

By: Moody

To: Public Health and
Welfare;
Appropriations

HOUSE BILL NO. 1432
(As Sent to Governor)

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE THAT PUBLIC HOSPITALS CANNOT PARTICIPATE IN THE
3 MEDICAID DISPROPORTIONATE SHARE PROGRAM UNLESS THEY PARTICIPATE IN
4 THE INTERGOVERNMENTAL TRANSFER PROGRAM; TO REVISE THE PROVISION
5 AUTHORIZING MEDICAID REIMBURSEMENT TO HOSPITALS FOR IMPLANTABLE
6 PROGRAMMABLE PUMPS, AND TO SPECIFY THE RATE OF REIMBURSEMENT FOR
7 THE DRUG USED IN THE PUMPS; TO CLARIFY THAT MEDICAID REIMBURSEMENT
8 FOR DUALY ELIGIBLE MEDICARE/MEDICAID BENEFICIARIES IS FOR
9 PHYSICIAN SERVICES AVAILABLE UNDER MEDICARE; AND FOR RELATED
10 PURPOSES.

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

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

16 43-13-117. Medical assistance as authorized by this article
17 shall include payment of part or all of the costs, at the
18 discretion of the division or its successor, with approval of the
19 Governor, of the following types of care and services rendered to
20 eligible applicants who shall have been determined to be eligible
21 for such care and services, within the limits of state
22 appropriations and federal matching funds:

23 (1) Inpatient hospital services.

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

29 (b) From and after July 1, 1994, the Executive
30 Director of the Division of Medicaid shall amend the Mississippi

31 Title XIX Inpatient Hospital Reimbursement Plan to remove the
32 occupancy rate penalty from the calculation of the Medicaid
33 Capital Cost Component utilized to determine total hospital costs
34 allocated to the Medicaid program.

35 (c) Hospitals will receive an additional payment
36 for the implantable programmable pump * * * implanted in an
37 inpatient basis. The payment pursuant to written invoice will be
38 in addition to the facility's per diem reimbursement and will
39 represent a reduction of costs on the facility's annual cost
40 report, and shall not exceed Ten Thousand Dollars (\$10,000.00) per
41 year per recipient. The drug used in the pump will be
42 reimbursable at ninety-five percent (95%) of the average wholesale
43 price to physicians or at the facility's outpatient rate. This
44 paragraph (c) shall stand repealed on July 1, 2001.

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

57 (3) Laboratory and x-ray services.

58 (4) Nursing facility services.

59 (a) The division shall make full payment to
60 nursing facilities for each day, not exceeding fifty-two (52) days
61 per year, that a patient is absent from the facility on home
62 leave. Payment may be made for the following home leave days in
63 addition to the fifty-two-day limitation: Christmas, the day
64 before Christmas, the day after Christmas, Thanksgiving, the day
65 before Thanksgiving and the day after Thanksgiving. However,
66 before payment may be made for more than eighteen (18) home leave
67 days in a year for a patient, the patient must have written

68 authorization from a physician stating that the patient is
69 physically and mentally able to be away from the facility on home
70 leave. Such authorization must be filed with the division before
71 it will be effective and the authorization shall be effective for
72 three (3) months from the date it is received by the division,
73 unless it is revoked earlier by the physician because of a change
74 in the condition of the patient.

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

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

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

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

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

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

127 (e) The division shall develop and implement a
128 case-mix payment add-on determined by time studies and other valid
129 statistical data which will reimburse a nursing facility for the
130 additional cost of caring for a resident who has a diagnosis of
131 Alzheimer's or other related dementia and exhibits symptoms that
132 require special care. Any such case-mix add-on payment shall be
133 supported by a determination of additional cost. The division

134 shall also develop and implement as part of the fair rental
135 reimbursement system for nursing facility beds, an Alzheimer's
136 resident bed depreciation enhanced reimbursement system which will
137 provide an incentive to encourage nursing facilities to convert or
138 construct beds for residents with Alzheimer's or other related
139 dementia.

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

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

166 (ii) Provide a proposed care plan and inform

167 the applicant or the applicant's legal representative regarding
168 the degree to which the services in the care plan are available in
169 a home- or in other community-based setting rather than nursing
170 facility care; and

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

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

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

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

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

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

196 (5) Periodic screening and diagnostic services for
197 individuals under age twenty-one (21) years as are needed to
198 identify physical and mental defects and to provide health care
199 treatment and other measures designed to correct or ameliorate

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

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

224 (6) Physician's services. All fees for physicians'
225 services that are covered only by Medicaid shall be reimbursed at
226 ninety percent (90%) of the rate established on January 1, 1999,
227 and as adjusted each January thereafter, under Medicare (Title
228 XVIII of the Social Security Act, as amended), and which shall in
229 no event be less than seventy percent (70%) of the rate
230 established on January 1, 1994. All fees for physicians' services
231 that are covered by both Medicare and Medicaid shall be reimbursed
232 at ten percent (10%) of the adjusted Medicare payment established

233 on January 1, 1999, and as adjusted each January thereafter, under
234 Medicare (Title XVIII of the Social Security Act, as amended), and
235 which shall in no event be less than seven percent (7%) of the
236 adjusted Medicare payment established on January 1, 1994.

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

240 (b) Repealed.

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

252 (9) Legend and other drugs as may be determined by the
253 division. The division may implement a program of prior approval
254 for drugs to the extent permitted by law. Payment by the division
255 for covered multiple source drugs shall be limited to the lower of
256 the upper limits established and published by the Health Care
257 Financing Administration (HCFA) plus a dispensing fee of Four
258 Dollars and Ninety-one Cents (\$4.91), or the estimated acquisition
259 cost (EAC) as determined by the division plus a dispensing fee of
260 Four Dollars and Ninety-one Cents (\$4.91), or the providers' usual
261 and customary charge to the general public. The division shall
262 allow five (5) prescriptions per month for noninstitutionalized
263 Medicaid recipients; however, exceptions for up to ten (10)
264 prescriptions per month shall be allowed, with the approval of the
265 director.

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

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

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

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

289 (10) Dental care that is an adjunct to treatment of an
290 acute medical or surgical condition; services of oral surgeons and
291 dentists in connection with surgery related to the jaw or any
292 structure contiguous to the jaw or the reduction of any fracture
293 of the jaw or any facial bone; and emergency dental extractions
294 and treatment related thereto. On July 1, 1999, all fees for
295 dental care and surgery under authority of this paragraph (10)
296 shall be increased to one hundred sixty percent (160%) of the
297 amount of the reimbursement rate that was in effect on June 30,
298 1999. It is the intent of the Legislature to encourage more

299 dentists to participate in the Medicaid program.

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

305 (12) Intermediate care facility services.

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

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

326 (c) The division is authorized to limit allowable
327 management fees and home office costs to either three percent
328 (3%), five percent (5%) or seven percent (7%) of other allowable
329 costs, including allowable therapy costs and property costs, based
330 on the types of management services provided, as follows:

331 A maximum of up to three percent (3%) shall be allowed where

332 centralized managerial and administrative services are provided by
333 the management company or home office.

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

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

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

344 (14) Clinic services. Such diagnostic, preventive,
345 therapeutic, rehabilitative or palliative services furnished to an
346 outpatient by or under the supervision of a physician or dentist
347 in a facility which is not a part of a hospital but which is
348 organized and operated to provide medical care to outpatients.
349 Clinic services shall include any services reimbursed as
350 outpatient hospital services which may be rendered in such a
351 facility, including those that become so after July 1, 1991. On
352 July 1, 1999, all fees for physicians' services reimbursed under
353 authority of this paragraph (14) shall be reimbursed at ninety
354 percent (90%) of the rate established on January 1, 1999, and as
355 adjusted each January thereafter, under Medicare (Title XVIII of
356 the Social Security Act, as amended), and which shall in no event
357 be less than seventy percent (70%) of the rate established on
358 January 1, 1994. All fees for physicians' services that are
359 covered by both Medicare and Medicaid shall be reimbursed at ten
360 percent (10%) of the adjusted Medicare payment established on
361 January 1, 1999, and as adjusted each January thereafter, under
362 Medicare (Title XVIII of the Social Security Act, as amended), and
363 which shall in no event be less than seven percent (7%) of the
364 adjusted Medicare payment established on January 1, 1994. On July

365 1, 1999, all fees for dentists' services reimbursed under
366 authority of this paragraph (14) shall be increased to one hundred
367 sixty percent (160%) of the amount of the reimbursement rate that
368 was in effect on June 30, 1999.

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

385 (16) Mental health services. Approved therapeutic and
386 case management services provided by (a) an approved regional
387 mental health/retardation center established under Sections
388 41-19-31 through 41-19-39, or by another community mental health
389 service provider meeting the requirements of the Department of
390 Mental Health to be an approved mental health/retardation center
391 if determined necessary by the Department of Mental Health, using
392 state funds which are provided from the appropriation to the State
393 Department of Mental Health and used to match federal funds under
394 a cooperative agreement between the division and the department,
395 or (b) a facility which is certified by the State Department of
396 Mental Health to provide therapeutic and case management services,
397 to be reimbursed on a fee for service basis. Any such services

398 provided by a facility described in paragraph (b) must have the
399 prior approval of the division to be reimbursable under this
400 section. After June 30, 1997, mental health services provided by
401 regional mental health/retardation centers established under
402 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
403 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
404 psychiatric residential treatment facilities as defined in Section
405 43-11-1, or by another community mental health service provider
406 meeting the requirements of the Department of Mental Health to be
407 an approved mental health/retardation center if determined
408 necessary by the Department of Mental Health, shall not be
409 included in or provided under any capitated managed care pilot
410 program provided for under paragraph (24) of this section.

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

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

429 (19) (a) Perinatal risk management services. The
430 division shall promulgate regulations to be effective from and

431 after October 1, 1988, to establish a comprehensive perinatal
432 system for risk assessment of all pregnant and infant Medicaid
433 recipients and for management, education and follow-up for those
434 who are determined to be at risk. Services to be performed
435 include case management, nutrition assessment/counseling,
436 psychosocial assessment/counseling and health education. The
437 division shall set reimbursement rates for providers in
438 conjunction with the State Department of Health.

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

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

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

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

479 (23) Inpatient psychiatric services. Inpatient
480 psychiatric services to be determined by the division for
481 recipients under age twenty-one (21) which are provided under the
482 direction of a physician in an inpatient program in a licensed
483 acute care psychiatric facility or in a licensed psychiatric
484 residential treatment facility, before the recipient reaches age
485 twenty-one (21) or, if the recipient was receiving the services
486 immediately before he reached age twenty-one (21), before the
487 earlier of the date he no longer requires the services or the date
488 he reaches age twenty-two (22), as provided by federal
489 regulations. Recipients shall be allowed forty-five (45) days per
490 year of psychiatric services provided in acute care psychiatric
491 facilities, and shall be allowed unlimited days of psychiatric
492 services provided in licensed psychiatric residential treatment
493 facilities. The division is authorized to limit allowable
494 management fees and home office costs to either three percent
495 (3%), five percent (5%) or seven percent (7%) of other allowable
496 costs, including allowable therapy costs and property costs, based

497 on the types of management services provided, as follows:

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

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

504 A maximum of up to seven percent (7%) shall be allowed where
505 a full spectrum of centralized managerial services, administrative
506 services, professional services and consultant services are
507 provided.

508 (24) Managed care services in a program to be developed
509 by the division by a public or private provider.

510 (a) Notwithstanding any other provision in this
511 article to the contrary, the division shall establish rates of
512 reimbursement to providers rendering care and services authorized
513 under this paragraph (24), and may revise such rates of
514 reimbursement without amendment to this section by the Legislature
515 for the purpose of achieving effective and accessible health
516 services, and for responsible containment of costs.

517 (b) The managed care services under this paragraph
518 (24) shall include, but not be limited to, one (1) module of
519 capitated managed care in a rural area, and one (1) module of
520 capitated managed care in an urban area; however, the capitated
521 managed care program operated by the division shall not be
522 implemented, conducted or expanded into any county or part of any
523 county other than the following counties: Covington, Forrest,
524 Hancock, Harrison, Lamar, Lauderdale, Pearl River, Perry, Warren
525 and Washington. From and after passage of this act, Medicaid
526 eligibility is guaranteed up to six (6) months for individuals
527 enrolled in a Medicaid managed care program. This subparagraph
528 (b) shall stand repealed on July 1, 2002.

529 (25) Birthing center services.

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

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

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

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

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

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

563 cooperative agreement between the division and the department.

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

570 (33) Podiatrist services.

571 (34) The division shall make application to the United
572 States Health Care Financing Administration for a waiver to
573 develop a program of services to personal care and assisted living
574 homes in Mississippi. This waiver shall be completed by December
575 1, 1999.

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

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

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

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

596 manipulation of the spine to correct a subluxation, if x-ray
597 demonstrates that a subluxation exists and if the subluxation has
598 resulted in a neuromusculoskeletal condition for which
599 manipulation is appropriate treatment. Reimbursement for
600 chiropractic services shall not exceed Seven Hundred Dollars
601 (\$700.00) per year per recipient.

602 (39) Dually eligible Medicare/Medicaid beneficiaries.
603 The division shall pay the Medicare deductible and ten percent
604 (10%) coinsurance amounts for physician services available under
605 Medicare for the duration and scope of services otherwise
606 available under the Medicaid program.

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

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

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

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

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

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