AN ACT TO AMEND SECTION 43-13-113, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT THE DIVISION OF MEDICAID SHALL FOLLOW THE GUIDELINES FOR RATE SETTING FOR REIMBURSEMENT OF LONG-TERM CARE FACILITIES AS SET FORTH IN THE STATE PLAN; TO REQUIRE LONG-TERM CARE FACILITIES TO BE NOTIFIED BEFORE THE DATE THAT RATES ARE TO BE SET; TO PROVIDE THAT IF THE REIMBURSEMENT RATE IS NOT SET WITHIN THE TIME FRAME PRESCRIBED BY THE STATE PLAN, EACH LONG-TERM CARE FACILITY IN THE STATE SHALL BE REIMBURSED AT THE MAXIMUM DAILY RATE DURING THE PERIOD OF TIME WHEN THE RATE SETTING IS DELINQUENT; TO BRING FORWARD SECTION 43-13-117, MISSISSIPPI CODE OF 1972; AND FOR RELATED PURPOSES.

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

SECTION 1. Section 43-13-113, Mississippi Code of 1972, is amended as follows:

43-13-113. (1) The State Treasurer shall receive on behalf of the state, and execute all instruments incidental thereto, federal and other funds to be used for financing the medical assistance plan or program adopted pursuant to this article, and place all such funds in a special account to the credit of the Governor's Office-Division of Medicaid, which funds shall be expended by the division for the purposes and under the provisions of this article, and shall be paid out by the State Treasurer as funds appropriated to carry out the provisions of this article are paid out by him.

The division shall issue all checks or electronic transfers for administrative expenses, and for medical assistance under the provisions of this article. All such checks or electronic transfers shall be drawn upon funds made available to the division by the State Auditor, upon requisition of the director. It is the purpose of this section to provide that the State Auditor shall
transfer, in lump sums, amounts to the division for disbursement under the regulations which shall be made by the director with the approval of the Governor; however, the division, or its fiscal agent in behalf of the division, shall be authorized in maintaining separate accounts with a Mississippi bank to handle claim payments, refund recoveries and related Medicaid program financial transactions, to aggressively manage the float in these accounts while awaiting clearance of checks or electronic transfers and/or other disposition so as to accrue maximum interest advantage of the funds in the account, and to retain all earned interest on these funds to be applied to match federal funds for Medicaid program operations.

(2) Disbursement of funds to providers shall be made as follows:

(a) All providers must submit all claims to the Division of Medicaid's fiscal agent no later than twelve (12) months from the date of service.

(b) The Division of Medicaid's fiscal agent must pay ninety percent (90%) of all clean claims within thirty (30) days of the date of receipt.

(c) The Division of Medicaid's fiscal agent must pay ninety-nine percent (99%) of all clean claims within ninety (90) days of the date of receipt.

(d) The Division of Medicaid's fiscal agent must pay all other claims within twelve (12) months of the date of receipt.

(e) If a claim is neither paid nor denied for valid and proper reasons by the end of the time periods as specified above, the Division of Medicaid's fiscal agent must pay the provider interest on the claim at the rate of one and one-half percent (1-1/2%) per month on the amount of such claim until it is finally settled or adjudicated.

(f) The Division of Medicaid shall follow the guidelines for rate setting as set forth in the State Plan.
Guidelines for the Reimbursement for Medical Assistance Recipients of Long-Term Care Facilities. Each facility shall be notified by certified mail on or before the date rates are to be set. If the reimbursement rate is not set within the time frame prescribed by the state plan, each long-term care facility in the state shall be reimbursed at the maximum daily rate during the period of time when the rate setting is delinquent.

(3) The date of receipt is the date the fiscal agent receives the claim as indicated by its date stamp on the claim or, for those claims filed electronically, the date of receipt is the date of transmission.

(4) The date of payment is the date of the check or, for those claims paid by electronic funds transfer, the date of the transfer.

(5) The above specified time limitations do not apply in the following circumstances:
   (a) Retroactive adjustments paid to providers reimbursed under a retrospective payment system;
   (b) If a claim for payment under Medicare has been filed in a timely manner, the fiscal agent may pay a Medicaid claim relating to the same services within six (6) months after it, or the provider, receives notice of the disposition of the Medicare claim;
   (c) Claims from providers under investigation for fraud or abuse; and
   (d) The Division of Medicaid and/or its fiscal agent may make payments at any time in accordance with a court order, to carry out hearing decisions or corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.

(6) The Division of Medicaid and its fiscal agent shall develop a contingency plan for reimbursement and eligibility
verification to be used in the event that on January 1, 2000, the computers and computer programs used by the Division of Medicaid and its fiscal agent have not been sufficiently modified to deal with the issues that will result because of the year 2000. Such contingency plan (a) must be ready to be implemented immediately upon the realization of a year 2000 problem, (b) must be developed so there will be no delay of eligibility verification or reimbursement resulting from such year 2000 problem, and (c) must include a periodic interim payment system for each Medicaid provider that will be immediately implemented, regardless of the purported effectiveness of the conversion process, should such conversion process or the lack thereof result in a Medicaid remittance payment to a Medicaid provider for two (2) payment cycles that is less than seventy percent (70%) of the average remittance to that provider during state fiscal year 1999. A draft of the contingency plan and a summary thereof must be available for review and comment by Medicaid providers no later than July 1, 1999. The Medicaid providers shall be entitled to submit written, substantive comments to the Division of Medicaid no later than September 1, 1999, regarding such contingency plan, which plan must be finalized no later than October 1, 1999, whereupon the Division of Medicaid shall then make available the contingency plan and a summary thereof to all Medicaid providers.

This subsection (6) shall stand repealed on July 1, 2001.

(7) If sufficient funds are appropriated therefor by the Legislature, the Division of Medicaid may contract with the Mississippi Dental Association, or an approved designee, to develop and operate a Donated Dental Services (DDS) program through which volunteer dentists will treat needy disabled, aged and medically-compromised individuals who are non-Medicaid eligible recipients.

SECTION 2. Section 43-13-117, Mississippi Code of 1972, is brought forward as follows:
43-13-117. Medical assistance as authorized by this article shall include payment of part or all of the costs, at the discretion of the division or its successor, with approval of the Governor, of the following types of care and services rendered to eligible applicants who shall have been determined to be eligible for such care and services, within the limits of state appropriations and federal matching funds:

(1) Inpatient hospital services.

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

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

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

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

(3) Laboratory and x-ray services.

(4) Nursing facility services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) Periodic screening and diagnostic services for individuals under age twenty-one (21) years as are needed to identify physical and mental defects and to provide health care treatment and other measures designed to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services regardless of whether these services are included in the state plan. The division may include in its periodic screening and diagnostic program those discretionary services authorized under the federal regulations adopted to implement Title XIX of the federal Social Security Act, as amended. The division, in obtaining physical therapy services, occupational therapy services, and services for individuals with speech, hearing and language disorders, may enter into a cooperative agreement with the State Department of Education for the provision of such services to handicapped students by public school districts using state funds which are provided from the appropriation to the Department of Education to obtain federal matching funds through the division. The division, in obtaining medical and psychological evaluations for children in the custody of the State Department of Human Services may enter into a
cooperative agreement with the State Department of Human Services for the provision of such services using state funds which are provided from the appropriation to the Department of Human Services to obtain federal matching funds through the division. On July 1, 1993, all fees for periodic screening and diagnostic services under this paragraph (5) shall be increased by twenty-five percent (25%) of the reimbursement rate in effect on June 30, 1993.

(6) Physician's services. All fees for physicians' services that are covered only by Medicaid shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act, as amended), and which shall in no event be less than seventy percent (70%) of the rate established on January 1, 1994. All fees for physicians' services that are covered by both Medicare and Medicaid shall be reimbursed at ten percent (10%) of the adjusted Medicare payment established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act, as amended), and which shall in no event be less than seven percent (7%) of the adjusted Medicare payment established on January 1, 1994.

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

(b) Repealed.

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

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

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

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

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

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

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

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

(12) Intermediate care facility services.

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

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

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

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

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

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

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

(14) Clinic services. Such diagnostic, preventive, therapeutic, rehabilitative or palliative services furnished to an outpatient by or under the supervision of a physician or dentist in a facility which is not a part of a hospital but which is
organized and operated to provide medical care to outpatients.

Clinic services shall include any services reimbursed as outpatient hospital services which may be rendered in such a facility, including those that become so after July 1, 1991. On July 1, 1999, all fees for physicians' services reimbursed under authority of this paragraph (14) shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act, as amended), and which shall in no event be less than seventy percent (70%) of the rate established on January 1, 1994. All fees for physicians' services that are covered by both Medicare and Medicaid shall be reimbursed at ten percent (10%) of the adjusted Medicare payment established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act, as amended), and which shall in no event be less than seven percent (7%) of the adjusted Medicare payment established on January 1, 1994. On July 1, 1999, all fees for dentists' services reimbursed under authority of this paragraph (14) shall be increased to one hundred sixty percent (160%) of the amount of the reimbursement rate that was in effect on June 30, 1999.

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

(16) Mental health services. Approved therapeutic and
case management services provided by (a) an approved regional
mental health/retardation center established under Sections
41-19-31 through 41-19-39, or by another community mental health
service provider meeting the requirements of the Department of
Mental Health to be an approved mental health/retardation center
if determined necessary by the Department of Mental Health, using
state funds which are provided from the appropriation to the State
Department of Mental Health and used to match federal funds under
a cooperative agreement between the division and the department,
or (b) a facility which is certified by the State Department of
Mental Health to provide therapeutic and case management services,
to be reimbursed on a fee for service basis. Any such services
provided by a facility described in paragraph (b) must have the
prior approval of the division to be reimbursable under this
section. After June 30, 1997, mental health services provided by
regional mental health/retardation centers established under
Sections 41-19-31 through 41-19-39, or by hospitals as defined in
Section 41-9-3(a) and/or their subsidiaries and divisions, or by
psychiatric residential treatment facilities as defined in Section
43-11-1, or by another community mental health service provider
meeting the requirements of the Department of Mental Health to be
an approved mental health/retardation center if determined
necessary by the Department of Mental Health, shall not be
included in or provided under any capitated managed care pilot
program provided for under paragraph (24) of this section. From
and after July 1, 2000, the division is authorized to contract
with a 134-bed specialty hospital located on Highway 39 North in
Lauderdale County for the use of not more than sixty (60) beds at
the facility to provide mental health services for children and 
adolescents and for crisis intervention services for emotionally 
disturbed children with behavioral problems, with priority to be 
given to children in the custody of the Department of Human 
Services who are, or otherwise will be, receiving such services 
out-of-state.

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

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

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

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

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

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

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

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

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

A maximum of up to three percent (3%) shall be allowed where centralized managerial and administrative services are provided by the management company or home office.
A maximum of up to five percent (5%) shall be allowed where centralized managerial and administrative services and limited professional and consultant services are provided.

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

(24) Managed care services in a program to be developed by the division by a public or private provider. If managed care services are provided by the division to Medicaid recipients, and those managed care services are operated, managed and controlled by and under the authority of the division, the division shall be responsible for educating the Medicaid recipients who are participants in the managed care program regarding the manner in which the participants should seek health care under the program.

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

(25) Birthing center services.

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

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

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

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

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

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

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

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

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

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

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

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

(39) Dually eligible Medicare/Medicaid beneficiaries.
(10%) coinsurance amounts for services available under Medicare for the duration and scope of services otherwise available under the Medicaid program.

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

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

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

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

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

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

SECTION 3. This act shall take effect and be in force from and after July 1, 2001.