MISSISSIPPI LEGISLATURE REGULAR SESSION 2000

By: Dearing

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2683

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE THAT MENTAL HEALTH COUNSELING SERVICES PROVIDED BY A
3 LICENSED PROFESSIONAL COUNSELOR (LPC) SHALL BE REIMBURSABLE UNDER
4 THE MEDICAID PROGRAM; AND FOR RELATED PURPOSES.

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

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

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

15 (1) Inpatient hospital services.

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

23 the age of six (6) years.

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

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

34 (3) Laboratory and x-ray services.

35 (4) Nursing facility services.

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

52 (b) From and after July 1, 1993, the division shall
53 implement the integrated case-mix payment and quality monitoring

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

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

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

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

80 (A) Matters relating to cost reports
81 including, but not limited to, allowable costs and cost

82 adjustments resulting from desk reviews and audits.

83 (B) Matters relating to the Minimum Data Set

84 Plus (MDS +) or successor assessment formats including but not

85 limited to audits, classifications and submissions.

86 (ii) The Review Board shall be composed of six (6)

87 members, three (3) having expertise in one (1) of the two (2)

88 areas set forth above and three (3) having expertise in the other

89 area set forth above. Each panel of three (3) shall only review

90 appeals arising in its area of expertise. The members shall be

91 appointed as follows:

92 (A) In each of the areas of expertise defined

93 under subparagraphs (i)(A) and (i)(B), the Executive Director of

94 the Division of Medicaid shall appoint one (1) person chosen from

95 the private sector nursing home industry in the state, which may

96 include independent accountants and consultants serving the

97 industry;

98 (B) In each of the areas of expertise defined

99 under subparagraphs (i)(A) and (i)(B), the Executive Director of

100 the Division of Medicaid shall appoint one (1) person who is

101 employed by the state who does not participate directly in desk

102 reviews or audits of nursing facilities in the two (2) areas of

103 review;

104 (C) The two (2) members appointed by the

105 Executive Director of the Division of Medicaid in each area of

106 expertise shall appoint a third member in the same area of

107 expertise.

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

109 Review Board members, the Executive Director of the Division of

110 Medicaid or the other two (2) panel members, as applicable, shall
111 appoint a substitute member for conducting a specific review.
112 (iii) The Review Board panels shall have the power
113 to preserve and enforce order during hearings; to issue subpoenas;
114 to administer oaths; to compel attendance and testimony of
115 witnesses; or to compel the production of books, papers, documents
116 and other evidence; or the taking of depositions before any
117 designated individual competent to administer oaths; to examine
118 witnesses; and to do all things conformable to law that may be
119 necessary to enable it effectively to discharge its duties. The
120 Review Board panels may appoint such person or persons as they
121 shall deem proper to execute and return process in connection
122 therewith.
123 (iv) The Review Board shall promulgate, publish
124 and disseminate to nursing facility providers rules of procedure
125 for the efficient conduct of proceedings, subject to the approval
126 of the Executive Director of the Division of Medicaid and in
127 accordance with federal and state administrative hearing laws and
128 regulations.
129 (v) Proceedings of the Review Board shall be of
130 record.
131 (vi) Appeals to the Review Board shall be in
132 writing and shall set out the issues, a statement of alleged facts
133 and reasons supporting the provider's position. Relevant
134 documents may also be attached. The appeal shall be filed within
135 thirty (30) days from the date the provider is notified of the
136 action being appealed or, if informal review procedures are taken,
137 as provided by administrative regulations of the Division of

138 Medicaid, within thirty (30) days after a decision has been
139 rendered through informal hearing procedures.

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

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

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

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

164 (xi) The action of the Division of Medicaid under
165 review shall be stayed until all administrative proceedings have

166 been exhausted.

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

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

194 Medicaid plan providing for such reimbursement.

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

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

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

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

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

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

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

249 Placement in a nursing facility may not be denied by the

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

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

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

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

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

278 the provision of such services to handicapped students by public
279 school districts using state funds which are provided from the
280 appropriation to the Department of Education to obtain federal
281 matching funds through the division. The division, in obtaining
282 medical and psychological evaluations for children in the custody
283 of the State Department of Human Services may enter into a
284 cooperative agreement with the State Department of Human Services
285 for the provision of such services using state funds which are
286 provided from the appropriation to the Department of Human
287 Services to obtain federal matching funds through the division.
288 On July 1, 1993, all fees for periodic screening and
289 diagnostic services under this paragraph (5) shall be increased by
290 twenty-five percent (25%) of the reimbursement rate in effect on
291 June 30, 1993.
292 (6) Physician's services. All fees for physicians' services
293 that are covered only by Medicaid shall be reimbursed at ninety
294 percent (90%) of the rate established on January 1, 1999, and as
295 adjusted each January thereafter, under Medicare (Title XVIII of
296 the Social Security Act), as amended, and which shall in no event
297 be less than seventy percent (70%) of the rate established on
298 January 1, 1994. All fees for physicians' services that are
299 covered by both Medicare and Medicaid shall be reimbursed at ten
300 percent (10%) of the adjusted Medicare payment established on
301 January 1, 1999, and as adjusted each January thereafter, under
302 Medicare (Title XVIII of the Social Security Act), as amended, and
303 which shall in no event be less than seven percent (7%) of the
304 adjusted Medicare payment established on January 1, 1994.
305 (7) (a) Home health services for eligible persons, not to

306 exceed in cost the prevailing cost of nursing facility services,
307 not to exceed sixty (60) visits per year.
308 (b) Repealed.
309 (8) Emergency medical transportation services. On January
310 1, 1994, emergency medical transportation services shall be
311 reimbursed at seventy percent (70%) of the rate established under
312 Medicare (Title XVIII of the Social Security Act), as amended.
313 "Emergency medical transportation services" shall mean, but shall
314 not be limited to, the following services by a properly permitted
315 ambulance operated by a properly licensed provider in accordance
316 with the Emergency Medical Services Act of 1974 (Section 41-59-1
317 et seq.): (i) basic life support, (ii) advanced life support,
318 (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi)
319 disposable supplies, (vii) similar services.
320 (9) Legend and other drugs as may be determined by the
321 division. The division may implement a program of prior approval
322 for drugs to the extent permitted by law. Payment by the division
323 for covered multiple source drugs shall be limited to the lower of
324 the upper limits established and published by the Health Care
325 Financing Administration (HCFA) plus a dispensing fee of Four
326 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
327 cost (EAC) as determined by the division plus a dispensing fee of
328 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual
329 and customary charge to the general public. The division shall
330 allow five (5) prescriptions per month for noninstitutionalized
331 Medicaid recipients; however, exceptions for up to ten (10)
332 prescriptions per month shall be allowed, with the approval of the
333 director.

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

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

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

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

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

362 and treatment related thereto. On July 1, 1999, all fees for
363 dental care and surgery under authority of this paragraph (10)
364 shall be increased to one hundred sixty percent (160%) of the
365 amount of the reimbursement rate that was in effect on June 30,
366 1999. It is the intent of the Legislature to encourage more
367 dentists to participate in the Medicaid program.
368 (11) Eyeglasses necessitated by reason of eye surgery, and
369 as prescribed by a physician skilled in diseases of the eye or an
370 optometrist, whichever the patient may select.
371 (12) Intermediate care facility services.
372 (a) The division shall make full payment to all
373 intermediate care facilities for the mentally retarded for each
374 day, not exceeding eighty-four (84) days per year, that a patient
375 is absent from the facility on home leave. Payment may be made
376 for the following home leave days in addition to the 84-day
377 limitation: Christmas, the day before Christmas, the day after
378 Christmas, Thanksgiving, the day before Thanksgiving and the day
379 after Thanksgiving. However, before payment may be made for more
380 than eighteen (18) home leave days in a year for a patient, the
381 patient must have written authorization from a physician stating
382 that the patient is physically and mentally able to be away from
383 the facility on home leave. Such authorization must be filed with
384 the division before it will be effective, and the authorization
385 shall be effective for three (3) months from the date it is
386 received by the division, unless it is revoked earlier by the
387 physician because of a change in the condition of the patient.
388 (b) All state-owned intermediate care facilities for
389 the mentally retarded shall be reimbursed on a full reasonable

390 cost basis.

391 (13) Family planning services, including drugs, supplies and
392 devices, when such services are under the supervision of a
393 physician.

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

418 was in effect on June 30, 1999.

419 (15) Home- and community-based services, as provided under
420 Title XIX of the federal Social Security Act, as amended, under
421 waivers, subject to the availability of funds specifically
422 appropriated therefor by the Legislature. Payment for such
423 services shall be limited to individuals who would be eligible for
424 and would otherwise require the level of care provided in a
425 nursing facility. The home- and community-based services
426 authorized under this paragraph shall be expanded over a five-year
427 period beginning July 1, 1999. The division shall certify case
428 management agencies to provide case management services and
429 provide for home- and community-based services for eligible
430 individuals under this paragraph. The home- and community-based
431 services under this paragraph and the activities performed by
432 certified case management agencies under this paragraph shall be
433 funded using state funds that are provided from the appropriation
434 to the Division of Medicaid and used to match federal funds.

435 (16) Mental health services. Approved therapeutic and case
436 management services provided by (a) an approved regional mental
437 health/retardation center established under Sections 41-19-31
438 through 41-19-39, or by another community mental health service
439 provider meeting the requirements of the Department of Mental
440 Health to be an approved mental health/retardation center if
441 determined necessary by the Department of Mental Health, using
442 state funds which are provided from the appropriation to the State
443 Department of Mental Health and used to match federal funds under
444 a cooperative agreement between the division and the department,
445 or (b) a facility which is certified by the State Department of

446 Mental Health to provide therapeutic and case management services,
447 to be reimbursed on a fee for service basis. Any such services
448 provided by a facility described in paragraph (b) must have the
449 prior approval of the division to be reimbursable under this
450 section. After June 30, 1997, mental health services provided by
451 regional mental health/retardation centers established under
452 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
453 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
454 psychiatric residential treatment facilities as defined in Section
455 43-11-1, or by another community mental health service provider
456 meeting the requirements of the Department of Mental Health to be
457 an approved mental health/retardation center if determined
458 necessary by the Department of Mental Health, shall not be
459 included in or provided under any capitated managed care pilot
460 program provided for under paragraph (24) of this section.
461 (17) Durable medical equipment services and medical supplies
462 restricted to patients receiving home health services unless
463 waived on an individual basis by the division. The division shall
464 not expend more than Three Hundred Thousand Dollars ($300,000.00)
465 of state funds annually to pay for medical supplies authorized
466 under this paragraph.
467 (18) Notwithstanding any other provision of this section to
468 the contrary, the division shall make additional reimbursement to
469 hospitals which serve a disproportionate share of low-income
470 patients and which meet the federal requirements for such payments
471 as provided in Section 1923 of the federal Social Security Act and
472 any applicable regulations.
473 (19) (a) Perinatal risk management services. The division

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

483 (b) Early intervention system services. The division
484 shall cooperate with the State Department of Health, acting as
485 lead agency, in the development and implementation of a statewide
486 system of delivery of early intervention services, pursuant to
487 Part H of the Individuals with Disabilities Education Act (IDEA).
488 The State Department of Health shall certify annually in writing
489 to the director of the division the dollar amount of state early
490 intervention funds available which shall be utilized as a
491 certified match for Medicaid matching funds. Those funds then
492 shall be used to provide expanded targeted case management
493 services for Medicaid eligible children with special needs who are
494 eligible for the state's early intervention system.
495 Qualifications for persons providing service coordination shall be
496 determined by the State Department of Health and the Division of
497 Medicaid.

498 (20) Home- and community-based services for physically
499 disabled approved services as allowed by a waiver from the U.S.
500 Department of Health and Human Services for home- and
501 community-based services for physically disabled people using

502 state funds which are provided from the appropriation to the State
503 Department of Rehabilitation Services and used to match federal
504 funds under a cooperative agreement between the division and the
505 department, provided that funds for these services are
506 specifically appropriated to the Department of Rehabilitation
507 Services.

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

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

523 (23) Inpatient psychiatric services. Inpatient psychiatric
524 services to be determined by the division for recipients under age
525 twenty-one (21) which are provided under the direction of a
526 physician in an inpatient program in a licensed acute care
527 psychiatric facility or in a licensed psychiatric residential
528 treatment facility, before the recipient reaches age twenty-one
529 (21) or, if the recipient was receiving the services immediately

530 before he reached age twenty-one (21), before the earlier of the
531 date he no longer requires the services or the date he reaches age
532 twenty-two (22), as provided by federal regulations. Recipients
533 shall be allowed forty-five (45) days per year of psychiatric
534 services provided in acute care psychiatric facilities, and shall
535 be allowed unlimited days of psychiatric services provided in
536 licensed psychiatric residential treatment facilities.
537 (24) Managed care services in a program to be developed by
538 the division by a public or private provider. Notwithstanding any
539 other provision in this article to the contrary, the division
540 shall establish rates of reimbursement to providers rendering care
541 and services authorized under this section, and may revise such
542 rates of reimbursement without amendment to this section by the
543 Legislature for the purpose of achieving effective and accessible
544 health services, and for responsible containment of costs. This
545 shall include, but not be limited to, one (1) module of capitated
546 managed care in a rural area, and one (1) module of capitated
547 managed care in an urban area.
548 (25) Birthing center services.
549 (26) Hospice care. As used in this paragraph, the term
550 "hospice care" means a coordinated program of active professional
551 medical attention within the home and outpatient and inpatient
552 care which treats the terminally ill patient and family as a unit,
553 employing a medically directed interdisciplinary team. The
554 program provides relief of severe pain or other physical symptoms
555 and supportive care to meet the special needs arising out of
556 physical, psychological, spiritual, social and economic stresses
557 which are experienced during the final stages of illness and

558 during dying and bereavement and meets the Medicare requirements
559 for participation as a hospice as provided in 42 CFR Part 418.
560 (27) Group health plan premiums and cost sharing if it is
561 cost effective as defined by the Secretary of Health and Human
562 Services.
563 (28) Other health insurance premiums which are cost
564 effective as defined by the Secretary of Health and Human
565 Services. Medicare eligible must have Medicare Part B before
566 other insurance premiums can be paid.
567 (29) The Division of Medicaid may apply for a waiver from
568 the Department of Health and Human Services for home- and
569 community-based services for developmentally disabled people using
570 state funds which are provided from the appropriation to the State
571 Department of Mental Health and used to match federal funds under
572 a cooperative agreement between the division and the department,
573 provided that funds for these services are specifically
574 appropriated to the Department of Mental Health.
575 (30) Pediatric skilled nursing services for eligible persons
576 under twenty-one (21) years of age.
577 (31) Targeted case management services for children with
578 special needs, under waivers from the U.S. Department of Health
579 and Human Services, using state funds that are provided from the
580 appropriation to the Mississippi Department of Human Services and
581 used to match federal funds under a cooperative agreement between
582 the division and the department.
583 (32) Care and services provided in Christian Science
584 Sanatoria operated by or listed and certified by The First Church
585 of Christ Scientist, Boston, Massachusetts, rendered in connection

586 with treatment by prayer or spiritual means to the extent that
587 such services are subject to reimbursement under Section 1903 of
588 the Social Security Act.
589 (33) Podiatrist services.
590 (34) Personal care services provided in a pilot program to
591 not more than forty (40) residents at a location or locations to
592 be determined by the division and delivered by individuals
593 qualified to provide such services, as allowed by waivers under
594 Title XIX of the Social Security Act, as amended. The division
595 shall not expend more than Three Hundred Thousand Dollars
596 ($300,000.00) annually to provide such personal care services.
597 The division shall develop recommendations for the effective
598 regulation of any facilities that would provide personal care
599 services which may become eligible for Medicaid reimbursement
600 under this section, and shall present such recommendations with
601 any proposed legislation to the 1996 Regular Session of the
602 Legislature on or before January 1, 1996.
603 (35) Services and activities authorized in Sections
604 43-27-101 and 43-27-103, using state funds that are provided from
605 the appropriation to the State Department of Human Services and
606 used to match federal funds under a cooperative agreement between
607 the division and the department.
608 (36) Nonemergency transportation services for
609 Medicaid-eligible persons, to be provided by the Department of
610 Human Services. The division may contract with additional
611 entities to administer nonemergency transportation services as it
612 deems necessary. All providers shall have a valid driver's
613 license, vehicle inspection sticker and a standard liability

614 insurance policy covering the vehicle.

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

622 (38) Chiropractic services: a chiropractor's manual
623 manipulation of the spine to correct a subluxation, if x-ray
624 demonstrates that a subluxation exists and if the subluxation has
625 resulted in a neuromusculoskeletal condition for which
626 manipulation is appropriate treatment. Reimbursement for
627 chiropractic services shall not exceed Seven Hundred Dollars
628 ($700.00) per year per recipient.

629 <u>(39) Mental health counseling services provided by a duly</u>
630 <u>licensed professional counselor (LPC).</u>

631 Notwithstanding any provision of this article, except as
632 authorized in the following paragraph and in Section 43-13-139,
633 neither (a) the limitations on quantity or frequency of use of or
634 the fees or charges for any of the care or services available to
635 recipients under this section, nor (b) the payments or rates of
636 reimbursement to providers rendering care or services authorized
637 under this section to recipients, may be increased, decreased or
638 otherwise changed from the levels in effect on July 1, 1986,
639 unless such is authorized by an amendment to this section by the
640 Legislature. However, the restriction in this paragraph shall not
641 prevent the division from changing the payments or rates of

642 reimbursement to providers without an amendment to this section
643 whenever such changes are required by federal law or regulation,
644 or whenever such changes are necessary to correct administrative
645 errors or omissions in calculating such payments or rates of
646 reimbursement.

647 Notwithstanding any provision of this article, no new groups
648 or categories of recipients and new types of care and services may
649 be added without enabling legislation from the Mississippi
650 Legislature, except that the division may authorize such changes
651 without enabling legislation when such addition of recipients or
652 services is ordered by a court of proper authority. The director
653 shall keep the Governor advised on a timely basis of the funds
654 available for expenditure and the projected expenditures. In the
655 event current or projected expenditures can be reasonably
656 anticipated to exceed the amounts appropriated for any fiscal
657 year, the Governor, after consultation with the director, shall
658 discontinue any or all of the payment of the types of care and
659 services as provided herein which are deemed to be optional
660 services under Title XIX of the federal Social Security Act, as
661 amended, for any period necessary to not exceed appropriated
662 funds, and when necessary shall institute any other cost
663 containment measures on any program or programs authorized under
664 the article to the extent allowed under the federal law governing
665 such program or programs, it being the intent of the Legislature
666 that expenditures during any fiscal year shall not exceed the
667 amounts appropriated for such fiscal year.

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