

By: Burton

To: Public Health and  
Welfare;  
Appropriations

SENATE BILL NO. 2889

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 MARRIAGE AND FAMILY THERAPIST 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  
25 Director of the Division of Medicaid shall amend the Mississippi  
26 Title XIX Inpatient Hospital Reimbursement Plan to remove the  
27 occupancy rate penalty from the calculation of the Medicaid

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

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

34 (3) Laboratory and x-ray services.

35 (4) Nursing facility services.

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

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

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

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

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

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

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

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

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

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

98 the industry;

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

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

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

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

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

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

130 (v) Proceedings of the Review Board shall be

131 of record.

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

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

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

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

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

164 becomes final.

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

168                   (xii) Appeals by nursing facility providers  
169 involving any issues other than those two (2) specified in  
170 subparagraphs (i)(A) and (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  
174 require a certificate of need for construction and that could not  
175 be eligible for Medicaid reimbursement is constructed to nursing  
176 facility specifications for licensure and certification, and the  
177 facility is subsequently converted to a nursing facility pursuant  
178 to a certificate of need that authorizes conversion only and the  
179 applicant for the certificate of need was assessed an application  
180 review fee based on capital expenditures incurred in constructing  
181 the facility, the division shall allow reimbursement for capital  
182 expenditures necessary for construction of the facility that were  
183 incurred within the twenty-four (24) consecutive calendar months  
184 immediately preceding the date that the certificate of need  
185 authorizing such conversion was issued, to the same extent that  
186 reimbursement would be allowed for construction of a new nursing  
187 facility pursuant to a certificate of need that authorizes such  
188 construction. The reimbursement authorized in this subparagraph  
189 (e) may be made only to facilities the construction of which was  
190 completed after June 30, 1989. Before the division shall be  
191 authorized to make the reimbursement authorized in this  
192 subparagraph (e), the division first must have received approval  
193 from the Health Care Financing Administration of the United States  
194 Department of Health and Human Services of the change in the state  
195 Medicaid plan providing for such reimbursement.

196                   (f) The division shall develop and implement a

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

309 (b) Repealed.

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

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

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

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

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

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

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

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

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

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

372 (12) Intermediate care facility services.

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

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

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

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

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

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

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

461 program provided for under paragraph (24) of this section.

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

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

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

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

494 services for Medicaid eligible children with special needs who are  
495 eligible for the state's early intervention system.

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

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

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

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

524           (23) Inpatient psychiatric services. Inpatient  
525 psychiatric services to be determined by the division for  
526 recipients under age twenty-one (21) which are provided under the

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

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

550           (25) Birthing center services.

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

560 during dying and bereavement and meets the Medicare requirements  
561 for participation as a hospice as provided in 42 CFR Part 418.

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

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

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

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

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

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

591 (33) Podiatrist services.

592 (34) Personal care services provided in a pilot program

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

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

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

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

624           (38) Chiropractic services: a chiropractor's manual  
625 manipulation of the spine to correct a subluxation, if x-ray

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

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

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

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

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

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