.

500 (20) Home- and community-based services for physically
501 disabled approved services as allowed by a waiver from the United
502 States Department of Health and Human Services for home- and
503 community-based services for physically disabled people using
504 state funds which are provided from the appropriation to the State
505 Department of Rehabilitation Services and used to match federal
506 funds under a cooperative agreement between the division and the
507 department, provided that funds for these services are
508 specifically appropriated to the Department of Rehabilitation
509 Services.

510 (21) Nurse practitioner services. Services furnished
511 by a registered nurse who is licensed and certified by the
512 Mississippi Board of Nursing as a nurse practitioner including,
513 but not limited to, nurse anesthetists, nurse midwives, family
514 nurse practitioners, family planning nurse practitioners,
515 pediatric nurse practitioners, obstetrics-gynecology nurse
516 practitioners and neonatal nurse practitioners, under regulations
517 adopted by the division. Reimbursement for such services shall
518 not exceed ninety percent (90%) of the reimbursement rate for
519 comparable services rendered by a physician.

520 (22) Ambulatory services delivered in federally
521 qualified health centers and in clinics of the local health
522 departments of the State Department of Health for individuals
523 eligible for medical assistance under this article based on
524 reasonable costs as determined by the division.

525 (23) Inpatient psychiatric services. Inpatient
526 psychiatric services to be determined by the division for

527 recipients under age twenty-one (21) which are provided under the
528 direction of a physician in an inpatient program in a licensed
529 acute care psychiatric facility or in a licensed psychiatric
530 residential treatment facility, before the recipient reaches age
531 twenty-one (21) or, if the recipient was receiving the services
532 immediately before he reached age twenty-one (21), before the
533 earlier of the date he no longer requires the services or the date
534 he reaches age twenty-two (22), as provided by federal
535 regulations. Recipients shall be allowed forty-five (45) days per
536 year of psychiatric services provided in acute care psychiatric
537 facilities, and shall be allowed unlimited days of psychiatric
538 services provided in licensed psychiatric residential treatment
539 facilities.

540 (24) Managed care services in a program to be developed
541 by the division by a public or private provider. Notwithstanding
542 any other provision in this article to the contrary, the division
543 shall establish rates of reimbursement to providers rendering care
544 and services authorized under this section, and may revise such
545 rates of reimbursement without amendment to this section by the
546 Legislature for the purpose of achieving effective and accessible
547 health services, and for responsible containment of costs. This
548 shall include, but not be limited to, one (1) module of capitated
549 managed care in a rural area, and one (1) module of capitated
550 managed care in an urban area.

551 (25) Birthing center services.

552 (26) Hospice care. As used in this paragraph, the term
553 "hospice care" means a coordinated program of active professional
554 medical attention within the home and outpatient and inpatient
555 care which treats the terminally ill patient and family as a unit,
556 employing a medically directed interdisciplinary team. The
557 program provides relief of severe pain or other physical symptoms
558 and supportive care to meet the special needs arising out of
559 physical, psychological, spiritual, social and economic stresses

560 which are experienced during the final stages of illness and
561 during dying and bereavement and meets the Medicare requirements
562 for participation as a hospice as provided in 42 CFR Part 418.

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

566 (28) Other health insurance premiums which are cost
567 effective as defined by the Secretary of Health and Human
568 Services. Medicare eligible must have Medicare Part B before
569 other insurance premiums can be paid.

570 (29) The Division of Medicaid may apply for a waiver
571 from the Department of Health and Human Services for home- and
572 community-based services for developmentally disabled people using
573 state funds which are provided from the appropriation to the State
574 Department of Mental Health and used to match federal funds under
575 a cooperative agreement between the division and the department,
576 provided that funds for these services are specifically
577 appropriated to the Department of Mental Health.

578 (30) Pediatric skilled nursing services for eligible
579 persons under twenty-one (21) years of age.

580 (31) Targeted case management services for children
581 with special needs, under waivers from the United States
582 Department of Health and Human Services, using state funds that
583 are provided from the appropriation to the Mississippi Department
584 of Human Services and used to match federal funds under a
585 cooperative agreement between the division and the department.

586 (32) Care and services provided in Christian Science
587 Sanatoria operated by or listed and certified by The First Church
588 of Christ Scientist, Boston, Massachusetts, rendered in connection
589 with treatment by prayer or spiritual means to the extent that
590 such services are subject to reimbursement under Section 1903 of
591 the Social Security Act.

592 (33) Podiatrist services.

593 (34) Personal care services provided in a pilot program
594 to not more than forty (40) residents at a location or locations
595 to be determined by the division and delivered by individuals
596 qualified to provide such services, as allowed by waivers under
597 Title XIX of the Social Security Act, as amended. The division
598 shall not expend more than Three Hundred Thousand Dollars
599 (\$300,000.00) annually to provide such personal care services.
600 The division shall develop recommendations for the effective
601 regulation of any facilities that would provide personal care
602 services which may become eligible for Medicaid reimbursement
603 under this section, and shall present such recommendations with
604 any proposed legislation to the 1996 Regular Session of the
605 Legislature on or before January 1, 1996.

606 (35) Services and activities authorized in Sections
607 43-27-101 and 43-27-103, using state funds that are provided from
608 the appropriation to the State Department of Human Services and
609 used to match federal funds under a cooperative agreement between
610 the division and the department.

611 (36) Nonemergency transportation services for
612 Medicaid-eligible persons, to be provided by the Department of
613 Human Services. The division may contract with additional
614 entities to administer nonemergency transportation services as it
615 deems necessary. All providers shall have a valid driver's
616 license, vehicle inspection sticker and a standard liability
617 insurance policy covering the vehicle.

618 (37) Targeted case management services for individuals
619 with chronic diseases, with expanded eligibility to cover services
620 to uninsured recipients, on a pilot program basis. This paragraph
621 (37) shall be contingent upon continued receipt of special funds
622 from the Health Care Financing Authority and private foundations
623 who have granted funds for planning these services. No funding
624 for these services shall be provided from state general funds.

625 (38) Chiropractic services: a chiropractor's manual

626 manipulation of the spine to correct a subluxation, if x-ray
627 demonstrates that a subluxation exists and if the subluxation has
628 resulted in a neuromusculoskeletal condition for which
629 manipulation is appropriate treatment. Reimbursement for
630 chiropractic services shall not exceed Seven Hundred Dollars
631 (\$700.00) per year per recipient.

632 (39) Mental health counseling services provided by a
633 duly licensed marriage and family therapist.

634 Notwithstanding any provision of this article, except as
635 authorized in the following paragraph and in Section 43-13-139,
636 neither (a) the limitations on quantity or frequency of use of or
637 the fees or charges for any of the care or services available to
638 recipients under this section, nor (b) the payments or rates of
639 reimbursement to providers rendering care or services authorized
640 under this section to recipients, may be increased, decreased or
641 otherwise changed from the levels in effect on July 1, 1986,
642 unless such is authorized by an amendment to this section by the
643 Legislature. However, the restriction in this paragraph shall not
644 prevent the division from changing the payments or rates of
645 reimbursement to providers without an amendment to this section
646 whenever such changes are required by federal law or regulation,
647 or whenever such changes are necessary to correct administrative
648 errors or omissions in calculating such payments or rates of
649 reimbursement.

650 Notwithstanding any provision of this article, no new groups
651 or categories of recipients and new types of care and services may
652 be added without enabling legislation from the Mississippi
653 Legislature, except that the division may authorize such changes
654 without enabling legislation when such addition of recipients or
655 services is ordered by a court of proper authority. The director
656 shall keep the Governor advised on a timely basis of the funds
657 available for expenditure and the projected expenditures. In the
658 event current or projected expenditures can be reasonably

659 anticipated to exceed the amounts appropriated for any fiscal
660 year, the Governor, after consultation with the director, shall
661 discontinue any or all of the payment of the types of care and
662 services as provided herein which are deemed to be optional
663 services under Title XIX of the federal Social Security Act, as
664 amended, for any period necessary to not exceed appropriated
665 funds, and when necessary shall institute any other cost
666 containment measures on any program or programs authorized under
667 the article to the extent allowed under the federal law governing
668 such program or programs, it being the intent of the Legislature
669 that expenditures during any fiscal year shall not exceed the
670 amounts appropriated for such fiscal year.

671 SECTION 2. This act shall take effect and be in force from
672 and after July 1, 2000.