

By: Smith, King

To: Public Health and
Welfare;
Appropriations

SENATE BILL NO. 2527

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE THAT VETERANS MAY PAY A PRICE NOT TO EXCEED THE
3 MEDICAID REIMBURSEMENT RATE FOR PRESCRIPTION MEDICINES PLUS A
4 PROCESSING FEE, FROM ALL PHARMACISTS PARTICIPATING IN THE MEDICAID
5 PROGRAM; AND FOR RELATED PURPOSES.

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

7 SECTION 1. Section 43-13-117, Mississippi Code of 1972, is
8 amended as follows:[RDD1]

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

16 (1) Inpatient hospital services.

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

23 hospitals as defined by the division for eligible infants under
24 the age of six (6) years.

25 (b) From and after July 1, 1994, the Executive Director
26 of the Division of Medicaid shall amend the Mississippi Title XIX
27 Inpatient Hospital Reimbursement Plan to remove the occupancy rate
28 penalty from the calculation of the Medicaid Capital Cost
29 Component utilized to determine total hospital costs allocated to
30 the Medicaid Program.

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

35 (3) Laboratory and x-ray services.

36 (4) Nursing facility services.

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

53 (b) From and after July 1, 1993, the division shall

54 implement the integrated case-mix payment and quality monitoring
55 system developed pursuant to Section 43-13-122, which includes the
56 fair rental system for property costs and in which recapture of
57 depreciation is eliminated. The division may revise the
58 reimbursement methodology for the case-mix payment system by
59 reducing payment for hospital leave and therapeutic home leave
60 days to the lowest case-mix category for nursing facilities,
61 modifying the current method of scoring residents so that only
62 services provided at the nursing facility are considered in
63 calculating a facility's per diem, and the division may limit
64 administrative and operating costs, but in no case shall these
65 costs be less than one hundred nine percent (109%) of the median
66 administrative and operating costs for each class of facility, not
67 to exceed the median used to calculate the nursing facility
68 reimbursement for fiscal year 1996, to be applied uniformly to all
69 long-term care facilities.

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

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

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

81 (A) Matters relating to cost reports

82 including, but not limited to, allowable costs and cost
83 adjustments resulting from desk reviews and audits.

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

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

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

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

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

109 In the event of a conflict of interest on the part of any

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

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

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

130 (v) Proceedings of the Review Board shall be of
131 record.

132 (vi) Appeals to the Review Board shall be in
133 writing and shall set out the issues, a statement of alleged facts
134 and reasons supporting the provider's position. Relevant
135 documents may also be attached. The appeal shall be filed within
136 thirty (30) days from the date the provider is notified of the
137 action being appealed or, if informal review procedures are taken,

138 as provided by administrative regulations of the Division of
139 Medicaid, within thirty (30) days after a decision has been
140 rendered through informal hearing procedures.

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

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

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

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

165 (xi) The action of the Division of Medicaid under

166 review shall be stayed until all administrative proceedings have
167 been exhausted.

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

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

194 Department of Health and Human Services of the change in the state
195 Medicaid plan providing for such reimbursement.

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

209 (g) The Division of Medicaid shall develop and
210 implement a referral process for long-term care alternatives for
211 Medicaid beneficiaries and applicants. No Medicaid beneficiary
212 shall be admitted to a Medicaid-certified nursing facility unless
213 a licensed physician certifies that nursing facility care is
214 appropriate for that person on a standardized form to be prepared
215 and provided to nursing facilities by the Division of Medicaid.
216 The physician shall forward a copy of that certification to the
217 Division of Medicaid within twenty-four (24) hours after it is
218 signed by the physician. Any physician who fails to forward the
219 certification to the Division of Medicaid within the time period
220 specified in this paragraph shall be ineligible for Medicaid
221 reimbursement for any physician's services performed for the

222 applicant. The Division of Medicaid shall determine, through an
223 assessment of the applicant conducted within two (2) business days
224 after receipt of the physician's certification, whether the
225 applicant also could live appropriately and cost-effectively at
226 home or in some other community-based setting if home- or
227 community-based services were available to the applicant. The
228 time limitation prescribed in this paragraph shall be waived in
229 cases of emergency. If the Division of Medicaid determines that a
230 home- or other community-based setting is appropriate and
231 cost-effective, the division shall:

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

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

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

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

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

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

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

261 The division shall apply for necessary federal waivers to
262 assure that additional services providing alternatives to nursing
263 facility care are made available to applicants for nursing
264 facility care.

265 (5) Periodic screening and diagnostic services for
266 individuals under age twenty-one (21) years as are needed to
267 identify physical and mental defects and to provide health care
268 treatment and other measures designed to correct or ameliorate
269 defects and physical and mental illness and conditions discovered
270 by the screening services regardless of whether these services are
271 included in the state plan. The division may include in its
272 periodic screening and diagnostic program those discretionary
273 services authorized under the federal regulations adopted to
274 implement Title XIX of the federal Social Security Act, as
275 amended. The division, in obtaining physical therapy services,
276 occupational therapy services, and services for individuals with
277 speech, hearing and language disorders, may enter into a

278 cooperative agreement with the State Department of Education for
279 the provision of such services to handicapped students by public
280 school districts using state funds which are provided from the
281 appropriation to the Department of Education to obtain federal
282 matching funds through the division. The division, in obtaining
283 medical and psychological evaluations for children in the custody
284 of the State Department of Human Services may enter into a
285 cooperative agreement with the State Department of Human Services
286 for the provision of such services using state funds which are
287 provided from the appropriation to the Department of Human
288 Services to obtain federal matching funds through the division.

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

293 (6) Physician's services. All fees for physicians' services
294 that are covered only by Medicaid shall be reimbursed at ninety
295 percent (90%) of the rate established on January 1, 1999, and as
296 adjusted each January thereafter, under Medicare (Title XVIII of
297 the Social Security Act), as amended, and which shall in no event
298 be less than seventy percent (70%) of the rate established on
299 January 1, 1994. All fees for physicians' services that are
300 covered by both Medicare and Medicaid shall be reimbursed at ten
301 percent (10%) of the adjusted Medicare payment established on
302 January 1, 1999, and as adjusted each January thereafter, under
303 Medicare (Title XVIII of the Social Security Act), as amended, and
304 which shall in no event be less than seven percent (7%) of the
305 adjusted Medicare payment established on January 1, 1994.

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

309 (b) Repealed.

310 (8) Emergency medical transportation services. On January
311 1, 1994, emergency medical transportation services shall be
312 reimbursed at seventy percent (70%) of the rate established under
313 Medicare (Title XVIII of the Social Security Act), as amended.

314 "Emergency medical transportation services" shall mean, but shall
315 not be limited to, the following services by a properly permitted
316 ambulance operated by a properly licensed provider in accordance
317 with the Emergency Medical Services Act of 1974 (Section 41-59-1
318 et seq.): (i) basic life support, (ii) advanced life support,
319 (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi)
320 disposable supplies, (vii) similar services.

321 (9) Legend and other drugs as may be determined by the
322 division. The division may implement a program of prior approval
323 for drugs to the extent permitted by law. Payment by the division
324 for covered multiple source drugs shall be limited to the lower of
325 the upper limits established and published by the Health Care
326 Financing Administration (HCFA) plus a dispensing fee of Four
327 Dollars and Ninety-one Cents (\$4.91), or the estimated acquisition
328 cost (EAC) as determined by the division plus a dispensing fee of
329 Four Dollars and Ninety-one Cents (\$4.91), or the providers' usual
330 and customary charge to the general public. The division shall
331 allow five (5) prescriptions per month for noninstitutionalized
332 Medicaid recipients; however, exceptions for up to ten (10)
333 prescriptions per month shall be allowed, with the approval of the

334 director.

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

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

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

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

358 As a condition of a pharmacy's participation in the Medicaid
359 program, the pharmacy, upon presentation of a valid prescription
360 for the patient and the patient's veterans identification card or
361 other proper document, shall charge veteran beneficiaries a price

362 that does not exceed the Medicaid reimbursement rate for
363 prescription medicines, and an amount, as set by the Division of
364 Medicaid to cover electronic transmission charges. However,
365 veteran beneficiaries shall not be allowed to use the Medicaid
366 reimbursement rate for over-the-counter medications or compounded
367 prescriptions. The Division of Medicaid shall determine the
368 proper identification to be shown by the veteran in order to
369 qualify for the rate prescribed herein, which may be the card
370 issued by the U.S. Bureau of Veterans Affairs if the veteran is
371 retired, or a DD214 form if the veteran is discharged but not
372 retired. The Division of Medicaid shall also provide a mechanism
373 to calculate and transmit the price to the pharmacy, but shall not
374 apply the Medicaid drug utilization review process for purposes of
375 this section. The division shall monitor pharmacy participation
376 with the requirements of this paragraph and report to the
377 Legislature annually on that participation including information
378 on any pharmacies that discontinue participation in the Medicaid
379 program and the reasons given for the discontinuance.

380 (10) Dental care that is an adjunct to treatment of an acute
381 medical or surgical condition; services of oral surgeons and
382 dentists in connection with surgery related to the jaw or any
383 structure contiguous to the jaw or the reduction of any fracture
384 of the jaw or any facial bone; and emergency dental extractions
385 and treatment related thereto. On July 1, 1999, all fees for
386 dental care and surgery under authority of this paragraph (10)
387 shall be increased to one hundred sixty percent (160%) of the
388 amount of the reimbursement rate that was in effect on June 30,
389 1999. It is the intent of the Legislature to encourage more

390 dentists to participate in the Medicaid program.

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

394 (12) Intermediate care facility services.

395 (a) The division shall make full payment to all
396 intermediate care facilities for the mentally retarded for each
397 day, not exceeding eighty-four (84) days per year, that a patient
398 is absent from the facility on home leave. Payment may be made
399 for the following home leave days in addition to the 84-day
400 limitation: Christmas, the day before Christmas, the day after
401 Christmas, Thanksgiving, the day before Thanksgiving and the day
402 after Thanksgiving. However, before payment may be made for more
403 than eighteen (18) home leave days in a year for a patient, the
404 patient must have written authorization from a physician stating
405 that the patient is physically and mentally able to be away from
406 the facility on home leave. Such authorization must be filed with
407 the division before it will be effective, and the authorization
408 shall be effective for three (3) months from the date it is
409 received by the division, unless it is revoked earlier by the
410 physician because of a change in the condition of the patient.

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

414 (13) Family planning services, including drugs, supplies and
415 devices, when such services are under the supervision of a
416 physician.

417 (14) Clinic services. Such diagnostic, preventive,

418 therapeutic, rehabilitative or palliative services furnished to an
419 outpatient by or under the supervision of a physician or dentist
420 in a facility which is not a part of a hospital but which is
421 organized and operated to provide medical care to outpatients.
422 Clinic services shall include any services reimbursed as
423 outpatient hospital services which may be rendered in such a
424 facility, including those that become so after July 1, 1991. On
425 July 1, 1999, all fees for physicians' services reimbursed under
426 authority of this paragraph (14) shall be reimbursed at ninety
427 percent (90%) of the rate established on January 1, 1999, and as
428 adjusted each January thereafter, under Medicare (Title XVIII of
429 the Social Security Act), as amended, and which shall in no event
430 be less than seventy percent (70%) of the rate established on
431 January 1, 1994. All fees for physicians' services that are
432 covered by both Medicare and Medicaid shall be reimbursed at ten
433 percent (10%) of the adjusted Medicare payment established on
434 January 1, 1999, and as adjusted each January thereafter, under
435 Medicare (Title XVIII of the Social Security Act), as amended, and
436 which shall in no event be less than seven percent (7%) of the
437 adjusted Medicare payment established on January 1, 1994. On July
438 1, 1999, all fees for dentists' services reimbursed under
439 authority of this paragraph (14) shall be increased to one hundred
440 sixty percent (160%) of the amount of the reimbursement rate that
441 was in effect on June 30, 1999.

442 (15) Home- and community-based services, as provided under
443 Title XIX of the federal Social Security Act, as amended, under
444 waivers, subject to the availability of funds specifically
445 appropriated therefor by the Legislature. Payment for such

446 services shall be limited to individuals who would be eligible for
447 and would otherwise require the level of care provided in a
448 nursing facility. The home- and community-based services
449 authorized under this paragraph shall be expanded over a five-year
450 period beginning July 1, 1999. The division shall certify case
451 management agencies to provide case management services and
452 provide for home- and community-based services for eligible
453 individuals under this paragraph. The home- and community-based
454 services under this paragraph and the activities performed by
455 certified case management agencies under this paragraph shall be
456 funded using state funds that are provided from the appropriation
457 to the Division of Medicaid and used to match federal funds.

458 (16) Mental health services. Approved therapeutic and case
459 management services provided by (a) an approved regional mental
460 health/retardation center established under Sections 41-19-31
461 through 41-19-39, or by another community mental health service
462 provider meeting the requirements of the Department of Mental
463 Health to be an approved mental health/retardation center if
464 determined necessary by the Department of Mental Health, using
465 state funds which are provided from the appropriation to the State
466 Department of Mental Health and used to match federal funds under
467 a cooperative agreement between the division and the department,
468 or (b) a facility which is certified by the State Department of
469 Mental Health to provide therapeutic and case management services,
470 to be reimbursed on a fee for service basis. Any such services
471 provided by a facility described in paragraph (b) must have the
472 prior approval of the division to be reimbursable under this
473 section. After June 30, 1997, mental health services provided by

474 regional mental health/retardation centers established under
475 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
476 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
477 psychiatric residential treatment facilities as defined in Section
478 43-11-1, or by another community mental health service provider
479 meeting the requirements of the Department of Mental Health to be
480 an approved mental health/retardation center if determined
481 necessary by the Department of Mental Health, shall not be
482 included in or provided under any capitated managed care pilot
483 program provided for under paragraph (24) of this section.

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

490 (18) Notwithstanding any other provision of this section to
491 the contrary, the division shall make additional reimbursement to
492 hospitals which serve a disproportionate share of low-income
493 patients and which meet the federal requirements for such payments
494 as provided in Section 1923 of the federal Social Security Act and
495 any applicable regulations.

496 (19) (a) Perinatal risk management services. The division
497 shall promulgate regulations to be effective from and after
498 October 1, 1988, to establish a comprehensive perinatal system for
499 risk assessment of all pregnant and infant Medicaid recipients and
500 for management, education and follow-up for those who are
501 determined to be at risk. Services to be performed include case

502 management, nutrition assessment/counseling, psychosocial
503 assessment/counseling and health education. The division shall
504 set reimbursement rates for providers in conjunction with the
505 State Department of Health.

506 (b) Early intervention system services. The division
507 shall cooperate with the State Department of Health, acting as
508 lead agency, in the development and implementation of a statewide
509 system of delivery of early intervention services, pursuant to
510 Part H of the Individuals with Disabilities Education Act (IDEA).

511 The State Department of Health shall certify annually in writing
512 to the director of the division the dollar amount of state early
513 intervention funds available which shall be utilized as a
514 certified match for Medicaid matching funds. Those funds then
515 shall be used to provide expanded targeted case management
516 services for Medicaid eligible children with special needs who are
517 eligible for the state's early intervention system.

518 Qualifications for persons providing service coordination shall be
519 determined by the State Department of Health and the Division of
520 Medicaid.

521 (20) Home- and community-based services for physically
522 disabled approved services as allowed by a waiver from the U.S.
523 Department of Health and Human Services for home- and
524 community-based services for physically disabled people using
525 state funds which are provided from the appropriation to the State
526 Department of Rehabilitation Services and used to match federal
527 funds under a cooperative agreement between the division and the
528 department, provided that funds for these services are
529 specifically appropriated to the Department of Rehabilitation

530 Services.

531 (21) Nurse practitioner services. Services furnished by a
532 registered nurse who is licensed and certified by the Mississippi
533 Board of Nursing as a nurse practitioner including, but not
534 limited to, nurse anesthetists, nurse midwives, family nurse
535 practitioners, family planning nurse practitioners, pediatric
536 nurse practitioners, obstetrics-gynecology nurse practitioners and
537 neonatal nurse practitioners, under regulations adopted by the
538 division. Reimbursement for such services shall not exceed ninety
539 percent (90%) of the reimbursement rate for comparable services
540 rendered by a physician.

541 (22) Ambulatory services delivered in federally qualified
542 health centers and in clinics of the local health departments of
543 the State Department of Health for individuals eligible for
544 medical assistance under this article based on reasonable costs as
545 determined by the division.

546 (23) Inpatient psychiatric services. Inpatient psychiatric
547 services to be determined by the division for recipients under age
548 twenty-one (21) which are provided under the direction of a
549 physician in an inpatient program in a licensed acute care
550 psychiatric facility or in a licensed psychiatric residential
551 treatment facility, before the recipient reaches age twenty-one
552 (21) or, if the recipient was receiving the services immediately
553 before he reached age twenty-one (21), before the earlier of the
554 date he no longer requires the services or the date he reaches age
555 twenty-two (22), as provided by federal regulations. Recipients
556 shall be allowed forty-five (45) days per year of psychiatric
557 services provided in acute care psychiatric facilities, and shall

558 be allowed unlimited days of psychiatric services provided in
559 licensed psychiatric residential treatment facilities.

560 (24) Managed care services in a program to be developed by
561 the division by a public or private provider. Notwithstanding any
562 other provision in this article to the contrary, the division
563 shall establish rates of reimbursement to providers rendering care
564 and services authorized under this section, and may revise such
565 rates of reimbursement without amendment to this section by the
566 Legislature for the purpose of achieving effective and accessible
567 health services, and for responsible containment of costs. This
568 shall include, but not be limited to, one (1) module of capitated
569 managed care in a rural area, and one (1) module of capitated
570 managed care in an urban area.

571 (25) Birthing center services.

572 (26) Hospice care. As used in this paragraph, the term
573 "hospice care" means a coordinated program of active professional
574 medical attention within the home and outpatient and inpatient
575 care which treats the terminally ill patient and family as a unit,
576 employing a medically directed interdisciplinary team. The
577 program provides relief of severe pain or other physical symptoms
578 and supportive care to meet the special needs arising out of
579 physical, psychological, spiritual, social and economic stresses
580 which are experienced during the final stages of illness and
581 during dying and bereavement and meets the Medicare requirements
582 for participation as a hospice as provided in 42 CFR Part 418.

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

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

590 (29) The Division of Medicaid may apply for a waiver from
591 the Department of Health and Human Services for home- and
592 community-based services for developmentally disabled people using
593 state funds which are provided from the appropriation to the State
594 Department of Mental Health and used to match federal funds under
595 a cooperative agreement between the division and the department,
596 provided that funds for these services are specifically
597 appropriated to the Department of Mental Health.

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

600 (31) Targeted case management services for children with
601 special needs, under waivers from the U.S. Department of Health
602 and Human Services, using state funds that are provided from the
603 appropriation to the Mississippi Department of Human Services and
604 used to match federal funds under a cooperative agreement between
605 the division and the department.

606 (32) Care and services provided in Christian Science
607 Sanatoria operated by or listed and certified by The First Church
608 of Christ Scientist, Boston, Massachusetts, rendered in connection
609 with treatment by prayer or spiritual means to the extent that
610 such services are subject to reimbursement under Section 1903 of
611 the Social Security Act.

612 (33) Podiatrist services.

613 (34) Personal care services provided in a pilot program to

614 not more than forty (40) residents at a location or locations to
615 be determined by the division and delivered by individuals
616 qualified to provide such services, as allowed by waivers under
617 Title XIX of the Social Security Act, as amended. The division
618 shall not expend more than Three Hundred Thousand Dollars
619 (\$300,000.00) annually to provide such personal care services.
620 The division shall develop recommendations for the effective
621 regulation of any facilities that would provide personal care
622 services which may become eligible for Medicaid reimbursement
623 under this section, and shall present such recommendations with
624 any proposed legislation to the 1996 Regular Session of the
625 Legislature on or before January 1, 1996.

626 (35) Services and activities authorized in Sections
627 43-27-101 and 43-27-103, using state funds that are provided from
628 the appropriation to the State Department of Human Services and
629 used to match federal funds under a cooperative agreement between
630 the division and the department.

631 (36) Nonemergency transportation services for
632 Medicaid-eligible persons, to be provided by the Department of
633 Human Services. The division may contract with additional
634 entities to administer nonemergency transportation services as it
635 deems necessary. All providers shall have a valid driver's
636 license, vehicle inspection sticker and a standard liability
637 insurance policy covering the vehicle.

638 (37) Targeted case management services for individuals with
639 chronic diseases, with expanded eligibility to cover services to
640 uninsured recipients, on a pilot program basis. This paragraph
641 (37) shall be contingent upon continued receipt of special funds

642 from the Health Care Financing Authority and private foundations
643 who have granted funds for planning these services. No funding
644 for these services shall be provided from State General Funds.

645 (38) Chiropractic services: a chiropractor's manual
646 manipulation of the spine to correct a subluxation, if x-ray
647 demonstrates that a subluxation exists and if the subluxation has
648 resulted in a neuromusculoskeletal condition for which
649 manipulation is appropriate treatment. Reimbursement for
650 chiropractic services shall not exceed Seven Hundred Dollars
651 (\$700.00) per year per recipient.

652 Notwithstanding any provision of this article, except as
653 authorized in the following paragraph and in Section 43-13-139,
654 neither (a) the limitations on quantity or frequency of use of or
655 the fees or charges for any of the care or services available to
656 recipients under this section, nor (b) the payments or rates of
657 reimbursement to providers rendering care or services authorized
658 under this section to recipients, may be increased, decreased or
659 otherwise changed from the levels in effect on July 1, 1986,
660 unless such is authorized by an amendment to this section by the
661 Legislature. However, the restriction in this paragraph shall not
662 prevent the division from changing the payments or rates of
663 reimbursement to providers without an amendment to this section
664 whenever such changes are required by federal law or regulation,
665 or whenever such changes are necessary to correct administrative
666 errors or omissions in calculating such payments or rates of
667 reimbursement.

668 Notwithstanding any provision of this article, no new groups
669 or categories of recipients and new types of care and services may

670 be added without enabling legislation from the Mississippi
671 Legislature, except that the division may authorize such changes
672 without enabling legislation when such addition of recipients or
673 services is ordered by a court of proper authority. The director
674 shall keep the Governor advised on a timely basis of the funds
675 available for expenditure and the projected expenditures. In the
676 event current or projected expenditures can be reasonably
677 anticipated to exceed the amounts appropriated for any fiscal
678 year, the Governor, after consultation with the director, shall
679 discontinue any or all of the payment of the types of care and
680 services as provided herein which are deemed to be optional
681 services under Title XIX of the federal Social Security Act, as
682 amended, for any period necessary to not exceed appropriated
683 funds, and when necessary shall institute any other cost
684 containment measures on any program or programs authorized under
685 the article to the extent allowed under the federal law governing
686 such program or programs, it being the intent of the Legislature
687 that expenditures during any fiscal year shall not exceed the
688 amounts appropriated for such fiscal year.

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