By: Representatives Holland, Scott (80th)

To: Public Health and Welfare; Appropriations

COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 1001

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE THAT THE DIVISION OF MEDICAID SHALL PAY THE MEDICARE
3 DEDUCTIBLE AND COINSURANCE AMOUNTS FOR QUALIFIED MEDICARE
4 BENEFICIARIES WHO ARE DUALLY ELIGIBLE AS MEDICARE/MEDICAID
5 BENEFICIARIES AND ARE PATIENTS IN DISTINCT PART SKILLED NURSING
6 FACILITIES OR DISTINCT PART GERIATRIC PSYCHIATRIC FACILITIES; TO
7 PROVIDE THAT THE DIVISION SHALL PAY FOR REHABILITATION SERVICES
8 PROVIDED TO INPATIENTS IN A LEVEL II REHABILITATIVE UNIT LICENSED
9 BY THE STATE DEPARTMENT OF HEALTH; AND FOR RELATED PURPOSES.

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

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

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

20 (1) Inpatient hospital services.

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

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

30 Capital Cost Component utilized to determine total hospital costs
31 allocated to the Medicaid program.
32 (c) Hospitals will receive an additional payment
33 for the implantable programmable pump implanted in an inpatient
34 basis. The payment pursuant to written invoice will be in
35 addition to the facility's per diem reimbursement and will
36 represent a reduction of costs on the facility's annual cost
37 report, and shall not exceed Ten Thousand Dollars ($10,000.00) per
38 year per recipient. This paragraph (c) shall stand repealed on
39 July 1, 2001.
40 (d) The division shall pay the Medicare deductible
41 and coinsurance amounts in amounts based on the full
42 Medicare-approved amount for coinsurance, deductibles and
43 copayments for qualified Medicare beneficiaries who are dually
44 eligible as Medicare/Medicaid beneficiaries and are patients in
45 distinct part skilled nursing facilities or distinct part
46 geriatric psychiatric facilities.
47 (e) The division shall pay for rehabilitation
48 services provided to inpatients in a Level II rehabilitative unit
49 licensed by the State Department of Health.
50 (2) Outpatient hospital services. Provided that where
51 the same services are reimbursed as clinic services, the division
52 may revise the rate or methodology of outpatient reimbursement to
53 maintain consistency, efficiency, economy and quality of care.
54 The division shall develop a Medicaid-specific cost-to-charge
55 ratio calculation from data provided by hospitals to determine an
56 allowable rate payment for outpatient hospital services, and shall
57 submit a report thereon to the Medical Advisory Committee on or
58 before December 1, 1999. The committee shall make a
59 recommendation on the specific cost-to-charge reimbursement method
60 for outpatient hospital services to the 2000 Regular Session of
61 the Legislature.
62 (3) Laboratory and x-ray services.

63 (4) Nursing facility services.

64 (a) The division shall make full payment to
65 nursing facilities for each day, not exceeding fifty-two (52) days
66 per year, that a patient is absent from the facility on home
67 leave. Payment may be made for the following home leave days in
68 addition to the fifty-two-day limitation: Christmas, the day
69 before Christmas, the day after Christmas, Thanksgiving, the day
70 before Thanksgiving and the day after Thanksgiving. However,
71 before payment may be made for more than eighteen (18) home leave
72 days in a year for a patient, the patient must have written
73 authorization from a physician stating that the patient is
74 physically and mentally able to be away from the facility on home
75 leave. Such authorization must be filed with the division before
76 it will be effective and the authorization shall be effective for
77 three (3) months from the date it is received by the division,
78 unless it is revoked earlier by the physician because of a change
79 in the condition of the patient.

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

96 A maximum of up to three percent (3%) shall be allowed where
97 centralized managerial and administrative services are provided by
98 the management company or home office.
99 A maximum of up to five percent (5%) shall be allowed where
100 centralized managerial and administrative services and limited
101 professional and consultant services are provided.
102 A maximum of up to seven percent (7%) shall be allowed where
103 a full spectrum of centralized managerial services, administrative
104 services, professional services and consultant services are
105 provided.
106 (c) From and after July 1, 1997, all state-owned
107 nursing facilities shall be reimbursed on a full reasonable cost
108 basis.
109 (d) When a facility of a category that does not
110 require a certificate of need for construction and that could not
111 be eligible for Medicaid reimbursement is constructed to nursing
112 facility specifications for licensure and certification, and the
113 facility is subsequently converted to a nursing facility pursuant
114 to a certificate of need that authorizes conversion only and the
115 applicant for the certificate of need was assessed an application
116 review fee based on capital expenditures incurred in constructing
117 the facility, the division shall allow reimbursement for capital
118 expenditures necessary for construction of the facility that were
119 incurred within the twenty-four (24) consecutive calendar months
120 immediately preceding the date that the certificate of need
121 authorizing such conversion was issued, to the same extent that
122 reimbursement would be allowed for construction of a new nursing
123 facility pursuant to a certificate of need that authorizes such
124 construction. The reimbursement authorized in this subparagraph
125 (d) may be made only to facilities the construction of which was
126 completed after June 30, 1989. Before the division shall be
127 authorized to make the reimbursement authorized in this
128 subparagraph (d), the division first must have received approval

129 from the Health Care Financing Administration of the United States
130 Department of Health and Human Services of the change in the state
131 Medicaid plan providing for such reimbursement.

132 (e) The division shall develop and implement, not
133 later than January 1, 2001, a case-mix payment add-on determined
134 by time studies and other valid statistical data which will
135 reimburse a nursing facility for the additional cost of caring for
136 a resident who has a diagnosis of Alzheimer's or other related
137 dementia and exhibits symptoms that require special care. Any
138 such case-mix add-on payment shall be supported by a determination
139 of additional cost. The division shall also develop and implement
140 as part of the fair rental reimbursement system for nursing
141 facility beds, an Alzheimer's resident bed depreciation enhanced
142 reimbursement system which will provide an incentive to encourage
143 nursing facilities to convert or construct beds for residents with
144 Alzheimer's or other related dementia.

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

162 home or in some other community-based setting if home- or
163 community-based services were available to the applicant. The
164 time limitation prescribed in this paragraph shall be waived in
165 cases of emergency. If the Division of Medicaid determines that a
166 home- or other community-based setting is appropriate and
167 cost-effective, the division shall:
168 (i) Advise the applicant or the applicant's
169 legal representative that a home- or other community-based setting
170 is appropriate;
171 (ii) Provide a proposed care plan and inform
172 the applicant or the applicant's legal representative regarding
173 the degree to which the services in the care plan are available in
174 a home- or in other community-based setting rather than nursing
175 facility care; and
176 (iii) Explain that such plan and services are
177 available only if the applicant or the applicant's legal
178 representative chooses a home- or community-based alternative to
179 nursing facility care, and that the applicant is free to choose
180 nursing facility care.
181 The Division of Medicaid may provide the services described
182 in this paragraph (f) directly or through contract with case
183 managers from the local Area Agencies on Aging, and shall
184 coordinate long-term care alternatives to avoid duplication with
185 hospital discharge planning procedures.
186 Placement in a nursing facility may not be denied by the
187 division if home- or community-based services that would be more
188 appropriate than nursing facility care are not actually available,
189 or if the applicant chooses not to receive the appropriate home-
190 or community-based services.
191 The division shall provide an opportunity for a fair hearing
192 under federal regulations to any applicant who is not given the
193 choice of home- or community-based services as an alternative to
194 institutional care.

195 The division shall make full payment for long-term care
196 alternative services.
197 The division shall apply for necessary federal waivers to
198 assure that additional services providing alternatives to nursing
199 facility care are made available to applicants for nursing
200 facility care.
201 (5) Periodic screening and diagnostic services for
202 individuals under age twenty-one (21) years as are needed to
203 identify physical and mental defects and to provide health care
204 treatment and other measures designed to correct or ameliorate
205 defects and physical and mental illness and conditions discovered
206 by the screening services regardless of whether these services are
207 included in the state plan. The division may include in its
208 periodic screening and diagnostic program those discretionary
209 services authorized under the federal regulations adopted to
210 implement Title XIX of the federal Social Security Act, as
211 amended. The division, in obtaining physical therapy services,
212 occupational therapy services, and services for individuals with
213 speech, hearing and language disorders, may enter into a
214 cooperative agreement with the State Department of Education for
215 the provision of such services to handicapped students by public
216 school districts using state funds which are provided from the
217 appropriation to the Department of Education to obtain federal
218 matching funds through the division. The division, in obtaining
219 medical and psychological evaluations for children in the custody
220 of the State Department of Human Services may enter into a
221 cooperative agreement with the State Department of Human Services
222 for the provision of such services using state funds which are
223 provided from the appropriation to the Department of Human
224 Services to obtain federal matching funds through the division.
225 On July 1, 1993, all fees for periodic screening and
226 diagnostic services under this paragraph (5) shall be increased by

227 twenty-five percent (25%) of the reimbursement rate in effect on
228 June 30, 1993.
229 (6) Physician's services. All fees for physicians'
230 services that are covered only by Medicaid shall be reimbursed at
231 ninety percent (90%) of the rate established on January 1, 1999,
232 and as adjusted each January thereafter, under Medicare (Title
233 XVIII of the Social Security Act, as amended), and which shall in
234 no event be less than seventy percent (70%) of the rate
235 established on January 1, 1994. All fees for physicians' services
236 that are covered by both Medicare and Medicaid shall be reimbursed
237 at ten percent (10%) of the adjusted Medicare payment established
238 on January 1, 1999, and as adjusted each January thereafter, under
239 Medicare (Title XVIII of the Social Security Act, as amended), and
240 which shall in no event be less than seven percent (7%) of the
241 adjusted Medicare payment established on January 1, 1994.
242 (7) (a) Home health services for eligible persons, not
243 to exceed in cost the prevailing cost of nursing facility
244 services, not to exceed sixty (60) visits per year.
245 (b) Repealed.
246 (8) Emergency medical transportation services. On
247 January 1, 1994, emergency medical transportation services shall
248 be reimbursed at seventy percent (70%) of the rate established
249 under Medicare (Title XVIII of the Social Security Act, as
250 amended). "Emergency medical transportation services" shall mean,
251 but shall not be limited to, the following services by a properly
252 permitted ambulance operated by a properly licensed provider in
253 accordance with the Emergency Medical Services Act of 1974
254 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
255 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
256 (vi) disposable supplies, (vii) similar services.
257 (9) Legend and other drugs as may be determined by the
258 division. The division may implement a program of prior approval
259 for drugs to the extent permitted by law. Payment by the division

260 for covered multiple source drugs shall be limited to the lower of
261 the upper limits established and published by the Health Care
262 Financing Administration (HCFA) plus a dispensing fee of Four
263 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
264 cost (EAC) as determined by the division plus a dispensing fee of
265 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual
266 and customary charge to the general public. The division shall
267 allow five (5) prescriptions per month for noninstitutionalized
268 Medicaid recipients; however, exceptions for up to ten (10)
269 prescriptions per month shall be allowed, with the approval of the
270 director.

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

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

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

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

292 drugs when the consensus of competent medical advice is that
293 trademarked drugs are substantially more effective.
294 (10) Dental care that is an adjunct to treatment of an
295 acute medical or surgical condition; services of oral surgeons and
296 dentists in connection with surgery related to the jaw or any
297 structure contiguous to the jaw or the reduction of any fracture
298 of the jaw or any facial bone; and emergency dental extractions
299 and treatment related thereto. On July 1, 1999, all fees for
300 dental care and surgery under authority of this paragraph (10)
301 shall be increased to one hundred sixty percent (160%) of the
302 amount of the reimbursement rate that was in effect on June 30,
303 1999. It is the intent of the Legislature to encourage more
304 dentists to participate in the Medicaid program.
305 (11) Eyeglasses necessitated by reason of eye surgery,
306 and as prescribed by a physician skilled in diseases of the eye or
307 an optometrist, whichever the patient may select, or one (1) pair
308 every three (3) years as prescribed by a physician or an
309 optometrist, whichever the patient may select.
310 (12) Intermediate care facility services.
311 (a) The division shall make full payment to all
312 intermediate care facilities for the mentally retarded for each
313 day, not exceeding eighty-four (84) days per year, that a patient
314 is absent from the facility on home leave. Payment may be made
315 for the following home leave days in addition to the
316 eighty-four-day limitation: Christmas, the day before Christmas,
317 the day after Christmas, Thanksgiving, the day before Thanksgiving
318 and the day after Thanksgiving. However, before payment may be
319 made for more than eighteen (18) home leave days in a year for a
320 patient, the patient must have written authorization from a
321 physician stating that the patient is physically and mentally able
322 to be away from the facility on home leave. Such authorization
323 must be filed with the division before it will be effective, and
324 the authorization shall be effective for three (3) months from the

325 date it is received by the division, unless it is revoked earlier
326 by the physician because of a change in the condition of the
327 patient.
328 (b) All state-owned intermediate care facilities
329 for the mentally retarded shall be reimbursed on a full reasonable
330 cost basis.
331 (c) The division is authorized to limit allowable
332 management fees and home office costs to either three percent
333 (3%), five percent (5%) or seven percent (7%) of other allowable
334 costs, including allowable therapy costs and property costs, based
335 on the types of management services provided, as follows:
336 A maximum of up to three percent (3%) shall be allowed where
337 centralized managerial and administrative services are provided by
338 the management company or home office.
339 A maximum of up to five percent (5%) shall be allowed where
340 centralized managerial and administrative services and limited
341 professional and consultant services are provided.
342 A maximum of up to seven percent (7%) shall be allowed where
343 a full spectrum of centralized managerial services, administrative
344 services, professional services and consultant services are
345 provided.
346 (13) Family planning services, including drugs,
347 supplies and devices, when such services are under the supervision
348 of a physician.
349 (14) Clinic services. Such diagnostic, preventive,
350 therapeutic, rehabilitative or palliative services furnished to an
351 outpatient by or under the supervision of a physician or dentist
352 in a facility which is not a part of a hospital but which is
353 organized and operated to provide medical care to outpatients.
354 Clinic services shall include any services reimbursed as
355 outpatient hospital services which may be rendered in such a
356 facility, including those that become so after July 1, 1991. On
357 July 1, 1999, all fees for physicians' services reimbursed under

358 authority of this paragraph (14) shall be reimbursed at ninety
359 percent (90%) of the rate established on January 1, 1999, and as
360 adjusted each January thereafter, under Medicare (Title XVIII of
361 the Social Security Act, as amended), and which shall in no event
362 be less than seventy percent (70%) of the rate established on
363 January 1, 1994. All fees for physicians' services that are
364 covered by both Medicare and Medicaid shall be reimbursed at ten
365 percent (10%) of the adjusted Medicare payment established on
366 January 1, 1999, and as adjusted each January thereafter, under
367 Medicare (Title XVIII of the Social Security Act, as amended), and
368 which shall in no event be less than seven percent (7%) of the
369 adjusted Medicare payment established on January 1, 1994. On July
370 1, 1999, all fees for dentists' services reimbursed under
371 authority of this paragraph (14) shall be increased to one hundred
372 sixty percent (160%) of the amount of the reimbursement rate that
373 was in effect on June 30, 1999.
374 (15) Home- and community-based services, as provided
375 under Title XIX of the federal Social Security Act, as amended,
376 under waivers, subject to the availability of funds specifically
377 appropriated therefor by the Legislature. Payment for such
378 services shall be limited to individuals who would be eligible for
379 and would otherwise require the level of care provided in a
380 nursing facility. The home- and community-based services
381 authorized under this paragraph shall be expanded over a five-year
382 period beginning July 1, 1999. The division shall certify case
383 management agencies to provide case management services and
384 provide for home- and community-based services for eligible
385 individuals under this paragraph. The home- and community-based
386 services under this paragraph and the activities performed by
387 certified case management agencies under this paragraph shall be
388 funded using state funds that are provided from the appropriation
389 to the Division of Medicaid and used to match federal funds.

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

423 Services who are, or otherwise will be, receiving such services
424 out-of-state.
425 (17) Durable medical equipment services and medical
426 supplies. The Division of Medicaid may require durable medical
427 equipment providers to obtain a surety bond in the amount and to
428 the specifications as established by the Balanced Budget Act of
429 1997.
430 (18) Notwithstanding any other provision of this
431 section to the contrary, the division shall make additional
432 reimbursement to hospitals which serve a disproportionate share of
433 low-income patients and which meet the federal requirements for
434 such payments as provided in Section 1923 of the federal Social
435 Security Act and any applicable regulations. However, from and
436 after January 1, 2000, no public hospital shall participate in the
437 Medicaid disproportionate share program unless the public hospital
438 participates in an intergovernmental transfer program as provided
439 in Section 1903 of the federal Social Security Act and any
440 applicable regulations. Administration and support for
441 participating hospitals shall be provided by the Mississippi
442 Hospital Association.
443 (19) (a) Perinatal risk management services. The
444 division shall promulgate regulations to be effective from and
445 after October 1, 1988, to establish a comprehensive perinatal
446 system for risk assessment of all pregnant and infant Medicaid
447 recipients and for management, education and follow-up for those
448 who are determined to be at risk. Services to be performed
449 include case management, nutrition assessment/counseling,
450 psychosocial assessment/counseling and health education. The
451 division shall set reimbursement rates for providers in
452 conjunction with the State Department of Health.
453 (b) Early intervention system services. The
454 division shall cooperate with the State Department of Health,
455 acting as lead agency, in the development and implementation of a

456 statewide system of delivery of early intervention services,
457 pursuant to Part H of the Individuals with Disabilities Education
458 Act (IDEA). The State Department of Health shall certify annually
459 in writing to the director of the division the dollar amount of
460 state early intervention funds available which shall be utilized
461 as a certified match for Medicaid matching funds. Those funds
462 then shall be used to provide expanded targeted case management
463 services for Medicaid eligible children with special needs who are
464 eligible for the state's early intervention system.
465 Qualifications for persons providing service coordination shall be
466 determined by the State Department of Health and the Division of
467 Medicaid.

468 (20) Home- and community-based services for physically
469 disabled approved services as allowed by a waiver from the United
470 States Department of Health and Human Services for home- and
471 community-based services for physically disabled people using
472 state funds which are provided from the appropriation to the State
473 Department of Rehabilitation Services and used to match federal
474 funds under a cooperative agreement between the division and the
475 department, provided that funds for these services are
476 specifically appropriated to the Department of Rehabilitation
477 Services.

478 (21) Nurse practitioner services. Services furnished
479 by a registered nurse who is licensed and certified by the
480 Mississippi Board of Nursing as a nurse practitioner including,
481 but not limited to, nurse anesthetists, nurse midwives, family
482 nurse practitioners, family planning nurse practitioners,
483 pediatric nurse practitioners, obstetrics-gynecology nurse
484 practitioners and neonatal nurse practitioners, under regulations
485 adopted by the division. Reimbursement for such services shall
486 not exceed ninety percent (90%) of the reimbursement rate for
487 comparable services rendered by a physician.

488 (22) Ambulatory services delivered in federally
489 qualified health centers and in clinics of the local health
490 departments of the State Department of Health for individuals
491 eligible for medical assistance under this article based on
492 reasonable costs as determined by the division.
493 (23) Inpatient psychiatric services. Inpatient
494 psychiatric services to be determined by the division for
495 recipients under age twenty-one (21) which are provided under the
496 direction of a physician in an inpatient program in a licensed
497 acute care psychiatric facility or in a licensed psychiatric
498 residential treatment facility, before the recipient reaches age
499 twenty-one (21) or, if the recipient was receiving the services
500 immediately before he reached age twenty-one (21), before the
501 earlier of the date he no longer requires the services or the date
502 he reaches age twenty-two (22), as provided by federal
503 regulations. Recipients shall be allowed forty-five (45) days per
504 year of psychiatric services provided in acute care psychiatric
505 facilities, and shall be allowed unlimited days of psychiatric
506 services provided in licensed psychiatric residential treatment
507 facilities. The division is authorized to limit allowable
508 management fees and home office costs to either three percent
509 (3%), five percent (5%) or seven percent (7%) of other allowable
510 costs, including allowable therapy costs and property costs, based
511 on the types of management services provided, as follows:
512 A maximum of up to three percent (3%) shall be allowed where
513 centralized managerial and administrative services are provided by
514 the management company or home office.
515 A maximum of up to five percent (5%) shall be allowed where
516 centralized managerial and administrative services and limited
517 professional and consultant services are provided.
518 A maximum of up to seven percent (7%) shall be allowed where
519 a full spectrum of centralized managerial services, administrative

520 services, professional services and consultant services are
521 provided.
522 (24) Managed care services in a program to be developed
523 by the division by a public or private provider. If managed care
524 services are provided by the division to Medicaid recipients, and
525 those managed care services are operated, managed and controlled
526 by and under the authority of the division, the division shall be
527 responsible for educating the Medicaid recipients who are
528 participants in the managed care program regarding the manner in
529 which the participants should seek health care under the program.
530 Notwithstanding any other provision in this article to the
531 contrary, the division shall establish rates of reimbursement to
532 providers rendering care and services authorized under this
533 paragraph (24), and may revise such rates of reimbursement without
534 amendment to this section by the Legislature for the purpose of
535 achieving effective and accessible health services, and for
536 responsible containment of costs.
537 (25) Birthing center services.
538 (26) Hospice care. As used in this paragraph, the term
539 "hospice care" means a coordinated program of active professional
540 medical attention within the home and outpatient and inpatient
541 care which treats the terminally ill patient and family as a unit,
542 employing a medically directed interdisciplinary team. The
543 program provides relief of severe pain or other physical symptoms
544 and supportive care to meet the special needs arising out of
545 physical, psychological, spiritual, social and economic stresses
546 which are experienced during the final stages of illness and
547 during dying and bereavement and meets the Medicare requirements
548 for participation as a hospice as provided in federal regulations.
549 (27) Group health plan premiums and cost sharing if it
550 is cost effective as defined by the Secretary of Health and Human
551 Services.

552 (28) Other health insurance premiums which are cost
553 effective as defined by the Secretary of Health and Human
554 Services. Medicare eligible must have Medicare Part B before
555 other insurance premiums can be paid.
556 (29) The Division of Medicaid may apply for a waiver
557 from the Department of Health and Human Services for home- and
558 community-based services for developmentally disabled people using
559 state funds which are provided from the appropriation to the State
560 Department of Mental Health and used to match federal funds under
561 a cooperative agreement between the division and the department,
562 provided that funds for these services are specifically
563 appropriated to the Department of Mental Health.
564 (30) Pediatric skilled nursing services for eligible
565 persons under twenty-one (21) years of age.
566 (31) Targeted case management services for children
567 with special needs, under waivers from the United States
568 Department of Health and Human Services, using state funds that
569 are provided from the appropriation to the Mississippi Department
570 of Human Services and used to match federal funds under a
571 cooperative agreement between the division and the department.
572 (32) Care and services provided in Christian Science
573 Sanatoria operated by or listed and certified by The First Church
574 of Christ Scientist, Boston, Massachusetts, rendered in connection
575 with treatment by prayer or spiritual means to the extent that
576 such services are subject to reimbursement under Section 1903 of
577 the Social Security Act.
578 (33) Podiatrist services.
579 (34) The division shall make application to the United
580 States Health Care Financing Administration for a waiver to
581 develop a program of services to personal care and assisted living
582 homes in Mississippi. This waiver shall be completed by December
583 1, 1999.

584 (35) Services and activities authorized in Sections
585 43-27-101 and 43-27-103, using state funds that are provided from
586 the appropriation to the State Department of Human Services and
587 used to match federal funds under a cooperative agreement between
588 the division and the department.
589 (36) Nonemergency transportation services for
590 Medicaid-eligible persons, to be provided by the Division of
591 Medicaid. The division may contract with additional entities to
592 administer nonemergency transportation services as it deems
593 necessary. All providers shall have a valid driver's license,
594 vehicle inspection sticker, valid vehicle license tags and a
595 standard liability insurance policy covering the vehicle.
596 (37) Targeted case management services for individuals
597 with chronic diseases, with expanded eligibility to cover services
598 to uninsured recipients, on a pilot program basis. This paragraph
599 (37) shall be contingent upon continued receipt of special funds
600 from the Health Care Financing Authority and private foundations
601 who have granted funds for planning these services. No funding
602 for these services shall be provided from state general funds.
603 (38) Chiropractic services: a chiropractor's manual
604 manipulation of the spine to correct a subluxation, if x-ray
605 demonstrates that a subluxation exists and if the subluxation has
606 resulted in a neuromusculoskeletal condition for which
607 manipulation is appropriate treatment. Reimbursement for
608 chiropractic services shall not exceed Seven Hundred Dollars
609 ($700.00) per year per recipient.
610 (39) Dually eligible Medicare/Medicaid beneficiaries.
611 The division shall pay the Medicare deductible and ten percent
612 (10%) coinsurance amounts for services available under Medicare
613 for the duration and scope of services otherwise available under
614 the Medicaid program.
615 (40) The division shall prepare an application for a
616 waiver to provide prescription drug benefits to as many

617 Mississippians as permitted under Title XIX of the Social Security
618 Act.
619 (41) Services provided by the State Department of
620 Rehabilitation Services for the care and rehabilitation of persons
621 with spinal cord injuries or traumatic brain injuries, as allowed
622 under waivers from the United States Department of Health and
623 Human Services, using up to seventy-five percent (75%) of the
624 funds that are appropriated to the Department of Rehabilitation
625 Services from the Spinal Cord and Head Injury Trust Fund
626 established under Section 37-33-261 and used to match federal
627 funds under a cooperative agreement between the division and the
628 department.
629 (42) Notwithstanding any other provision in this
630 article to the contrary, the division is hereby authorized to
631 develop a population health management program for women and
632 children health services through the age of two (2). This program
633 is primarily for obstetrical care associated with low birth weight
634 and pre-term babies. In order to effect cost savings, the
635 division may develop a revised payment methodology which may
636 include at-risk capitated payments.
637 (43) The division shall provide reimbursement,
638 according to a payment schedule developed by the division, for
639 smoking cessation medications for pregnant women during their
640 pregnancy and other Medicaid-eligible women who are of
641 child-bearing age.
642 Notwithstanding any provision of this article, except as
643 authorized in the following paragraph and in Section 43-13-139,
644 neither (a) the limitations on quantity or frequency of use of or
645 the fees or charges for any of the care or services available to
646 recipients under this section, nor (b) the payments or rates of
647 reimbursement to providers rendering care or services authorized
648 under this section to recipients, may be increased, decreased or
649 otherwise changed from the levels in effect on July 1, 1999,

650 unless such is authorized by an amendment to this section by the
651 Legislature. However, the restriction in this paragraph shall not
652 prevent the division from changing the payments or rates of
653 reimbursement to providers without an amendment to this section
654 whenever such changes are required by federal law or regulation,
655 or whenever such changes are necessary to correct administrative
656 errors or omissions in calculating such payments or rates of
657 reimbursement.

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

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