

By: Moody

To: Public Health and
Welfare;
Appropriations

COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 1280

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE THAT IF THE DIVISION OF MEDICAID PROVIDES MANAGED CARE
3 SERVICES TO MEDICAID RECIPIENTS, THE DIVISION SHALL BE RESPONSIBLE
4 FOR EDUCATING THE PARTICIPANTS IN THE MANAGED CARE PROGRAM
5 REGARDING THE MANNER IN WHICH THEY SHOULD SEEK HEALTH CARE UNDER
6 THE PROGRAM; TO PROVIDE THAT IF A PARTICIPANT IN THE DIVISION'S
7 MANAGED CARE PROGRAM SEEKS HEALTH CARE IN A HOSPITAL EMERGENCY
8 ROOM, THE DIVISION SHALL NOT EVALUATE, FOR PAYMENT PURPOSES, THE
9 PROPRIETY OF THE PARTICIPANT PRESENTING HIMSELF AT THE EMERGENCY
10 ROOM, AND SHALL REIMBURSE THE HOSPITAL IN ACCORDANCE WITH THE
11 MEDICAL TREATMENT RENDERED TO THE PARTICIPANT BY THE HOSPITAL; TO
12 DELETE THE AUTHORITY OF THE DIVISION TO OPERATE A CAPITATED
13 MANAGED CARE PROGRAM; AND FOR RELATED PURPOSES.

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

15 SECTION 1. Section 43-13-117, Mississippi Code of 1972, as
16 amended by Senate Bill No. 2143, 1999 Regular Session, which
17 became law after veto by approval of the Legislature during the
18 2000 Regular Session, is amended as follows:[RF1]

19 43-13-117. Medical assistance as authorized by this article
20 shall include payment of part or all of the costs, at the
21 discretion of the division or its successor, with approval of the
22 Governor, of the following types of care and services rendered to
23 eligible applicants who shall have been determined to be eligible
24 for such care and services, within the limits of state
25 appropriations and federal matching funds:

26 (1) Inpatient hospital services.

27 (a) The division shall allow thirty (30) days of
28 inpatient hospital care annually for all Medicaid recipients. The
29 division shall be authorized to allow unlimited days in
30 disproportionate hospitals as defined by the division for eligible
31 infants under the age of six (6) years.

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

38 (c) Hospitals will receive an additional payment
39 for the implantable programmable pump for approved spasticity
40 patients implanted in an inpatient setting, to be determined by
41 the Division of Medicaid and approved by the Medical Advisory
42 Committee. The payment pursuant to written invoice will be in
43 addition to the facility's per diem reimbursement and will
44 represent a reduction of costs on the facility's annual cost
45 report, and shall not exceed Ten Thousand Dollars (\$10,000.00) per
46 year per recipient. This paragraph (c) shall stand repealed on
47 July 1, 2000.

48 (2) Outpatient hospital services. Provided that where
49 the same services are reimbursed as clinic services, the division
50 may revise the rate or methodology of outpatient reimbursement to
51 maintain consistency, efficiency, economy and quality of care.
52 The division shall develop a Medicaid-specific cost-to-charge
53 ratio calculation from data provided by hospitals to determine an
54 allowable rate payment for outpatient hospital services, and shall
55 submit a report thereon to the Medical Advisory Committee on or
56 before December 1, 1999. The committee shall make a
57 recommendation on the specific cost-to-charge reimbursement method
58 for outpatient hospital services to the 2000 Regular Session of
59 the Legislature.

60 (3) Laboratory and x-ray services.

61 (4) Nursing facility services.

62 (a) The division shall make full payment to
63 nursing facilities for each day, not exceeding fifty-two (52) days
64 per year, that a patient is absent from the facility on home

65 leave. Payment may be made for the following home leave days in
66 addition to the fifty-two-day limitation: Christmas, the day
67 before Christmas, the day after Christmas, Thanksgiving, the day
68 before Thanksgiving and the day after Thanksgiving. However,
69 before payment may be made for more than eighteen (18) home leave
70 days in a year for a patient, the patient must have written
71 authorization from a physician stating that the patient is
72 physically and mentally able to be away from the facility on home
73 leave. Such authorization must be filed with the division before
74 it will be effective and the authorization shall be effective for
75 three (3) months from the date it is received by the division,
76 unless it is revoked earlier by the physician because of a change
77 in the condition of the patient.

78 (b) From and after July 1, 1997, the division
79 shall implement the integrated case-mix payment and quality
80 monitoring system, which includes the fair rental system for
81 property costs and in which recapture of depreciation is
82 eliminated. The division may reduce the payment for hospital
83 leave and therapeutic home leave days to the lower of the case-mix
84 category as computed for the resident on leave using the
85 assessment being utilized for payment at that point in time, or a
86 case-mix score of 1.000 for nursing facilities, and shall compute
87 case-mix scores of residents so that only services provided at the
88 nursing facility are considered in calculating a facility's per
89 diem. The division is authorized to limit allowable management
90 fees and home office costs to either three percent (3%), five
91 percent (5%) or seven percent (7%) of other allowable costs,
92 including allowable therapy costs and property costs, based on the
93 types of management services provided, as follows:

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

97 A maximum of up to five percent (5%) shall be allowed where

98 centralized managerial and administrative services and limited
99 professional and consultant services are provided.

100 A maximum of up to seven percent (7%) shall be allowed where
101 a full spectrum of centralized managerial services, administrative
102 services, professional services and consultant services are
103 provided.

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

107 (d) When a facility of a category that does not
108 require a certificate of need for construction and that could not
109 be eligible for Medicaid reimbursement is constructed to nursing
110 facility specifications for licensure and certification, and the
111 facility is subsequently converted to a nursing facility pursuant
112 to a certificate of need that authorizes conversion only and the
113 applicant for the certificate of need was assessed an application
114 review fee based on capital expenditures incurred in constructing
115 the facility, the division shall allow reimbursement for capital
116 expenditures necessary for construction of the facility that were
117 incurred within the twenty-four (24) consecutive calendar months
118 immediately preceding the date that the certificate of need
119 authorizing such conversion was issued, to the same extent that
120 reimbursement would be allowed for construction of a new nursing
121 facility pursuant to a certificate of need that authorizes such
122 construction. The reimbursement authorized in this subparagraph
123 (d) may be made only to facilities the construction of which was
124 completed after June 30, 1989. Before the division shall be
125 authorized to make the reimbursement authorized in this
126 subparagraph (d), the division first must have received approval
127 from the Health Care Financing Administration of the United States
128 Department of Health and Human Services of the change in the state
129 Medicaid plan providing for such reimbursement.

130 (e) The division shall develop and implement a

131 case-mix payment add-on determined by time studies and other valid
132 statistical data which will reimburse a nursing facility for the
133 additional cost of caring for a resident who has a diagnosis of
134 Alzheimer's or other related dementia and exhibits symptoms that
135 require special care. Any such case-mix add-on payment shall be
136 supported by a determination of additional cost. The division
137 shall also develop and implement as part of the fair rental
138 reimbursement system for nursing facility beds, an Alzheimer's
139 resident bed depreciation enhanced reimbursement system which will
140 provide an incentive to encourage nursing facilities to convert or
141 construct beds for residents with Alzheimer's or other related
142 dementia.

143 (f) The Division of Medicaid shall develop and
144 implement a referral process for long-term care alternatives for
145 Medicaid beneficiaries and applicants. No Medicaid beneficiary
146 shall be admitted to a Medicaid-certified nursing facility unless
147 a licensed physician certifies that nursing facility care is
148 appropriate for that person on a standardized form to be prepared
149 and provided to nursing facilities by the Division of Medicaid.
150 The physician shall forward a copy of that certification to the
151 Division of Medicaid within twenty-four (24) hours after it is
152 signed by the physician. Any physician who fails to forward the
153 certification to the Division of Medicaid within the time period
154 specified in this paragraph shall be ineligible for Medicaid
155 reimbursement for any physician's services performed for the
156 applicant. The Division of Medicaid shall determine, through an
157 assessment of the applicant conducted within two (2) business days
158 after receipt of the physician's certification, whether the
159 applicant also could live appropriately and cost-effectively at
160 home or in some other community-based setting if home- or
161 community-based services were available to the applicant. The
162 time limitation prescribed in this paragraph shall be waived in
163 cases of emergency. If the Division of Medicaid determines that a

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

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

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

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

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

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

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

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

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

197 facility care are made available to applicants for nursing
198 facility care.

199 (5) Periodic screening and diagnostic services for
200 individuals under age twenty-one (21) years as are needed to
201 identify physical and mental defects and to provide health care
202 treatment and other measures designed to correct or ameliorate
203 defects and physical and mental illness and conditions discovered
204 by the screening services regardless of whether these services are
205 included in the state plan. The division may include in its
206 periodic screening and diagnostic program those discretionary
207 services authorized under the federal regulations adopted to
208 implement Title XIX of the federal Social Security Act, as
209 amended. The division, in obtaining physical therapy services,
210 occupational therapy services, and services for individuals with
211 speech, hearing and language disorders, may enter into a
212 cooperative agreement with the State Department of Education for
213 the provision of such services to handicapped students by public
214 school districts using state funds which are provided from the
215 appropriation to the Department of Education to obtain federal
216 matching funds through the division. The division, in obtaining
217 medical and psychological evaluations for children in the custody
218 of the State Department of Human Services may enter into a
219 cooperative agreement with the State Department of Human Services
220 for the provision of such services using state funds which are
221 provided from the appropriation to the Department of Human
222 Services to obtain federal matching funds through the division.

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

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

230 and as adjusted each January thereafter, under Medicare (Title
231 XVIII of the Social Security Act, as amended), and which shall in
232 no event be less than seventy percent (70%) of the rate
233 established on January 1, 1994. All fees for physicians' services
234 that are covered by both Medicare and Medicaid shall be reimbursed
235 at ten percent (10%) of the adjusted Medicare payment established
236 on January 1, 1999, and as adjusted each January thereafter, under
237 Medicare (Title XVIII of the Social Security Act, as amended), and
238 which shall in no event be less than seven percent (7%) of the
239 adjusted Medicare payment established on January 1, 1994.

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

243 (b) Repealed.

244 (8) Emergency medical transportation services. On
245 January 1, 1994, emergency medical transportation services shall
246 be reimbursed at seventy percent (70%) of the rate established
247 under Medicare (Title XVIII of the Social Security Act, as
248 amended). "Emergency medical transportation services" shall mean,
249 but shall not be limited to, the following services by a properly
250 permitted ambulance operated by a properly licensed provider in
251 accordance with the Emergency Medical Services Act of 1974
252 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
253 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
254 (vi) disposable supplies, (vii) similar services.

255 (9) Legend and other drugs as may be determined by the
256 division. The division may implement a program of prior approval
257 for drugs to the extent permitted by law. Payment by the division
258 for covered multiple source drugs shall be limited to the lower of
259 the upper limits established and published by the Health Care
260 Financing Administration (HCFA) plus a dispensing fee of Four
261 Dollars and Ninety-one Cents (\$4.91), or the estimated acquisition
262 cost (EAC) as determined by the division plus a dispensing fee of

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

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

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

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

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

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

296 of the jaw or any facial bone; and emergency dental extractions
297 and treatment related thereto. On July 1, 1999, all fees for
298 dental care and surgery under authority of this paragraph (10)
299 shall be increased to one hundred sixty percent (160%) of the
300 amount of the reimbursement rate that was in effect on June 30,
301 1999. It is the intent of the Legislature to encourage more
302 dentists to participate in the Medicaid program.

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

308 (12) Intermediate care facility services.

309 (a) The division shall make full payment to all
310 intermediate care facilities for the mentally retarded for each
311 day, not exceeding eighty-four (84) days per year, that a patient
312 is absent from the facility on home leave. Payment may be made
313 for the following home leave days in addition to the
314 eighty-four-day limitation: Christmas, the day before Christmas,
315 the day after Christmas, Thanksgiving, the day before Thanksgiving
316 and the day after Thanksgiving. However, before payment may be
317 made for more than eighteen (18) home leave days in a year for a
318 patient, the patient must have written authorization from a
319 physician stating that the patient is physically and mentally able
320 to be away from the facility on home leave. Such authorization
321 must be filed with the division before it will be effective, and
322 the authorization shall be effective for three (3) months from the
323 date it is received by the division, unless it is revoked earlier
324 by the physician because of a change in the condition of the
325 patient.

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

329 (c) The division is authorized to limit allowable
330 management fees and home office costs to either three percent
331 (3%), five percent (5%) or seven percent (7%) of other allowable
332 costs, including allowable therapy costs and property costs, based
333 on the types of management services provided, as follows:

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

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

340 A maximum of up to seven percent (7%) shall be allowed where
341 a full spectrum of centralized managerial services, administrative
342 services, professional services and consultant services are
343 provided.

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

347 (14) Clinic services. Such diagnostic, preventive,
348 therapeutic, rehabilitative or palliative services furnished to an
349 outpatient by or under the supervision of a physician or dentist
350 in a facility which is not a part of a hospital but which is
351 organized and operated to provide medical care to outpatients.
352 Clinic services shall include any services reimbursed as
353 outpatient hospital services which may be rendered in such a
354 facility, including those that become so after July 1, 1991. On
355 July 1, 1999, all fees for physicians' services reimbursed under
356 authority of this paragraph (14) shall be reimbursed at ninety
357 percent (90%) of the rate established on January 1, 1999, and as
358 adjusted each January thereafter, under Medicare (Title XVIII of
359 the Social Security Act, as amended), and which shall in no event
360 be less than seventy percent (70%) of the rate established on
361 January 1, 1994. All fees for physicians' services that are

362 covered by both Medicare and Medicaid shall be reimbursed at ten
363 percent (10%) of the adjusted Medicare payment established on
364 January 1, 1999, and as adjusted each January thereafter, under
365 Medicare (Title XVIII of the Social Security Act, as amended), and
366 which shall in no event be less than seven percent (7%) of the
367 adjusted Medicare payment established on January 1, 1994. On July
368 1, 1999, all fees for dentists' services reimbursed under
369 authority of this paragraph (14) shall be increased to one hundred
370 sixty percent (160%) of the amount of the reimbursement rate that
371 was in effect on June 30, 1999.

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

388 (16) Mental health services. Approved therapeutic and
389 case management services provided by (a) an approved regional
390 mental health/retardation center established under Sections
391 41-19-31 through 41-19-39, or by another community mental health
392 service provider meeting the requirements of the Department of
393 Mental Health to be an approved mental health/retardation center
394 if determined necessary by the Department of Mental Health, using

395 state funds which are provided from the appropriation to the State
396 Department of Mental Health and used to match federal funds under
397 a cooperative agreement between the division and the department,
398 or (b) a facility which is certified by the State Department of
399 Mental Health to provide therapeutic and case management services,
400 to be reimbursed on a fee for service basis. Any such services
401 provided by a facility described in paragraph (b) must have the
402 prior approval of the division to be reimbursable under this
403 section. After June 30, 1997, mental health services provided by
404 regional mental health/retardation centers established under
405 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
406 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
407 psychiatric residential treatment facilities as defined in Section
408 43-11-1, or by another community mental health service provider
409 meeting the requirements of the Department of Mental Health to be
410 an approved mental health/retardation center if determined
411 necessary by the Department of Mental Health, shall not be
412 included in or provided under any capitated managed care pilot
413 program provided for under paragraph (24) of this section.

414 (17) Durable medical equipment services and medical
415 supplies. The Division of Medicaid may require durable medical
416 equipment providers to obtain a surety bond in the amount and to
417 the specifications as established by the Balanced Budget Act of
418 1997.

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

425 (19) (a) Perinatal risk management services. The
426 division shall promulgate regulations to be effective from and
427 after October 1, 1988, to establish a comprehensive perinatal

428 system for risk assessment of all pregnant and infant Medicaid
429 recipients and for management, education and follow-up for those
430 who are determined to be at risk. Services to be performed
431 include case management, nutrition assessment/counseling,
432 psychosocial assessment/counseling and health education. The
433 division shall set reimbursement rates for providers in
434 conjunction with the State Department of Health.

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

447 Qualifications for persons providing service coordination shall
448 be determined by the State Department of Health and the Division
449 of Medicaid.

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

460 (21) Nurse practitioner services. Services furnished

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

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

475 (23) Inpatient psychiatric services. Inpatient
476 psychiatric services to be determined by the division for
477 recipients under age twenty-one (21) which are provided under the
478 direction of a physician in an inpatient program in a licensed
479 acute care psychiatric facility or in a licensed psychiatric
480 residential treatment facility, before the recipient reaches age
481 twenty-one (21) or, if the recipient was receiving the services
482 immediately before he reached age twenty-one (21), before the
483 earlier of the date he no longer requires the services or the date
484 he reaches age twenty-two (22), as provided by federal
485 regulations. Recipients shall be allowed forty-five (45) days per
486 year of psychiatric services provided in acute care psychiatric
487 facilities, and shall be allowed unlimited days of psychiatric
488 services provided in licensed psychiatric residential treatment
489 facilities. The division is authorized to limit allowable
490 management fees and home office costs to either three percent
491 (3%), five percent (5%) or seven percent (7%) of other allowable
492 costs, including allowable therapy costs and property costs, based
493 on the types of management services provided, as follows:

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

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

500 A maximum of up to seven percent (7%) shall be allowed where
501 a full spectrum of centralized managerial services, administrative
502 services, professional services and consultant services are
503 provided.

504 (24) Managed care services in a program to be developed
505 by the division by a public or private provider. If managed care
506 services are provided by the division to Medicaid recipients, and
507 those managed care services are operated, managed and controlled
508 by and under the authority of the division, the division shall be
509 responsible for educating the Medicaid recipients who are
510 participants in the managed care program regarding the manner in
511 which the participants should seek health care under the program.
512 If a Medicaid recipient who is a participant in the division's
513 managed care program seeks health care in an emergency room of a
514 hospital, the division shall not evaluate, for payment purposes,
515 the propriety of the participant presenting himself at the
516 emergency room, and shall reimburse the hospital in accordance
517 with the medical treatment rendered to the participant by the
518 hospital. Notwithstanding any other provision in this article to
519 the contrary, the division shall establish rates of reimbursement
520 to providers rendering care and services authorized under this
521 paragraph (24), and may revise such rates of reimbursement without
522 amendment to this section by the Legislature for the purpose of
523 achieving effective and accessible health services, and for
524 responsible containment of costs.

525 * * *

526 (25) Birthing center services.

527 (26) Hospice care. As used in this paragraph, the term
528 "hospice care" means a coordinated program of active professional
529 medical attention within the home and outpatient and inpatient
530 care which treats the terminally ill patient and family as a unit,
531 employing a medically directed interdisciplinary team. The
532 program provides relief of severe pain or other physical symptoms
533 and supportive care to meet the special needs arising out of
534 physical, psychological, spiritual, social and economic stresses
535 which are experienced during the final stages of illness and
536 during dying and bereavement and meets the Medicare requirements
537 for participation as a hospice as provided in federal regulations.

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

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

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

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

555 (31) Targeted case management services for children
556 with special needs, under waivers from the United States
557 Department of Health and Human Services, using state funds that
558 are provided from the appropriation to the Mississippi Department
559 of Human Services and used to match federal funds under a

560 cooperative agreement between the division and the department.

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

567 (33) Podiatrist services.

568 (34) The division shall make application to the United
569 States Health Care Financing Administration for a waiver to
570 develop a program of services to personal care and assisted living
571 homes in Mississippi. This waiver shall be completed by December
572 1, 1999.

573 (35) Services and activities authorized in Sections
574 43-27-101 and 43-27-103, using state funds that are provided from
575 the appropriation to the State Department of Human Services and
576 used to match federal funds under a cooperative agreement between
577 the division and the department.

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

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

592 (38) Chiropractic services: a chiropractor's manual

593 manipulation of the spine to correct a subluxation, if x-ray
594 demonstrates that a subluxation exists and if the subluxation has
595 resulted in a neuromusculoskeletal condition for which
596 manipulation is appropriate treatment. Reimbursement for
597 chiropractic services shall not exceed Seven Hundred Dollars
598 (\$700.00) per year per recipient.

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

604 (40) The division shall prepare an application for a
605 waiver to provide prescription drug benefits to as many
606 Mississippians as permitted under Title XIX of the Social Security
607 Act.

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

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

626 unless such is authorized by an amendment to this section by the
627 Legislature. However, the restriction in this paragraph shall not
628 prevent the division from changing the payments or rates of
629 reimbursement to providers without an amendment to this section
630 whenever such changes are required by federal law or regulation,
631 or whenever such changes are necessary to correct administrative
632 errors or omissions in calculating such payments or rates of
633 reimbursement.

634 Notwithstanding any provision of this article, no new groups
635 or categories of recipients and new types of care and services may
636 be added without enabling legislation from the Mississippi
637 Legislature, except that the division may authorize such changes
638 without enabling legislation when such addition of recipients or
639 services is ordered by a court of proper authority. The director
640 shall keep the Governor advised on a timely basis of the funds
641 available for expenditure and the projected expenditures. In the
642 event current or projected expenditures can be reasonably
643 anticipated to exceed the amounts appropriated for any fiscal
644 year, the Governor, after consultation with the director, shall
645 discontinue any or all of the payment of the types of care and
646 services as provided herein which are deemed to be optional
647 services under Title XIX of the federal Social Security Act, as
648 amended, for any period necessary to not exceed appropriated
649 funds, and when necessary shall institute any other cost
650 containment measures on any program or programs authorized under
651 the article to the extent allowed under the federal law governing
652 such program or programs, it being the intent of the Legislature
653 that expenditures during any fiscal year shall not exceed the
654 amounts appropriated for such fiscal year.

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