MISSISSIPPI LEGISLATURE REGULAR SESSION 2000

By: Huggins

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2869

AN ACT TO BRING FORWARD SECTIONS 43-13-115 AND 43-13-117, MISSISSIPPI CODE OF 1972, WHICH DEFINE THOSE INDIVIDUALS ELIGIBLE FOR PARTICIPATION IN THE MISSISSIPPI MEDICAID PROGRAM AND DEFINE THOSE SERVICES ELIGIBLE FOR MEDICAID REIMBURSEMENT; AND FOR RELATED PURPOSES.

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

SECTION 1. Section 43-13-115, Mississippi Code of 1972, is brought forward as follows:[JU1]

43-13-115. Recipients of medical assistance shall be the following persons only:

(1) Who are qualified for public assistance grants under provisions of Title IV-A and E of the federal Social Security Act, as amended, including those statutorily deemed to be IV-A as determined by the State Department of Human Services and certified to the Division of Medicaid, but not optional groups unless otherwise specifically covered in this section. For the purposes of this paragraph (1) and paragraphs (3), (4), (8), (14), (17) and (18) of this section, any reference to Title IV-A or to Part A of Title IV of the federal Social Security Act, as amended, or the state plan under Title IV-A or Part A of Title IV, shall be considered as a reference to Title IV-A of the federal Social Security Act, as amended, and the state plan under Title IV-A, including the income and resource standards and methodologies under Title IV-A and the state plan, as they existed on July 16, 1996.

(2) Those qualified for supplemental security income (SSI) benefits under Title XVI of the federal Social Security Act,

as amended. The eligibility of individuals covered in this paragraph shall be determined by the Social Security Administration and certified to the Division of Medicaid.

(3) Qualified pregnant women as defined in Section 1905(n) of the federal Social Security Act, as amended, and as determined to be eligible by the State Department of Human Services and certified to the Division of Medicaid, who:

(a) Would be eligible for assistance under Part A of Title IV (or would be eligible for such assistance if coverage under the state plan under Part A of Title IV included assistance pursuant to Section 407 of Title IV-A of the federal Social Security Act, as amended) if her child had been born and was living with her in the month such assistance would be paid, and such pregnancy has been medically verified; or

(b) Is a member of a family which would be eligible for assistance under the state plan under Part A of Title IV of the federal Social Security Act, as amended, pursuant to Section 407 if the plan required the payment of assistance pursuant to such section.

(4) Qualified children who are under five (5) years of age, who were born after September 30, 1983, and who meet the income and resource requirements of the state plan under Part A of Title IV of the federal Social Security Act, as amended. The eligibility of individuals covered in this paragraph shall be determined by the State Department of Human Services and certified to the Division of Medicaid.

(5) A child born on or after October 1, 1984, to a woman eligible for and receiving medical assistance under the state plan on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and will remain eligible for such assistance for a period of one (1) year so long as the child is a member of the woman's household and the woman remains eligible for such assistance or would be eligible for assistance if pregnant. The eligibility of individuals covered in this paragraph shall be determined by the State Department of Human Services and certified to the Division

of Medicaid.

(6) Children certified by the State Department of Human Services to the Division of Medicaid of whom the state and county human services agency has custody and financial responsibility, and children who are in adoptions subsidized in full or part by the Department of Human Services, who are approvable under Title XIX of the Medicaid program.

(7) (a) Persons certified by the Division of Medicaid who are patients in a medical facility (nursing home, hospital, tuberculosis sanatorium or institution for treatment of mental diseases), and who, except for the fact that they are patients in such medical facility, would qualify for grants under Title IV, supplementary security income benefits under Title XVI or state supplements, and those aged, blind and disabled persons who would not be eligible for supplemental security income benefits under Title XVI or state supplements if they were not institutionalized in a medical facility but whose income is below the maximum standard set by the Division of Medicaid, which standard shall not exceed that prescribed by federal regulation;

(b) Individuals who have elected to receive hospice care benefits and who are eligible using the same criteria and special income limits as those in institutions as described in subparagraph (a) of this paragraph (7).

(8) Children under eighteen (18) years of age and pregnant women (including those in intact families) who meet the financial standards of the state plan approved under Title IV-A of the federal Social Security Act, as amended. The eligibility of children covered under this paragraph shall be determined by the State Department of Human Services and certified to the Division of Medicaid.

(9) Individuals who are:

(a) Children born after September 30, 1983, who have not attained the age of nineteen (19), with family income

that does not exceed one hundred percent (100%) of the nonfarm official poverty line;

(b) Pregnant women, infants and children who have not attained the age of six (6), with family income that does not exceed one hundred thirty-three percent (133%) of the federal poverty level; and

(c) Pregnant women and infants who have not attained the age of one (1), with family income that does not exceed one hundred eighty-five percent (185%) of the federal poverty level.

The eligibility of individuals covered in (a), (b) and (c) of this paragraph shall be determined by the Department of Human Services.

(10) Certain disabled children age eighteen (18) or under who are living at home, who would be eligible, if in a medical institution, for SSI or a state supplemental payment under Title XVI of the federal Social Security Act, as amended, and therefore for Medicaid under the plan, and for whom the state has made a determination as required under Section 1902(e)(3)(b) of the federal Social Security Act, as amended. The eligibility of individuals under this paragraph shall be determined by the Division of Medicaid.

(11) Individuals who are sixty-five (65) years of age or older or are disabled as determined under Section 1614(a)(3) of the federal Social Security Act, as amended, and who meet the following criteria:

(a) Whose income does not exceed one hundred percent (100%) of the nonfarm official poverty line as defined by the Office of Management and Budget and revised annually.

(b) Whose resources do not exceed those allowed under the Supplemental Security Income (SSI) program.

The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid, and such

individuals determined eligible shall receive the same Medicaid services as other categorical eligible individuals.

(12) Individuals who are qualified Medicare beneficiaries (QMB) entitled to Part A Medicare as defined under Section 301, Public Law 100-360, known as the Medicare Catastrophic Coverage Act of 1988, and who meet the following criteria:

(a) Whose income does not exceed one hundred percent (100%) of the nonfarm official poverty line as defined by the Office of Management and Budget and revised annually.

(b) Whose resources do not exceed two hundred percent (200%) of the amount allowed under the Supplemental Security Income (SSI) program as more fully prescribed under Section 301, Public Law 100-360.

The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid, and such individuals determined eligible shall receive Medicare cost-sharing expenses only as more fully defined by the Medicare Catastrophic Coverage Act of 1988.

(13) Individuals who are entitled to Medicare Part B as defined in Section 4501 of the Omnibus Budget Reconciliation Act of 1990, and who meet the following criteria:

(a) Whose income does not exceed the percentage of the nonfarm official poverty line as defined by the Office of Management and Budget and revised annually which, on or after:

(i) January 1, 1993, is one hundred ten percent (110%); and

(ii) January 1, 1995, is one hundred twenty percent (120%).

(b) Whose resources do not exceed two hundred percent (200%) of the amount allowed under the Supplemental Security Income (SSI) program as described in Section 301 of the Medicare Catastrophic Coverage Act of 1988.

The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid, and such individuals determined eligible shall receive Medicare cost sharing.

(14) Individuals in families who would be eligible for the unemployed parent program under Section 407 of Title IV-A of the federal Social Security Act, as amended, but do not receive payments pursuant to that section. The eligibility of individuals covered in this paragraph shall be determined by the Department of Human Services.

(15) Disabled workers who are eligible to enroll in Part A Medicare as required by Public Law 101-239, known as the Omnibus Budget Reconciliation Act of 1989, and whose income does not exceed two hundred percent (200%) of the federal poverty level as determined in accordance with the Supplemental Security Income (SSI) program. The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid and such individuals shall be entitled to buy-in coverage of Medicare Part A premiums only under the provisions of this paragraph (15).

(16) In accordance with the terms and conditions of approved Title XIX waiver from the United States Department of Health and Human Services, persons provided home- and community-based services who are physically disabled and certified by the Division of Medicaid as eligible due to applying the income and deeming requirements as if they were institutionalized.

(17) In accordance with the terms of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193), persons who become ineligible for assistance under Title IV-A of the federal Social Security Act, as amended, because of increased income from or hours of employment of the caretaker relative or because of the expiration of the applicable earned income disregards, who were eligible for Medicaid for at least three (3) of the six (6) months preceding

the month in which such ineligibility begins, shall be eligible for Medicaid assistance for up to twenty-four (24) months; however, Medicaid assistance for more than twelve (12) months may be provided only if a federal waiver is obtained to provide such assistance for more than twelve (12) months and federal and state funds are available to provide such assistance.

(18) Persons who become ineligible for assistance under Title IV-A of the federal Social Security Act, as amended, as a result, in whole or in part, of the collection or increased collection of child or spousal support under Title IV-D of the federal Social Security Act, as amended, who were eligible for Medicaid for at least three (3) of the six (6) months immediately preceding the month in which such ineligibility begins, shall be eligible for Medicaid for an additional four (4) months beginning with the month in which such ineligibility begins.

(19) Disabled workers, whose incomes are above the Medicaid eligibility limits, but below two hundred fifty percent (250%) of the federal poverty level, shall be allowed to purchase Medicaid coverage on a sliding fee scale developed by the Division of Medicaid.

SECTION 2. Section 43-13-117, Mississippi Code of 1972, is brought forward as follows:[CRG2]

43-13-117. Medical assistance 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 shall have been determined to be eligible for such 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; however, before any recipient will be allowed more than fifteen

(15) days of inpatient hospital care in any one (1) year, he must obtain prior approval therefor from the division. The division shall be authorized to 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.

(2) Outpatient hospital services. Provided that 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. However, before payment may be made for more than eighteen (18) home leave days in a year for a patient, the patient must have written authorization from a physician stating that the patient is physically and mentally able to be away from the facility on home leave. Such authorization must be filed with the division before it will be effective and the authorization shall be effective for three (3) months from the date it is received by the division, unless it is revoked earlier by the physician because of a change in the condition of the patient.

(b) From and after July 1, 1993, the division shall implement the integrated case-mix payment and quality monitoring system developed pursuant to Section 43-13-122, which includes the fair rental system for property costs and in which recapture of depreciation is eliminated. The division may revise the reimbursement methodology for the case-mix payment system by reducing payment for hospital leave and therapeutic home leave days to the lowest case-mix category for nursing facilities, modifying the current method of scoring residents so that only services provided at the nursing facility are considered in calculating a facility's per diem, and the division may limit administrative and operating costs, but in no case shall these costs be less than one hundred nine percent (109%) of the median administrative and operating costs for each class of facility, not to exceed the median used to calculate the nursing facility reimbursement for fiscal year 1996, to be applied uniformly to all long-term care facilities.

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

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

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

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

(B) Matters relating to the Minimum Data

Set Plus (MDS +) or successor assessment formats including but not limited to audits, classifications and submissions.

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

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

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

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

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

(iii) The Review Board panels shall have the power to preserve and enforce order during hearings; to issue subpoenas; to administer oaths; to compel attendance and testimony of witnesses; or to compel the production of books, papers,

documents and other evidence; or the taking of depositions before any designated individual competent to administer oaths; to examine witnesses; and to do all things conformable to law that may be necessary to enable it effectively to discharge its duties. The Review Board panels may appoint such person or persons as they shall deem proper to execute and return process in connection therewith.

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

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

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

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

(viii) Within thirty (30) days from the date of the hearing, the Review Board panel shall render a written

recommendation to the Executive Director of the Division of Medicaid setting forth the issues, findings of fact and applicable law, regulations or provisions.

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

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

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

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

(e) 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 pursuant to 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 such conversion was issued, to the same extent that reimbursement would be allowed for construction of a new nursing facility pursuant to a certificate of need that authorizes such construction. The reimbursement authorized in this subparagraph (e) 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 (e), 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 such reimbursement.

(f) The division shall develop and implement a case-mix payment add-on determined by time studies and other valid statistical data which 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 which will provide an incentive to encourage nursing facilities to convert or construct beds for residents with Alzheimer's or other related dementia.

(g) 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 such 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 (g) 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 such services to handicapped students by public school districts using state funds which 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 such services using state funds which 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. 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 seven percent (7%) 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.

(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. Payment by the division for covered multiple source drugs shall be limited to the lower of the upper limits established and published by the Health Care Financing Administration (HCFA) 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 five (5) prescriptions per month for noninstitutionalized Medicaid recipients; however, exceptions for up to ten (10) prescriptions per month shall be allowed, with the approval of the director.

Payment for other covered drugs, other than multiple source drugs with HCFA 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.

(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. However, before payment may be

made for more than eighteen (18) home leave days in a year for a patient, the patient must have written authorization from a physician stating that the patient is physically and mentally able to be away from the facility on home leave. Such authorization must be filed with the division before it will be effective, and the authorization shall be effective for three (3) months from the date it is received by the division, unless it is revoked earlier by the physician because of a change in the condition of the patient.

(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 such 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 which is not a part of a hospital but which is organized and operated to provide medical care to outpatients. Clinic services shall include any services reimbursed as outpatient hospital services which 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 seven percent (7%) 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 such 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 which 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 which 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. 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 restricted to patients receiving home health services unless waived on an individual basis by the division. The division shall not expend more than Three Hundred Thousand Dollars ($300,000.00) of state funds annually to pay for medical supplies authorized under this paragraph.

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

(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 director of the division the dollar amount of state early intervention funds available which shall 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 U.S. Department of Health and Human Services for home- and community-based services for physically disabled people using state funds which 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 such 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) which 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. Recipients shall be allowed forty-five (45) days per year of psychiatric services provided in acute care psychiatric facilities, and shall be allowed unlimited days of psychiatric services provided in licensed psychiatric residential treatment facilities.

(24) Managed care services in a program to be developed by the division by a public or private provider. 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 section, and may revise such 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. This shall include, but not be limited to, one (1) module of capitated managed care in a rural area, and one (1) module of capitated managed care in an urban area.

(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 which 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 which 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 42 CFR Part 418.

(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 which 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 which 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 U.S. 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 such services are subject to reimbursement under Section 1903 of the Social Security Act.

(33) Podiatrist services.

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

(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 Department of Human Services. 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 and a standard liability insurance policy covering the vehicle.

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

(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.

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, 1986, unless such is 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 such changes are required by federal law or regulation,

or whenever such changes are necessary to correct administrative errors or omissions in calculating such 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 such changes without enabling legislation when such addition of recipients or services is ordered by a court of proper authority. The director shall keep the Governor advised on a timely basis of the funds available for expenditure and the projected expenditures. In the event current or projected expenditures can be reasonably anticipated to exceed the amounts appropriated for any fiscal year, the Governor, after consultation with the director, shall discontinue any or all of the payment of the types of care and services as provided herein which 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 such program or programs, it being the intent of the Legislature that expenditures during any fiscal year shall not exceed the amounts appropriated for such fiscal year.

SECTION 3. This act shall take effect and be in force from and after July 1, 2000.