MISSISSIPPI LEGISLATURE REGULAR SESSION 2001

By: Representative Scott (80th)

To: Public Health and Welfare; Appropriations

HOUSE BILL NO. 1266

1 AN ACT TO PROVIDE FOR THE REIMBURSEMENT OF RELOCATION
2 EXPENSES FOR LICENSED PHYSICIANS TO MOVE AND PRACTICE FAMILY
3 MEDICINE IN CRITICAL NEEDS AREAS FOR PRIMARY MEDICAL CARE; TO
4 PROVIDE FOR THE PAYMENT OF START-UP EXPENSES AND MEDICAL
5 MALPRACTICE INSURANCE PREMIUMS FOR THOSE PHYSICIANS; TO PROVIDE
6 FOR THE PAYMENT OF ANNUAL INCOME SUBSIDIES FOR THOSE PHYSICIANS;
7 TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO PROVIDE
8 AN ADDITIONAL 10% FEE INCREASE IN MEDICAID REIMBURSEMENT FOR
9 PHYSICIANS WHO PRACTICE IN CRITICAL NEEDS AREAS FOR PRIMARY
10 MEDICAL CARE; TO PROVIDE A CREDIT AGAINST STATE INCOME TAXES FOR
11 PHYSICIANS WHO PRACTICE FULL-TIME IN CRITICAL NEEDS AREAS FOR
12 PRIMARY MEDICAL CARE; AND FOR RELATED PURPOSES.

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

14 SECTION 1. (1) The Board of Trustees of State Institutions
15 of Higher Learning shall prescribe rules and regulations which,
16 subject to available appropriations, allow for reimbursement to
17 licensed physicians who practice family medicine in a critical
18 needs area for primary medical care as designated under subsection
19 (4) of Section 37-143-6, for the expense of moving when the
20 employment necessitates the relocation of the physician or his
21 family to a different geographical area than that in which the
22 physician resides. If the reimbursement is approved, the board of
23 trustees shall provide funds to reimburse the physician an amount
24 not to exceed One Thousand Dollars ($1,000.00) for the documented
25 actual expenses incurred in the course of relocating, including
26 the expense of any professional moving company or persons employed
27 to assist with the move, rented moving vehicles or equipment,
28 mileage in the amount authorized for state employees under Section
29 25-3-41 if the physician used his personal vehicle for the move,
30 meals and such other expenses associated with the relocation in
31 accordance with the established rules and regulations.

32 (2) The Board of Trustees of State Institutions of Higher
33 Learning shall prescribe rules and regulations which, subject to
34 available appropriations, allow for reimbursement to licensed
35 physicians to practice family medicine in a critical needs area
36 for primary medical care as designated under subsection (4) of
37 Section 37-143-6, for the direct expense associated with starting
38 a full-time medical practice, including the cost of building,
39 lease payments, equipment purchases, furniture, medical supplies
40 and medical malpractice insurance associated with a family
41 practice. If the reimbursement is approved, the board of trustees
42 shall provide funds to reimburse the physician an amount not to
43 exceed Twenty Thousand Dollars ($20,000.00) over a two (2) year
44 period for the documented actual expenses incurred in starting a
45 physician's practice.
46 (3) The Board of Trustees of State Institutions of Higher
47 Learning shall prescribe rules and regulations which, subject to
48 available appropriations, allow income subsidies for licensed
49 physicians who practice family medicine full time in a critical
50 needs area for primary medical care as designated under subsection
51 (4) of Section 37-143-6, to recognize the reduced earning capacity
52 associated with practicing in a rural area. If the income subsidy
53 is approved, the board of trustees shall provide funds to
54 compensate the physician in an amount not to exceed Twenty
55 Thousand Dollars ($20,000.00) annually.
56 SECTION 2. Section 43-13-117, Mississippi Code of 1972, is
57 amended as follows:
58 43-13-117. Medical assistance as authorized by this article
59 shall include payment of part or all of the costs, at the
60 discretion of the division or its successor, with approval of the
61 Governor, of the following types of care and services rendered to
62 eligible applicants who shall have been determined to be eligible
63 for such care and services, within the limits of state
64 appropriations and federal matching funds:

65 (1) Inpatient hospital services.
66 (a) The division shall allow thirty (30) days of
67 inpatient hospital care annually for all Medicaid recipients. The
68 division shall be authorized to allow unlimited days in
69 disproportionate hospitals as defined by the division for eligible
70 infants under the age of six (6) years.
71 (b) From and after July 1, 1994, the Executive
72 Director of the Division of Medicaid shall amend the Mississippi
73 Title XIX Inpatient Hospital Reimbursement Plan to remove the
74 occupancy rate penalty from the calculation of the Medicaid
75 Capital Cost Component utilized to determine total hospital costs
76 allocated to the Medicaid program.
77 (c) Hospitals will receive an additional payment
78 for the implantable programmable pump implanted in an inpatient
79 basis. The payment pursuant to written invoice will be in
80 addition to the facility's per diem reimbursement and will
81 represent a reduction of costs on the facility's annual cost
82 report, and shall not exceed Ten Thousand Dollars ($10,000.00) per
83 year per recipient. This paragraph (c) shall stand repealed on
84 July 1, 2001.
85 (2) Outpatient hospital services. Provided that where
86 the same services are reimbursed as clinic services, the division
87 may revise the rate or methodology of outpatient reimbursement to
88 maintain consistency, efficiency, economy and quality of care.
89 The division shall develop a Medicaid-specific cost-to-charge
90 ratio calculation from data provided by hospitals to determine an
91 allowable rate payment for outpatient hospital services, and shall
92 submit a report thereon to the Medical Advisory Committee on or
93 before December 1, 1999. The committee shall make a
94 recommendation on the specific cost-to-charge reimbursement method
95 for outpatient hospital services to the 2000 Regular Session of
96 the Legislature.
97 (3) Laboratory and x-ray services.

98 (4) Nursing facility services.
99 (a) The division shall make full payment to
100 nursing facilities for each day, not exceeding fifty-two (52) days
101 per year, that a patient is absent from the facility on home
102 leave. Payment may be made for the following home leave days in
103 addition to the fifty-two-day limitation: Christmas, the day
104 before Christmas, the day after Christmas, Thanksgiving, the day
105 before Thanksgiving and the day after Thanksgiving. However,
106 before payment may be made for more than eighteen (18) home leave
107 days in a year for a patient, the patient must have written
108 authorization from a physician stating that the patient is
109 physically and mentally able to be away from the facility on home
110 leave. Such authorization must be filed with the division before
111 it will be effective and the authorization shall be effective for
112 three (3) months from the date it is received by the division,
113 unless it is revoked earlier by the physician because of a change
114 in the condition of the patient.
115 (b) From and after July 1, 1997, the division
116 shall implement the integrated case-mix payment and quality
117 monitoring system, which includes the fair rental system for
118 property costs and in which recapture of depreciation is
119 eliminated. The division may reduce the payment for hospital
120 leave and therapeutic home leave days to the lower of the case-mix
121 category as computed for the resident on leave using the
122 assessment being utilized for payment at that point in time, or a
123 case-mix score of 1.000 for nursing facilities, and shall compute
124 case-mix scores of residents so that only services provided at the
125 nursing facility are considered in calculating a facility's per
126 diem. The division is authorized to limit allowable management
127 fees and home office costs to either three percent (3%), five
128 percent (5%) or seven percent (7%) of other allowable costs,
129 including allowable therapy costs and property costs, based on the
130 types of management services provided, as follows:

131 A maximum of up to three percent (3%) shall be allowed where
132 centralized managerial and administrative services are provided by
133 the management company or home office.
134 A maximum of up to five percent (5%) shall be allowed where
135 centralized managerial and administrative services and limited
136 professional and consultant services are provided.
137 A maximum of up to seven percent (7%) shall be allowed where
138 a full spectrum of centralized managerial services, administrative
139 services, professional services and consultant services are
140 provided.
141 (c) From and after July 1, 1997, all state-owned
142 nursing facilities shall be reimbursed on a full reasonable cost
143 basis.
144 (d) When a facility of a category that does not
145 require a certificate of need for construction and that could not
146 be eligible for Medicaid reimbursement is constructed to nursing
147 facility specifications for licensure and certification, and the
148 facility is subsequently converted to a nursing facility pursuant
149 to a certificate of need that authorizes conversion only and the
150 applicant for the certificate of need was assessed an application
151 review fee based on capital expenditures incurred in constructing
152 the facility, the division shall allow reimbursement for capital
153 expenditures necessary for construction of the facility that were
154 incurred within the twenty-four (24) consecutive calendar months
155 immediately preceding the date that the certificate of need
156 authorizing such conversion was issued, to the same extent that
157 reimbursement would be allowed for construction of a new nursing
158 facility pursuant to a certificate of need that authorizes such
159 construction. The reimbursement authorized in this subparagraph
160 (d) may be made only to facilities the construction of which was
161 completed after June 30, 1989. Before the division shall be
162 authorized to make the reimbursement authorized in this
163 subparagraph (d), the division first must have received approval

164 from the Health Care Financing Administration of the United States
165 Department of Health and Human Services of the change in the state
166 Medicaid plan providing for such reimbursement.

167 (e) The division shall develop and implement, not
168 later than January 1, 2001, a case-mix payment add-on determined
169 by time studies and other valid statistical data which will
170 reimburse a nursing facility for the additional cost of caring for
171 a resident who has a diagnosis of Alzheimer's or other related
172 dementia and exhibits symptoms that require special care. Any
173 such case-mix add-on payment shall be supported by a determination
174 of additional cost. The division shall also develop and implement
175 as part of the fair rental reimbursement system for nursing
176 facility beds, an Alzheimer's resident bed depreciation enhanced
177 reimbursement system which will provide an incentive to encourage
178 nursing facilities to convert or construct beds for residents with
179 Alzheimer's or other related dementia.

180 (f) The Division of Medicaid shall develop and
181 implement a referral process for long-term care alternatives for
182 Medicaid beneficiaries and applicants. No Medicaid beneficiary
183 shall be admitted to a Medicaid-certified nursing facility unless
184 a licensed physician certifies that nursing facility care is
185 appropriate for that person on a standardized form to be prepared
186 and provided to nursing facilities by the Division of Medicaid.
187 The physician shall forward a copy of that certification to the
188 Division of Medicaid within twenty-four (24) hours after it is
189 signed by the physician. Any physician who fails to forward the
190 certification to the Division of Medicaid within the time period
191 specified in this paragraph shall be ineligible for Medicaid
192 reimbursement for any physician's services performed for the
193 applicant. The Division of Medicaid shall determine, through an
194 assessment of the applicant conducted within two (2) business days
195 after receipt of the physician's certification, whether the
196 applicant also could live appropriately and cost-effectively at

197 home or in some other community-based setting if home- or
198 community-based services were available to the applicant. The
199 time limitation prescribed in this paragraph shall be waived in
200 cases of emergency. If the Division of Medicaid determines that a
201 home- or other community-based setting is appropriate and
202 cost-effective, the division shall:

203 (i) Advise the applicant or the applicant's
204 legal representative that a home- or other community-based setting
205 is appropriate;

206 (ii) Provide a proposed care plan and inform
207 the applicant or the applicant's legal representative regarding
208 the degree to which the services in the care plan are available in
209 a home- or in other community-based setting rather than nursing
210 facility care; and

211 (iii) Explain that such plan and services are
212 available only if the applicant or the applicant's legal
213 representative chooses a home- or community-based alternative to
214 nursing facility care, and that the applicant is free to choose
215 nursing facility care.

216 The Division of Medicaid may provide the services described
217 in this paragraph (f) directly or through contract with case
218 managers from the local Area Agencies on Aging, and shall
219 coordinate long-term care alternatives to avoid duplication with
220 hospital discharge planning procedures.

221 Placement in a nursing facility may not be denied by the
222 division if home- or community-based services that would be more
223 appropriate than nursing facility care are not actually available,
224 or if the applicant chooses not to receive the appropriate home-
225 or community-based services.

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

230 The division shall make full payment for long-term care
231 alternative services.
232 The division shall apply for necessary federal waivers to
233 assure that additional services providing alternatives to nursing
234 facility care are made available to applicants for nursing
235 facility care.
236 (5) Periodic screening and diagnostic services for
237 individuals under age twenty-one (21) years as are needed to
238 identify physical and mental defects and to provide health care
239 treatment and other measures designed to correct or ameliorate
240 defects and physical and mental illness and conditions discovered
241 by the screening services regardless of whether these services are
242 included in the state plan. The division may include in its
243 periodic screening and diagnostic program those discretionary
244 services authorized under the federal regulations adopted to
245 implement Title XIX of the federal Social Security Act, as
246 amended. The division, in obtaining physical therapy services,
247 occupational therapy services, and services for individuals with
248 speech, hearing and language disorders, may enter into a
249 cooperative agreement with the State Department of Education for
250 the provision of such services to handicapped students by public
251 school districts using state funds which are provided from the
252 appropriation to the Department of Education to obtain federal
253 matching funds through the division. The division, in obtaining
254 medical and psychological evaluations for children in the custody
255 of the State Department of Human Services may enter into a
256 cooperative agreement with the State Department of Human Services
257 for the provision of such services using state funds which are
258 provided from the appropriation to the Department of Human
259 Services to obtain federal matching funds through the division.
260 On July 1, 1993, all fees for periodic screening and
261 diagnostic services under this paragraph (5) shall be increased by

262 twenty-five percent (25%) of the reimbursement rate in effect on
263 June 30, 1993.
264 (6) Physician's services. All fees for physicians'
265 services that are covered only by Medicaid shall be reimbursed at
266 ninety percent (90%) of the rate established on January 1, 1999,
267 and as adjusted each January thereafter, under Medicare (Title
268 XVIII of the Social Security Act, as amended), and which shall in
269 no event be less than seventy percent (70%) of the rate
270 established on January 1, 1994. All fees for physicians' services
271 that are covered by both Medicare and Medicaid shall be reimbursed
272 at ten percent (10%) of the adjusted Medicare payment established
273 on January 1, 1999, and as adjusted each January thereafter, under
274 Medicare (Title XVIII of the Social Security Act, as amended), and
275 which shall in no event be less than seven percent (7%) of the
276 adjusted Medicare payment established on January 1, 1994. All
277 fees for physicians' services that are covered by Medicaid shall
278 be reimbursed at one hundred ten percent (110%) of the current
279 rate for licensed physicians who practice family medicine in
280 critical needs areas for primary medical care as designated under
281 subsection (4) of Section 37-143-6.
282 (7) (a) Home health services for eligible persons, not
283 to exceed in cost the prevailing cost of nursing facility
284 services, not to exceed sixty (60) visits per year.
285 (b) Repealed.
286 (8) Emergency medical transportation services. On
287 January 1, 1994, emergency medical transportation services shall
288 be reimbursed at seventy percent (70%) of the rate established
289 under Medicare (Title XVIII of the Social Security Act, as
290 amended). "Emergency medical transportation services" shall mean,
291 but shall not be limited to, the following services by a properly
292 permitted ambulance operated by a properly licensed provider in
293 accordance with the Emergency Medical Services Act of 1974
294 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced

295 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
296 (vi) disposable supplies, (vii) similar services.
297 (9) Legend and other drugs as may be determined by the
298 division. The division may implement a program of prior approval
299 for drugs to the extent permitted by law. Payment by the division
300 for covered multiple source drugs shall be limited to the lower of
301 the upper limits established and published by the Health Care
302 Financing Administration (HCFA) plus a dispensing fee of Four
303 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
304 cost (EAC) as determined by the division plus a dispensing fee of
305 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual
306 and customary charge to the general public. The division shall
307 allow five (5) prescriptions per month for noninstitutionalized
308 Medicaid recipients; however, exceptions for up to ten (10)
309 prescriptions per month shall be allowed, with the approval of the
310 director.
311 Payment for other covered drugs, other than multiple source
312 drugs with HCFA upper limits, shall not exceed the lower of the
313 estimated acquisition cost as determined by the division plus a
314 dispensing fee of Four Dollars and Ninety-one Cents ($4.91) or the
315 providers' usual and customary charge to the general public.
316 Payment for nonlegend or over-the-counter drugs covered on
317 the division's formulary shall be reimbursed at the lower of the
318 division's estimated shelf price or the providers' usual and
319 customary charge to the general public. No dispensing fee shall
320 be paid.
321 The division shall develop and implement a program of payment
322 for additional pharmacist services, with payment to be based on
323 demonstrated savings, but in no case shall the total payment
324 exceed twice the amount of the dispensing fee.
325 As used in this paragraph (9), "estimated acquisition cost"
326 means the division's best estimate of what price providers
327 generally are paying for a drug in the package size that providers

328 buy most frequently. Product selection shall be made in
329 compliance with existing state law; however, the division may
330 reimburse as if the prescription had been filled under the generic
331 name. The division may provide otherwise in the case of specified
332 drugs when the consensus of competent medical advice is that
333 trademarked drugs are substantially more effective.
334 (10) Dental care that is an adjunct to treatment of an
335 acute medical or surgical condition; services of oral surgeons and
336 dentists in connection with surgery related to the jaw or any
337 structure contiguous to the jaw or the reduction of any fracture
338 of the jaw or any facial bone; and emergency dental extractions
339 and treatment related thereto. On July 1, 1999, all fees for
340 dental care and surgery under authority of this paragraph (10)
341 shall be increased to one hundred sixty percent (160%) of the
342 amount of the reimbursement rate that was in effect on June 30,
343 1999. It is the intent of the Legislature to encourage more
344 dentists to participate in the Medicaid program.
345 (11) Eyeglasses necessitated by reason of eye surgery,
346 and as prescribed by a physician skilled in diseases of the eye or
347 an optometrist, whichever the patient may select, or one (1) pair
348 every three (3) years as prescribed by a physician or an
349 optometrist, whichever the patient may select.
350 (12) Intermediate care facility services.
351 (a) The division shall make full payment to all
352 intermediate care facilities for the mentally retarded for each
353 day, not exceeding eighty-four (84) days per year, that a patient
354 is absent from the facility on home leave. Payment may be made
355 for the following home leave days in addition to the
356 eighty-four-day limitation: Christmas, the day before Christmas,
357 the day after Christmas, Thanksgiving, the day before Thanksgiving
358 and the day after Thanksgiving. However, before payment may be
359 made for more than eighteen (18) home leave days in a year for a
360 patient, the patient must have written authorization from a

361 physician stating that the patient is physically and mentally able
362 to be away from the facility on home leave. Such authorization
363 must be filed with the division before it will be effective, and
364 the authorization shall be effective for three (3) months from the
365 date it is received by the division, unless it is revoked earlier
366 by the physician because of a change in the condition of the
367 patient.

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

371 (c) The division is authorized to limit allowable
372 management fees and home office costs to either three percent
373 (3%), five percent (5%) or seven percent (7%) of other allowable
374 costs, including allowable therapy costs and property costs, based
375 on the types of management services provided, as follows:

376 A maximum of up to three percent (3%) shall be allowed where
377 centralized managerial and administrative services are provided by
378 the management company or home office.

379 A maximum of up to five percent (5%) shall be allowed where
380 centralized managerial and administrative services and limited
381 professional and consultant services are provided.

382 A maximum of up to seven percent (7%) shall be allowed where
383 a full spectrum of centralized managerial services, administrative
384 services, professional services and consultant services are
385 provided.

386 (13) Family planning services, including drugs,
387 supplies and devices, when such services are under the supervision
388 of a physician.

389 (14) Clinic services. Such diagnostic, preventive,
390 therapeutic, rehabilitative or palliative services furnished to an
391 outpatient by or under the supervision of a physician or dentist
392 in a facility which is not a part of a hospital but which is
393 organized and operated to provide medical care to outpatients.

394 Clinic services shall include any services reimbursed as
395 outpatient hospital services which may be rendered in such a
396 facility, including those that become so after July 1, 1991. On
397 July 1, 1999, all fees for physicians' services reimbursed under
398 authority of this paragraph (14) shall be reimbursed at ninety
399 percent (90%) of the rate established on January 1, 1999, and as
400 adjusted each January thereafter, under Medicare (Title XVIII of
401 the Social Security Act, as amended), and which shall in no event
402 be less than seventy percent (70%) of the rate established on
403 January 1, 1994. All fees for physicians' services that are
404 covered by both Medicare and Medicaid shall be reimbursed at ten
405 percent (10%) of the adjusted Medicare payment established on
406 January 1, 1999, and as adjusted each January thereafter, under
407 Medicare (Title XVIII of the Social Security Act, as amended), and
408 which shall in no event be less than seven percent (7%) of the
409 adjusted Medicare payment established on January 1, 1994. On July
410 1, 1999, all fees for dentists' services reimbursed under
411 authority of this paragraph (14) shall be increased to one hundred
412 sixty percent (160%) of the amount of the reimbursement rate that
413 was in effect on June 30, 1999.
414 (15) Home- and community-based services, as provided
415 under Title XIX of the federal Social Security Act, as amended,
416 under waivers, subject to the availability of funds specifically
417 appropriated therefor by the Legislature. Payment for such
418 services shall be limited to individuals who would be eligible for
419 and would otherwise require the level of care provided in a
420 nursing facility. The home- and community-based services
421 authorized under this paragraph shall be expanded over a five-year
422 period beginning July 1, 1999. The division shall certify case
423 management agencies to provide case management services and
424 provide for home- and community-based services for eligible
425 individuals under this paragraph. The home- and community-based
426 services under this paragraph and the activities performed by

427 certified case management agencies under this paragraph shall be
428 funded using state funds that are provided from the appropriation
429 to the Division of Medicaid and used to match federal funds.
430 (16) Mental health services. Approved therapeutic and
431 case management services provided by (a) an approved regional
432 mental health/retardation center established under Sections
433 41-19-31 through 41-19-39, or by another community mental health
434 service provider meeting the requirements of the Department of
435 Mental Health to be an approved mental health/retardation center
436 if determined necessary by the Department of Mental Health, using
437 state funds which are provided from the appropriation to the State
438 Department of Mental Health and used to match federal funds under
439 a cooperative agreement between the division and the department,
440 or (b) a facility which is certified by the State Department of
441 Mental Health to provide therapeutic and case management services,
442 to be reimbursed on a fee for service basis. Any such services
443 provided by a facility described in paragraph (b) must have the
444 prior approval of the division to be reimbursable under this
445 section. After June 30, 1997, mental health services provided by
446 regional mental health/retardation centers established under
447 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
448 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
449 psychiatric residential treatment facilities as defined in Section
450 43-11-1, or by another community mental health service provider
451 meeting the requirements of the Department of Mental Health to be
452 an approved mental health/retardation center if determined
453 necessary by the Department of Mental Health, shall not be
454 included in or provided under any capitated managed care pilot
455 program provided for under paragraph (24) of this section. From
456 and after July 1, 2000, the division is authorized to contract
457 with a 134-bed specialty hospital located on Highway 39 North in
458 Lauderdale County for the use of not more than sixty (60) beds at
459 the facility to provide mental health services for children and

460 adolescents and for crisis intervention services for emotionally
461 disturbed children with behavioral problems, with priority to be
462 given to children in the custody of the Department of Human
463 Services who are, or otherwise will be, receiving such services
464 out-of-state.
465 (17) Durable medical equipment services and medical
466 supplies. The Division of Medicaid may require durable medical
467 equipment providers to obtain a surety bond in the amount and to
468 the specifications as established by the Balanced Budget Act of
469 1997.
470 (18) Notwithstanding any other provision of this
471 section to the contrary, the division shall make additional
472 reimbursement to hospitals which serve a disproportionate share of
473 low-income patients and which meet the federal requirements for
474 such payments as provided in Section 1923 of the federal Social
475 Security Act and any applicable regulations. However, from and
476 after January 1, 2000, no public hospital shall participate in the
477 Medicaid disproportionate share program unless the public hospital
478 participates in an intergovernmental transfer program as provided
479 in Section 1903 of the federal Social Security Act and any
480 applicable regulations. Administration and support for
481 participating hospitals shall be provided by the Mississippi
482 Hospital Association.
483 (19) (a) Perinatal risk management services. The
484 division shall promulgate regulations to be effective from and
485 after October 1, 1988, to establish a comprehensive perinatal
486 system for risk assessment of all pregnant and infant Medicaid
487 recipients and for management, education and follow-up for those
488 who are determined to be at risk. Services to be performed
489 include case management, nutrition assessment/counseling,
490 psychosocial assessment/counseling and health education. The
491 division shall set reimbursement rates for providers in
492 conjunction with the State Department of Health.

493 (b) Early intervention system services. The
494 division shall cooperate with the State Department of Health,
495 acting as lead agency, in the development and implementation of a
496 statewide system of delivery of early intervention services,
497 pursuant to Part H of the Individuals with Disabilities Education
498 Act (IDEA). The State Department of Health shall certify annually
499 in writing to the director of the division the dollar amount of
500 state early intervention funds available which shall be utilized
501 as a certified match for Medicaid matching funds. Those funds
502 then shall be used to provide expanded targeted case management
503 services for Medicaid eligible children with special needs who are
504 eligible for the state's early intervention system.
505 Qualifications for persons providing service coordination shall be
506 determined by the State Department of Health and the Division of
507 Medicaid.
508 (20) Home- and community-based services for physically
509 disabled approved services as allowed by a waiver from the United
510 States Department of Health and Human Services for home- and
511 community-based services for physically disabled people using
512 state funds which are provided from the appropriation to the State
513 Department of Rehabilitation Services and used to match federal
514 funds under a cooperative agreement between the division and the
515 department, provided that funds for these services are
516 specifically appropriated to the Department of Rehabilitation
517 Services.
518 (21) Nurse practitioner services. Services furnished
519 by a registered nurse who is licensed and certified by the
520 Mississippi Board of Nursing as a nurse practitioner including,
521 but not limited to, nurse anesthetists, nurse midwives, family
522 nurse practitioners, family planning nurse practitioners,
523 pediatric nurse practitioners, obstetrics-gynecology nurse
524 practitioners and neonatal nurse practitioners, under regulations
525 adopted by the division. Reimbursement for such services shall

526 not exceed ninety percent (90%) of the reimbursement rate for
527 comparable services rendered by a physician.
528 (22) Ambulatory services delivered in federally
529 qualified health centers and in clinics of the local health
530 departments of the State Department of Health for individuals
531 eligible for medical assistance under this article based on
532 reasonable costs as determined by the division.
533 (23) Inpatient psychiatric services. Inpatient
534 psychiatric services to be determined by the division for
535 recipients under age twenty-one (21) which are provided under the
536 direction of a physician in an inpatient program in a licensed
537 acute care psychiatric facility or in a licensed psychiatric
538 residential treatment facility, before the recipient reaches age
539 twenty-one (21) or, if the recipient was receiving the services
540 immediately before he reached age twenty-one (21), before the
541 earlier of the date he no longer requires the services or the date
542 he reaches age twenty-two (22), as provided by federal
543 regulations. Recipients shall be allowed forty-five (45) days per
544 year of psychiatric services provided in acute care psychiatric
545 facilities, and shall be allowed unlimited days of psychiatric
546 services provided in licensed psychiatric residential treatment
547 facilities. The division is authorized to limit allowable
548 management fees and home office costs to either three percent
549 (3%), five percent (5%) or seven percent (7%) of other allowable
550 costs, including allowable therapy costs and property costs, based
551 on the types of management services provided, as follows:
552 A maximum of up to three percent (3%) shall be allowed where
553 centralized managerial and administrative services are provided by
554 the management company or home office.
555 A maximum of up to five percent (5%) shall be allowed where
556 centralized managerial and administrative services and limited
557 professional and consultant services are provided.

558 A maximum of up to seven percent (7%) shall be allowed where
559 a full spectrum of centralized managerial services, administrative
560 services, professional services and consultant services are
561 provided.
562 (24) Managed care services in a program to be developed
563 by the division by a public or private provider. If managed care
564 services are provided by the division to Medicaid recipients, and
565 those managed care services are operated, managed and controlled
566 by and under the authority of the division, the division shall be
567 responsible for educating the Medicaid recipients who are
568 participants in the managed care program regarding the manner in
569 which the participants should seek health care under the program.
570 Notwithstanding any other provision in this article to the
571 contrary, the division shall establish rates of reimbursement to
572 providers rendering care and services authorized under this
573 paragraph (24), and may revise such rates of reimbursement without
574 amendment to this section by the Legislature for the purpose of
575 achieving effective and accessible health services, and for
576 responsible containment of costs.
577 (25) Birthing center services.
578 (26) Hospice care. As used in this paragraph, the term
579 "hospice care" means a coordinated program of active professional
580 medical attention within the home and outpatient and inpatient
581 care which treats the terminally ill patient and family as a unit,
582 employing a medically directed interdisciplinary team. The
583 program provides relief of severe pain or other physical symptoms
584 and supportive care to meet the special needs arising out of
585 physical, psychological, spiritual, social and economic stresses
586 which are experienced during the final stages of illness and
587 during dying and bereavement and meets the Medicare requirements
588 for participation as a hospice as provided in federal regulations.

589 (27) Group health plan premiums and cost sharing if it
590 is cost effective as defined by the Secretary of Health and Human
591 Services.
592 (28) Other health insurance premiums which are cost
593 effective as defined by the Secretary of Health and Human
594 Services. Medicare eligible must have Medicare Part B before
595 other insurance premiums can be paid.
596 (29) The Division of Medicaid may apply for a waiver
597 from the Department of Health and Human Services for home- and
598 community-based services for developmentally disabled people using
599 state funds which are provided from the appropriation to the State
600 Department of Mental Health and used to match federal funds under
601 a cooperative agreement between the division and the department,
602 provided that funds for these services are specifically
603 appropriated to the Department of Mental Health.
604 (30) Pediatric skilled nursing services for eligible
605 persons under twenty-one (21) years of age.
606 (31) Targeted case management services for children
607 with special needs, under waivers from the United States
608 Department of Health and Human Services, using state funds that
609 are provided from the appropriation to the Mississippi Department
610 of Human Services and used to match federal funds under a
611 cooperative agreement between the division and the department.
612 (32) Care and services provided in Christian Science
613 Sanatoria operated by or listed and certified by The First Church
614 of Christ Scientist, Boston, Massachusetts, rendered in connection
615 with treatment by prayer or spiritual means to the extent that
616 such services are subject to reimbursement under Section 1903 of
617 the Social Security Act.
618 (33) Podiatrist services.
619 (34) The division shall make application to the United
620 States Health Care Financing Administration for a waiver to
621 develop a program of services to personal care and assisted living

622 homes in Mississippi. This waiver shall be completed by December
623 1, 1999.
624 (35) Services and activities authorized in Sections
625 43-27-101 and 43-27-103, using state funds that are provided from
626 the appropriation to the State Department of Human Services and
627 used to match federal funds under a cooperative agreement between
628 the division and the department.
629 (36) Nonemergency transportation services for
630 Medicaid-eligible persons, to be provided by the Division of
631 Medicaid. The division may contract with additional entities to
632 administer nonemergency transportation services as it deems
633 necessary. All providers shall have a valid driver's license,
634 vehicle inspection sticker, valid vehicle license tags and a
635 standard liability insurance policy covering the vehicle.
636 (37) Targeted case management services for individuals
637 with chronic diseases, with expanded eligibility to cover services
638 to uninsured recipients, on a pilot program basis. This paragraph
639 (37) shall be contingent upon continued receipt of special funds
640 from the Health Care Financing Authority and private foundations
641 who have granted funds for planning these services. No funding
642 for these services shall be provided from state general funds.
643 (38) Chiropractic services: a chiropractor's manual
644 manipulation of the spine to correct a subluxation, if x-ray
645 demonstrates that a subluxation exists and if the subluxation has
646 resulted in a neuromusculoskeletal condition for which
647 manipulation is appropriate treatment. Reimbursement for
648 chiropractic services shall not exceed Seven Hundred Dollars
649 ($700.00) per year per recipient.
650 (39) Dually eligible Medicare/Medicaid beneficiaries.
651 The division shall pay the Medicare deductible and ten percent
652 (10%) coinsurance amounts for services available under Medicare
653 for the duration and scope of services otherwise available under
654 the Medicaid program.

655 (40) The division shall prepare an application for a
656 waiver to provide prescription drug benefits to as many
657 Mississippians as permitted under Title XIX of the Social Security
658 Act.
659 (41) Services provided by the State Department of
660 Rehabilitation Services for the care and rehabilitation of persons
661 with spinal cord injuries or traumatic brain injuries, as allowed
662 under waivers from the United States Department of Health and
663 Human Services, using up to seventy-five percent (75%) of the
664 funds that are appropriated to the Department of Rehabilitation
665 Services from the Spinal Cord and Head Injury Trust Fund
666 established under Section 37-33-261 and used to match federal
667 funds under a cooperative agreement between the division and the
668 department.
669 (42) Notwithstanding any other provision in this
670 article to the contrary, the division is hereby authorized to
671 develop a population health management program for women and
672 children health services through the age of two (2). This program
673 is primarily for obstetrical care associated with low birth weight
674 and pre-term babies. In order to effect cost savings, the
675 division may develop a revised payment methodology which may
676 include at-risk capitated payments.
677 (43) The division shall provide reimbursement,
678 according to a payment schedule developed by the division, for
679 smoking cessation medications for pregnant women during their
680 pregnancy and other Medicaid-eligible women who are of
681 child-bearing age.
682 Notwithstanding any provision of this article, except as
683 authorized in the following paragraph and in Section 43-13-139,
684 neither (a) the limitations on quantity or frequency of use of or
685 the fees or charges for any of the care or services available to
686 recipients under this section, nor (b) the payments or rates of
687 reimbursement to providers rendering care or services authorized

688 under this section to recipients, may be increased, decreased or
689 otherwise changed from the levels in effect on July 1, 1999,
690 unless such is authorized by an amendment to this section by the
691 Legislature. However, the restriction in this paragraph shall not
692 prevent the division from changing the payments or rates of
693 reimbursement to providers without an amendment to this section
694 whenever such changes are required by federal law or regulation,
695 or whenever such changes are necessary to correct administrative
696 errors or omissions in calculating such payments or rates of
697 reimbursement.

698 Notwithstanding any provision of this article, no new groups
699 or categories of recipients and new types of care and services may
700 be added without enabling legislation from the Mississippi
701 Legislature, except that the division may authorize such changes
702 without enabling legislation when such addition of recipients or
703 services is ordered by a court of proper authority. The director
704 shall keep the Governor advised on a timely basis of the funds
705 available for expenditure and the projected expenditures. In the
706 event current or projected expenditures can be reasonably
707 anticipated to exceed the amounts appropriated for any fiscal
708 year, the Governor, after consultation with the director, shall
709 discontinue any or all of the payment of the types of care and
710 services as provided herein which are deemed to be optional
711 services under Title XIX of the federal Social Security Act, as
712 amended, for any period necessary to not exceed appropriated
713 funds, and when necessary shall institute any other cost
714 containment measures on any program or programs authorized under
715 the article to the extent allowed under the federal law governing
716 such program or programs, it being the intent of the Legislature
717 that expenditures during any fiscal year shall not exceed the
718 amounts appropriated for such fiscal year.

719 <u>SECTION 3.</u> (1) Any licensed physician who practices full
720 time in any critical needs area for primary medical care as

721 designated under subsection (4) of Section 37-143-6 shall be
722 allowed a credit against the taxes imposed by this chapter in an
723 amount equal to fifty percent (50%) of the physician's income tax
724 liability that results from income derived from his or her
725 practice in any such underserved area. The credit shall be
726 allowed for a maximum of ten (10) years for all practice in any
727 such critical needs areas for primary medical care in which the
728 physician practices during his or her career.

729 (2) Subsection (1) of this section shall be codified as a
730 new section in Article 1, Chapter 7, Title 27, Mississippi Code of
731 1972.

732 SECTION 4. This act shall take effect and be in force from
733 and after July 1, 2001; provided that Section 3 of this act shall
734 take effect and be in force from and after January 1, 2001.

ST: Physicians; provide grants and tax credits to practice family medicine in critical needs areas.