By: Scott (80th)

To: Universities and Colleges; Appropriations

HOUSE BILL NO. 1503

1 AN ACT TO CREATE NEW SECTION 37-143-6, MISSISSIPPI CODE OF
2 1972, TO ESTABLISH A MEDICAL EDUCATION SCHOLARSHIP PROGRAM TO
3 PROVIDE FIFTEEN NEW STUDENTS EACH YEAR WITH A FULL SCHOLARSHIP TO
4 OBTAIN A MEDICAL EDUCATION AND A FAMILY MEDICINE RESIDENCY AT THE
5 UNIVERSITY OF MISSISSIPPI SCHOOL OF MEDICINE AT NO COST; TO
6 PROVIDE THAT THE PROGRAM SHALL BE ADMINISTERED BY THE BOARD OF
7 TRUSTEES OF STATE INSTITUTIONS OF HIGHER LEARNING; TO PROVIDE THAT
8 THE PROGRAM SHALL BE FUNDED FROM MONIES APPROPRIATED FROM THE
9 HEALTH CARE EXPENDABLE FUND; TO PROVIDE THAT SCHOLARSHIP
10 RECIPIENTS MUST AGREE TO PRACTICE FAMILY MEDICINE FOR AT LEAST TEN
11 YEARS IN AN AREA OF THE STATE THAT IS A PRIMARY MEDICAL CARE
12 SHORTAGE AREA AND A RURAL AREA NOT LOCATED WITHIN A CERTAIN
13 DISTANCE OF MAJOR URBAN AREAS; TO PROVIDE THAT IF A SCHOLARSHIP
14 RECIPIENT LEAVES MEDICAL SCHOOL OR THE FAMILY MEDICINE RESIDENCY
15 BEFORE COMPLETION OR LEAVES PRACTICING FAMILY MEDICINE IN A
16 MEDICAL CARE SHORTAGE AREA BEFORE THE END OF TEN YEARS, THE FULL
17 AMOUNT THAT THE RECIPIENT RECEIVED UNDER THE SCHOLARSHIP SHALL BE
18 DUE AND PAYABLE WITHIN 90 DAYS, TOGETHER WITH INTEREST; TO PROVIDE
19 FOR THE REIMBURSEMENT OF RELOCATION EXPENSES FOR LICENSED
20 PHYSICIANS TO MOVE AND PRACTICE FAMILY MEDICINE IN AN UNDERSERVED
21 AREA OF THE STATE; TO PROVIDE FOR THE PAYMENT OF START-UP EXPENSES
22 AND MEDICAL MALPRACTICE INSURANCE PREMIUMS FOR THOSE PHYSICIANS;
23 TO PROVIDE FOR THE PAYMENT OF ANNUAL INCOME SUBSIDIES FOR THOSE
24 PHYSICIANS; TO BRING FORWARD SECTION 37-143-5, MISSISSIPPI CODE OF
25 1972, WHICH IS THE MEDICAL EDUCATION LOAN OR SCHOLARSHIP PROGRAM;
26 TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO PROVIDE
27 AN ADDITIONAL 10% FEE INCREASE IN MEDICAID REIMBURSEMENT FOR
28 PHYSICIANS WHO PRACTICE IN AN UNDERSERVED AREA OF THE STATE; TO
29 PROVIDE A CREDIT AGAINST STATE INCOME TAXES FOR PHYSICIANS WHO
30 PRACTICE FULL-TIME IN AN UNDERSERVED AREA OF THE STATE; AND FOR
31 RELATED PURPOSES.

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

33 SECTION 1. The following shall be codified as Section
34 37-143-6, Mississippi Code of 1972:

35 <u>37-143-6.</u> (1) There is established a medical education
36 scholarship program, which shall be administered by the Board of
37 Trustees of State Institutions of Higher Learning. The program
38 shall provide a certain number of eligible applicants each year
39 with a full scholarship to obtain a medical education and a family
40 medicine residency at the University of Mississippi School of

41 Medicine at no cost to the recipient, if the recipient meets the
42 conditions upon which the scholarship is granted.
43 (2) The program shall provide scholarships to fifteen (15)
44 new students each year, and the program shall be funded from
45 monies appropriated from the Health Care Expendable Fund
46 established under Section 43-13-407 and from any other funds
47 appropriated to or otherwise made available to the board of
48 trustees for that purpose.
49 (3) The scholarship shall be in an amount that will pay the
50 full cost of the tuition and other expenses of recipient at the
51 University of Mississippi School of Medicine for the entire time
52 necessary to complete the requirements for a medical degree and a
53 residency in family medicine.
54 (4) Before being granted a scholarship, each applicant shall
55 enter into a contract with the board of trustees, which shall be
56 deemed a contract with the State of Mississippi, agreeing to the
57 terms and conditions upon which the scholarship will be granted.
58 In order to receive a scholarship under the program, the recipient
59 must agree in the contract to practice family medicine for a
60 period of not less than ten (10) years after completion of his or
61 her residency, in an area of the state that is, at the time of his
62 or her entry into medical practice:
63 (a) A Group 1 degree-of-shortage health professional
64 shortage area for primary medical care, as designated by the
65 United States Department of Health and Human Services;
66 (b) Classified as a rural area by the United States
67 Census Bureau; and
68 (c) Located more than fifty (50) miles from any
69 standard metropolitan statistical area, as defined and established
70 by the United States Census Bureau, and from any incorporated
71 municipality having a population of twenty-five thousand (25,000)
72 or more, according to the most recent federal decennial census.
73 (5) If a scholarship recipient leaves the University of
74 Mississippi School of Medicine before graduation, or leaves the
75 family medicine residency before completion, or fails to practice
76 family medicine in an area of the state described in subsection
77 (4) of this section for a period of ten (10) years, the full

78 amount that the recipient received under the scholarship shall be
79 due and payable within ninety (90) days, together with interest.
80 The amount of interest due shall be equal to the annual rate of
81 return on the Health Care Trust Fund established under Section
82 43-13-405 for each year from the time the recipient received the
83 scholarship money until the time the scholarship money is repaid.
84 The board of trustees may bring suit against any scholarship
85 recipient to recover the amount due to the state under this
86 section for the recipient's failure to comply with the conditions
87 upon which the scholarship was granted, as provided in this
88 section and in the contract between the recipient and the board of
89 trustees.

90 (6) The board of trustees shall establish such rules and
91 regulations as it deems necessary and proper to carry out the
92 purposes and intent of this section.

93 SECTION 2. (1) The Board of Trustees of State Institutions
94 of Higher Learning shall prescribe rules and regulations which,
95 subject to available appropriations, allow for reimbursement to
96 licensed physicians who practice family medicine in an underserved
97 area of the State of Mississippi as described in subsection (4) of
98 Section 37-143-6, for the expense of moving when the employment
99 necessitates the relocation of the physician or his family to a
100 different geographical area than that in which the physician
101 resides. If the reimbursement is approved, the board of trustees
102 shall provide funds to reimburse the physician an amount not to
103 exceed One Thousand Dollars ($1,000.00) for the documented actual
104 expenses incurred in the course of relocating, including the
105 expense of any professional moving company or persons employed to
106 assist with the move, rented moving vehicles or equipment, mileage
107 in the amount authorized for state employees under Section 25-3-41
108 if the physician used his personal vehicle for the move, meals and
109 such other expenses associated with the relocation in accordance
110 with the established rules and regulations.

111 (2) The Board of Trustees of State Institutions of Higher
112 Learning shall prescribe rules and regulations which, subject to
113 available appropriations, allow for reimbursement to licensed
114 physicians to practice family medicine in an underserved area of
115 the State of Mississippi as described in subsection (4) of Section
116 37-143-6, for the direct expense associated with starting a
117 full-time medical practice, including the cost of building, lease
118 payments, equipment purchases, furniture, medical supplies and
119 medical malpractice insurance associated with a family practice.
120 If the reimbursement is approved, the board of trustees shall
121 provide funds to reimburse the physician an amount not to exceed
122 Twenty Thousand Dollars ($20,000.00) over a two (2) year period
123 for the documented actual expenses incurred in starting a
124 physician's practice.
125 (3) The Board of Trustees of State Institutions of Higher
126 Learning shall prescribe rules and regulations which, subject to
127 available appropriations, allow income subsidies for licensed
128 physicians who practice family medicine full time in an
129 underserved area of the State of Mississippi as described in
130 subsection (4) of Section 37-143-6, to recognize the reduced
131 earning capacity associated with practicing in a rural area. If
132 the income subsidy is approved, the board of trustees shall
133 provide funds to compensate the physician in an amount not to
134 exceed Twenty Thousand Dollars ($20,000.00) annually.
135 SECTION 3. Section 37-143-5, Mississippi Code of 1972, is
136 brought forward as follows:[MS1]
137 37-143-5. (1) There is hereby created the medical loan or
138 scholarship program. The purpose of such program shall be to
139 enable eligible applicants who desire to become physicians to
140 obtain a medical education in the University of Mississippi School
141 of Medicine, which will qualify them to become licensed,
142 practicing physicians and surgeons.
143 (2) The Board of Trustees of State Institutions of Higher

144 Learning shall establish, by rule and regulation, the maximum
145 annual award which may be made under this program at an amount not
146 to exceed the cost of tuition and other expenses, and shall
147 establish the maximum number of awards which may be made not to
148 exceed the length of time required to complete the degree
149 requirements and internship or residency.
150 (3) Loans made to applicants under this program may be made
151 under similar terms and conditions as then current provisions of
152 the Federal Guaranteed Student Loan Program, or its successor, as
153 to the repayment of principal and interest. Such loans shall be
154 eligible for deferment during attendance as a full-time student in
155 an approved course of training. No interest shall accrue on such
156 loan during the time the recipient is in such attendance. Such
157 loans may be eligible for other deferments for such other causes
158 as may be established by the board by rule and regulations not
159 inconsistent with the foregoing.
160 (4) Loans made to applicants shall be made and based upon
161 the following options for repayment or conversion to interest-free
162 scholarships:
163 (a) Payment in full of principal and interest must be
164 made in sixty (60) or less equal monthly installments, commencing
165 one (1) month after graduation and internship or residency, or
166 termination of attendance as a full-time student;
167 (b) In lieu of payment in full of both principal and
168 interest, a loan recipient may elect to repay by entry into public
169 health work at a state health institution as defined in Section
170 37-143-13(2), or community health centers that are grantees under
171 Section 330 of the United States Public Health Service Act.
172 Repayment under this option shall convert loan to scholarship, and
173 discharge the same, on the basis of one (1) year's service for one
174 (1) year's loan amount, or the appropriate proportion of the total
175 outstanding balance of principal and interest, all as shall be
176 established by rule and regulation of the board of trustees. If

177 at any time prior to the repayment in full of the total obligation
178 the recipient abandons or abrogates repayment by this option, the
179 provisions of Section 37-143-5(d) shall apply;
180 (c) In lieu of payment in full of both principal and
181 interest, a loan recipient may elect to repay by entry into the
182 practice of medicine in a primary health care field in an area
183 outside of a metropolitan statistical area, as defined and
184 established by the United States Census Bureau, and within a
185 region ranking between 1 and 54, inclusively, on the Relative
186 Needs Index of Five Factors for Primary Care Physicians, as
187 annually determined by the State Board of Health, for a period of
188 five (5) years. Repayment under this option shall convert loan to
189 scholarship, and discharge the same on the basis of one (1) year's
190 service for one (1) year's loan amount, or the appropriate
191 proportion of the total outstanding balance of principal and
192 interest, all as shall be established by rule and regulation of
193 the board of trustees. If at any time prior to the repayment in
194 full of the total obligation the recipient abandons or abrogates
195 repayment by this option, the provisions of Section 37-143-5(4)(d)
196 shall apply;
197 (d) In the event of abandonment or abrogation of the
198 options for repayment as provided for in Section 37-143-5(4)(b)
199 and (c), the remaining balance of unpaid or undischarged principal
200 and interest shall become due and payable over the remaining
201 period of time as if the option provided for in Section
202 37-143-5(4)(a) had been elected upon graduation and internship or
203 residency.
204 (5) The board of trustees shall establish such rules and
205 regulations as it deems necessary and proper to carry out the
206 purposes and intent of this section.
207 SECTION 4. Section 43-13-117, Mississippi Code of 1972, is
208 amended as follows:[RDD2]
209 43-13-117. Medical assistance as authorized by this article

210 shall include payment of part or all of the costs, at the
211 discretion of the division or its successor, with approval of the
212 Governor, of the following types of care and services rendered to
213 eligible applicants who shall have been determined to be eligible
214 for such care and services, within the limits of state
215 appropriations and federal matching funds:
216 (1) Inpatient hospital services.
217 (a) The division shall allow thirty (30) days of
218 inpatient hospital care annually for all Medicaid recipients;
219 however, before any recipient will be allowed more than fifteen
220 (15) days of inpatient hospital care in any one (1) year, he must
221 obtain prior approval therefor from the division. The division
222 shall be authorized to allow unlimited days in disproportionate
223 hospitals as defined by the division for eligible infants under
224 the age of six (6) years.
225 (b) From and after July 1, 1994, the Executive
226 Director of the Division of Medicaid shall amend the Mississippi
227 Title XIX Inpatient Hospital Reimbursement Plan to remove the
228 occupancy rate penalty from the calculation of the Medicaid
229 Capital Cost Component utilized to determine total hospital costs
230 allocated to the Medicaid Program.
231 (2) Outpatient hospital services. Provided that where
232 the same services are reimbursed as clinic services, the division
233 may revise the rate or methodology of outpatient reimbursement to
234 maintain consistency, efficiency, economy and quality of care.
235 (3) Laboratory and x-ray services.
236 (4) Nursing facility services.
237 (a) The division shall make full payment to
238 nursing facilities for each day, not exceeding fifty-two (52) days
239 per year, that a patient is absent from the facility on home
240 leave. Payment may be made for the following home leave days in
241 addition to the fifty-two-day limitation: Christmas, the day
242 before Christmas, the day after Christmas, Thanksgiving, the day

243 before Thanksgiving and the day after Thanksgiving. However,
244 before payment may be made for more than eighteen (18) home leave
245 days in a year for a patient, the patient must have written
246 authorization from a physician stating that the patient is
247 physically and mentally able to be away from the facility on home
248 leave. Such authorization must be filed with the division before
249 it will be effective and the authorization shall be effective for
250 three (3) months from the date it is received by the division,
251 unless it is revoked earlier by the physician because of a change
252 in the condition of the patient.
253 (b) From and after July 1, 1993, the division
254 shall implement the integrated case-mix payment and quality
255 monitoring system developed pursuant to Section 43-13-122, which
256 includes the fair rental system for property costs and in which
257 recapture of depreciation is eliminated. The division may revise
258 the reimbursement methodology for the case-mix payment system by
259 reducing payment for hospital leave and therapeutic home leave
260 days to the lowest case-mix category for nursing facilities,
261 modifying the current method of scoring residents so that only
262 services provided at the nursing facility are considered in
263 calculating a facility's per diem, and the division may limit
264 administrative and operating costs, but in no case shall these
265 costs be less than one hundred nine percent (109%) of the median
266 administrative and operating costs for each class of facility, not
267 to exceed the median used to calculate the nursing facility
268 reimbursement for fiscal year 1996, to be applied uniformly to all
269 long-term care facilities.
270 (c) From and after July 1, 1997, all state-owned
271 nursing facilities shall be reimbursed on a full reasonable costs
272 basis. From and after July 1, 1997, payments by the division to
273 nursing facilities for return on equity capital shall be made at
274 the rate paid under Medicare (Title XVIII of the Social Security
275 Act), but shall be no less than seven and one-half percent (7.5%)

276 nor greater than ten percent (10%).

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

280 (i) Review shall be heard in the following
281 areas:

282 (A) Matters relating to cost reports
283 including, but not limited to, allowable costs and cost
284 adjustments resulting from desk reviews and audits.

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

288 (ii) The Review Board shall be composed of
289 six (6) members, three (3) having expertise in one (1) of the two
290 (2) areas set forth above and three (3) having expertise in the
291 other area set forth above. Each panel of three (3) shall only
292 review appeals arising in its area of expertise. The members
293 shall be appointed as follows:

294 (A) In each of the areas of expertise
295 defined under subparagraphs (i)(A) and (i)(B), the Executive
296 Director of the Division of Medicaid shall appoint one (1) person
297 chosen from the private sector nursing home industry in the state,
298 which may include independent accountants and consultants serving
299 the industry;

300 (B) In each of the areas of expertise
301 defined under subparagraphs (i)(A) and (i)(B), the Executive
302 Director of the Division of Medicaid shall appoint one (1) person
303 who is employed by the state who does not participate directly in
304 desk reviews or audits of nursing facilities in the two (2) areas
305 of review;

306 (C) The two (2) members appointed by the
307 Executive Director of the Division of Medicaid in each area of
308 expertise shall appoint a third member in the same area of

309 expertise.
310 In the event of a conflict of interest on the part of any
311 Review Board members, the Executive Director of the Division of
312 Medicaid or the other two (2) panel members, as applicable, shall
313 appoint a substitute member for conducting a specific review.
314 (iii) The Review Board panels shall have the
315 power to preserve and enforce order during hearings; to issue
316 subpoenas; to administer oaths; to compel attendance and testimony
317 of witnesses; or to compel the production of books, papers,
318 documents and other evidence; or the taking of depositions before
319 any designated individual competent to administer oaths; to
320 examine witnesses; and to do all things conformable to law that
321 may be necessary to enable it effectively to discharge its duties.
322 The Review Board panels may appoint such person or persons as
323 they shall deem proper to execute and return process in connection
324 therewith.
325 (iv) The Review Board shall promulgate,
326 publish and disseminate to nursing facility providers rules of
327 procedure for the efficient conduct of proceedings, subject to the
328 approval of the Executive Director of the Division of Medicaid and
329 in accordance with federal and state administrative hearing laws
330 and regulations.
331 (v) Proceedings of the Review Board shall be
332 of record.
333 (vi) Appeals to the Review Board shall be in
334 writing and shall set out the issues, a statement of alleged facts
335 and reasons supporting the provider's position. Relevant
336 documents may also be attached. The appeal shall be filed within
337 thirty (30) days from the date the provider is notified of the
338 action being appealed or, if informal review procedures are taken,
339 as provided by administrative regulations of the Division of
340 Medicaid, within thirty (30) days after a decision has been
341 rendered through informal hearing procedures.

342 (vii) The provider shall be notified of the
343 hearing date by certified mail within thirty (30) days from the
344 date the Division of Medicaid receives the request for appeal.
345 Notification of the hearing date shall in no event be less than
346 thirty (30) days before the scheduled hearing date. The appeal
347 may be heard on shorter notice by written agreement between the
348 provider and the Division of Medicaid.
349 (viii) Within thirty (30) days from the date
350 of the hearing, the Review Board panel shall render a written
351 recommendation to the Executive Director of the Division of
352 Medicaid setting forth the issues, findings of fact and applicable
353 law, regulations or provisions.
354 (ix) The Executive Director of the Division
355 of Medicaid shall, upon review of the recommendation, the
356 proceedings and the record, prepare a written decision which shall
357 be mailed to the nursing facility provider no later than twenty
358 (20) days after the submission of the recommendation by the panel.
359 The decision of the executive director is final, subject only to
360 judicial review.
361 (x) Appeals from a final decision shall be
362 made to the Chancery Court of Hinds County. The appeal shall be
363 filed with the court within thirty (30) days from the date the
364 decision of the Executive Director of the Division of Medicaid
365 becomes final.
366 (xi) The action of the Division of Medicaid
367 under review shall be stayed until all administrative proceedings
368 have been exhausted.
369 (xii) Appeals by nursing facility providers
370 involving any issues other than those two (2) specified in
371 subparagraphs (i)(A) and <u>(i)</u>(B) shall be taken in accordance with
372 the administrative hearing procedures established by the Division
373 of Medicaid.
374 (e) When a facility of a category that does not

375 require a certificate of need for construction and that could not
376 be eligible for Medicaid reimbursement is constructed to nursing
377 facility specifications for licensure and certification, and the
378 facility is subsequently converted to a nursing facility pursuant
379 to a certificate of need that authorizes conversion only and the
380 applicant for the certificate of need was assessed an application
381 review fee based on capital expenditures incurred in constructing
382 the facility, the division shall allow reimbursement for capital
383 expenditures necessary for construction of the facility that were
384 incurred within the twenty-four (24) consecutive calendar months
385 immediately preceding the date that the certificate of need
386 authorizing such conversion was issued, to the same extent that
387 reimbursement would be allowed for construction of a new nursing
388 facility pursuant to a certificate of need that authorizes such
389 construction. The reimbursement authorized in this subparagraph
390 (e) may be made only to facilities the construction of which was
391 completed after June 30, 1989. Before the division shall be
392 authorized to make the reimbursement authorized in this
393 subparagraph (e), the division first must have received approval
394 from the Health Care Financing Administration of the United States
395 Department of Health and Human Services of the change in the state
396 Medicaid plan providing for such reimbursement.
397 (f) The division shall develop and implement a
398 case-mix payment add-on determined by time studies and other valid
399 statistical data which will reimburse a nursing facility for the
400 additional cost of caring for a resident who has a diagnosis of
401 Alzheimer's or other related dementia and exhibits symptoms that
402 require special care. Any such case-mix add-on payment shall be
403 supported by a determination of additional cost. The division
404 shall also develop and implement as part of the fair rental
405 reimbursement system for nursing facility beds, an Alzheimer's
406 resident bed depreciation enhanced reimbursement system which will
407 provide an incentive to encourage nursing facilities to convert or

408 construct beds for residents with Alzheimer's or other related
409 dementia.
410 (g) The Division of Medicaid shall develop and
411 implement a referral process for long-term care alternatives for
412 Medicaid beneficiaries and applicants. No Medicaid beneficiary
413 shall be admitted to a Medicaid-certified nursing facility unless
414 a licensed physician certifies that nursing facility care is
415 appropriate for that person on a standardized form to be prepared
416 and provided to nursing facilities by the Division of Medicaid.
417 The physician shall forward a copy of that certification to the
418 Division of Medicaid within twenty-four (24) hours after it is
419 signed by the physician. Any physician who fails to forward the
420 certification to the Division of Medicaid within the time period
421 specified in this paragraph shall be ineligible for Medicaid
422 reimbursement for any physician's services performed for the
423 applicant. The Division of Medicaid shall determine, through an
424 assessment of the applicant conducted within two (2) business days
425 after receipt of the physician's certification, whether the
426 applicant also could live appropriately and cost-effectively at
427 home or in some other community-based setting if home- or
428 community-based services were available to the applicant. The
429 time limitation prescribed in this paragraph shall be waived in
430 cases of emergency. If the Division of Medicaid determines that a
431 home- or other community-based setting is appropriate and
432 cost-effective, the division shall:
433 (i) Advise the applicant or the applicant's
434 legal representative that a home- or other community-based setting
435 is appropriate;
436 (ii) Provide a proposed care plan and inform
437 the applicant or the applicant's legal representative regarding
438 the degree to which the services in the care plan are available in
439 a home- or in other community-based setting rather than nursing
440 facility care; and

441 (iii) Explain that such plan and services are
442 available only if the applicant or the applicant's legal
443 representative chooses a home- or community-based alternative to
444 nursing facility care, and that the applicant is free to choose
445 nursing facility care.

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

451 Placement in a nursing facility may not be denied by the
452 division if home- or community-based services that would be more
453 appropriate than nursing facility care are not actually available,
454 or if the applicant chooses not to receive the appropriate home-
455 or community-based services.

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

460 The division shall make full payment for long-term care
461 alternative services.

462 The division shall apply for necessary federal waivers to
463 assure that additional services providing alternatives to nursing
464 facility care are made available to applicants for nursing
465 facility care.

466 (5) Periodic screening and diagnostic services for
467 individuals under age twenty-one (21) years as are needed to
468 identify physical and mental defects and to provide health care
469 treatment and other measures designed to correct or ameliorate
470 defects and physical and mental illness and conditions discovered
471 by the screening services regardless of whether these services are
472 included in the state plan. The division may include in its
473 periodic screening and diagnostic program those discretionary

474 services authorized under the federal regulations adopted to
475 implement Title XIX of the federal Social Security Act, as
476 amended. The division, in obtaining physical therapy services,
477 occupational therapy services, and services for individuals with
478 speech, hearing and language disorders, may enter into a
479 cooperative agreement with the State Department of Education for
480 the provision of such services to handicapped students by public
481 school districts using state funds which are provided from the
482 appropriation to the Department of Education to obtain federal
483 matching funds through the division. The division, in obtaining
484 medical and psychological evaluations for children in the custody
485 of the State Department of Human Services may enter into a
486 cooperative agreement with the State Department of Human Services
487 for the provision of such services using state funds which are
488 provided from the appropriation to the Department of Human
489 Services to obtain federal matching funds through the division.
490 On July 1, 1993, all fees for periodic screening and
491 diagnostic services under this paragraph (5) shall be increased by
492 twenty-five percent (25%) of the reimbursement rate in effect on
493 June 30, 1993.
494 (6) Physician's services. All fees for physicians'
495 services that are covered only by Medicaid shall be reimbursed at
496 ninety percent (90%) of the rate established on January 1, 1999,
497 and as adjusted each January thereafter, under Medicare (Title
498 XVIII of the Social Security Act), as amended, and which shall in
499 no event be less than seventy percent (70%) of the rate
500 established on January 1, 1994. All fees for physicians' services
501 that are covered by both Medicare and Medicaid shall be reimbursed
502 at ten percent (10%) of the adjusted Medicare payment established
503 on January 1, 1999, and as adjusted each January thereafter, under
504 Medicare (Title XVIII of the Social Security Act), as amended, and
505 which shall in no event be less than seven percent (7%) of the
506 adjusted Medicare payment established on January 1, 1994. <u>All</u>

507 <u>fees for physicians' services that are covered by Medicaid shall</u>
508 <u>be reimbursed at one hundred ten percent (110%) of the current</u>
509 <u>rate for licensed physicians who practice family medicine in an</u>
510 <u>underserved area of the State of Mississippi as described in</u>
511 <u>subsection (4) of Section 37-143-6.</u>
512 (7) (a) Home health services for eligible persons, not
513 to exceed in cost the prevailing cost of nursing facility
514 services, not to exceed sixty (60) visits per year.
515 (b) Repealed.
516 (8) Emergency medical transportation services. On
517 January 1, 1994, emergency medical transportation services shall
518 be reimbursed at seventy percent (70%) of the rate established
519 under Medicare (Title XVIII of the Social Security Act), as
520 amended. "Emergency medical transportation services" shall mean,
521 but shall not be limited to, the following services by a properly
522 permitted ambulance operated by a properly licensed provider in
523 accordance with the Emergency Medical Services Act of 1974
524 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
525 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
526 (vi) disposable supplies, (vii) similar services.
527 (9) Legend and other drugs as may be determined by the
528 division. The division may implement a program of prior approval
529 for drugs to the extent permitted by law. Payment by the division
530 for covered multiple source drugs shall be limited to the lower of
531 the upper limits established and published by the Health Care
532 Financing Administration (HCFA) plus a dispensing fee of Four
533 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
534 cost (EAC) as determined by the division plus a dispensing fee of
535 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual
536 and customary charge to the general public. The division shall
537 allow five (5) prescriptions per month for noninstitutionalized
538 Medicaid recipients; however, exceptions for up to ten (10)
539 prescriptions per month shall be allowed, with the approval of the

540 director.

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

546 Payment for nonlegend or over-the-counter drugs covered on
547 the division's formulary shall be reimbursed at the lower of the
548 division's estimated shelf price or the providers' usual and
549 customary charge to the general public. No dispensing fee shall
550 be paid.

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

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

564 (10) Dental care that is an adjunct to treatment of an
565 acute medical or surgical condition; services of oral surgeons and
566 dentists in connection with surgery related to the jaw or any
567 structure contiguous to the jaw or the reduction of any fracture
568 of the jaw or any facial bone; and emergency dental extractions
569 and treatment related thereto. On July 1, 1999, all fees for
570 dental care and surgery under authority of this paragraph (10)
571 shall be increased to one hundred sixty percent (160%) of the
572 amount of the reimbursement rate that was in effect on June 30,

573 1999. It is the intent of the Legislature to encourage more
574 dentists to participate in the Medicaid program.
575 (11) Eyeglasses necessitated by reason of eye surgery,
576 and as prescribed by a physician skilled in diseases of the eye or
577 an optometrist, whichever the patient may select.
578 (12) Intermediate care facility services.
579 (a) The division shall make full payment to all
580 intermediate care facilities for the mentally retarded for each
581 day, not exceeding eighty-four (84) days per year, that a patient
582 is absent from the facility on home leave. Payment may be made
583 for the following home leave days in addition to the
584 eighty-four-day limitation: Christmas, the day before Christmas,
585 the day after Christmas, Thanksgiving, the day before Thanksgiving
586 and the day after Thanksgiving. However, before payment may be
587 made for more than eighteen (18) home leave days in a year for a
588 patient, the patient must have written authorization from a
589 physician stating that the patient is physically and mentally able
590 to be away from the facility on home leave. Such authorization
591 must be filed with the division before it will be effective, and
592 the authorization shall be effective for three (3) months from the
593 date it is received by the division, unless it is revoked earlier
594 by the physician because of a change in the condition of the
595 patient.
596 (b) All state-owned intermediate care facilities
597 for the mentally retarded shall be reimbursed on a full reasonable
598 cost basis.
599 (13) Family planning services, including drugs,
600 supplies and devices, when such services are under the supervision
601 of a physician.
602 (14) Clinic services. Such diagnostic, preventive,
603 therapeutic, rehabilitative or palliative services furnished to an
604 outpatient by or under the supervision of a physician or dentist
605 in a facility which is not a part of a hospital but which is

606 organized and operated to provide medical care to outpatients.
607 Clinic services shall include any services reimbursed as
608 outpatient hospital services which may be rendered in such a
609 facility, including those that become so after July 1, 1991. On
610 July 1, 1999, all fees for physicians' services reimbursed under
611 authority of this paragraph (14) shall be reimbursed at ninety
612 percent (90%) of the rate established on January 1, 1999, and as
613 adjusted each January thereafter, under Medicare (Title XVIII of
614 the Social Security Act), as amended, and which shall in no event
615 be less than seventy percent (70%) of the rate established on
616 January 1, 1994. All fees for physicians' services that are
617 covered by both Medicare and Medicaid shall be reimbursed at ten
618 percent (10%) of the adjusted Medicare payment established on
619 January 1, 1999, and as adjusted each January thereafter, under
620 Medicare (Title XVIII of the Social Security Act), as amended, and
621 which shall in no event be less than seven percent (7%) of the
622 adjusted Medicare payment established on January 1, 1994. On July
623 1, 1999, all fees for dentists' services reimbursed under
624 authority of this paragraph (14) shall be increased to one hundred
625 sixty percent (160%) of the amount of the reimbursement rate that
626 was in effect on June 30, 1999.
627 (15) Home- and community-based services, as provided
628 under Title XIX of the federal Social Security Act, as amended,
629 under waivers, subject to the availability of funds specifically
630 appropriated therefor by the Legislature. Payment for such
631 services shall be limited to individuals who would be eligible for
632 and would otherwise require the level of care provided in a
633 nursing facility. The home- and community-based services
634 authorized under this paragraph shall be expanded over a five-year
635 period beginning July 1, 1999. The division shall certify case
636 management agencies to provide case management services and
637 provide for home- and community-based services for eligible
638 individuals under this paragraph. The home- and community-based

639 services under this paragraph and the activities performed by
640 certified case management agencies under this paragraph shall be
641 funded using state funds that are provided from the appropriation
642 to the Division of Medicaid and used to match federal funds.
643 (16) Mental health services. Approved therapeutic and
644 case management services provided by (a) an approved regional
645 mental health/retardation center established under Sections
646 41-19-31 through 41-19-39, or by another community mental health
647 service provider meeting the requirements of the Department of
648 Mental Health to be an approved mental health/retardation center
649 if determined necessary by the Department of Mental Health, using
650 state funds which are provided from the appropriation to the State
651 Department of Mental Health and used to match federal funds under
652 a cooperative agreement between the division and the department,
653 or (b) a facility which is certified by the State Department of
654 Mental Health to provide therapeutic and case management services,
655 to be reimbursed on a fee for service basis. Any such services
656 provided by a facility described in paragraph (b) must have the
657 prior approval of the division to be reimbursable under this
658 section. After June 30, 1997, mental health services provided by
659 regional mental health/retardation centers established under
660 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
661 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
662 psychiatric residential treatment facilities as defined in Section
663 43-11-1, or by another community mental health service provider
664 meeting the requirements of the Department of Mental Health to be
665 an approved mental health/retardation center if determined
666 necessary by the Department of Mental Health, shall not be
667 included in or provided under any capitated managed care pilot
668 program provided for under paragraph (24) of this section.
669 (17) Durable medical equipment services and medical
670 supplies restricted to patients receiving home health services
671 unless waived on an individual basis by the division. The

672 division shall not expend more than Three Hundred Thousand Dollars
673 ($300,000.00) of state funds annually to pay for medical supplies
674 authorized under this paragraph.

675 (18) Notwithstanding any other provision of this
676 section to the contrary, the division shall make additional
677 reimbursement to hospitals which serve a disproportionate share of
678 low-income patients and which meet the federal requirements for
679 such payments as provided in Section 1923 of the federal Social
680 Security Act and any applicable regulations.

681 (19) (a) Perinatal risk management services. The
682 division shall promulgate regulations to be effective from and
683 after October 1, 1988, to establish a comprehensive perinatal
684 system for risk assessment of all pregnant and infant Medicaid
685 recipients and for management, education and follow-up for those
686 who are determined to be at risk. Services to be performed
687 include case management, nutrition assessment/counseling,
688 psychosocial assessment/counseling and health education. The
689 division shall set reimbursement rates for providers in
690 conjunction with the State Department of Health.

691 (b) Early intervention system services. The
692 division shall cooperate with the State Department of Health,
693 acting as lead agency, in the development and implementation of a
694 statewide system of delivery of early intervention services,
695 pursuant to Part H of the Individuals with Disabilities Education
696 Act (IDEA). The State Department of Health shall certify annually
697 in writing to the director of the division the dollar amount of
698 state early intervention funds available which shall be utilized
699 as a certified match for Medicaid matching funds. Those funds
700 then shall be used to provide expanded targeted case management
701 services for Medicaid eligible children with special needs who are
702 eligible for the state's early intervention system.
703 Qualifications for persons providing service coordination shall be
704 determined by the State Department of Health and the Division of

705 Medicaid.

706 (20) Home- and community-based services for physically
707 disabled approved services as allowed by a waiver from the U.S.
708 Department of Health and Human Services for home- and
709 community-based services for physically disabled people using
710 state funds which are provided from the appropriation to the State
711 Department of Rehabilitation Services and used to match federal
712 funds under a cooperative agreement between the division and the
713 department, provided that funds for these services are
714 specifically appropriated to the Department of Rehabilitation
715 Services.

716 (21) Nurse practitioner services. Services furnished
717 by a registered nurse who is licensed and certified by the
718 Mississippi Board of Nursing as a nurse practitioner including,
719 but not limited to, nurse anesthetists, nurse midwives, family
720 nurse practitioners, family planning nurse practitioners,
721 pediatric nurse practitioners, obstetrics-gynecology nurse
722 practitioners and neonatal nurse practitioners, under regulations
723 adopted by the division. Reimbursement for such services shall
724 not exceed ninety percent (90%) of the reimbursement rate for
725 comparable services rendered by a physician.

726 (22) Ambulatory services delivered in federally
727 qualified health centers and in clinics of the local health
728 departments of the State Department of Health for individuals
729 eligible for medical assistance under this article based on
730 reasonable costs as determined by the division.

731 (23) Inpatient psychiatric services. Inpatient
732 psychiatric services to be determined by the division for
733 recipients under age twenty-one (21) which are provided under the
734 direction of a physician in an inpatient program in a licensed
735 acute care psychiatric facility or in a licensed psychiatric
736 residential treatment facility, before the recipient reaches age
737 twenty-one (21) or, if the recipient was receiving the services

738 immediately before he reached age twenty-one (21), before the
739 earlier of the date he no longer requires the services or the date
740 he reaches age twenty-two (22), as provided by federal
741 regulations. Recipients shall be allowed forty-five (45) days per
742 year of psychiatric services provided in acute care psychiatric
743 facilities, and shall be allowed unlimited days of psychiatric
744 services provided in licensed psychiatric residential treatment
745 facilities.

746 (24) Managed care services in a program to be developed
747 by the division by a public or private provider. Notwithstanding
748 any other provision in this article to the contrary, the division
749 shall establish rates of reimbursement to providers rendering care
750 and services authorized under this section, and may revise such
751 rates of reimbursement without amendment to this section by the
752 Legislature for the purpose of achieving effective and accessible
753 health services, and for responsible containment of costs. This
754 shall include, but not be limited to, one (1) module of capitated
755 managed care in a rural area, and one (1) module of capitated
756 managed care in an urban area.

757 (25) Birthing center services.

758 (26) Hospice care. As used in this paragraph, the term
759 "hospice care" means a coordinated program of active professional
760 medical attention within the home and outpatient and inpatient
761 care which treats the terminally ill patient and family as a unit,
762 employing a medically directed interdisciplinary team. The
763 program provides relief of severe pain or other physical symptoms
764 and supportive care to meet the special needs arising out of
765 physical, psychological, spiritual, social and economic stresses
766 which are experienced during the final stages of illness and
767 during dying and bereavement and meets the Medicare requirements
768 for participation as a hospice as provided in 42 CFR Part 418.

769 (27) Group health plan premiums and cost sharing if it
770 is cost effective as defined by the Secretary of Health and Human

771 Services.

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

776 (29) The Division of Medicaid may apply for a waiver
777 from the Department of Health and Human Services for home- and
778 community-based services for developmentally disabled people using
779 state funds which are provided from the appropriation to the State
780 Department of Mental Health and used to match federal funds under
781 a cooperative agreement between the division and the department,
782 provided that funds for these services are specifically
783 appropriated to the Department of Mental Health.

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

786 (31) Targeted case management services for children
787 with special needs, under waivers from the U.S. Department of
788 Health and Human Services, using state funds that are provided
789 from the appropriation to the Mississippi Department of Human
790 Services and used to match federal funds under a cooperative
791 agreement between the division and the department.

792 (32) Care and services provided in Christian Science
793 Sanatoria operated by or listed and certified by The First Church
794 of Christ Scientist, Boston, Massachusetts, rendered in connection
795 with treatment by prayer or spiritual means to the extent that
796 such services are subject to reimbursement under Section 1903 of
797 the Social Security Act.

798 (33) Podiatrist services.

799 (34) Personal care services provided in a pilot program
800 to not more than forty (40) residents at a location or locations
801 to be determined by the division and delivered by individuals
802 qualified to provide such services, as allowed by waivers under
803 Title XIX of the Social Security Act, as amended. The division

804 shall not expend more than Three Hundred Thousand Dollars
805 ($300,000.00) annually to provide such personal care services.
806 The division shall develop recommendations for the effective
807 regulation of any facilities that would provide personal care
808 services which may become eligible for Medicaid reimbursement
809 under this section, and shall present such recommendations with
810 any proposed legislation to the 1996 Regular Session of the
811 Legislature on or before January 1, 1996.
812 (35) Services and activities authorized in Sections
813 43-27-101 and 43-27-103, using state funds that are provided from
814 the appropriation to the State Department of Human Services and
815 used to match federal funds under a cooperative agreement between
816 the division and the department.
817 (36) Nonemergency transportation services for
818 Medicaid-eligible persons, to be provided by the Department of
819 Human Services. The division may contract with additional
820 entities to administer nonemergency transportation services as it
821 deems necessary. All providers shall have a valid driver's
822 license, vehicle inspection sticker and a standard liability
823 insurance policy covering the vehicle.
824 (37) Targeted case management services for individuals
825 with chronic diseases, with expanded eligibility to cover services
826 to uninsured recipients, on a pilot program basis. This paragraph
827 (37) shall be contingent upon continued receipt of special funds
828 from the Health Care Financing Authority and private foundations
829 who have granted funds for planning these services. No funding
830 for these services shall be provided from state general funds.
831 (38) Chiropractic services: a chiropractor's manual
832 manipulation of the spine to correct a subluxation, if x-ray
833 demonstrates that a subluxation exists and if the subluxation has
834 resulted in a neuromusculoskeletal condition for which
835 manipulation is appropriate treatment. Reimbursement for
836 chiropractic services shall not exceed Seven Hundred Dollars

837 ($700.00) per year per recipient.

838 Notwithstanding any provision of this article, except as
839 authorized in the following paragraph and in Section 43-13-139,
840 neither (a) the limitations on quantity or frequency of use of or
841 the fees or charges for any of the care or services available to
842 recipients under this section, nor (b) the payments or rates of
843 reimbursement to providers rendering care or services authorized
844 under this section to recipients, may be increased, decreased or
845 otherwise changed from the levels in effect on July 1, 1986,
846 unless such is authorized by an amendment to this section by the
847 Legislature. However, the restriction in this paragraph shall not
848 prevent the division from changing the payments or rates of
849 reimbursement to providers without an amendment to this section
850 whenever such changes are required by federal law or regulation,
851 or whenever such changes are necessary to correct administrative
852 errors or omissions in calculating such payments or rates of
853 reimbursement.

854 Notwithstanding any provision of this article, no new groups
855 or categories of recipients and new types of care and services may
856 be added without enabling legislation from the Mississippi
857 Legislature, except that the division may authorize such changes
858 without enabling legislation when such addition of recipients or
859 services is ordered by a court of proper authority. The director
860 shall keep the Governor advised on a timely basis of the funds
861 available for expenditure and the projected expenditures. In the
862 event current or projected expenditures can be reasonably
863 anticipated to exceed the amounts appropriated for any fiscal
864 year, the Governor, after consultation with the director, shall
865 discontinue any or all of the payment of the types of care and
866 services as provided herein which are deemed to be optional
867 services under Title XIX of the federal Social Security Act, as
868 amended, for any period necessary to not exceed appropriated
869 funds, and when necessary shall institute any other cost

870 containment measures on any program or programs authorized under
871 the article to the extent allowed under the federal law governing
872 such program or programs, it being the intent of the Legislature
873 that expenditures during any fiscal year shall not exceed the
874 amounts appropriated for such fiscal year.

875 SECTION 5. (1) Any licensed physician who practices full
876 time in any underserved area of the State of Mississippi as
877 described in subsection (4) of Section 37-143-6 shall be allowed a
878 credit against the taxes imposed by this chapter in an amount
879 equal to fifty percent (50%) of the physician's income tax
880 liability that results from income derived from his or her
881 practice in any such underserved area. The credit shall be
882 allowed for a maximum of ten (10) years for all practice in any
883 such underserved areas in which the physician practices during his
884 or her career.

885 (2) Subsection 1 of this section shall be codified as a new
886 section in Article 1, Chapter 7, Title 27, Mississippi Code of
887 1972.

888 SECTION 6. This act shall take effect and be in force from
889 and after July 1, 2000; provided that Section 5 of this act shall
890 take effect and be in force from and after January 1, 2000.