

By: Representative Ford

To: Public Health and  
Welfare; Appropriations

HOUSE BILL NO. 473

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,  
2 WHICH CONTAINS THE PROVISION OF LAW THAT ALLOWS HOSPITALS TO  
3 RECEIVE AN ADDITIONAL PAYMENT FOR THE IMPLANTABLE PROGRAMMABLE  
4 PUMP, TO EXTEND THE REPEAL DATE FROM JULY 1, 2001, TO JULY 1,  
5 2002; AND FOR RELATED PURPOSES.

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

7 SECTION 1. Section 43-13-117, Mississippi Code of 1972, is  
8 amended as follows:

9 43-13-117. Medical assistance as authorized by this article  
10 shall include payment of part or all of the costs, at the  
11 discretion of the division or its successor, with approval of the  
12 Governor, of the following types of care and services rendered to  
13 eligible applicants who shall have been determined to be eligible  
14 for such care and services, within the limits of state  
15 appropriations and federal matching funds:

16 (1) Inpatient hospital services.

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

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

28                   (c) Hospitals will receive an additional payment  
29 for the implantable programmable pump implanted in an inpatient  
30 basis. The payment pursuant to written invoice will be in  
31 addition to the facility's per diem reimbursement and will  
32 represent a reduction of costs on the facility's annual cost  
33 report, and shall not exceed Ten Thousand Dollars (\$10,000.00) per  
34 year per recipient. This paragraph (c) shall stand repealed on  
35 July 1, 2002.

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

48                   (3) Laboratory and x-ray services.

49                   (4) Nursing facility services.

50                   (a) The division shall make full payment to  
51 nursing facilities for each day, not exceeding fifty-two (52) days  
52 per year, that a patient is absent from the facility on home  
53 leave. Payment may be made for the following home leave days in  
54 addition to the fifty-two-day limitation: Christmas, the day  
55 before Christmas, the day after Christmas, Thanksgiving, the day  
56 before Thanksgiving and the day after Thanksgiving. However,  
57 before payment may be made for more than eighteen (18) home leave  
58 days in a year for a patient, the patient must have written  
59 authorization from a physician stating that the patient is  
60 physically and mentally able to be away from the facility on home

61 leave. Such authorization must be filed with the division before  
62 it will be effective and the authorization shall be effective for  
63 three (3) months from the date it is received by the division,  
64 unless it is revoked earlier by the physician because of a change  
65 in the condition of the patient.

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

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

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

88 A maximum of up to seven percent (7%) shall be allowed where  
89 a full spectrum of centralized managerial services, administrative  
90 services, professional services and consultant services are  
91 provided.

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

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

118 (e) The division shall develop and implement, not  
119 later than January 1, 2001, a case-mix payment add-on determined  
120 by time studies and other valid statistical data which will  
121 reimburse a nursing facility for the additional cost of caring for  
122 a resident who has a diagnosis of Alzheimer's or other related  
123 dementia and exhibits symptoms that require special care. Any  
124 such case-mix add-on payment shall be supported by a determination

125 of additional cost. The division shall also develop and implement  
126 as part of the fair rental reimbursement system for nursing  
127 facility beds, an Alzheimer's resident bed depreciation enhanced  
128 reimbursement system which will provide an incentive to encourage  
129 nursing facilities to convert or construct beds for residents with  
130 Alzheimer's or other related dementia.

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

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

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

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

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

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

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

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

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

187           (5) Periodic screening and diagnostic services for  
188 individuals under age twenty-one (21) years as are needed to  
189 identify physical and mental defects and to provide health care

190 treatment and other measures designed to correct or ameliorate  
191 defects and physical and mental illness and conditions discovered  
192 by the screening services regardless of whether these services are  
193 included in the state plan. The division may include in its  
194 periodic screening and diagnostic program those discretionary  
195 services authorized under the federal regulations adopted to  
196 implement Title XIX of the federal Social Security Act, as  
197 amended. The division, in obtaining physical therapy services,  
198 occupational therapy services, and services for individuals with  
199 speech, hearing and language disorders, may enter into a  
200 cooperative agreement with the State Department of Education for  
201 the provision of such services to handicapped students by public  
202 school districts using state funds which are provided from the  
203 appropriation to the Department of Education to obtain federal  
204 matching funds through the division. The division, in obtaining  
205 medical and psychological evaluations for children in the custody  
206 of the State Department of Human Services may enter into a  
207 cooperative agreement with the State Department of Human Services  
208 for the provision of such services using state funds which are  
209 provided from the appropriation to the Department of Human  
210 Services to obtain federal matching funds through the division.

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

215 (6) Physician's services. All fees for physicians'  
216 services that are covered only by Medicaid shall be reimbursed at  
217 ninety percent (90%) of the rate established on January 1, 1999,  
218 and as adjusted each January thereafter, under Medicare (Title  
219 XVIII of the Social Security Act, as amended), and which shall in  
220 no event be less than seventy percent (70%) of the rate  
221 established on January 1, 1994. All fees for physicians' services  
222 that are covered by both Medicare and Medicaid shall be reimbursed

223 at ten percent (10%) of the adjusted Medicare payment established  
224 on January 1, 1999, and as adjusted each January thereafter, under  
225 Medicare (Title XVIII of the Social Security Act, as amended), and  
226 which shall in no event be less than seven percent (7%) of the  
227 adjusted Medicare payment established on January 1, 1994.

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

231 (b) Repealed.

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

243 (9) Legend and other drugs as may be determined by the  
244 division. The division may implement a program of prior approval  
245 for drugs to the extent permitted by law. Payment by the division  
246 for covered multiple source drugs shall be limited to the lower of  
247 the upper limits established and published by the Health Care  
248 Financing Administration (HCFA) plus a dispensing fee of Four  
249 Dollars and Ninety-one Cents (\$4.91), or the estimated acquisition  
250 cost (EAC) as determined by the division plus a dispensing fee of  
251 Four Dollars and Ninety-one Cents (\$4.91), or the providers' usual  
252 and customary charge to the general public. The division shall  
253 allow five (5) prescriptions per month for noninstitutionalized  
254 Medicaid recipients; however, exceptions for up to ten (10)



255 prescriptions per month shall be allowed, with the approval of the  
256 director.

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

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

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

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

280 (10) Dental care that is an adjunct to treatment of an  
281 acute medical or surgical condition; services of oral surgeons and  
282 dentists in connection with surgery related to the jaw or any  
283 structure contiguous to the jaw or the reduction of any fracture  
284 of the jaw or any facial bone; and emergency dental extractions  
285 and treatment related thereto. On July 1, 1999, all fees for  
286 dental care and surgery under authority of this paragraph (10)  
287 shall be increased to one hundred sixty percent (160%) of the

288 amount of the reimbursement rate that was in effect on June 30,  
289 1999. It is the intent of the Legislature to encourage more  
290 dentists to participate in the Medicaid program.

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

296 (12) Intermediate care facility services.

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

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

317 (c) The division is authorized to limit allowable  
318 management fees and home office costs to either three percent  
319 (3%), five percent (5%) or seven percent (7%) of other allowable

320 costs, including allowable therapy costs and property costs, based  
321 on the types of management services provided, as follows:

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

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

328 A maximum of up to seven percent (7%) shall be allowed where  
329 a full spectrum of centralized managerial services, administrative  
330 services, professional services and consultant services are  
331 provided.

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

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

353 Medicare (Title XVIII of the Social Security Act, as amended), and  
354 which shall in no event be less than seven percent (7%) of the  
355 adjusted Medicare payment established on January 1, 1994. On July  
356 1, 1999, all fees for dentists' services reimbursed under  
357 authority of this paragraph (14) shall be increased to one hundred  
358 sixty percent (160%) of the amount of the reimbursement rate that  
359 was in effect on June 30, 1999.

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

376           (16) Mental health services. Approved therapeutic and  
377 case management services provided by (a) an approved regional  
378 mental health/retardation center established under Sections  
379 41-19-31 through 41-19-39, or by another community mental health  
380 service provider meeting the requirements of the Department of  
381 Mental Health to be an approved mental health/retardation center  
382 if determined necessary by the Department of Mental Health, using  
383 state funds which are provided from the appropriation to the State  
384 Department of Mental Health and used to match federal funds under  
385 a cooperative agreement between the division and the department,

386 or (b) a facility which is certified by the State Department of  
387 Mental Health to provide therapeutic and case management services,  
388 to be reimbursed on a fee for service basis. Any such services  
389 provided by a facility described in paragraph (b) must have the  
390 prior approval of the division to be reimbursable under this  
391 section. After June 30, 1997, mental health services provided by  
392 regional mental health/retardation centers established under  
393 Sections 41-19-31 through 41-19-39, or by hospitals as defined in  
394 Section 41-9-3(a) and/or their subsidiaries and divisions, or by  
395 psychiatric residential treatment facilities as defined in Section  
396 43-11-1, or by another community mental health service provider  
397 meeting the requirements of the Department of Mental Health to be  
398 an approved mental health/retardation center if determined  
399 necessary by the Department of Mental Health, shall not be  
400 included in or provided under any capitated managed care pilot  
401 program provided for under paragraph (24) of this section. From  
402 and after July 1, 2000, the division is authorized to contract  
403 with a 134-bed specialty hospital located on Highway 39 North in  
404 Lauderdale County for the use of not more than sixty (60) beds at  
405 the facility to provide mental health services for children and  
406 adolescents and for crisis intervention services for emotionally  
407 disturbed children with behavioral problems, with priority to be  
408 given to children in the custody of the Department of Human  
409 Services who are, or otherwise will be, receiving such services  
410 out-of-state.

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. If managed care  
510 services are provided by the division to Medicaid recipients, and  
511 those managed care services are operated, managed and controlled  
512 by and under the authority of the division, the division shall be  
513 responsible for educating the Medicaid recipients who are  
514 participants in the managed care program regarding the manner in  
515 which the participants should seek health care under the program.  
516 Notwithstanding any other provision in this article to the  
517 contrary, the division shall establish rates of reimbursement to



518 providers rendering care and services authorized under this  
519 paragraph (24), and may revise such rates of reimbursement without  
520 amendment to this section by the Legislature for the purpose of  
521 achieving effective and accessible health services, and for  
522 responsible containment of costs.

523 (25) Birthing center services.

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

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

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

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

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

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

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

564           (33) Podiatrist services.

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

570           (35) Services and activities authorized in Sections  
571 43-27-101 and 43-27-103, using state funds that are provided from  
572 the appropriation to the State Department of Human Services and  
573 used to match federal funds under a cooperative agreement between  
574 the division and the department.

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

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

589           (38) Chiropractic services: a chiropractor's manual  
590 manipulation of the spine to correct a subluxation, if x-ray  
591 demonstrates that a subluxation exists and if the subluxation has  
592 resulted in a neuromusculoskeletal condition for which  
593 manipulation is appropriate treatment. Reimbursement for  
594 chiropractic services shall not exceed Seven Hundred Dollars  
595 (\$700.00) per year per recipient.

596           (39) Dually eligible Medicare/Medicaid beneficiaries.  
597 The division shall pay the Medicare deductible and ten percent  
598 (10%) coinsurance amounts for services available under Medicare  
599 for the duration and scope of services otherwise available under  
600 the Medicaid program.

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

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

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

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

628           Notwithstanding any provision of this article, except as  
629 authorized in the following paragraph and in Section 43-13-139,  
630 neither (a) the limitations on quantity or frequency of use of or  
631 the fees or charges for any of the care or services available to  
632 recipients under this section, nor (b) the payments or rates of  
633 reimbursement to providers rendering care or services authorized  
634 under this section to recipients, may be increased, decreased or  
635 otherwise changed from the levels in effect on July 1, 1999,  
636 unless such is authorized by an amendment to this section by the  
637 Legislature. However, the restriction in this paragraph shall not  
638 prevent the division from changing the payments or rates of  
639 reimbursement to providers without an amendment to this section  
640 whenever such changes are required by federal law or regulation,  
641 or whenever such changes are necessary to correct administrative  
642 errors or omissions in calculating such payments or rates of  
643 reimbursement.

644           Notwithstanding any provision of this article, no new groups  
645 or categories of recipients and new types of care and services may  
646 be added without enabling legislation from the Mississippi  
647 Legislature, except that the division may authorize such changes

648 without enabling legislation when such addition of recipients or  
649 services is ordered by a court of proper authority. The director  
650 shall keep the Governor advised on a timely basis of the funds  
651 available for expenditure and the projected expenditures. In the  
652 event current or projected expenditures can be reasonably  
653 anticipated to exceed the amounts appropriated for any fiscal  
654 year, the Governor, after consultation with the director, shall  
655 discontinue any or all of the payment of the types of care and  
656 services as provided herein which are deemed to be optional  
657 services under Title XIX of the federal Social Security Act, as  
658 amended, for any period necessary to not exceed appropriated  
659 funds, and when necessary shall institute any other cost  
660 containment measures on any program or programs authorized under  
661 the article to the extent allowed under the federal law governing  
662 such program or programs, it being the intent of the Legislature  
663 that expenditures during any fiscal year shall not exceed the  
664 amounts appropriated for such fiscal year.

665 SECTION 2. This act shall take effect and be in force from  
666 and after July 1, 2001.