REPORT OF CONFERENCE COMMITTEE

MR. SPEAKER AND MR. PRESIDENT:

We, the undersigned conferees, have had under consideration the amendments to the following entitled BILL:

H.B. No. 1332: Medicaid; create Medical Advisory Committee to, and revise reimbursement for physician's services.

We, therefore, respectfully submit the following report and recommendation:

1. **That the Senate recede from its Amendment No. 1.**

2. **That the House and Senate adopt the following amendment:**

Amend by striking all after the enacting clause and inserting in lieu thereof the following:

11 SECTION 1. Section 43-13-117, Mississippi Code of 1972, as
12 amended by House Bill No. 57, 1999 Regular Session, and House Bill
13 No. 403, 1999 Regular Session, is amended as follows:
14 43-13-117. Medical assistance as authorized by this article
15 shall include payment of part or all of the costs, at the
16 discretion of the division or its successor, with approval of the
17 Governor, of the following types of care and services rendered to
18 eligible applicants who shall have been determined to be eligible
19 for such care and services, within the limits of state
20 appropriations and federal matching funds:
21 (1) Inpatient hospital services.
22 (a) The division shall allow thirty (30) days of
23 inpatient hospital care annually for all Medicaid recipients;
24 however, before any recipient will be allowed more than fifteen
25 (15) days of inpatient hospital care in any one (1) year, he must
26 obtain prior approval therefor from the division. The division
27 shall be authorized to allow unlimited days in disproportionate
28 hospitals as defined by the division for eligible infants under
29 the age of six (6) years.
30 (b) From and after July 1, 1994, the Executive Director
31 of the Division of Medicaid shall amend the Mississippi Title XIX
32 Inpatient Hospital Reimbursement Plan to remove the occupancy rate
33 penalty from the calculation of the Medicaid Capital Cost

34 Component utilized to determine total hospital costs allocated to
35 the Medicaid Program.
36 (2) Outpatient hospital services. Provided that where the
37 same services are reimbursed as clinic services, the division may
38 revise the rate or methodology of outpatient reimbursement to
39 maintain consistency, efficiency, economy and quality of care.
40 (3) Laboratory and x-ray services.
41 (4) Nursing facility services.
42 (a) The division shall make full payment to nursing
43 facilities for each day, not exceeding fifty-two (52) days per
44 year, that a patient is absent from the facility on home leave.
45 Payment may be made for the following home leave days in addition
46 to the 52-day limitation: Christmas, the day before Christmas,
47 the day after Christmas, Thanksgiving, the day before Thanksgiving
48 and the day after Thanksgiving. However, before payment may be
49 made for more than eighteen (18) home leave days in a year for a
50 patient, the patient must have written authorization from a
51 physician stating that the patient is physically and mentally able
52 to be away from the facility on home leave. Such authorization
53 must be filed with the division before it will be effective and
54 the authorization shall be effective for three (3) months from the
55 date it is received by the division, unless it is revoked earlier
56 by the physician because of a change in the condition of the
57 patient.
58 (b) From and after July 1, 1993, the division shall
59 implement the integrated case-mix payment and quality monitoring
60 system developed pursuant to Section 43-13-122, which includes the
61 fair rental system for property costs and in which recapture of
62 depreciation is eliminated. The division may revise the
63 reimbursement methodology for the case-mix payment system by
64 reducing payment for hospital leave and therapeutic home leave
65 days to the lowest case-mix category for nursing facilities,
66 modifying the current method of scoring residents so that only
67 services provided at the nursing facility are considered in
68 calculating a facility's per diem, and the division may limit

69 administrative and operating costs, but in no case shall these
70 costs be less than one hundred nine percent (109%) of the median
71 administrative and operating costs for each class of facility, not
72 to exceed the median used to calculate the nursing facility
73 reimbursement for Fiscal Year 1996, to be applied uniformly to all
74 long-term care facilities. *** * ***

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

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

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

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

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

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

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

104 (B) In each of the areas of expertise defined
105 under subparagraphs (i)(A) and (i)(B), the Executive Director of
106 the Division of Medicaid shall appoint one (1) person who is
107 employed by the state who does not participate directly in desk
108 reviews or audits of nursing facilities in the two (2) areas of
109 review;
110 (C) The two (2) members appointed by the
111 Executive Director of the Division of Medicaid in each area of
112 expertise shall appoint a third member in the same area of
113 expertise.
114 In the event of a conflict of interest on the part of any
115 Review Board members, the Executive Director of the Division of
116 Medicaid or the other two (2) panel members, as applicable, shall
117 appoint a substitute member for conducting a specific review.
118 (iii) The Review Board panels shall have the power
119 to preserve and enforce order during hearings; to issue subpoenas;
120 to administer oaths; to compel attendance and testimony of
121 witnesses; or to compel the production of books, papers, documents
122 and other evidence; or the taking of depositions before any
123 designated individual competent to administer oaths; to examine
124 witnesses; and to do all things conformable to law that may be
125 necessary to enable it effectively to discharge its duties. The
126 Review Board panels may appoint such person or persons as they
127 shall deem proper to execute and return process in connection
128 therewith.
129 (iv) The Review Board shall promulgate, publish
130 and disseminate to nursing facility providers rules of procedure
131 for the efficient conduct of proceedings, subject to the approval
132 of the Executive Director of the Division of Medicaid and in
133 accordance with federal and state administrative hearing laws and
134 regulations.
135 (v) Proceedings of the Review Board shall be of
136 record.
137 (vi) Appeals to the Review Board shall be in
138 writing and shall set out the issues, a statement of alleged facts

139 and reasons supporting the provider's position. Relevant
140 documents may also be attached. The appeal shall be filed within
141 thirty (30) days from the date the provider is notified of the
142 action being appealed or, if informal review procedures are taken,
143 as provided by administrative regulations of the Division of
144 Medicaid, within thirty (30) days after a decision has been
145 rendered through informal hearing procedures.

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

153 (viii) Within thirty (30) days from the date of
154 the hearing, the Review Board panel shall render a written
155 recommendation to the Executive Director of the Division of
156 Medicaid setting forth the issues, findings of fact and applicable
157 law, regulations or provisions.

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

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

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

173 (xii) Appeals by nursing facility providers

174 involving any issues other than those two (2) specified in
175 subparagraphs (i)(A) and (ii)(B) shall be taken in accordance with
176 the administrative hearing procedures established by the Division
177 of Medicaid.

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

201 (f) The division shall develop and implement a case-mix
202 payment add-on determined by time studies and other valid
203 statistical data which will reimburse a nursing facility for the
204 additional cost of caring for a resident who has a diagnosis of
205 Alzheimer's or other related dementia and exhibits symptoms that
206 require special care. Any such case-mix add-on payment shall be
207 supported by a determination of additional cost. The division
208 shall also develop and implement as part of the fair rental

209 <u>reimbursement system for nursing facility beds, an Alzheimer's</u>
210 <u>resident bed depreciation enhanced reimbursement system which will</u>
211 <u>provide an incentive to encourage nursing facilities to convert or</u>
212 <u>construct beds for residents with Alzheimer's or other related</u>
213 <u>dementia.</u>
214 (5) Periodic screening and diagnostic services for
215 individuals under age twenty-one (21) years as are needed to
216 identify physical and mental defects and to provide health care
217 treatment and other measures designed to correct or ameliorate
218 defects and physical and mental illness and conditions discovered
219 by the screening services regardless of whether these services are
220 included in the state plan. The division may include in its
221 periodic screening and diagnostic program those discretionary
222 services authorized under the federal regulations adopted to
223 implement Title XIX of the federal Social Security Act, as
224 amended. The division, in obtaining physical therapy services,
225 occupational therapy services, and services for individuals with
226 speech, hearing and language disorders, may enter into a
227 cooperative agreement with the State Department of Education for
228 the provision of such services to handicapped students by public
229 school districts using state funds which are provided from the
230 appropriation to the Department of Education to obtain federal
231 matching funds through the division. The division, in obtaining
232 medical and psychological evaluations for children in the custody
233 of the State Department of Human Services may enter into a
234 cooperative agreement with the State Department of Human Services
235 for the provision of such services using state funds which are
236 provided from the appropriation to the Department of Human
237 Services to obtain federal matching funds through the division.
238 On July 1, 1993, all fees for periodic screening and
239 diagnostic services under this paragraph (5) shall be increased by
240 twenty-five percent (25%) of the reimbursement rate in effect on
241 June 30, 1993.
242 (6) Physician's services. *** * *** All fees for
243 physicians' services <u>that are covered only by Medicaid</u> shall be

244 reimbursed at <u>ninety percent (90%)</u> of the rate established on
245 January 1, <u>1999, and as adjusted each January thereafter,</u> under
246 Medicare (Title XVIII of the Social Security Act), as amended, and
247 <u>which shall in no event be less than seventy percent (70%) of the</u>
248 <u>rate established on January 1, 1994. All fees for physicians'</u>
249 <u>services that are covered by both Medicare and Medicaid shall be</u>
250 <u>reimbursed at ten percent (10%) of the adjusted Medicare payment</u>
251 <u>established on January 1, 1999, and as adjusted each January</u>
252 <u>thereafter, under Medicare (Title XVIII of the Social Security</u>
253 <u>Act), as amended, and which shall in no event be less than seven</u>
254 <u>percent (7%) of the adjusted Medicare payment established on</u>
255 <u>January 1, 1994.</u>
256 (7) (a) Home health services for eligible persons, not to
257 exceed in cost the prevailing cost of nursing facility services,
258 not to exceed sixty (60) visits per year.
259 (b) Repealed.
260 (8) Emergency medical transportation services. On January
261 1, 1994, emergency medical transportation services shall be
262 reimbursed at seventy percent (70%) of the rate established under
263 Medicare (Title XVIII of the Social Security Act), as amended.
264 "Emergency medical transportation services" shall mean, but shall
265 not be limited to, the following services by a properly permitted
266 ambulance operated by a properly licensed provider in accordance
267 with the Emergency Medical Services Act of 1974 (Section 41-59-1
268 et seq.): (i) basic life support, (ii) advanced life support,
269 (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi)
270 disposable supplies, (vii) similar services.
271 (9) Legend and other drugs as may be determined by the
272 division. The division may implement a program of prior approval
273 for drugs to the extent permitted by law. Payment by the division
274 for covered multiple source drugs shall be limited to the lower of
275 the upper limits established and published by the Health Care
276 Financing Administration (HCFA) plus a dispensing fee of Four
277 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
278 cost (EAC) as determined by the division plus a dispensing fee of

279 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual
280 and customary charge to the general public. The division shall
281 allow five (5) prescriptions per month for noninstitutionalized
282 Medicaid recipients<u>; however, exceptions for up to ten (10)</u>
283 <u>prescriptions per month shall be allowed, with the approval of the</u>
284 <u>director</u>.
285 Payment for other covered drugs, other than multiple source
286 drugs with HCFA upper limits, shall not exceed the lower of the
287 estimated acquisition cost as determined by the division plus a
288 dispensing fee of Four Dollars and Ninety-one Cents ($4.91) or the
289 providers' usual and customary charge to the general public.
290 Payment for nonlegend or over-the-counter drugs covered on
291 the division's formulary shall be reimbursed at the lower of the
292 division's estimated shelf price or the providers' usual and
293 customary charge to the general public. No dispensing fee shall
294 be paid.
295 The division shall develop and implement a program of payment
296 for additional pharmacist services, with payment to be based on
297 demonstrated savings, but in no case shall the total payment
298 exceed twice the amount of the dispensing fee.
299 As used in this paragraph (9), "estimated acquisition cost"
300 means the division's best estimate of what price providers
301 generally are paying for a drug in the package size that providers
302 buy most frequently. Product selection shall be made in
303 compliance with existing state law; however, the division may
304 reimburse as if the prescription had been filled under the generic
305 name. The division may provide otherwise in the case of specified
306 drugs when the consensus of competent medical advice is that
307 trademarked drugs are substantially more effective.
308 (10) Dental care that is an adjunct to treatment of an acute
309 medical or surgical condition; services of oral surgeons and
310 dentists in connection with surgery related to the jaw or any
311 structure contiguous to the jaw or the reduction of any fracture
312 of the jaw or any facial bone; and emergency dental extractions
313 and treatment related thereto. On <u>July</u> 1, <u>1999</u>, all fees for

314 dental care and surgery under authority of this paragraph (10)
315 shall be increased to one hundred sixty percent (160%) of the
316 amount of the reimbursement rate that was in effect on June 30,
317 1999. It is the intent of the Legislature to encourage more
318 dentists to participate in the Medicaid program.
319 (11) Eyeglasses necessitated by reason of eye surgery, and
320 as prescribed by a physician skilled in diseases of the eye or an
321 optometrist, whichever the patient may select.
322 (12) Intermediate care facility services.
323 (a) The division shall make full payment to all
324 intermediate care facilities for the mentally retarded for each
325 day, not exceeding eighty-four (84) days per year, that a patient
326 is absent from the facility on home leave. Payment may be made
327 for the following home leave days in addition to the 84-day
328 limitation: Christmas, the day before Christmas, the day after
329 Christmas, Thanksgiving, the day before Thanksgiving and the day
330 after Thanksgiving. However, before payment may be made for more
331 than eighteen (18) home leave days in a year for a patient, the
332 patient must have written authorization from a physician stating
333 that the patient is physically and mentally able to be away from
334 the facility on home leave. Such authorization must be filed with
335 the division before it will be effective, and the authorization
336 shall be effective for three (3) months from the date it is
337 received by the division, unless it is revoked earlier by the
338 physician because of a change in the condition of the patient.
339 (b) All state-owned intermediate care facilities for
340 the mentally retarded shall be reimbursed on a full reasonable
341 cost basis.
342 (13) Family planning services, including drugs, supplies and
343 devices, when such services are under the supervision of a
344 physician.
345 (14) Clinic services. Such diagnostic, preventive,
346 therapeutic, rehabilitative or palliative services furnished to an
347 outpatient by or under the supervision of a physician or dentist
348 in a facility which is not a part of a hospital but which is

349 organized and operated to provide medical care to outpatients.
350 Clinic services shall include any services reimbursed as
351 outpatient hospital services which may be rendered in such a
352 facility, including those that become so after July 1, 1991. On
353 July 1, 1999, all fees for physicians' services reimbursed under
354 authority of this paragraph (14) shall be reimbursed at ninety
355 percent (90%) of the rate established on January 1, 1999, and as
356 adjusted each January thereafter, under Medicare (Title XVIII of
357 the Social Security Act), as amended, and which shall in no event
358 be less than seventy percent (70%) of the rate established on
359 January 1, 1994. All fees for physicians' services that are
360 covered by both Medicare and Medicaid shall be reimbursed at ten
361 percent (10%) of the adjusted Medicare payment established on
362 January 1, 1999, and as adjusted each January thereafter, under
363 Medicare (Title XVIII of the Social Security Act), as amended, and
364 which shall in no event be less than seven percent (7%) of the
365 adjusted Medicare payment established on January 1, 1994. On July
366 1, 1999, all fees for dentists' services reimbursed under
367 authority of this paragraph (14) shall be increased to one hundred
368 sixty percent (160%) of the amount of the reimbursement rate that
369 was in effect on June 30, 1999.
370 (15) Home- and community-based services, as provided under
371 Title XIX of the federal Social Security Act, as amended, under
372 waivers, subject to the availability of funds specifically
373 appropriated therefor by the Legislature. Payment for such
374 services shall be limited to individuals who would be eligible for
375 and would otherwise require the level of care provided in a
376 nursing facility. The division shall certify case management
377 agencies to provide case management services and provide for home-
378 and community-based services for eligible individuals under this
379 paragraph. The home- and community-based services under this
380 paragraph and the activities performed by certified case
381 management agencies under this paragraph shall be funded using
382 state funds that are provided from the appropriation to the
383 Division of Medicaid and used to match federal funds under a

384 cooperative agreement between the division and the Department of
385 Human Services.
386 (16) Mental health services. Approved therapeutic and case
387 management services provided by (a) an approved regional mental
388 health/retardation center established under Sections 41-19-31
389 through 41-19-39, or by another community mental health service
390 provider meeting the requirements of the Department of Mental
391 Health to be an approved mental health/retardation center if
392 determined necessary by the Department of Mental Health, using
393 state funds which are provided from the appropriation to the State
394 Department of Mental Health and used to match federal funds under
395 a cooperative agreement between the division and the department,
396 or (b) a facility which is certified by the State Department of
397 Mental Health to provide therapeutic and case management services,
398 to be reimbursed on a fee for service basis. Any such services
399 provided by a facility described in paragraph (b) must have the
400 prior approval of the division to be reimbursable under this
401 section. After June 30, 1997, mental health services provided by
402 regional mental health/retardation centers established under
403 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
404 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
405 psychiatric residential treatment facilities as defined in Section
406 43-11-1, or by another community mental health service provider
407 meeting the requirements of the Department of Mental Health to be
408 an approved mental health/retardation center if determined
409 necessary by the Department of Mental Health, shall not be
410 included in or provided under any capitated managed care pilot
411 program provided for under paragraph (24) of this section.
412 (17) Durable medical equipment services and medical supplies
413 restricted to patients receiving home health services unless
414 waived on an individual basis by the division. The division shall
415 not expend more than Three Hundred Thousand Dollars ($300,000.00)
416 of state funds annually to pay for medical supplies authorized
417 under this paragraph.
418 (18) Notwithstanding any other provision of this section to

419 the contrary, the division shall make additional reimbursement to
420 hospitals which serve a disproportionate share of low-income
421 patients and which meet the federal requirements for such payments
422 as provided in Section 1923 of the federal Social Security Act and
423 any applicable regulations.

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

434 (b) Early intervention system services. The division
435 shall cooperate with the State Department of Health, acting as
436 lead agency, in the development and implementation of a statewide
437 system of delivery of early intervention services, pursuant to
438 Part H of the Individuals with Disabilities Education Act (IDEA).
439 The State Department of Health shall certify annually in writing
440 to the director of the division the dollar amount of state early
441 intervention funds available which shall be utilized as a
442 certified match for Medicaid matching funds. Those funds then
443 shall be used to provide expanded targeted case management
444 services for Medicaid eligible children with special needs who are
445 eligible for the state's early intervention system.
446 Qualifications for persons providing service coordination shall be
447 determined by the State Department of Health and the Division of
448 Medicaid.

449 (20) Home- and community-based services for physically
450 disabled approved services as allowed by a waiver from the U.S.
451 Department of Health and Human Services for home- and
452 community-based services for physically disabled people using
453 state funds which are provided from the appropriation to the State

454 Department of Rehabilitation Services and used to match federal
455 funds under a cooperative agreement between the division and the
456 department, provided that funds for these services are
457 specifically appropriated to the Department of Rehabilitation
458 Services.

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

469 (22) Ambulatory services delivered in federally qualified
470 health centers and in clinics of the local health departments of
471 the State Department of Health for individuals eligible for
472 medical assistance under this article based on reasonable costs as
473 determined by the division.

474 (23) Inpatient psychiatric services. Inpatient psychiatric
475 services to be determined by the division for recipients under age
476 twenty-one (21) which are provided under the direction of a
477 physician in an inpatient program in a licensed acute care
478 psychiatric facility or in a licensed psychiatric residential
479 treatment facility, before the recipient reaches age twenty-one
480 (21) or, if the recipient was receiving the services immediately
481 before he reached age twenty-one (21), before the earlier of the
482 date he no longer requires the services or the date he reaches age
483 twenty-two (22), as provided by federal regulations. Recipients
484 shall be allowed forty-five (45) days per year of psychiatric
485 services provided in acute care psychiatric facilities, and shall
486 be allowed unlimited days of psychiatric services provided in
487 licensed psychiatric residential treatment facilities.

488 (24) Managed care services in a program to be developed by

489 the division by a public or private provider. Notwithstanding any
490 other provision in this article to the contrary, the division
491 shall establish rates of reimbursement to providers rendering care
492 and services authorized under this section, and may revise such
493 rates of reimbursement without amendment to this section by the
494 Legislature for the purpose of achieving effective and accessible
495 health services, and for responsible containment of costs. This
496 shall include, but not be limited to, one (1) module of capitated
497 managed care in a rural area, and one (1) module of capitated
498 managed care in an urban area.

499 (25) Birthing center services.

500 (26) Hospice care. As used in this paragraph, the term
501 "hospice care" means a coordinated program of active professional
502 medical attention within the home and outpatient and inpatient
503 care which treats the terminally ill patient and family as a unit,
504 employing a medically directed interdisciplinary team. The
505 program provides relief of severe pain or other physical symptoms
506 and supportive care to meet the special needs arising out of
507 physical, psychological, spiritual, social and economic stresses
508 which are experienced during the final stages of illness and
509 during dying and bereavement and meets the Medicare requirements
510 for participation as a hospice as provided in 42 CFR Part 418.

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

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

518 (29) The Division of Medicaid may apply for a waiver from
519 the Department of Health and Human Services for home- and
520 community-based services for developmentally disabled people using
521 state funds which are provided from the appropriation to the State
522 Department of Mental Health and used to match federal funds under
523 a cooperative agreement between the division and the department,

524 provided that funds for these services are specifically
525 appropriated to the Department of Mental Health.
526 (30) Pediatric skilled nursing services for eligible persons
527 under twenty-one (21) years of age.
528 (31) Targeted case management services for children with
529 special needs, under waivers from the U.S. Department of Health
530 and Human Services, using state funds that are provided from the
531 appropriation to the Mississippi Department of Human Services and
532 used to match federal funds under a cooperative agreement between
533 the division and the department.
534 (32) Care and services provided in Christian Science
535 Sanatoria operated by or listed and certified by The First Church
536 of Christ Scientist, Boston, Massachusetts, rendered in connection
537 with treatment by prayer or spiritual means to the extent that
538 such services are subject to reimbursement under Section 1903 of
539 the Social Security Act.
540 (33) Podiatrist services.
541 (34) Personal care services provided in a pilot program to
542 not more than forty (40) residents at a location or locations to
543 be determined by the division and delivered by individuals
544 qualified to provide such services, as allowed by waivers under
545 Title XIX of the Social Security Act, as amended. The division
546 shall not expend more than Three Hundred Thousand Dollars
547 ($300,000.00) annually to provide such personal care services.
548 The division shall develop recommendations for the effective
549 regulation of any facilities that would provide personal care
550 services which may become eligible for Medicaid reimbursement
551 under this section, and shall present such recommendations with
552 any proposed legislation to the 1996 Regular Session of the
553 Legislature on or before January 1, 1996.
554 (35) Services and activities authorized in Sections
555 43-27-101 and 43-27-103, using state funds that are provided from
556 the appropriation to the State Department of Human Services and
557 used to match federal funds under a cooperative agreement between
558 the division and the department.

559 (36) Nonemergency transportation services for
560 Medicaid-eligible persons, to be provided by the Department of
561 Human Services. The division may contract with additional
562 entities to administer nonemergency transportation services as it
563 deems necessary. All providers shall have a valid driver's
564 license, vehicle inspection sticker and a standard liability
565 insurance policy covering the vehicle.
566 (37) Targeted case management services for individuals with
567 chronic diseases, with expanded eligibility to cover services to
568 uninsured recipients, on a pilot program basis. This paragraph
569 (37) shall be contingent upon continued receipt of special funds
570 from the Health Care Financing Authority and private foundations
571 who have granted funds for planning these services. No funding
572 for these services shall be provided from State General Funds.
573 (38) Chiropractic services: a chiropractor's manual
574 manipulation of the spine to correct a subluxation, if x-ray
575 demonstrates that a subluxation exists and if the subluxation has
576 resulted in a neuromusculoskeletal condition for which
577 manipulation is appropriate treatment. Reimbursement for
578 chiropractic services shall not exceed Seven Hundred Dollars
579 ($700.00) per year per recipient.
580 Notwithstanding any provision of this article, except as
581 authorized in the following paragraph and in Section 43-13-139,
582 neither (a) the limitations on quantity or frequency of use of or
583 the fees or charges for any of the care or services available to
584 recipients under this section, nor (b) the payments or rates of
585 reimbursement to providers rendering care or services authorized
586 under this section to recipients, may be increased, decreased or
587 otherwise changed from the levels in effect on July 1, 1986,
588 unless such is authorized by an amendment to this section by the
589 Legislature. However, the restriction in this paragraph shall not
590 prevent the division from changing the payments or rates of
591 reimbursement to providers without an amendment to this section
592 whenever such changes are required by federal law or regulation,
593 or whenever such changes are necessary to correct administrative

594 errors or omissions in calculating such payments or rates of
595 reimbursement.
596 Notwithstanding any provision of this article, no new groups
597 or categories of recipients and new types of care and services may
598 be added without enabling legislation from the Mississippi
599 Legislature, except that the division may authorize such changes
600 without enabling legislation when such addition of recipients or
601 services is ordered by a court of proper authority. The director
602 shall keep the Governor advised on a timely basis of the funds
603 available for expenditure and the projected expenditures. In the
604 event current or projected expenditures can be reasonably
605 anticipated to exceed the amounts appropriated for any fiscal
606 year, the Governor, after consultation with the director, shall
607 discontinue any or all of the payment of the types of care and
608 services as provided herein which are deemed to be optional
609 services under Title XIX of the federal Social Security Act, as
610 amended, for any period necessary to not exceed appropriated
611 funds, and when necessary shall institute any other cost
612 containment measures on any program or programs authorized under
613 the article to the extent allowed under the federal law governing
614 such program or programs, it being the intent of the Legislature
615 that expenditures during any fiscal year shall not exceed the
616 amounts appropriated for such fiscal year.
617 SECTION 2. This act shall take effect and be in force from
618 and after June 30, 1999.

Further, amend by striking the title in its entirety and inserting in lieu thereof the following:

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 AS AMENDED BY HOUSE BILL NO. 57, 1999 REGULAR SESSION, AND HOUSE
3 BILL NO. 403, 1999 REGULAR SESSION, TO REVISE THE MEDICAID
4 REIMBURSEMENT RATE FOR PHYSICIANS' SERVICES, TO REVISE THE
5 MEDICAID REIMBURSEMENT RATE FOR DENTISTS' SERVICES, TO DELETE THE
6 REPEALER ON THE CASE-MIX REIMBURSEMENT SYSTEM FOR NURSING FACILITY
7 SERVICES, TO AUTHORIZE A CASE-MIX REIMBURSEMENT ADD-ON AND

8 DEPRECIATION REIMBURSEMENT FOR RESIDENTS OF NURSING FACILITIES
9 WITH ALZHEIMER'S OR RELATED DEMENTIA; AND FOR RELATED PURPOSES.

CONFEREES FOR THE HOUSE:	CONFEREES FOR THE SENATE:
X______________________	X______________________
Bobby Moody	Willie Simmons
X______________________	X______________________
Jim C. Barnett	Dick Hall
X______________________	X______________________
D. Stephen Holland	Jim Bean