

By: Representatives Moody, Scott (80th)

To: Public Health and Welfare; Appropriations

HOUSE BILL NO. 1000

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,  
 2 TO PROVIDE THAT NURSING FACILITY SERVICES FOR THE SEVERELY  
 3 DISABLED WILL BE MEDICAID REIMBURSABLE; TO PROVIDE THAT THOSE  
 4 SERVICES MUST BE PROVIDED IN A LONG-TERM CARE NURSING FACILITY  
 5 DEDICATED TO THE CARE AND TREATMENT OF PERSONS WITH SEVERE  
 6 DISABILITIES; TO PROVIDE THAT THOSE SERVICES SHALL BE REIMBURSED  
 7 AS A SEPARATE CATEGORY OF NURSING FACILITIES; AND FOR RELATED  
 8 PURPOSES.

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

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

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

19 (1) Inpatient hospital services.

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

25 (b) From and after July 1, 1994, the Executive  
 26 Director of the Division of Medicaid shall amend the Mississippi  
 27 Title XIX Inpatient Hospital Reimbursement Plan to remove the  
 28 occupancy rate penalty from the calculation of the Medicaid

29 Capital Cost Component utilized to determine total hospital costs  
30 allocated to the Medicaid program.

31 (c) Hospitals will receive an additional payment  
32 for the implantable programmable pump implanted in an inpatient  
33 basis. The payment pursuant to written invoice will be in  
34 addition to the facility's per diem reimbursement and will  
35 represent a reduction of costs on the facility's annual cost  
36 report, and shall not exceed Ten Thousand Dollars (\$10,000.00) per  
37 year per recipient. This paragraph (c) shall stand repealed on  
38 July 1, 2001.

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

51 (3) Laboratory and x-ray services.

52 (4) Nursing facility services.

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

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

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

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

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

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

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

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

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

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

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

157 (i) Advise the applicant or the applicant's  
158 legal representative that a home- or other community-based setting  
159 is appropriate;

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

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

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

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

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

184 The division shall make full payment for long-term care  
185 alternative services.

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

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

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

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

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

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

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

234 (b) Repealed.

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

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



258 prescriptions per month shall be allowed, with the approval of the  
259 director.

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

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

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

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

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

291 amount of the reimbursement rate that was in effect on June 30,  
292 1999. It is the intent of the Legislature to encourage more  
293 dentists to participate in the Medicaid program.

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

299 (12) Intermediate care facility services.

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

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

320 (c) The division is authorized to limit allowable  
321 management fees and home office costs to either three percent  
322 (3%), five percent (5%) or seven percent (7%) of other allowable

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

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

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

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

335 (13) Family planning services, including drugs,  
336 supplies and devices, when such services are under the supervision  
337 of a physician.

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

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

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

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

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

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. However, from and  
425 after January 1, 2000, no public hospital shall participate in the  
426 Medicaid disproportionate share program unless the public hospital  
427 participates in an intergovernmental transfer program as provided  
428 in Section 1903 of the federal Social Security Act and any  
429 applicable regulations. Administration and support for  
430 participating hospitals shall be provided by the Mississippi  
431 Hospital Association.

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

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

454 Qualifications for persons providing service coordination shall be

455 determined by the State Department of Health and the Division of  
456 Medicaid.

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

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

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

482           (23) Inpatient psychiatric services. Inpatient  
483 psychiatric services to be determined by the division for  
484 recipients under age twenty-one (21) which are provided under the  
485 direction of a physician in an inpatient program in a licensed  
486 acute care psychiatric facility or in a licensed psychiatric  
487 residential treatment facility, before the recipient reaches age

488 twenty-one (21) or, if the recipient was receiving the services  
489 immediately before he reached age twenty-one (21), before the  
490 earlier of the date he no longer requires the services or the date  
491 he reaches age twenty-two (22), as provided by federal  
492 regulations. Recipients shall be allowed forty-five (45) days per  
493 year of psychiatric services provided in acute care psychiatric  
494 facilities, and shall be allowed unlimited days of psychiatric  
495 services provided in licensed psychiatric residential treatment  
496 facilities. The division is authorized to limit allowable  
497 management fees and home office costs to either three percent  
498 (3%), five percent (5%) or seven percent (7%) of other allowable  
499 costs, including allowable therapy costs and property costs, based  
500 on the types of management services provided, as follows:

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

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

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

511       (24) Managed care services in a program to be developed  
512 by the division by a public or private provider. If managed care  
513 services are provided by the division to Medicaid recipients, and  
514 those managed care services are operated, managed and controlled  
515 by and under the authority of the division, the division shall be  
516 responsible for educating the Medicaid recipients who are  
517 participants in the managed care program regarding the manner in  
518 which the participants should seek health care under the program.  
519 Notwithstanding any other provision in this article to the  
520 contrary, the division shall establish rates of reimbursement to



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

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 the Medicare deductible and ten percent  
601 (10%) coinsurance amounts for services available under Medicare  
602 for the duration and scope of services otherwise available under  
603 the 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           (42) Notwithstanding any other provision in this  
619 article to the contrary, the division is hereby authorized to  
620 develop a population health management program for women and  
621 children health services through the age of two (2). This program  
622 is primarily for obstetrical care associated with low birth weight  
623 and pre-term babies. In order to effect cost savings, the  
624 division may develop a revised payment methodology which may  
625 include at-risk capitated payments.

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

631           (44) Nursing facility services for the severely  
632 disabled.

633                   (a) Severe disabilities include, but are not  
634 limited to, spinal cord injuries, closed head injuries and  
635 ventilator dependent patients.

636                   (b) Those services must be provided in a long-term  
637 care nursing facility dedicated to the care and treatment of  
638 persons with severe disabilities, and shall be reimbursed as a  
639 separate category of nursing facilities.

640           Notwithstanding any provision of this article, except as  
641 authorized in the following paragraph and in Section 43-13-139,  
642 neither (a) the limitations on quantity or frequency of use of or  
643 the fees or charges for any of the care or services available to  
644 recipients under this section, nor (b) the payments or rates of  
645 reimbursement to providers rendering care or services authorized  
646 under this section to recipients, may be increased, decreased or  
647 otherwise changed from the levels in effect on July 1, 1999,  
648 unless such is authorized by an amendment to this section by the  
649 Legislature. However, the restriction in this paragraph shall not  
650 prevent the division from changing the payments or rates of

651 reimbursement to providers without an amendment to this section  
652 whenever such changes are required by federal law or regulation,  
653 or whenever such changes are necessary to correct administrative  
654 errors or omissions in calculating such payments or rates of  
655 reimbursement.

656         Notwithstanding any provision of this article, no new groups  
657 or categories of recipients and new types of care and services may  
658 be added without enabling legislation from the Mississippi  
659 Legislature, except that the division may authorize such changes  
660 without enabling legislation when such addition of recipients or  
661 services is ordered by a court of proper authority. The director  
662 shall keep the Governor advised on a timely basis of the funds  
663 available for expenditure and the projected expenditures. In the  
664 event current or projected expenditures can be reasonably  
665 anticipated to exceed the amounts appropriated for any fiscal  
666 year, the Governor, after consultation with the director, shall  
667 discontinue any or all of the payment of the types of care and  
668 services as provided herein which are deemed to be optional  
669 services under Title XIX of the federal Social Security Act, as  
670 amended, for any period necessary to not exceed appropriated  
671 funds, and when necessary shall institute any other cost  
672 containment measures on any program or programs authorized under  
673 the article to the extent allowed under the federal law governing  
674 such program or programs, it being the intent of the Legislature  
675 that expenditures during any fiscal year shall not exceed the  
676 amounts appropriated for such fiscal year.

677         SECTION 2. This act shall take effect and be in force from  
678 and after its passage.