MISSISSIPPI LEGISLATURE REGULAR SESSION 2002

By: Representative Masterson

To: Insurance;
Appropriations

HOUSE BILL NO. 949

AN ACT TO REQUIRE THAT PRIOR AUTHORIZATION IN HEALTH PLANS MUST HAVE THE ACTIVE PARTICIPATION OF BOTH THE PRESCRIBING PHYSICIAN AND THE BENEFIT MANAGER OR CONTRACTOR; TO REQUIRE THE BENEFIT MANAGER OR CONTRACTOR MUST ALLOCATE AN APPROPRIATE PORTION OF THE FEES IT RECEIVES FOR PRIOR AUTHORIZATION SERVICES TO PAY PHYSICIANS FOR THE TIME SPENT IN OBTAINING AUTHORIZATION; TO REQUIRE THE BENEFIT MANAGER OR CONTRACTOR THAT ADMINISTERS A PRIOR AUTHORIZATION PROGRAM TO ENSURE A REAL-TIME RESPONSE TO PHYSICIAN CALLS; TO AMEND SECTIONS 25-15-9, 43-13-117 AND 83-41-409, MISSISSIPPI CODE OF 1972, TO CONFORM TO THE PRECEDING PROVISIONS; AND FOR RELATED PURPOSES.

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

SECTION 1. (1) Prior authorization is effective as a benefit management technique only if there is active participation by both the prescribing physician and the benefit manager or contractor. No benefit manager or contractor shall be paid by the state for prior authorization services unless the benefit manager or contractor allocates an appropriate portion of the fees it receives for those services to pay physicians for the time spent in obtaining authorization and appealing denials.

(2) A benefit manager or contractor that is paid to administer a prior authorization program shall ensure a real-time response to physician calls with no more than a ten-minute wait on the telephone. As a condition of payment by the state, the benefit manager or contractor shall implement systems to track dropped calls and the time a caller spends waiting on the telephone. From the fees it receives from the state for administering the prior authorization system, the benefit manager or contractor shall provide compensation to physicians for excess time waiting on the telephone and for dropped calls. The rate of

that compensation to physicians shall be comparable to the rates paid to physicians by the state for office consultations.

SECTION 2. Section 25-15-9, Mississippi Code of 1972, is amended as follows:

25-15-9. (1) (a) The board shall design a plan of health insurance for state employees which provides benefits for semiprivate rooms in addition to other incidental coverages that the board deems necessary. The amount of the coverages shall be in such reasonable amount as may be determined by the board to be adequate, after due consideration of current health costs in Mississippi. The plan shall also include major medical benefits in such amounts as the board * * * determines. The board is also authorized to accept bids for such alternate coverage and optional benefits as the board * * * deems proper. Any prior authorization program used in connection with the plan shall be in compliance with the provisions of Section 1 of this act. Any contract for alternative coverage and optional benefits shall be awarded by the board after it has carefully studied and evaluated the bids and selected the best and most cost-effective bid. The board may reject all such bids; however, the board shall notify all bidders of the rejection and shall actively solicit new bids if all bids are rejected. The board may employ or contract for such consulting or actuarial services as may be necessary to formulate the plan, and to assist the board in the preparation of specifications and in the process of advertising for the bids for the plan. Such contracts shall be solicited and entered into in accordance with Section 25-15-5. The board shall keep a record of all persons, agents and corporations who contract with or assist the board in preparing and developing the plan. The board in a timely manner shall provide copies of this record to the members of the advisory council created in this section and those legislators, or their designees, who may attend meetings of the advisory council. The board shall provide copies of this record

in the solicitation of bids for the administration or servicing of the self-insured program. Each person, agent or corporation which, during the previous fiscal year, has assisted in the development of the plan or employed or compensated any person who assisted in the development of the plan, and which bids on the administration or servicing of the plan, shall submit to the board a statement accompanying the bid explaining in detail its participation with the development of the plan. This statement shall include the amount of compensation paid by the bidder to any such employee during the previous fiscal year. The board shall make all such information available to the members of the advisory council and those legislators, or their designees, who may attend meetings of the advisory council before any action is taken by the board on the bids submitted. The failure of any bidder to fully and accurately comply with this paragraph shall result in the rejection of any bid submitted by that bidder or the cancellation of any contract executed when the failure is discovered after the acceptance of that bid. The board is authorized to promulgate rules and regulations to implement the provisions of this subsection.

The board shall develop plans for the insurance plan authorized by this section in accordance with the provisions of Section 25-15-5.

Any corporation, association, company or individual that contracts with the board for the third-party claims administration of the self-insured plan shall prepare and keep on file an explanation of benefits for each claim processed. The explanation of benefits shall contain such information relative to each processed claim which the board deems necessary, and, at a minimum, each explanation shall provide the claimant's name, claim number, provider number, provider name, service dates, type of services, amount of charges, amount allowed to the claimant and reason codes. The information contained in the explanation of

benefits shall be available for inspection upon request by the board. The board shall have access to all claims information utilized in the issuance of payments to employees and providers.

(b) There is created an advisory council to advise the board in the formulation of the State and School Employees Health Insurance Plan. The council shall be composed of the State Insurance Commissioner or his designee, an employee-representative of the institutions of higher learning appointed by the board of trustees thereof, an employee-representative of the Department of Transportation appointed by the director thereof, an employee-representative of the State Tax Commission appointed by the Commissioner of Revenue, an employee-representative of the Mississippi Department of Health appointed by the State Health Officer, an employee-representative of the Mississippi Department of Corrections appointed by the Commissioner of Corrections, and an employee-representative of the Department of Human Services appointed by the Executive Director of Human Services, two (2) certificated public school administrators appointed by the State Board of Education, two (2) certificated classroom teachers appointed by the State Board of Education, a noncertificated school employee appointed by the State Board of Education and a community/junior college employee appointed by the State Board for Community and Junior Colleges.

The Lieutenant Governor may designate the Secretary of the Senate, the Chairman of the Senate Appropriations Committee, the Chairman of the Senate Education Committee and the Chairman of the Senate Insurance Committee, and the Speaker of the House of Representatives may designate the Clerk of the House, the Chairman of the House Appropriations Committee, the Chairman of the House Education Committee and the Chairman of the House Insurance Committee, to attend any meeting of the State and School Employees Insurance Advisory Council. The appointing authorities may designate an alternate member from their respective houses to

serve when the regular designee is unable to attend such meetings of the council. Such designees shall have no jurisdiction or vote on any matter within the jurisdiction of the council. For attending meetings of the council, such legislators shall receive per diem and expenses which shall be paid from the contingent expense funds of their respective houses in the same amounts as provided for committee meetings when the Legislature is not in session; however, no per diem and expenses for attending meetings of the council will be paid while the Legislature is in session. No per diem and expenses will be paid except for attending meetings of the council without prior approval of the proper committee in their respective houses.

(c) No change in the terms of the State and School Employees Health Insurance Plan may be made effective unless the board, or its designee, has provided notice to the State and School Employees Health Insurance Advisory Council and has called a meeting of the council at least fifteen (15) days before the effective date of such change. In the event that the State and School Employees Health Insurance Advisory Council does not meet to advise the board on the proposed changes, the changes to the plan shall become effective at such time as the board has informed the council that the changes shall become effective.

(d) **Medical benefits for retired employees and dependents under age sixty-five (65) years and not eligible for Medicare benefits**. The same health insurance coverage as for all other active employees and their dependents shall be available to retired employees and all dependents under age sixty-five (65) years who are not eligible for Medicare benefits, the level of benefits to be the same level as for all other active participants. This section will apply to those employees who retire due to one hundred percent (100%) medical disability as well as those employees electing early retirement.

(e) **Medical benefits for retired employees and dependents over age sixty-five (65) years or otherwise eligible for Medicare benefits.** The health insurance coverage available to retired employees over age sixty-five (65) years or otherwise eligible for Medicare benefits, and all dependents over age sixty-five (65) years or otherwise eligible for Medicare benefits, shall be the major medical coverage with the lifetime maximum of One Million Dollars ($1,000,000.00). Benefits shall be reduced by Medicare benefits as though such Medicare benefits were the base plan.

All covered individuals shall be assumed to have full Medicare coverage, Parts A and B; and any Medicare payments under both Parts A and B shall be computed to reduce benefits payable under this plan.

(2) Nonduplication of benefits--reduction of benefits by Title XIX benefits: When benefits would be payable under more than one (1) group plan, benefits under those plans will be coordinated to the extent that the total benefits under all plans will not exceed the total expenses incurred.

Benefits for hospital or surgical or medical benefits shall be reduced by any similar benefits payable in accordance with Title XIX of the Social Security Act or under any amendments thereto, or any implementing legislation.

Benefits for hospital or surgical or medical benefits shall be reduced by any similar benefits payable by workers' compensation.

(3) (a) Schedule of life insurance benefits--group term: The amount of term life insurance for each active employee of a department, agency or institution of the state government shall not be in excess of One Hundred Thousand Dollars ($100,000.00), or twice the amount of the employee's annual wage to the next highest One Thousand Dollars ($1,000.00), whichever may be less, but in no case less than Thirty Thousand Dollars ($30,000.00), with a like

amount for accidental death and dismemberment on a twenty-four-hour basis. The plan will further contain a premium waiver provision if a covered employee becomes totally and permanently disabled prior to age sixty-five (65) years. Employees retiring after June 30, 1999, shall be eligible to continue life insurance coverage in an amount of Five Thousand Dollars ($5,000.00), Ten Thousand Dollars ($10,000.00) or Twenty Thousand Dollars ($20,000.00) into retirement.

(b) Effective October 1, 1999, schedule of life insurance benefits--group term: The amount of term life insurance for each active employee of any school district, community/junior college, public library or university-based program authorized under Section 37-23-31 for deaf, aphasic and emotionally disturbed children or any regular nonstudent bus driver shall not be in excess of One Hundred Thousand Dollars ($100,000.00), or twice the amount of the employee's annual wage to the next highest One Thousand Dollars ($1,000.00), whichever may be less, but in no case less than Thirty Thousand Dollars ($30,000.00), with a like amount for accidental death and dismemberment on a twenty-four-hour basis. The plan will further contain a premium waiver provision if a covered employee of any school district, community/junior college, public library or university-based program authorized under Section 37-23-31 for deaf, aphasic and emotionally disturbed children or any regular nonstudent bus driver becomes totally and permanently disabled prior to age sixty-five (65) years. Employees of any school district, community/junior college, public library or university-based program authorized under Section 37-23-31 for deaf, aphasic and emotionally disturbed children or any regular nonstudent bus driver retiring after September 30, 1999, shall be eligible to continue life insurance coverage in an amount of Five Thousand Dollars ($5,000.00), Ten Thousand Dollars ($10,000.00) or Twenty Thousand Dollars ($20,000.00) into retirement.

(4) Any eligible employee who on March 1, 1971, was participating in a group life insurance program which has provisions different from those included herein and for which the State of Mississippi was paying a part of the premium may, at his discretion, continue to participate in such plan. Such employee shall pay in full all additional costs, if any, above the minimum program established by this article. Under no circumstances shall any individual who begins employment with the state after March 1, 1971, be eligible for the provisions of this paragraph.

(5) The board may offer medical savings accounts as defined in Section 71-9-3 as a plan option.

(6) Any premium differentials, differences in coverages, discounts determined by risk or by any other factors shall be uniformly applied to all active employees participating in the insurance plan. It is the intent of the Legislature that the state contribution to the plan be the same for each employee throughout the state.

(7) On October 1, 1999, any school district, community/junior college district or public library may elect to remain with an existing policy or policies of group life insurance with an insurance company approved by the State and School Employees Health Insurance Management Board, in lieu of participation in the State and School Life Insurance Plan. The state's contribution of up to fifty percent (50%) of the active employee's premium under the State and School Life Insurance Plan may be applied toward the cost of coverage for full-time employees participating in the approved life insurance company group plan. For purposes of this subsection (7), "life insurance company group plan" means a plan administered or sold by a private insurance company. After October 1, 1999, the board may assess charges in addition to the existing State and School Life Insurance Plan rates to such employees as a condition of enrollment in the State and School Life Insurance Plan. In order for any life insurance

company group plan existing as of October 1, 1999, to be approved by the State and School Employees Health Insurance Management Board under this subsection (7), it shall meet the following criteria:

(a) The insurance company offering the group life insurance plan shall be rated "A-" or better by A.M. Best state insurance rating service and be licensed as an admitted carrier in the State of Mississippi by the Mississippi Department of Insurance.

(b) The insurance company group life insurance plan shall provide the same life insurance, accidental death and dismemberment insurance and waiver of premium benefits as provided in the State and School Life Insurance Plan.

(c) The insurance company group life insurance plan shall be fully insured, and no form of self-funding life insurance by such company shall be approved.

(d) The insurance company group life insurance plan shall have one (1) composite rate per One Thousand Dollars ($1,000.00) of coverage for active employees regardless of age and one (1) composite rate per One Thousand Dollars ($1,000.00) of coverage for all retirees regardless of age or type of retiree.

(e) The insurance company and its group life insurance plan shall comply with any administrative requirements of the State and School Employees Health Insurance Management Board. In the event any insurance company providing group life insurance benefits to employees under this subsection (7) fails to comply with any requirements specified herein or any administrative requirements of the board, the state shall discontinue providing funding for the cost of such insurance.

SECTION 3. Section 43-13-117, Mississippi Code of 1972, is amended as follows:

43-13-117. <u>Medicaid</u> as authorized by this article shall include payment of part or all of the costs, at the discretion of

the division or its successor, with approval of the Governor, of the following types of care and services rendered to eligible applicants who * * * have been determined to be eligible for that care and services, within the limits of state appropriations and federal matching funds:

(1) Inpatient hospital services.

(a) The division shall allow thirty (30) days of inpatient hospital care annually for all Medicaid recipients. Precertification of inpatient days must be obtained as required by the division. The division may allow unlimited days in disproportionate hospitals as defined by the division for eligible infants under the age of six (6) years.

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

(c) Hospitals will receive an additional payment for the implantable programmable baclofen drug pump used to treat spasticity which is implanted on an inpatient basis. The payment pursuant to written invoice will be in addition to the facility's per diem reimbursement and will represent a reduction of costs on the facility's annual cost report, and shall not exceed Ten Thousand Dollars ($10,000.00) per year per recipient. This paragraph (c) shall stand repealed on July 1, 2005.

(2) Outpatient hospital services. * * * Where the same services are reimbursed as clinic services, the division may revise the rate or methodology of outpatient reimbursement to maintain consistency, efficiency, economy and quality of care. * * *

(3) Laboratory and x-ray services.

(4) Nursing facility services.

(a) The division shall make full payment to nursing facilities for each day, not exceeding fifty-two (52) days per year, that a patient is absent from the facility on home leave. Payment may be made for the following home leave days in addition to the fifty-two-day limitation: Christmas, the day before Christmas, the day after Christmas, Thanksgiving, the day before Thanksgiving and the day after Thanksgiving.

(b) From and after July 1, 1997, the division shall implement the integrated case-mix payment and quality monitoring system, which includes the fair rental system for property costs and in which recapture of depreciation is eliminated. The division may reduce the payment for hospital leave and therapeutic home leave days to the lower of the case-mix category as computed for the resident on leave using the assessment being utilized for payment at that point in time, or a case-mix score of 1.000 for nursing facilities, and shall compute case-mix scores of residents so that only services provided at the nursing facility are considered in calculating a facility's per diem.

(c) From and after July 1, 1997, all state-owned nursing facilities shall be reimbursed on a full reasonable cost basis.

(d) When a facility of a category that does not require a certificate of need for construction and that could not be eligible for Medicaid reimbursement is constructed to nursing facility specifications for licensure and certification, and the facility is subsequently converted to a nursing facility under a certificate of need that authorizes conversion only and the applicant for the certificate of need was assessed an application review fee based on capital expenditures incurred in constructing the facility, the division shall allow reimbursement for capital expenditures necessary for construction of the facility that were incurred within the twenty-four (24) consecutive calendar months

immediately preceding the date that the certificate of need authorizing the conversion was issued, to the same extent that reimbursement would be allowed for construction of a new nursing facility under a certificate of need that authorizes that construction. The reimbursement authorized in this subparagraph (d) may be made only to facilities the construction of which was completed after June 30, 1989. Before the division shall be authorized to make the reimbursement authorized in this subparagraph (d), the division first must have received approval from the Health Care Financing Administration of the United States Department of Health and Human Services of the change in the state Medicaid plan providing for the reimbursement.

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

(f) The Division of Medicaid shall develop and implement a referral process for long-term care alternatives for Medicaid beneficiaries and applicants. No Medicaid beneficiary shall be admitted to a Medicaid-certified nursing facility unless a licensed physician certifies that nursing facility care is appropriate for that person on a standardized form to be prepared and provided to nursing facilities by the Division of Medicaid. The physician shall forward a copy of that certification to the

Division of Medicaid within twenty-four (24) hours after it is signed by the physician. Any physician who fails to forward the certification to the Division of Medicaid within the time period specified in this paragraph shall be ineligible for Medicaid reimbursement for any physician's services performed for the applicant. The Division of Medicaid shall determine, through an assessment of the applicant conducted within two (2) business days after receipt of the physician's certification, whether the applicant also could live appropriately and cost-effectively at home or in some other community-based setting if home- or community-based services were available to the applicant. The time limitation prescribed in this paragraph shall be waived in cases of emergency. If the Division of Medicaid determines that a home- or other community-based setting is appropriate and cost-effective, the division shall:

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

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

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

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

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

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

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

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

(5) Periodic screening and diagnostic services for individuals under age twenty-one (21) years as are needed to identify physical and mental defects and to provide health care treatment and other measures designed to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services regardless of whether these services are included in the state plan. The division may include in its periodic screening and diagnostic program those discretionary services authorized under the federal regulations adopted to implement Title XIX of the federal Social Security Act, as amended. The division, in obtaining physical therapy services, occupational therapy services, and services for individuals with speech, hearing and language disorders, may enter into a cooperative agreement with the State Department of Education for the provision of <u>those</u> services to handicapped students by public school districts using state funds <u>that</u> are provided from the appropriation to the Department of Education to obtain federal matching funds through the division. The division, in obtaining

medical and psychological evaluations for children in the custody of the State Department of Human Services may enter into a cooperative agreement with the State Department of Human Services for the provision of those services using state funds that are provided from the appropriation to the Department of Human Services to obtain federal matching funds through the division.

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

(6) Physician's services. The division shall allow twelve (12) physician visits annually. All fees for physicians' services that are covered only by Medicaid shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act, as amended), and which shall in no event be less than seventy percent (70%) of the rate established on January 1, 1994. All fees for physicians' services that are covered by both Medicare and Medicaid shall be reimbursed at ten percent (10%) of the adjusted Medicare payment established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act, as amended), and which shall in no event be less than seventy percent (70%) of the adjusted Medicare payment established on January 1, 1994.

(7) (a) Home health services for eligible persons, not to exceed in cost the prevailing cost of nursing facility services, not to exceed sixty (60) visits per year. All home health visits must be precertified as required by the division.

(b) Repealed.

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

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

(9) Legend and other drugs as may be determined by the division. The division may implement a program of prior approval for drugs to the extent permitted by law. Any prior approval program of the division shall be in compliance with the provisions of Section 1 of this act. Payment by the division for covered multiple source drugs shall be limited to the lower of the upper limits established and published by the Centers for Medicare and Medicaid Services (CMS) plus a dispensing fee of Four Dollars and Ninety-one Cents ($4.91), or the estimated acquisition cost (EAC) as determined by the division plus a dispensing fee of Four Dollars and Ninety-one Cents ($4.91), or the providers' usual and customary charge to the general public. The division shall allow ten (10) prescriptions per month for noninstitutionalized Medicaid recipients.

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

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

The division shall develop and implement a program of payment for additional pharmacist services, with payment to be based on

demonstrated savings, but in no case shall the total payment exceed twice the amount of the dispensing fee.

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

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

(11) Eyeglasses necessitated by reason of eye surgery, and as prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the patient may select, or one (1) pair every three (3) years as prescribed by a physician or an optometrist, whichever the patient may select.

(12) Intermediate care facility services.

(a) The division shall make full payment to all intermediate care facilities for the mentally retarded for each day, not exceeding eighty-four (84) days per year, that a patient is absent from the facility on home leave. Payment may be made for the following home leave days in addition to the

eighty-four-day limitation: Christmas, the day before Christmas, the day after Christmas, Thanksgiving, the day before Thanksgiving and the day after Thanksgiving.

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

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

(14) Clinic services. Such diagnostic, preventive, therapeutic, rehabilitative or palliative services furnished to an outpatient by or under the supervision of a physician or dentist in a facility that is not a part of a hospital but that is organized and operated to provide medical care to outpatients. Clinic services shall include any services reimbursed as outpatient hospital services that may be rendered in such a facility, including those that become so after July 1, 1991. On July 1, 1999, all fees for physicians' services reimbursed under authority of this paragraph (14) shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act, as amended), and which shall in no event be less than seventy percent (70%) of the rate established on January 1, 1994. All fees for physicians' services that are covered by both Medicare and Medicaid shall be reimbursed at ten percent (10%) of the adjusted Medicare payment established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act, as amended), and which shall in no event be less than seventy percent (70%) of the adjusted Medicare payment established on January 1, 1994. On July 1, 1999, all fees for dentists' services reimbursed under authority of this paragraph (14) shall be increased to one hundred

sixty percent (160%) of the amount of the reimbursement rate that was in effect on June 30, 1999.

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

(16) Mental health services. Approved therapeutic and case management services provided by (a) an approved regional mental health/retardation center established under Sections 41-19-31 through 41-19-39, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/retardation center if determined necessary by the Department of Mental Health, using state funds that are provided from the appropriation to the State Department of Mental Health and used to match federal funds under a cooperative agreement between the division and the department, or (b) a facility that is certified by the State Department of Mental Health to provide therapeutic and case management services, to be reimbursed on a fee for service basis. Any such services provided by a facility described in paragraph (b) must have the prior approval of the division to be reimbursable under this

section. Any prior approval program of the division shall be in compliance with the provisions of Section 1 of this act. After June 30, 1997, mental health services provided by regional mental health/retardation centers established under Sections 41-19-31 through 41-19-39, or by hospitals as defined in Section 41-9-3(a) and/or their subsidiaries and divisions, or by psychiatric residential treatment facilities as defined in Section 43-11-1, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/retardation center if determined necessary by the Department of Mental Health, shall not be included in or provided under any capitated managed care pilot program provided for under paragraph (24) of this section.

(17) Durable medical equipment services and medical supplies. Precertification of durable medical equipment and medical supplies must be obtained as required by the division. The Division of Medicaid may require durable medical equipment providers to obtain a surety bond in the amount and to the specifications as established by the Balanced Budget Act of 1997.

(18) (a) Notwithstanding any other provision of this section to the contrary, the division shall make additional reimbursement to hospitals that serve a disproportionate share of low-income patients and that meet the federal requirements for those payments as provided in Section 1923 of the federal Social Security Act and any applicable regulations. However, from and after January 1, 2000, no public hospital shall participate in the Medicaid disproportionate share program unless the public hospital participates in an intergovernmental transfer program as provided in Section 1903 of the federal Social Security Act and any applicable regulations. Administration and support for participating hospitals shall be provided by the Mississippi Hospital Association.

(b) The division shall establish a Medicare Upper Payment Limits Program as defined in Section 1902(a)(30) of the federal Social Security Act and any applicable federal regulations. The division shall assess each hospital for the sole purpose of financing the state portion of the Medicare Upper Payment Limits Program. This assessment shall be based on Medicaid utilization, or other appropriate method consistent with federal regulations, and will remain in effect as long as the state participates in the Medicare Upper Payment Limits Program. The division shall make additional reimbursement to hospitals for the Medicare Upper Payment Limits as defined in Section 1902(a)(30) of the federal Social Security Act and any applicable federal regulations. This paragraph (b) shall stand repealed from and after July 1, 2005.

(c) The division shall contract with the Mississippi Hospital Association to provide administrative support for the operation of the disproportionate share hospital program and the Medicare Upper Payment Limits Program. This paragraph (c) shall stand repealed from and after July 1, 2005.

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

(b) Early intervention system services. The division shall cooperate with the State Department of Health, acting as lead agency, in the development and implementation of a statewide system of delivery of early intervention services,

pursuant to Part H of the Individuals with Disabilities Education Act (IDEA). The State Department of Health shall certify annually in writing to the executive director of the division the dollar amount of state early intervention funds available that will be utilized as a certified match for Medicaid matching funds. Those funds then shall be used to provide expanded targeted case management services for Medicaid eligible children with special needs who are eligible for the state's early intervention system. Qualifications for persons providing service coordination shall be determined by the State Department of Health and the Division of Medicaid.

(20) Home- and community-based services for physically disabled approved services as allowed by a waiver from the United States Department of Health and Human Services for home- and community-based services for physically disabled people using state funds that are provided from the appropriation to the State Department of Rehabilitation Services and used to match federal funds under a cooperative agreement between the division and the department, provided that funds for these services are specifically appropriated to the Department of Rehabilitation Services.

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

(22) Ambulatory services delivered in federally qualified health centers and in clinics of the local health

departments of the State Department of Health for individuals eligible for medical assistance under this article based on reasonable costs as determined by the division.

(23) Inpatient psychiatric services. Inpatient psychiatric services to be determined by the division for recipients under age twenty-one (21) that are provided under the direction of a physician in an inpatient program in a licensed acute care psychiatric facility or in a licensed psychiatric residential treatment facility, before the recipient reaches age twenty-one (21) or, if the recipient was receiving the services immediately before he reached age twenty-one (21), before the earlier of the date he no longer requires the services or the date he reaches age twenty-two (22), as provided by federal regulations. Precertification of inpatient days and residential treatment days must be obtained as required by the division.

(24) Managed care services in a program to be developed by the division by a public or private provider. If managed care services are provided by the division to Medicaid recipients, and those managed care services are operated, managed and controlled by and under the authority of the division, the division shall be responsible for educating the Medicaid recipients who are participants in the managed care program regarding the manner in which the participants should seek health care under the program. Notwithstanding any other provision in this article to the contrary, the division shall establish rates of reimbursement to providers rendering care and services authorized under this paragraph (24), and may revise those rates of reimbursement without amendment to this section by the Legislature for the purpose of achieving effective and accessible health services, and for responsible containment of costs.

(25) Birthing center services.

(26) Hospice care. As used in this paragraph, the term "hospice care" means a coordinated program of active professional

medical attention within the home and outpatient and inpatient care that treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses that are experienced during the final stages of illness and during dying and bereavement and meets the Medicare requirements for participation as a hospice as provided in federal regulations.

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

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

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

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

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

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

(33) Podiatrist services.

(34) The division shall make application to the United States Health Care Financing Administration for a waiver to develop a program of services to personal care and assisted living homes in Mississippi. This waiver shall be completed by December 1, 1999.

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

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

(37) [Deleted]

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

(39) Dually eligible Medicare/Medicaid beneficiaries. The division shall pay the Medicare deductible and ten percent (10%) coinsurance amounts for services available under Medicare for the duration and scope of services otherwise available under the Medicaid program.

(40) [Deleted]

(41) Services provided by the State Department of Rehabilitation Services for the care and rehabilitation of persons with spinal cord injuries or traumatic brain injuries, as allowed under waivers from the United States Department of Health and Human Services, using up to seventy-five percent (75%) of the funds that are appropriated to the Department of Rehabilitation Services from the Spinal Cord and Head Injury Trust Fund established under Section 37-33-261 and used to match federal funds under a cooperative agreement between the division and the department.

(42) Notwithstanding any other provision in this article to the contrary, the division may develop a population health management program for women and children health services through the age of two (2) years. This program is primarily for obstetrical care associated with low birth weight and pre-term babies. In order to effect cost savings, the division may develop a revised payment methodology that may include at-risk capitated payments.

(43) The division shall provide reimbursement, according to a payment schedule developed by the division, for smoking cessation medications for pregnant women during their pregnancy and other Medicaid-eligible women who are of child-bearing age.

(44) Nursing facility services for the severely disabled.

(a) Severe disabilities include, but are not limited to, spinal cord injuries, closed head injuries and ventilator dependent patients.

(b) Those services must be provided in a long-term care nursing facility dedicated to the care and treatment of persons with severe disabilities, and shall be reimbursed as a separate category of nursing facilities.

(45) Physician assistant services. Services furnished by a physician assistant who is licensed by the State Board of Medical Licensure and is practicing with physician supervision under regulations adopted by the board, under regulations adopted by the division. Reimbursement for those services shall not exceed ninety percent (90%) of the reimbursement rate for comparable services rendered by a physician.

(46) The division shall make application to the federal Centers for Medicare and Medicaid Services (CMS) for a waiver to develop and provide services for children with serious emotional disturbances as defined in Section 43-14-1(1), which may include home- and community-based services, case management services or managed care services through mental health providers certified by the Department of Mental Health. The division may implement and provide services under this waivered program only if funds for these services are specifically appropriated for this purpose by the Legislature, or if funds are voluntarily provided by affected agencies.

Notwithstanding any provision of this article, except as authorized in the following paragraph and in Section 43-13-139, neither (a) the limitations on quantity or frequency of use of or the fees or charges for any of the care or services available to recipients under this section, nor (b) the payments or rates of reimbursement to providers rendering care or services authorized under this section to recipients, may be increased, decreased or otherwise changed from the levels in effect on July 1, 1999,

unless they are authorized by an amendment to this section by the Legislature. However, the restriction in this paragraph shall not prevent the division from changing the payments or rates of reimbursement to providers without an amendment to this section whenever those changes are required by federal law or regulation, or whenever those changes are necessary to correct administrative errors or omissions in calculating those payments or rates of reimbursement.

Notwithstanding any provision of this article, no new groups or categories of recipients and new types of care and services may be added without enabling legislation from the Mississippi Legislature, except that the division may authorize those changes without enabling legislation when the addition of recipients or services is ordered by a court of proper authority. The executive director shall keep the Governor advised on a timely basis of the funds available for expenditure and the projected expenditures. If current or projected expenditures of the division can be reasonably anticipated to exceed the amounts appropriated for any fiscal year, the Governor, after consultation with the executive director, shall discontinue any or all of the payment of the types of care and services as provided in this section that are deemed to be optional services under Title XIX of the federal Social Security Act, as amended, for any period necessary to not exceed appropriated funds, and when necessary shall institute any other cost containment measures on any program or programs authorized under the article to the extent allowed under the federal law governing that program or programs, it being the intent of the Legislature that expenditures during any fiscal year shall not exceed the amounts appropriated for that fiscal year.

Notwithstanding any other provision of this article, it shall be the duty of each nursing facility, intermediate care facility for the mentally retarded, psychiatric residential treatment facility, and nursing facility for the severely disabled that is

participating in the Medicaid program to keep and maintain books, documents, and other records as prescribed by the Division of Medicaid in substantiation of its cost reports for a period of three (3) years after the date of submission to the Division of Medicaid of an original cost report, or three (3) years after the date of submission to the Division of Medicaid of an amended cost report.

SECTION 4. Section 83-41-409, Mississippi Code of 1972, is amended as follows:

83-41-409. In order to be certified and recertified under this article, a managed care plan shall:

(a) Provide enrollees or other applicants with written information on the terms and conditions of coverage in easily understandable language including, but not limited to, information on the following:

(i) Coverage provisions, benefits, limitations, exclusions and restrictions on the use of any providers of care;

(ii) Summary of utilization review and quality assurance policies; and

(iii) Enrollee financial responsibility for copayments, deductibles and payments for out-of-plan services or supplies;

(b) Demonstrate that its provider network has providers of sufficient number throughout the service area to assure reasonable access to care with minimum inconvenience by plan enrollees;

(c) File a summary of the plan credentialing criteria and process and policies with the State Department of Insurance to be available upon request;

(d) Provide a participating provider with a copy of his/her individual profile if economic or practice profiles, or both, are used in the credentialing process upon request;

(e) When any provider application for participation is denied or contract is terminated, the reasons for denial or termination shall be reviewed by the managed care plan upon the request of the provider; *** * ***

(f) Establish procedures to ensure that all applicable state and federal laws designed to protect the confidentiality of medical records are followed; and

(g) Provide satisfactory documentation to show that any prior authorization program used in connection with the managed care plan is in compliance with the provisions of Section 1 of this act.

SECTION 5. This act shall take effect and be in force from and after July 1, 2002.