By: Reynolds

To: Public Health and Welfare; Appropriations

HOUSE BILL NO. 1460

1 AN ACT TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE THAT PERSONS WHO ARE ELIGIBLE FOR MEDICARE AND WHOSE
3 INCOME DOES NOT EXCEED 150% OF THE POVERTY LEVEL SHALL BE ELIGIBLE
4 FOR MEDICAID; TO PROVIDE THAT THOSE PERSONS SHALL BE ELIGIBLE ONLY
5 FOR PRESCRIPTION DRUGS COVERED UNDER MEDICAID; TO DIRECT THE
6 DIVISION OF MEDICAID TO APPLY FOR A FEDERAL WAIVER TO ALLOW FOR
7 THE IMPLEMENTATION OF THE PRECEDING PROVISIONS; TO AMEND SECTION
8 43-13-117, MISSISSIPPI CODE OF 1972, IN CONFORMITY TO THE
9 PROVISIONS OF THIS ACT; AND FOR RELATED PURPOSES.

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

11 SECTION 1. Section 43-13-115, Mississippi Code of 1972, is
12 amended as follows:

13 43-13-115. Recipients of medical assistance shall be the
14 following persons only:

15 (1) Who are qualified for public assistance grants under
16 provisions of Title IV-A and E of the federal Social Security Act,
17 as amended, including those statutorily deemed to be IV-A as
18 determined by the State Department of Human Services and certified
19 to the Division of Medicaid, but not optional groups unless
20 otherwise specifically covered in this section. For the purposes
21 of this paragraph (1) and paragraphs (3), (4), (8), (14), (17) and
22 (18) of this section, any reference to Title IV-A or to Part A of
23 Title IV of the federal Social Security Act, as amended, or the
24 state plan under Title IV-A or Part A of Title IV, shall be
25 considered as a reference to Title IV-A of the federal Social
26 Security Act, as amended, and the state plan under Title IV-A,
27 including the income and resource standards and methodologies
28 under Title IV-A and the state plan, as they existed on July 16,
29 1996.

30 (2) Those qualified for Supplemental Security Income (SSI)
31 benefits under Title XVI of the federal Social Security Act, as
32 amended. The eligibility of individuals covered in this paragraph
33 shall be determined by the Social Security Administration and
34 certified to the Division of Medicaid.
35 (3) Qualified pregnant women as defined in Section 1905(n)
36 of the federal Social Security Act, as amended, and as determined
37 to be eligible by the State Department of Human Services and
38 certified to the Division of Medicaid, who:
39 (a) Would be eligible for assistance under Part A of
40 Title IV (or would be eligible for such assistance if coverage
41 under the state plan under Part A of Title IV included assistance
42 pursuant to Section 407 of Title IV-A of the federal Social
43 Security Act, as amended) if her child had been born and was
44 living with her in the month such assistance would be paid, and
45 such pregnancy has been medically verified; or
46 (b) Is a member of a family which would be eligible
47 for assistance under the state plan under Part A of Title IV of
48 the federal Social Security Act, as amended, pursuant to Section
49 407 if the plan required the payment of assistance pursuant to
50 such section.
51 (4) Qualified children who are under five (5) years of age,
52 who were born after September 30, 1983, and who meet the income
53 and resource requirements of the state plan under Part A of Title
54 IV of the federal Social Security Act, as amended. The
55 eligibility of individuals covered in this paragraph shall be
56 determined by the State Department of Human Services and certified
57 to the Division of Medicaid.
58 (5) A child born on or after October 1, 1984, to a woman
59 eligible for and receiving medical assistance under the state plan
60 on the date of the child's birth shall be deemed to have applied
61 for medical assistance and to have been found eligible for such
62 assistance under such plan on the date of such birth and will

63 remain eligible for such assistance for a period of one (1) year
64 so long as the child is a member of the woman's household and the
65 woman remains eligible for such assistance or would be eligible
66 for assistance if pregnant. The eligibility of individuals
67 covered in this paragraph shall be determined by the State
68 Department of Human Services and certified to the Division of
69 Medicaid.

70 (6) Children certified by the State Department of Human
71 Services to the Division of Medicaid of whom the state and county
72 human services agency has custody and financial responsibility,
73 and children who are in adoptions subsidized in full or part by
74 the Department of Human Services, who are approvable under Title
75 XIX of the Medicaid program.

76 (7) (a) Persons certified by the Division of Medicaid who
77 are patients in a medical facility (nursing home, hospital,
78 tuberculosis sanatorium or institution for treatment of mental
79 diseases), and who, except for the fact that they are patients in
80 such medical facility, would qualify for grants under Title IV,
81 supplementary security income benefits under Title XVI or state
82 supplements, and those aged, blind and disabled persons who would
83 not be eligible for supplemental security income benefits under
84 Title XVI or state supplements if they were not institutionalized
85 in a medical facility but whose income is below the maximum
86 standard set by the Division of Medicaid, which standard shall not
87 exceed that prescribed by federal regulation;

88 (b) Individuals who have elected to receive hospice
89 care benefits and who are eligible using the same criteria and
90 special income limits as those in institutions as described in
91 subparagraph (a) of this paragraph (7).

92 (8) Children under eighteen (18) years of age and pregnant
93 women (including those in intact families) who meet the financial
94 standards of the state plan approved under Title IV-A of the
95 federal Social Security Act, as amended. The eligibility of

96 children covered under this paragraph shall be determined by the
97 State Department of Human Services and certified to the Division
98 of Medicaid.
99 (9) Individuals who are:
100 (a) Children born after September 30, 1983, who have
101 not attained the age of nineteen (19), with family income that
102 does not exceed one hundred percent (100%) of the nonfarm official
103 poverty line;
104 (b) Pregnant women, infants and children who have not
105 attained the age of six (6), with family income that does not
106 exceed one hundred thirty-three percent (133%) of the federal
107 poverty level; and
108 (c) Pregnant women and infants who have not attained
109 the age of one (1), with family income that does not exceed one
110 hundred eighty-five percent (185%) of the federal poverty level.
111 The eligibility of individuals covered in (a), (b) and (c) of
112 this paragraph shall be determined by the Department of Human
113 Services.
114 (10) Certain disabled children age eighteen (18) or under
115 who are living at home, who would be eligible, if in a medical
116 institution, for SSI or a state supplemental payment under Title
117 XVI of the federal Social Security Act, as amended, and therefore
118 for Medicaid under the plan, and for whom the state has made a
119 determination as required under Section 1902(e)(3)(b) of the
120 federal Social Security Act, as amended. The eligibility of
121 individuals under this paragraph shall be determined by the
122 Division of Medicaid.
123 (11) Individuals who are sixty-five (65) years of age or
124 older or are disabled as determined under Section 1614(a)(3) of
125 the federal Social Security Act, as amended, and who meet the
126 following criteria:
127 (a) Whose income does not exceed one hundred percent
128 (100%) of the nonfarm official poverty line as defined by the

129 Office of Management and Budget and revised annually.
130 (b) Whose resources do not exceed those allowed under
131 the Supplemental Security Income (SSI) program.
132 The eligibility of individuals covered under this paragraph
133 shall be determined by the Division of Medicaid, and such
134 individuals determined eligible shall receive the same Medicaid
135 services as other categorical eligible individuals.
136 (12) Individuals who are qualified Medicare beneficiaries
137 (QMB) entitled to Part A Medicare as defined under Section 301,
138 Public Law 100-360, known as the Medicare Catastrophic Coverage
139 Act of 1988, and who meet the following criteria:
140 (a) Whose income does not exceed one hundred percent
141 (100%) of the nonfarm official poverty line as defined by the
142 Office of Management and Budget and revised annually.
143 (b) Whose resources do not exceed two hundred percent
144 (200%) of the amount allowed under the Supplemental Security
145 Income (SSI) program as more fully prescribed under Section 301,
146 Public Law 100-360.
147 The eligibility of individuals covered under this paragraph
148 shall be determined by the Division of Medicaid, and such
149 individuals determined eligible shall receive Medicare
150 cost-sharing expenses only as more fully defined by the Medicare
151 Catastrophic Coverage Act of 1988.
152 (13) Individuals who are entitled to Medicare Part B as
153 defined in Section 4501 of the Omnibus Budget Reconciliation Act
154 of 1990, and who meet the following criteria:
155 (a) Whose income does not exceed the percentage of the
156 nonfarm official poverty line as defined by the Office of
157 Management and Budget and revised annually which, on or after:
158 (i) January 1, 1993, is one hundred ten percent
159 (110%); and
160 (ii) January 1, 1995, is one hundred twenty
161 percent (120%).

162 (b) Whose resources do not exceed two hundred percent
163 (200%) of the amount allowed under the Supplemental Security
164 Income (SSI) program as described in Section 301 of the Medicare
165 Catastrophic Coverage Act of 1988.
166 The eligibility of individuals covered under this paragraph
167 shall be determined by the Division of Medicaid, and such
168 individuals determined eligible shall receive Medicare cost
169 sharing.
170 (14) Individuals in families who would be eligible for the
171 unemployed parent program under Section 407 of Title IV-A of the
172 federal Social Security Act, as amended, but do not receive
173 payments pursuant to that section. The eligibility of individuals
174 covered in this paragraph shall be determined by the Department of
175 Human Services.
176 (15) Disabled workers who are eligible to enroll in Part A
177 Medicare as required by Public Law 101-239, known as the Omnibus
178 Budget Reconciliation Act of 1989, and whose income does not
179 exceed two hundred percent (200%) of the federal poverty level as
180 determined in accordance with the Supplemental Security Income
181 (SSI) program. The eligibility of individuals covered under this
182 paragraph shall be determined by the Division of Medicaid and such
183 individuals shall be entitled to buy-in coverage of Medicare Part
184 A premiums only under the provisions of this paragraph (15).
185 (16) In accordance with the terms and conditions of approved
186 Title XIX waiver from the United States Department of Health and
187 Human Services, persons provided home- and community-based
188 services who are physically disabled and certified by the Division
189 of Medicaid as eligible due to applying the income and deeming
190 requirements as if they were institutionalized.
191 (17) In accordance with the terms of the federal Personal
192 Responsibility and Work Opportunity Reconciliation Act of 1996
193 (Public Law 104-193), persons who become ineligible for assistance
194 under Title IV-A of the federal Social Security Act, as amended,

195 because of increased income from or hours of employment of the
196 caretaker relative or because of the expiration of the applicable
197 earned income disregards, who were eligible for Medicaid for at
198 least three (3) of the six (6) months preceding the month in which
199 such ineligibility begins, shall be eligible for Medicaid
200 assistance for up to twenty-four (24) months; however, Medicaid
201 assistance for more than twelve (12) months may be provided only
202 if a federal waiver is obtained to provide such assistance for
203 more than twelve (12) months and federal and state funds are
204 available to provide such assistance.

205 (18) Persons who become ineligible for assistance under
206 Title IV-A of the federal Social Security Act, as amended, as a
207 result, in whole or in part, of the collection or increased
208 collection of child or spousal support under Title IV-D of the
209 federal Social Security Act, as amended, who were eligible for
210 Medicaid for at least three (3) of the six (6) months immediately
211 preceding the month in which such ineligibility begins, shall be
212 eligible for Medicaid for an additional four (4) months beginning
213 with the month in which such ineligibility begins.

214 (19) Disabled workers, whose incomes are above the Medicaid
215 eligibility limits, but below two hundred fifty percent (250%) of
216 the federal poverty level, shall be allowed to purchase Medicaid
217 coverage on a sliding fee scale developed by the Division of
218 Medicaid.

219 <u>(20) Individuals who are eligible for Medicare, who</u>
220 <u>otherwise would not be eligible for Medicaid because of their</u>
221 <u>income or resources and whose income does not exceed one hundred</u>
222 <u>fifty percent (150%) of the federal poverty level. The</u>
223 <u>eligibility of individuals covered under this paragraph (20) shall</u>
224 <u>be determined by the Division of Medicaid. Individuals who are</u>
225 <u>determined eligible shall only receive prescription drugs covered</u>
226 <u>under Section 43-13-117(9) and not any other services covered</u>
227 <u>under Section 43-13-117. However, any individual eligible under</u>

228 this paragraph (20) who is also eligible under any other paragraph
229 of this section shall receive the benefits to which he or she is
230 entitled under the other paragraph, in addition to prescription
231 drugs covered under Section 43-13-117(9).
232 The Division of Medicaid shall apply to the United States
233 Secretary of Health and Human Services for a federal waiver of the
234 applicable provisions of Title XIX of the federal Social Security
235 Act, as amended, and any other applicable provisions of federal
236 law as necessary to allow for the implementation of this paragraph
237 (20). The provisions of this paragraph (20) shall be implemented
238 from and after the date that the Division of Medicaid receives the
239 federal waiver.
240 SECTION 2. Section 43-13-117, Mississippi Code of 1972, is
241 amended as follows:
242 43-13-117. Medical assistance as authorized by this article
243 shall include payment of part or all of the costs, at the
244 discretion of the division or its successor, with approval of the
245 Governor, of the following types of care and services rendered to
246 eligible applicants who shall have been determined to be eligible
247 for such care and services, within the limits of state
248 appropriations and federal matching funds:
249 (1) Inpatient hospital services.
250 (a) The division shall allow thirty (30) days of
251 inpatient hospital care annually for all Medicaid recipients;
252 however, before any recipient will be allowed more than fifteen
253 (15) days of inpatient hospital care in any one (1) year, he must
254 obtain prior approval therefor from the division. The division
255 shall be authorized to allow unlimited days in disproportionate
256 hospitals as defined by the division for eligible infants under
257 the age of six (6) years.
258 (b) From and after July 1, 1994, the Executive Director
259 of the Division of Medicaid shall amend the Mississippi Title XIX
260 Inpatient Hospital Reimbursement Plan to remove the occupancy rate

261 penalty from the calculation of the Medicaid Capital Cost
262 Component utilized to determine total hospital costs allocated to
263 the Medicaid Program.
264 (2) Outpatient hospital services. Provided that where the
265 same services are reimbursed as clinic services, the division may
266 revise the rate or methodology of outpatient reimbursement to
267 maintain consistency, efficiency, economy and quality of care.
268 (3) Laboratory and x-ray services.
269 (4) Nursing facility services.
270 (a) The division shall make full payment to nursing
271 facilities for each day, not exceeding fifty-two (52) days per
272 year, that a patient is absent from the facility on home leave.
273 Payment may be made for the following home leave days in addition
274 to the 52-day limitation: Christmas, the day before Christmas,
275 the day after Christmas, Thanksgiving, the day before Thanksgiving
276 and the day after Thanksgiving. However, before payment may be
277 made for more than eighteen (18) home leave days in a year for a
278 patient, the patient must have written authorization from a
279 physician stating that the patient is physically and mentally able
280 to be away from the facility on home leave. Such authorization
281 must be filed with the division before it will be effective and
282 the authorization shall be effective for three (3) months from the
283 date it is received by the division, unless it is revoked earlier
284 by the physician because of a change in the condition of the
285 patient.
286 (b) From and after July 1, 1993, the division shall
287 implement the integrated case-mix payment and quality monitoring
288 system developed pursuant to Section 43-13-122, which includes the
289 fair rental system for property costs and in which recapture of
290 depreciation is eliminated. The division may revise the
291 reimbursement methodology for the case-mix payment system by
292 reducing payment for hospital leave and therapeutic home leave
293 days to the lowest case-mix category for nursing facilities,

294 modifying the current method of scoring residents so that only
295 services provided at the nursing facility are considered in
296 calculating a facility's per diem, and the division may limit
297 administrative and operating costs, but in no case shall these
298 costs be less than one hundred nine percent (109%) of the median
299 administrative and operating costs for each class of facility, not
300 to exceed the median used to calculate the nursing facility
301 reimbursement for fiscal year 1996, to be applied uniformly to all
302 long-term care facilities. *** * ***
303 (c) From and after July 1, 1997, all state-owned
304 nursing facilities shall be reimbursed on a full reasonable costs
305 basis. From and after July 1, 1997, payments by the division to
306 nursing facilities for return on equity capital shall be made at
307 the rate paid under Medicare (Title XVIII of the Social Security
308 Act), but shall be no less than seven and one-half percent (7.5%)
309 nor greater than ten percent (10%).
310 (d) A Review Board for nursing facilities is
311 established to conduct reviews of the Division of Medicaid's
312 decision in the areas set forth below:
313 (i) Review shall be heard in the following areas:
314 (A) Matters relating to cost reports
315 including, but not limited to, allowable costs and cost
316 adjustments resulting from desk reviews and audits.
317 (B) Matters relating to the Minimum Data Set
318 Plus (MDS +) or successor assessment formats including but not
319 limited to audits, classifications and submissions.
320 (ii) The Review Board shall be composed of six (6)
321 members, three (3) having expertise in one (1) of the two (2)
322 areas set forth above and three (3) having expertise in the other
323 area set forth above. Each panel of three (3) shall only review
324 appeals arising in its area of expertise. The members shall be
325 appointed as follows:
326 (A) In each of the areas of expertise defined

327 under subparagraphs (i)(A) and (i)(B), the Executive Director of
328 the Division of Medicaid shall appoint one (1) person chosen from
329 the private sector nursing home industry in the state, which may
330 include independent accountants and consultants serving the
331 industry;

332 (B) In each of the areas of expertise defined
333 under subparagraphs (i)(A) and (i)(B), the Executive Director of
334 the Division of Medicaid shall appoint one (1) person who is
335 employed by the state who does not participate directly in desk
336 reviews or audits of nursing facilities in the two (2) areas of
337 review;

338 (C) The two (2) members appointed by the
339 Executive Director of the Division of Medicaid in each area of
340 expertise shall appoint a third member in the same area of
341 expertise.

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

346 (iii) The Review Board panels shall have the power
347 to preserve and enforce order during hearings; to issue subpoenas;
348 to administer oaths; to compel attendance and testimony of
349 witnesses; or to compel the production of books, papers, documents
350 and other evidence; or the taking of depositions before any
351 designated individual competent to administer oaths; to examine
352 witnesses; and to do all things conformable to law that may be
353 necessary to enable it effectively to discharge its duties. The
354 Review Board panels may appoint such person or persons as they
355 shall deem proper to execute and return process in connection
356 therewith.

357 (iv) The Review Board shall promulgate, publish
358 and disseminate to nursing facility providers rules of procedure
359 for the efficient conduct of proceedings, subject to the approval

360 of the Executive Director of the Division of Medicaid and in
361 accordance with federal and state administrative hearing laws and
362 regulations.
363 (v) Proceedings of the Review Board shall be of
364 record.
365 (vi) Appeals to the Review Board shall be in
366 writing and shall set out the issues, a statement of alleged facts
367 and reasons supporting the provider's position. Relevant
368 documents may also be attached. The appeal shall be filed within
369 thirty (30) days from the date the provider is notified of the
370 action being appealed or, if informal review procedures are taken,
371 as provided by administrative regulations of the Division of
372 Medicaid, within thirty (30) days after a decision has been
373 rendered through informal hearing procedures.
374 (vii) The provider shall be notified of the
375 hearing date by certified mail within thirty (30) days from the
376 date the Division of Medicaid receives the request for appeal.
377 Notification of the hearing date shall in no event be less than
378 thirty (30) days before the scheduled hearing date. The appeal
379 may be heard on shorter notice by written agreement between the
380 provider and the Division of Medicaid.
381 (viii) Within thirty (30) days from the date of
382 the hearing, the Review Board panel shall render a written
383 recommendation to the Executive Director of the Division of
384 Medicaid setting forth the issues, findings of fact and applicable
385 law, regulations or provisions.
386 (ix) The Executive Director of the Division of
387 Medicaid shall, upon review of the recommendation, the proceedings
388 and the record, prepare a written decision which shall be mailed
389 to the nursing facility provider no later than twenty (20) days
390 after the submission of the recommendation by the panel. The
391 decision of the executive director is final, subject only to
392 judicial review.

393 (x) Appeals from a final decision shall be made to
394 the Chancery Court of Hinds County. The appeal shall be filed
395 with the court within thirty (30) days from the date the decision
396 of the Executive Director of the Division of Medicaid becomes
397 final.
398 (xi) The action of the Division of Medicaid under
399 review shall be stayed until all administrative proceedings have
400 been exhausted.
401 (xii) Appeals by nursing facility providers
402 involving any issues other than those two (2) specified in
403 subparagraphs (i)(A) and (ii)(B) shall be taken in accordance with
404 the administrative hearing procedures established by the Division
405 of Medicaid.
406 (e) When a facility of a category that does not require
407 a certificate of need for construction and that could not be
408 eligible for Medicaid reimbursement is constructed to nursing
409 facility specifications for licensure and certification, and the
410 facility is subsequently converted to a nursing facility pursuant
411 to a certificate of need that authorizes conversion only and the
412 applicant for the certificate of need was assessed an application
413 review fee based on capital expenditures incurred in constructing
414 the facility, the division shall allow reimbursement for capital
415 expenditures necessary for construction of the facility that were
416 incurred within the twenty-four (24) consecutive calendar months
417 immediately preceding the date that the certificate of need
418 authorizing such conversion was issued, to the same extent that
419 reimbursement would be allowed for construction of a new nursing
420 facility pursuant to a certificate of need that authorizes such
421 construction. The reimbursement authorized in this subparagraph
422 (e) may be made only to facilities the construction of which was
423 completed after June 30, 1989. Before the division shall be
424 authorized to make the reimbursement authorized in this
425 subparagraph (e), the division first must have received approval

426 from the Health Care Financing Administration of the United States
427 Department of Health and Human Services of the change in the state
428 Medicaid plan providing for such reimbursement.
429 (f) The division shall develop and implement a case-mix
430 payment add-on determined by time studies and other valid
431 statistical data which will reimburse a nursing facility for the
432 additional cost of caring for a resident who has a diagnosis of
433 Alzheimer's or other related dementia and exhibits symptoms that
434 require special care. Any such case-mix add-on payment shall be
435 supported by a determination of additional cost. The division
436 shall also develop and implement as part of the fair rental
437 reimbursement system for nursing facility beds, an Alzheimer's
438 resident bed depreciation enhanced reimbursement system which will
439 provide an incentive to encourage nursing facilities to convert or
440 construct beds for residents with Alzheimer's or other related
441 dementia.
442 (g) The Division of Medicaid shall develop and
443 implement a referral process for long-term care alternatives for
444 Medicaid beneficiaries and applicants. No Medicaid beneficiary
445 shall be admitted to a Medicaid-certified nursing facility unless
446 a licensed physician certifies that nursing facility care is
447 appropriate for that person on a standardized form to be prepared
448 and provided to nursing facilities by the Division of Medicaid.
449 The physician shall forward a copy of that certification to the
450 Division of Medicaid within twenty-four (24) hours after it is
451 signed by the physician. Any physician who fails to forward the
452 certification to the Division of Medicaid within the time period
453 specified in this paragraph shall be ineligible for Medicaid
454 reimbursement for any physician's services performed for the
455 applicant. The Division of Medicaid shall determine, through an
456 assessment of the applicant conducted within two (2) business days
457 after receipt of the physician's certification, whether the
458 applicant also could live appropriately and cost-effectively at

459 home or in some other community-based setting if home- or
460 community-based services were available to the applicant. The
461 time limitation prescribed in this paragraph shall be waived in
462 cases of emergency. If the Division of Medicaid determines that a
463 home- or other community-based setting is appropriate and
464 cost-effective, the division shall:
465 (i) Advise the applicant or the applicant's legal
466 representative that a home- or other community-based setting is
467 appropriate;
468 (ii) Provide a proposed care plan and inform the
469 applicant or the applicant's legal representative regarding the
470 degree to which the services in the care plan are available in a
471 home- or in other community-based setting rather than nursing
472 facility care; and
473 (iii) Explain that such plan and services are
474 available only if the applicant or the applicant's legal
475 representative chooses a home- or community-based alternative to
476 nursing facility care, and that the applicant is free to choose
477 nursing facility care.
478 The Division of Medicaid may provide the services described
479 in this paragraph (g) directly or through contract with case
480 managers from the local Area Agencies on Aging, and shall
481 coordinate long-term care alternatives to avoid duplication with
482 hospital discharge planning procedures.
483 Placement in a nursing facility may not be denied by the
484 division if home- or community-based services that would be more
485 appropriate than nursing facility care are not actually available,
486 or if the applicant chooses not to receive the appropriate home-
487 or community-based services.
488 The division shall provide an opportunity for a fair hearing
489 under federal regulations to any applicant who is not given the
490 choice of home- or community-based services as an alternative to
491 institutional care.

492 The division shall make full payment for long-term care
493 alternative services.
494 The division shall apply for necessary federal waivers to
495 assure that additional services providing alternatives to nursing
496 facility care are made available to applicants for nursing
497 facility care.
498 (5) Periodic screening and diagnostic services for
499 individuals under age twenty-one (21) years as are needed to
500 identify physical and mental defects and to provide health care
501 treatment and other measures designed to correct or ameliorate
502 defects and physical and mental illness and conditions discovered
503 by the screening services regardless of whether these services are
504 included in the state plan. The division may include in its
505 periodic screening and diagnostic program those discretionary
506 services authorized under the federal regulations adopted to
507 implement Title XIX of the federal Social Security Act, as
508 amended. The division, in obtaining physical therapy services,
509 occupational therapy services, and services for individuals with
510 speech, hearing and language disorders, may enter into a
511 cooperative agreement with the State Department of Education for
512 the provision of such services to handicapped students by public
513 school districts using state funds which are provided from the
514 appropriation to the Department of Education to obtain federal
515 matching funds through the division. The division, in obtaining
516 medical and psychological evaluations for children in the custody
517 of the State Department of Human Services may enter into a
518 cooperative agreement with the State Department of Human Services
519 for the provision of such services using state funds which are
520 provided from the appropriation to the Department of Human
521 Services to obtain federal matching funds through the division.
522 On July 1, 1993, all fees for periodic screening and
523 diagnostic services under this paragraph (5) shall be increased by
524 twenty-five percent (25%) of the reimbursement rate in effect on

525 June 30, 1993.

526 (6) Physician's services. * * * All fees for physicians'
527 services that are covered only by Medicaid shall be reimbursed at
528 ninety percent (90%) of the rate established on January 1, 1999,
529 and as adjusted each January thereafter, under Medicare (Title
530 XVIII of the Social Security Act), as amended, and which shall in
531 no event be less than seventy percent (70%) of the rate
532 established on January 1, 1994. All fees for physicians' services
533 that are covered by both Medicare and Medicaid shall be reimbursed
534 at ten percent (10%) of the adjusted Medicare payment established
535 on January 1, 1999, and as adjusted each January thereafter, under
536 Medicare (Title XVIII of the Social Security Act), as amended, and
537 which shall in no event be less than seven percent (7%) of the
538 adjusted Medicare payment established on January 1, 1994.

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

542 (b) Repealed.

543 (8) Emergency medical transportation services. On January
544 1, 1994, emergency medical transportation services shall be
545 reimbursed at seventy percent (70%) of the rate established under
546 Medicare (Title XVIII of the Social Security Act), as amended.
547 "Emergency medical transportation services" shall mean, but shall
548 not be limited to, the following services by a properly permitted
549 ambulance operated by a properly licensed provider in accordance
550 with the Emergency Medical Services Act of 1974 (Section 41-59-1
551 et seq.): (i) basic life support, (ii) advanced life support,
552 (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi)
553 disposable supplies, (vii) similar services.

554 (9) Legend and other drugs as may be determined by the
555 division. The division may implement a program of prior approval
556 for drugs to the extent permitted by law. Payment by the division
557 for covered multiple source drugs shall be limited to the lower of

558 the upper limits established and published by the Health Care
559 Financing Administration (HCFA) plus a dispensing fee of Four
560 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
561 cost (EAC) as determined by the division plus a dispensing fee of
562 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual
563 and customary charge to the general public. The division shall
564 allow five (5) prescriptions per month for noninstitutionalized
565 Medicaid recipients; however, exceptions for up to ten (10)
566 prescriptions per month shall be allowed, with the approval of the
567 director, and there shall be no limit on the number of
568 prescriptions per month for noninstitutionalized Medicaid
569 recipients who are eligible under Section 43-13-115(20).

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

575 Payment for nonlegend or over-the-counter drugs covered on
576 the division's formulary shall be reimbursed at the lower of the
577 division's estimated shelf price or the providers' usual and
578 customary charge to the general public. No dispensing fee shall
579 be paid.

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

584 As used in this paragraph (9), "estimated acquisition cost"
585 means the division's best estimate of what price providers
586 generally are paying for a drug in the package size that providers
587 buy most frequently. Product selection shall be made in
588 compliance with existing state law; however, the division may
589 reimburse as if the prescription had been filled under the generic
590 name. The division may provide otherwise in the case of specified

591 drugs when the consensus of competent medical advice is that
592 trademarked drugs are substantially more effective.
593 (10) Dental care that is an adjunct to treatment of an acute
594 medical or surgical condition; services of oral surgeons and
595 dentists in connection with surgery related to the jaw or any
596 structure contiguous to the jaw or the reduction of any fracture
597 of the jaw or any facial bone; and emergency dental extractions
598 and treatment related thereto. On July 1, 1999, all fees for
599 dental care and surgery under authority of this paragraph (10)
600 shall be increased to one hundred sixty percent (160%) of the
601 amount of the reimbursement rate that was in effect on June 30,
602 1999. It is the intent of the Legislature to encourage more
603 dentists to participate in the Medicaid program.
604 (11) Eyeglasses necessitated by reason of eye surgery, and
605 as prescribed by a physician skilled in diseases of the eye or an
606 optometrist, whichever the patient may select.
607 (12) Intermediate care facility services.
608 (a) The division shall make full payment to all
609 intermediate care facilities for the mentally retarded for each
610 day, not exceeding eighty-four (84) days per year, that a patient
611 is absent from the facility on home leave. Payment may be made
612 for the following home leave days in addition to the 84-day
613 limitation: Christmas, the day before Christmas, the day after
614 Christmas, Thanksgiving, the day before Thanksgiving and the day
615 after Thanksgiving. However, before payment may be made for more
616 than eighteen (18) home leave days in a year for a patient, the
617 patient must have written authorization from a physician stating
618 that the patient is physically and mentally able to be away from
619 the facility on home leave. Such authorization must be filed with
620 the division before it will be effective, and the authorization
621 shall be effective for three (3) months from the date it is
622 received by the division, unless it is revoked earlier by the
623 physician because of a change in the condition of the patient.

624 (b) All state-owned intermediate care facilities for
625 the mentally retarded shall be reimbursed on a full reasonable
626 cost basis.
627 (13) Family planning services, including drugs, supplies and
628 devices, when such services are under the supervision of a
629 physician.
630 (14) Clinic services. Such diagnostic, preventive,
631 therapeutic, rehabilitative or palliative services furnished to an
632 outpatient by or under the supervision of a physician or dentist
633 in a facility which is not a part of a hospital but which is
634 organized and operated to provide medical care to outpatients.
635 Clinic services shall include any services reimbursed as
636 outpatient hospital services which may be rendered in such a
637 facility, including those that become so after July 1, 1991. On
638 July 1, 1999, all fees for physicians' services reimbursed under
639 authority of this paragraph (14) shall be reimbursed at ninety
640 percent (90%) of the rate established on January 1, 1999, and as
641 adjusted each January thereafter, under Medicare (Title XVIII of
642 the Social Security Act), as amended, and which shall in no event
643 be less than seventy percent (70%) of the rate established on
644 January 1, 1994. All fees for physicians' services that are
645 covered by both Medicare and Medicaid shall be reimbursed at ten
646 percent (10%) of the adjusted Medicare payment established on
647 January 1, 1999, and as adjusted each January thereafter, under
648 Medicare (Title XVIII of the Social Security Act), as amended, and
649 which shall in no event be less than seven percent (7%) of the
650 adjusted Medicare payment established on January 1, 1994. On July
651 1, 1999, all fees for dentists' services reimbursed under
652 authority of this paragraph (14) shall be increased to one hundred
653 sixty percent (160%) of the amount of the reimbursement rate that
654 was in effect on June 30, 1999.
655 (15) Home- and community-based services, as provided under
656 Title XIX of the federal Social Security Act, as amended, under

657 waivers, subject to the availability of funds specifically
658 appropriated therefor by the Legislature. Payment for such
659 services shall be limited to individuals who would be eligible for
660 and would otherwise require the level of care provided in a
661 nursing facility. The home- and community-based services
662 authorized under this paragraph shall be expanded over a five-year
663 period beginning July 1, 1999. The division shall certify case
664 management agencies to provide case management services and
665 provide for home- and community-based services for eligible
666 individuals under this paragraph. The home- and community-based
667 services under this paragraph and the activities performed by
668 certified case management agencies under this paragraph shall be
669 funded using state funds that are provided from the appropriation
670 to the Division of Medicaid and used to match federal funds * * *.
671 (16) Mental health services. Approved therapeutic and case
672 management services provided by (a) an approved regional mental
673 health/retardation center established under Sections 41-19-31
674 through 41-19-39, or by another community mental health service
675 provider meeting the requirements of the Department of Mental
676 Health to be an approved mental health/retardation center if
677 determined necessary by the Department of Mental Health, using
678 state funds which are provided from the appropriation to the State
679 Department of Mental Health and used to match federal funds under
680 a cooperative agreement between the division and the department,
681 or (b) a facility which is certified by the State Department of
682 Mental Health to provide therapeutic and case management services,
683 to be reimbursed on a fee for service basis. Any such services
684 provided by a facility described in paragraph (b) must have the
685 prior approval of the division to be reimbursable under this
686 section. After June 30, 1997, mental health services provided by
687 regional mental health/retardation centers established under
688 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
689 Section 41-9-3(a) and/or their subsidiaries and divisions, or by

690 psychiatric residential treatment facilities as defined in Section
691 43-11-1, or by another community mental health service provider
692 meeting the requirements of the Department of Mental Health to be
693 an approved mental health/retardation center if determined
694 necessary by the Department of Mental Health, shall not be
695 included in or provided under any capitated managed care pilot
696 program provided for under paragraph (24) of this section.
697 (17) Durable medical equipment services and medical supplies
698 restricted to patients receiving home health services unless
699 waived on an individual basis by the division. The division shall
700 not expend more than Three Hundred Thousand Dollars ($300,000.00)
701 of state funds annually to pay for medical supplies authorized
702 under this paragraph.
703 (18) Notwithstanding any other provision of this section to
704 the contrary, the division shall make additional reimbursement to
705 hospitals which serve a disproportionate share of low-income
706 patients and which meet the federal requirements for such payments
707 as provided in Section 1923 of the federal Social Security Act and
708 any applicable regulations.
709 (19) (a) Perinatal risk management services. The division
710 shall promulgate regulations to be effective from and after
711 October 1, 1988, to establish a comprehensive perinatal system for
712 risk assessment of all pregnant and infant Medicaid recipients and
713 for management, education and follow-up for those who are
714 determined to be at risk. Services to be performed include case
715 management, nutrition assessment/counseling, psychosocial
716 assessment/counseling and health education. The division shall
717 set reimbursement rates for providers in conjunction with the
718 State Department of Health.
719 (b) Early intervention system services. The division
720 shall cooperate with the State Department of Health, acting as
721 lead agency, in the development and implementation of a statewide
722 system of delivery of early intervention services, pursuant to

723 Part H of the Individuals with Disabilities Education Act (IDEA).
724 The State Department of Health shall certify annually in writing
725 to the director of the division the dollar amount of state early
726 intervention funds available which shall be utilized as a
727 certified match for Medicaid matching funds. Those funds then
728 shall be used to provide expanded targeted case management
729 services for Medicaid eligible children with special needs who are
730 eligible for the state's early intervention system.
731 Qualifications for persons providing service coordination shall be
732 determined by the State Department of Health and the Division of
733 Medicaid.
734 (20) Home- and community-based services for physically
735 disabled approved services as allowed by a waiver from the U.S.
736 Department of Health and Human Services for home- and
737 community-based services for physically disabled people using
738 state funds which are provided from the appropriation to the State
739 Department of Rehabilitation Services and used to match federal
740 funds under a cooperative agreement between the division and the
741 department, provided that funds for these services are
742 specifically appropriated to the Department of Rehabilitation
743 Services.
744 (21) Nurse practitioner services. Services furnished by a
745 registered nurse who is licensed and certified by the Mississippi
746 Board of Nursing as a nurse practitioner including, but not
747 limited to, nurse anesthetists, nurse midwives, family nurse
748 practitioners, family planning nurse practitioners, pediatric
749 nurse practitioners, obstetrics-gynecology nurse practitioners and
750 neonatal nurse practitioners, under regulations adopted by the
751 division. Reimbursement for such services shall not exceed ninety
752 percent (90%) of the reimbursement rate for comparable services
753 rendered by a physician.
754 (22) Ambulatory services delivered in federally qualified
755 health centers and in clinics of the local health departments of

756 the State Department of Health for individuals eligible for
757 medical assistance under this article based on reasonable costs as
758 determined by the division.
759 (23) Inpatient psychiatric services. Inpatient psychiatric
760 services to be determined by the division for recipients under age
761 twenty-one (21) which are provided under the direction of a
762 physician in an inpatient program in a licensed acute care
763 psychiatric facility or in a licensed psychiatric residential
764 treatment facility, before the recipient reaches age twenty-one
765 (21) or, if the recipient was receiving the services immediately
766 before he reached age twenty-one (21), before the earlier of the
767 date he no longer requires the services or the date he reaches age
768 twenty-two (22), as provided by federal regulations. Recipients
769 shall be allowed forty-five (45) days per year of psychiatric
770 services provided in acute care psychiatric facilities, and shall
771 be allowed unlimited days of psychiatric services provided in
772 licensed psychiatric residential treatment facilities.
773 (24) Managed care services in a program to be developed by
774 the division by a public or private provider. Notwithstanding any
775 other provision in this article to the contrary, the division
776 shall establish rates of reimbursement to providers rendering care
777 and services authorized under this section, and may revise such
778 rates of reimbursement without amendment to this section by the
779 Legislature for the purpose of achieving effective and accessible
780 health services, and for responsible containment of costs. This
781 shall include, but not be limited to, one (1) module of capitated
782 managed care in a rural area, and one (1) module of capitated
783 managed care in an urban area.
784 (25) Birthing center services.
785 (26) Hospice care. As used in this paragraph, the term
786 "hospice care" means a coordinated program of active professional
787 medical attention within the home and outpatient and inpatient
788 care which treats the terminally ill patient and family as a unit,

789 employing a medically directed interdisciplinary team. The
790 program provides relief of severe pain or other physical symptoms
791 and supportive care to meet the special needs arising out of
792 physical, psychological, spiritual, social and economic stresses
793 which are experienced during the final stages of illness and
794 during dying and bereavement and meets the Medicare requirements
795 for participation as a hospice as provided in 42 CFR Part 418.
796 (27) Group health plan premiums and cost sharing if it is
797 cost effective as defined by the Secretary of Health and Human
798 Services.
799 (28) Other health insurance premiums which are cost
800 effective as defined by the Secretary of Health and Human
801 Services. Medicare eligible must have Medicare Part B before
802 other insurance premiums can be paid.
803 (29) The Division of Medicaid may apply for a waiver from
804 the Department of Health and Human Services for home- and
805 community-based services for developmentally disabled people using
806 state funds which are provided from the appropriation to the State
807 Department of Mental Health and used to match federal funds under
808 a cooperative agreement between the division and the department,
809 provided that funds for these services are specifically
810 appropriated to the Department of Mental Health.
811 (30) Pediatric skilled nursing services for eligible persons
812 under twenty-one (21) years of age.
813 (31) Targeted case management services for children with
814 special needs, under waivers from the U.S. Department of Health
815 and Human Services, using state funds that are provided from the
816 appropriation to the Mississippi Department of Human Services and
817 used to match federal funds under a cooperative agreement between
818 the division and the department.
819 (32) Care and services provided in Christian Science
820 Sanatoria operated by or listed and certified by The First Church
821 of Christ Scientist, Boston, Massachusetts, rendered in connection

822 with treatment by prayer or spiritual means to the extent that
823 such services are subject to reimbursement under Section 1903 of
824 the Social Security Act.
825 (33) Podiatrist services.
826 (34) Personal care services provided in a pilot program to
827 not more than forty (40) residents at a location or locations to
828 be determined by the division and delivered by individuals
829 qualified to provide such services, as allowed by waivers under
830 Title XIX of the Social Security Act, as amended. The division
831 shall not expend more than Three Hundred Thousand Dollars
832 ($300,000.00) annually to provide such personal care services.
833 The division shall develop recommendations for the effective
834 regulation of any facilities that would provide personal care
835 services which may become eligible for Medicaid reimbursement
836 under this section, and shall present such recommendations with
837 any proposed legislation to the 1996 Regular Session of the
838 Legislature on or before January 1, 1996.
839 (35) Services and activities authorized in Sections
840 43-27-101 and 43-27-103, using state funds that are provided from
841 the appropriation to the State Department of Human Services and
842 used to match federal funds under a cooperative agreement between
843 the division and the department.
844 (36) Nonemergency transportation services for
845 Medicaid-eligible persons, to be provided by the Department of
846 Human Services. The division may contract with additional
847 entities to administer nonemergency transportation services as it
848 deems necessary. All providers shall have a valid driver's
849 license, vehicle inspection sticker and a standard liability
850 insurance policy covering the vehicle.
851 (37) Targeted case management services for individuals with
852 chronic diseases, with expanded eligibility to cover services to
853 uninsured recipients, on a pilot program basis. This paragraph
854 (37) shall be contingent upon continued receipt of special funds

855 from the Health Care Financing Authority and private foundations
856 who have granted funds for planning these services. No funding
857 for these services shall be provided from State General Funds.
858 (38) Chiropractic services: a chiropractor's manual
859 manipulation of the spine to correct a subluxation, if x-ray
860 demonstrates that a subluxation exists and if the subluxation has
861 resulted in a neuromusculoskeletal condition for which
862 manipulation is appropriate treatment. Reimbursement for
863 chiropractic services shall not exceed Seven Hundred Dollars
864 ($700.00) per year per recipient.
865 Notwithstanding any provision of this article, except as
866 authorized in the following paragraph and in Section 43-13-139,
867 neither (a) the limitations on quantity or frequency of use of or
868 the fees or charges for any of the care or services available to
869 recipients under this section, nor (b) the payments or rates of
870 reimbursement to providers rendering care or services authorized
871 under this section to recipients, may be increased, decreased or
872 otherwise changed from the levels in effect on July 1, 1986,
873 unless such is authorized by an amendment to this section by the
874 Legislature. However, the restriction in this paragraph shall not
875 prevent the division from changing the payments or rates of
876 reimbursement to providers without an amendment to this section
877 whenever such changes are required by federal law or regulation,
878 or whenever such changes are necessary to correct administrative
879 errors or omissions in calculating such payments or rates of
880 reimbursement.
881 Notwithstanding any provision of this article, no new groups
882 or categories of recipients and new types of care and services may
883 be added without enabling legislation from the Mississippi
884 Legislature, except that the division may authorize such changes
885 without enabling legislation when such addition of recipients or
886 services is ordered by a court of proper authority. The director
887 shall keep the Governor advised on a timely basis of the funds

888 available for expenditure and the projected expenditures. In the
889 event current or projected expenditures can be reasonably
890 anticipated to exceed the amounts appropriated for any fiscal
891 year, the Governor, after consultation with the director, shall
892 discontinue any or all of the payment of the types of care and
893 services as provided herein which are deemed to be optional
894 services under Title XIX of the federal Social Security Act, as
895 amended, for any period necessary to not exceed appropriated
896 funds, and when necessary shall institute any other cost
897 containment measures on any program or programs authorized under
898 the article to the extent allowed under the federal law governing
899 such program or programs, it being the intent of the Legislature
900 that expenditures during any fiscal year shall not exceed the
901 amounts appropriated for such fiscal year.
902 SECTION 3. This act shall take effect and be in force from
903 and after July 1, 2000.