MISSISSIPPI LEGISLATURE REGULAR SESSION 2001

By: Representative Moody

To: Public Health and Welfare; Appropriations

HOUSE BILL NO. 1449

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

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

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

15 43-13-113. (1) The State Treasurer shall receive on behalf
16 of the state, and execute all instruments incidental thereto,
17 federal and other funds to be used for financing the medical
18 assistance plan or program adopted pursuant to this article, and
19 place all such funds in a special account to the credit of the
20 Governor's Office-Division of Medicaid, which funds shall be
21 expended by the division for the purposes and under the provisions
22 of this article, and shall be paid out by the State Treasurer as
23 funds appropriated to carry out the provisions of this article are
24 paid out by him.

25 The division shall issue all checks or electronic transfers
26 for administrative expenses, and for medical assistance under the
27 provisions of this article. All such checks or electronic
28 transfers shall be drawn upon funds made available to the division
29 by the State Auditor, upon requisition of the director. It is the
30 purpose of this section to provide that the State Auditor shall

31 transfer, in lump sums, amounts to the division for disbursement
32 under the regulations which shall be made by the director with the
33 approval of the Governor; however, the division, or its fiscal
34 agent in behalf of the division, shall be authorized in
35 maintaining separate accounts with a Mississippi bank to handle
36 claim payments, refund recoveries and related Medicaid program
37 financial transactions, to aggressively manage the float in these
38 accounts while awaiting clearance of checks or electronic
39 transfers and/or other disposition so as to accrue maximum
40 interest advantage of the funds in the account, and to retain all
41 earned interest on these funds to be applied to match federal
42 funds for Medicaid program operations.

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

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

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

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

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

56 (e) If a claim is neither paid nor denied for valid and
57 proper reasons by the end of the time periods as specified above,
58 the Division of Medicaid's fiscal agent must pay the provider
59 interest on the claim at the rate of one and one-half percent
60 (1-1/2%) per month on the amount of such claim until it is finally
61 settled or adjudicated.

62 <u>(f) The Division of Medicaid shall follow the</u>
63 <u>guidelines for rate setting as set forth in the State Plan,</u>

64 Guidelines for the Reimbursement for Medical Assistance Recipients
65 of Long-Term Care Facilities. Each facility shall be notified by
66 certified mail on or before the date rates are to be set. If the
67 reimbursement rate is not set within the time frame prescribed by
68 the state plan, each long-term care facility in the state shall be
69 reimbursed at the maximum daily rate during the period of time
70 when the rate setting is delinquent.

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

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

78 (5) The above specified time limitations do not apply in the
79 following circumstances:

80 (a) Retroactive adjustments paid to providers
81 reimbursed under a retrospective payment system;

82 (b) If a claim for payment under Medicare has been
83 filed in a timely manner, the fiscal agent may pay a Medicaid
84 claim relating to the same services within six (6) months after
85 it, or the provider, receives notice of the disposition of the
86 Medicare claim;

87 (c) Claims from providers under investigation for fraud
88 or abuse; and

89 (d) The Division of Medicaid and/or its fiscal agent
90 may make payments at any time in accordance with a court order, to
91 carry out hearing decisions or corrective actions taken to resolve
92 a dispute, or to extend the benefits of a hearing decision,
93 corrective action, or court order to others in the same situation
94 as those directly affected by it.

95 (6) The Division of Medicaid and its fiscal agent shall
96 develop a contingency plan for reimbursement and eligibility

97 verification to be used in the event that on January 1, 2000, the
98 computers and computer programs used by the Division of Medicaid
99 and its fiscal agent have not been sufficiently modified to deal
100 with the issues that will result because of the year 2000. Such
101 contingency plan (a) must be ready to be implemented immediately
102 upon the realization of a year 2000 problem, (b) must be developed
103 so there will be no delay of eligibility verification or
104 reimbursement resulting from such year 2000 problem, and (c) must
105 include a periodic interim payment system for each Medicaid
106 provider that will be immediately implemented, regardless of the
107 purported effectiveness of the conversion process, should such
108 conversion process or the lack thereof result in a Medicaid
109 remittance payment to a Medicaid provider for two (2) payment
110 cycles that is less than seventy percent (70%) of the average
111 remittance to that provider during state fiscal year 1999. A
112 draft of the contingency plan and a summary thereof must be
113 available for review and comment by Medicaid providers no later
114 than July 1, 1999. The Medicaid providers shall be entitled to
115 submit written, substantive comments to the Division of Medicaid
116 no later than September 1, 1999, regarding such contingency plan,
117 which plan must be finalized no later than October 1, 1999,
118 whereupon the Division of Medicaid shall then make available the
119 contingency plan and a summary thereof to all Medicaid providers.
120 This subsection (6) shall stand repealed on July 1, 2001.
121 (7) If sufficient funds are appropriated therefor by the
122 Legislature, the Division of Medicaid may contract with the
123 Mississippi Dental Association, or an approved designee, to
124 develop and operate a Donated Dental Services (DDS) program
125 through which volunteer dentists will treat needy disabled, aged
126 and medically-compromised individuals who are non-Medicaid
127 eligible recipients.
128 SECTION 2. Section 43-13-117, Mississippi Code of 1972, is
129 brought forward as follows:

130 43-13-117. Medical assistance as authorized by this article
131 shall include payment of part or all of the costs, at the
132 discretion of the division or its successor, with approval of the
133 Governor, of the following types of care and services rendered to
134 eligible applicants who shall have been determined to be eligible
135 for such care and services, within the limits of state
136 appropriations and federal matching funds:
137 (1) Inpatient hospital services.
138 (a) The division shall allow thirty (30) days of
139 inpatient hospital care annually for all Medicaid recipients. The
140 division shall be authorized to allow unlimited days in
141 disproportionate hospitals as defined by the division for eligible
142 infants under the age of six (6) years.
143 (b) From and after July 1, 1994, the Executive
144 Director of the Division of Medicaid shall amend the Mississippi
145 Title XIX Inpatient Hospital Reimbursement Plan to remove the
146 occupancy rate penalty from the calculation of the Medicaid
147 Capital Cost Component utilized to determine total hospital costs
148 allocated to the Medicaid program.
149 (c) Hospitals will receive an additional payment
150 for the implantable programmable pump implanted in an inpatient
151 basis. The payment pursuant to written invoice will be in
152 addition to the facility's per diem reimbursement and will
153 represent a reduction of costs on the facility's annual cost
154 report, and shall not exceed Ten Thousand Dollars ($10,000.00) per
155 year per recipient. This paragraph (c) shall stand repealed on
156 July 1, 2001.
157 (2) Outpatient hospital services. Provided that where
158 the same services are reimbursed as clinic services, the division
159 may revise the rate or methodology of outpatient reimbursement to
160 maintain consistency, efficiency, economy and quality of care.
161 The division shall develop a Medicaid-specific cost-to-charge
162 ratio calculation from data provided by hospitals to determine an

163 allowable rate payment for outpatient hospital services, and shall
164 submit a report thereon to the Medical Advisory Committee on or
165 before December 1, 1999. The committee shall make a
166 recommendation on the specific cost-to-charge reimbursement method
167 for outpatient hospital services to the 2000 Regular Session of
168 the Legislature.
169 (3) Laboratory and x-ray services.
170 (4) Nursing facility services.
171 (a) The division shall make full payment to
172 nursing facilities for each day, not exceeding fifty-two (52) days
173 per year, that a patient is absent from the facility on home
174 leave. Payment may be made for the following home leave days in
175 addition to the fifty-two-day limitation: Christmas, the day
176 before Christmas, the day after Christmas, Thanksgiving, the day
177 before Thanksgiving and the day after Thanksgiving. However,
178 before payment may be made for more than eighteen (18) home leave
179 days in a year for a patient, the patient must have written
180 authorization from a physician stating that the patient is
181 physically and mentally able to be away from the facility on home
182 leave. Such authorization must be filed with the division before
183 it will be effective and the authorization shall be effective for
184 three (3) months from the date it is received by the division,
185 unless it is revoked earlier by the physician because of a change
186 in the condition of the patient.
187 (b) From and after July 1, 1997, the division
188 shall implement the integrated case-mix payment and quality
189 monitoring system, which includes the fair rental system for
190 property costs and in which recapture of depreciation is
191 eliminated. The division may reduce the payment for hospital
192 leave and therapeutic home leave days to the lower of the case-mix
193 category as computed for the resident on leave using the
194 assessment being utilized for payment at that point in time, or a
195 case-mix score of 1.000 for nursing facilities, and shall compute

196 case-mix scores of residents so that only services provided at the
197 nursing facility are considered in calculating a facility's per
198 diem. The division is authorized to limit allowable management
199 fees and home office costs to either three percent (3%), five
200 percent (5%) or seven percent (7%) of other allowable costs,
201 including allowable therapy costs and property costs, based on the
202 types of management services provided, as follows:

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

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

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

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

216 (d) When a facility of a category that does not
217 require a certificate of need for construction and that could not
218 be eligible for Medicaid reimbursement is constructed to nursing
219 facility specifications for licensure and certification, and the
220 facility is subsequently converted to a nursing facility pursuant
221 to a certificate of need that authorizes conversion only and the
222 applicant for the certificate of need was assessed an application
223 review fee based on capital expenditures incurred in constructing
224 the facility, the division shall allow reimbursement for capital
225 expenditures necessary for construction of the facility that were
226 incurred within the twenty-four (24) consecutive calendar months
227 immediately preceding the date that the certificate of need
228 authorizing such conversion was issued, to the same extent that

229 reimbursement would be allowed for construction of a new nursing
230 facility pursuant to a certificate of need that authorizes such
231 construction. The reimbursement authorized in this subparagraph
232 (d) may be made only to facilities the construction of which was
233 completed after June 30, 1989. Before the division shall be
234 authorized to make the reimbursement authorized in this
235 subparagraph (d), the division first must have received approval
236 from the Health Care Financing Administration of the United States
237 Department of Health and Human Services of the change in the state
238 Medicaid plan providing for such reimbursement.

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

252 (f) The Division of Medicaid shall develop and
253 implement a referral process for long-term care alternatives for
254 Medicaid beneficiaries and applicants. No Medicaid beneficiary
255 shall be admitted to a Medicaid-certified nursing facility unless
256 a licensed physician certifies that nursing facility care is
257 appropriate for that person on a standardized form to be prepared
258 and provided to nursing facilities by the Division of Medicaid.
259 The physician shall forward a copy of that certification to the
260 Division of Medicaid within twenty-four (24) hours after it is
261 signed by the physician. Any physician who fails to forward the

262 certification to the Division of Medicaid within the time period
263 specified in this paragraph shall be ineligible for Medicaid
264 reimbursement for any physician's services performed for the
265 applicant. The Division of Medicaid shall determine, through an
266 assessment of the applicant conducted within two (2) business days
267 after receipt of the physician's certification, whether the
268 applicant also could live appropriately and cost-effectively at
269 home or in some other community-based setting if home- or
270 community-based services were available to the applicant. The
271 time limitation prescribed in this paragraph shall be waived in
272 cases of emergency. If the Division of Medicaid determines that a
273 home- or other community-based setting is appropriate and
274 cost-effective, the division shall:

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

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

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

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

293 Placement in a nursing facility may not be denied by the
294 division if home- or community-based services that would be more

295 appropriate than nursing facility care are not actually available,
296 or if the applicant chooses not to receive the appropriate home-
297 or community-based services.

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

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

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

308 (5) Periodic screening and diagnostic services for
309 individuals under age twenty-one (21) years as are needed to
310 identify physical and mental defects and to provide health care
311 treatment and other measures designed to correct or ameliorate
312 defects and physical and mental illness and conditions discovered
313 by the screening services regardless of whether these services are
314 included in the state plan. The division may include in its
315 periodic screening and diagnostic program those discretionary
316 services authorized under the federal regulations adopted to
317 implement Title XIX of the federal Social Security Act, as
318 amended. The division, in obtaining physical therapy services,
319 occupational therapy services, and services for individuals with
320 speech, hearing and language disorders, may enter into a
321 cooperative agreement with the State Department of Education for
322 the provision of such services to handicapped students by public
323 school districts using state funds which are provided from the
324 appropriation to the Department of Education to obtain federal
325 matching funds through the division. The division, in obtaining
326 medical and psychological evaluations for children in the custody
327 of the State Department of Human Services may enter into a

328 cooperative agreement with the State Department of Human Services
329 for the provision of such services using state funds which are
330 provided from the appropriation to the Department of Human
331 Services to obtain federal matching funds through the division.
332 On July 1, 1993, all fees for periodic screening and
333 diagnostic services under this paragraph (5) shall be increased by
334 twenty-five percent (25%) of the reimbursement rate in effect on
335 June 30, 1993.
336 (6) Physician's services. All fees for physicians'
337 services that are covered only by Medicaid shall be reimbursed at
338 ninety percent (90%) of the rate established on January 1, 1999,
339 and as adjusted each January thereafter, under Medicare (Title
340 XVIII of the Social Security Act, as amended), and which shall in
341 no event be less than seventy percent (70%) of the rate
342 established on January 1, 1994. All fees for physicians' services
343 that are covered by both Medicare and Medicaid shall be reimbursed
344 at ten percent (10%) of the adjusted Medicare payment established
345 on January 1, 1999, and as adjusted each January thereafter, under
346 Medicare (Title XVIII of the Social Security Act, as amended), and
347 which shall in no event be less than seven percent (7%) of the
348 adjusted Medicare payment established on January 1, 1994.
349 (7) (a) Home health services for eligible persons, not
350 to exceed in cost the prevailing cost of nursing facility
351 services, not to exceed sixty (60) visits per year.
352 (b) Repealed.
353 (8) Emergency medical transportation services. On
354 January 1, 1994, emergency medical transportation services shall
355 be reimbursed at seventy percent (70%) of the rate established
356 under Medicare (Title XVIII of the Social Security Act, as
357 amended). "Emergency medical transportation services" shall mean,
358 but shall not be limited to, the following services by a properly
359 permitted ambulance operated by a properly licensed provider in
360 accordance with the Emergency Medical Services Act of 1974

361 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
362 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
363 (vi) disposable supplies, (vii) similar services.
364 (9) Legend and other drugs as may be determined by the
365 division. The division may implement a program of prior approval
366 for drugs to the extent permitted by law. Payment by the division
367 for covered multiple source drugs shall be limited to the lower of
368 the upper limits established and published by the Health Care
369 Financing Administration (HCFA) plus a dispensing fee of Four
370 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
371 cost (EAC) as determined by the division plus a dispensing fee of
372 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual
373 and customary charge to the general public. The division shall
374 allow five (5) prescriptions per month for noninstitutionalized
375 Medicaid recipients; however, exceptions for up to ten (10)
376 prescriptions per month shall be allowed, with the approval of the
377 director.
378 Payment for other covered drugs, other than multiple source
379 drugs with HCFA upper limits, shall not exceed the lower of the
380 estimated acquisition cost as determined by the division plus a
381 dispensing fee of Four Dollars and Ninety-one Cents ($4.91) or the
382 providers' usual and customary charge to the general public.
383 Payment for nonlegend or over-the-counter drugs covered on
384 the division's formulary shall be reimbursed at the lower of the
385 division's estimated shelf price or the providers' usual and
386 customary charge to the general public. No dispensing fee shall
387 be paid.
388 The division shall develop and implement a program of payment
389 for additional pharmacist services, with payment to be based on
390 demonstrated savings, but in no case shall the total payment
391 exceed twice the amount of the dispensing fee.
392 As used in this paragraph (9), "estimated acquisition cost"
393 means the division's best estimate of what price providers

394 generally are paying for a drug in the package size that providers
395 buy most frequently. Product selection shall be made in
396 compliance with existing state law; however, the division may
397 reimburse as if the prescription had been filled under the generic
398 name. The division may provide otherwise in the case of specified
399 drugs when the consensus of competent medical advice is that
400 trademarked drugs are substantially more effective.
401 (10) Dental care that is an adjunct to treatment of an
402 acute medical or surgical condition; services of oral surgeons and
403 dentists in connection with surgery related to the jaw or any
404 structure contiguous to the jaw or the reduction of any fracture
405 of the jaw or any facial bone; and emergency dental extractions
406 and treatment related thereto. On July 1, 1999, all fees for
407 dental care and surgery under authority of this paragraph (10)
408 shall be increased to one hundred sixty percent (160%) of the
409 amount of the reimbursement rate that was in effect on June 30,
410 1999. It is the intent of the Legislature to encourage more
411 dentists to participate in the Medicaid program.
412 (11) Eyeglasses necessitated by reason of eye surgery,
413 and as prescribed by a physician skilled in diseases of the eye or
414 an optometrist, whichever the patient may select, or one (1) pair
415 every three (3) years as prescribed by a physician or an
416 optometrist, whichever the patient may select.
417 (12) Intermediate care facility services.
418 (a) The division shall make full payment to all
419 intermediate care facilities for the mentally retarded for each
420 day, not exceeding eighty-four (84) days per year, that a patient
421 is absent from the facility on home leave. Payment may be made
422 for the following home leave days in addition to the
423 eighty-four-day limitation: Christmas, the day before Christmas,
424 the day after Christmas, Thanksgiving, the day before Thanksgiving
425 and the day after Thanksgiving. However, before payment may be
426 made for more than eighteen (18) home leave days in a year for a

427 patient, the patient must have written authorization from a
428 physician stating that the patient is physically and mentally able
429 to be away from the facility on home leave. Such authorization
430 must be filed with the division before it will be effective, and
431 the authorization shall be effective for three (3) months from the
432 date it is received by the division, unless it is revoked earlier
433 by the physician because of a change in the condition of the
434 patient.

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

438 (c) The division is authorized to limit allowable
439 management fees and home office costs to either three percent
440 (3%), five percent (5%) or seven percent (7%) of other allowable
441 costs, including allowable therapy costs and property costs, based
442 on the types of management services provided, as follows:

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

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

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

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

456 (14) Clinic services. Such diagnostic, preventive,
457 therapeutic, rehabilitative or palliative services furnished to an
458 outpatient by or under the supervision of a physician or dentist
459 in a facility which is not a part of a hospital but which is

460 organized and operated to provide medical care to outpatients.
461 Clinic services shall include any services reimbursed as
462 outpatient hospital services which may be rendered in such a
463 facility, including those that become so after July 1, 1991. On
464 July 1, 1999, all fees for physicians' services reimbursed under
465 authority of this paragraph (14) shall be reimbursed at ninety
466 percent (90%) of the rate established on January 1, 1999, and as
467 adjusted each January thereafter, under Medicare (Title XVIII of
468 the Social Security Act, as amended), and which shall in no event
469 be less than seventy percent (70%) of the rate established on
470 January 1, 1994. All fees for physicians' services that are
471 covered by both Medicare and Medicaid shall be reimbursed at ten
472 percent (10%) of the adjusted Medicare payment established on
473 January 1, 1999, and as adjusted each January thereafter, under
474 Medicare (Title XVIII of the Social Security Act, as amended), and
475 which shall in no event be less than seven percent (7%) of the
476 adjusted Medicare payment established on January 1, 1994. On July
477 1, 1999, all fees for dentists' services reimbursed under
478 authority of this paragraph (14) shall be increased to one hundred
479 sixty percent (160%) of the amount of the reimbursement rate that
480 was in effect on June 30, 1999.
481 (15) Home- and community-based services, as provided
482 under Title XIX of the federal Social Security Act, as amended,
483 under waivers, subject to the availability of funds specifically
484 appropriated therefor by the Legislature. Payment for such
485 services shall be limited to individuals who would be eligible for
486 and would otherwise require the level of care provided in a
487 nursing facility. The home- and community-based services
488 authorized under this paragraph shall be expanded over a five-year
489 period beginning July 1, 1999. The division shall certify case
490 management agencies to provide case management services and
491 provide for home- and community-based services for eligible
492 individuals under this paragraph. The home- and community-based

493 services under this paragraph and the activities performed by
494 certified case management agencies under this paragraph shall be
495 funded using state funds that are provided from the appropriation
496 to the Division of Medicaid and used to match federal funds.
497 (16) Mental health services. Approved therapeutic and
498 case management services provided by (a) an approved regional
499 mental health/retardation center established under Sections
500 41-19-31 through 41-19-39, or by another community mental health
501 service provider meeting the requirements of the Department of
502 Mental Health to be an approved mental health/retardation center
503 if determined necessary by the Department of Mental Health, using
504 state funds which are provided from the appropriation to the State
505 Department of Mental Health and used to match federal funds under
506 a cooperative agreement between the division and the department,
507 or (b) a facility which is certified by the State Department of
508 Mental Health to provide therapeutic and case management services,
509 to be reimbursed on a fee for service basis. Any such services
510 provided by a facility described in paragraph (b) must have the
511 prior approval of the division to be reimbursable under this
512 section. After June 30, 1997, mental health services provided by
513 regional mental health/retardation centers established under
514 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
515 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
516 psychiatric residential treatment facilities as defined in Section
517 43-11-1, or by another community mental health service provider
518 meeting the requirements of the Department of Mental Health to be
519 an approved mental health/retardation center if determined
520 necessary by the Department of Mental Health, shall not be
521 included in or provided under any capitated managed care pilot
522 program provided for under paragraph (24) of this section. From
523 and after July 1, 2000, the division is authorized to contract
524 with a 134-bed specialty hospital located on Highway 39 North in
525 Lauderdale County for the use of not more than sixty (60) beds at

526 the facility to provide mental health services for children and
527 adolescents and for crisis intervention services for emotionally
528 disturbed children with behavioral problems, with priority to be
529 given to children in the custody of the Department of Human
530 Services who are, or otherwise will be, receiving such services
531 out-of-state.
532 (17) Durable medical equipment services and medical
533 supplies. The Division of Medicaid may require durable medical
534 equipment providers to obtain a surety bond in the amount and to
535 the specifications as established by the Balanced Budget Act of
536 1997.
537 (18) Notwithstanding any other provision of this
538 section to the contrary, the division shall make additional
539 reimbursement to hospitals which serve a disproportionate share of
540 low-income patients and which meet the federal requirements for
541 such payments as provided in Section 1923 of the federal Social
542 Security Act and any applicable regulations. However, from and
543 after January 1, 2000, no public hospital shall participate in the
544 Medicaid disproportionate share program unless the public hospital
545 participates in an intergovernmental transfer program as provided
546 in Section 1903 of the federal Social Security Act and any
547 applicable regulations. Administration and support for
548 participating hospitals shall be provided by the Mississippi
549 Hospital Association.
550 (19) (a) Perinatal risk management services. The
551 division shall promulgate regulations to be effective from and
552 after October 1, 1988, to establish a comprehensive perinatal
553 system for risk assessment of all pregnant and infant Medicaid
554 recipients and for management, education and follow-up for those
555 who are determined to be at risk. Services to be performed
556 include case management, nutrition assessment/counseling,
557 psychosocial assessment/counseling and health education. The

558 division shall set reimbursement rates for providers in
559 conjunction with the State Department of Health.
560 (b) Early intervention system services. The
561 division shall cooperate with the State Department of Health,
562 acting as lead agency, in the development and implementation of a
563 statewide system of delivery of early intervention services,
564 pursuant to Part H of the Individuals with Disabilities Education
565 Act (IDEA). The State Department of Health shall certify annually
566 in writing to the director of the division the dollar amount of
567 state early intervention funds available which shall be utilized
568 as a certified match for Medicaid matching funds. Those funds
569 then shall be used to provide expanded targeted case management
570 services for Medicaid eligible children with special needs who are
571 eligible for the state's early intervention system.
572 Qualifications for persons providing service coordination shall be
573 determined by the State Department of Health and the Division of
574 Medicaid.
575 (20) Home- and community-based services for physically
576 disabled approved services as allowed by a waiver from the United
577 States Department of Health and Human Services for home- and
578 community-based services for physically disabled people using
579 state funds which are provided from the appropriation to the State
580 Department of Rehabilitation Services and used to match federal
581 funds under a cooperative agreement between the division and the
582 department, provided that funds for these services are
583 specifically appropriated to the Department of Rehabilitation
584 Services.
585 (21) Nurse practitioner services. Services furnished
586 by a registered nurse who is licensed and certified by the
587 Mississippi Board of Nursing as a nurse practitioner including,
588 but not limited to, nurse anesthetists, nurse midwives, family
589 nurse practitioners, family planning nurse practitioners,
590 pediatric nurse practitioners, obstetrics-gynecology nurse

591 practitioners and neonatal nurse practitioners, under regulations
592 adopted by the division. Reimbursement for such services shall
593 not exceed ninety percent (90%) of the reimbursement rate for
594 comparable services rendered by a physician.
595 (22) Ambulatory services delivered in federally
596 qualified health centers and in clinics of the local health
597 departments of the State Department of Health for individuals
598 eligible for medical assistance under this article based on
599 reasonable costs as determined by the division.
600 (23) Inpatient psychiatric services. Inpatient
601 psychiatric services to be determined by the division for
602 recipients under age twenty-one (21) which are provided under the
603 direction of a physician in an inpatient program in a licensed
604 acute care psychiatric facility or in a licensed psychiatric
605 residential treatment facility, before the recipient reaches age
606 twenty-one (21) or, if the recipient was receiving the services
607 immediately before he reached age twenty-one (21), before the
608 earlier of the date he no longer requires the services or the date
609 he reaches age twenty-two (22), as provided by federal
610 regulations. Recipients shall be allowed forty-five (45) days per
611 year of psychiatric services provided in acute care psychiatric
612 facilities, and shall be allowed unlimited days of psychiatric
613 services provided in licensed psychiatric residential treatment
614 facilities. The division is authorized to limit allowable
615 management fees and home office costs to either three percent
616 (3%), five percent (5%) or seven percent (7%) of other allowable
617 costs, including allowable therapy costs and property costs, based
618 on the types of management services provided, as follows:
619 A maximum of up to three percent (3%) shall be allowed where
620 centralized managerial and administrative services are provided by
621 the management company or home office.

622 A maximum of up to five percent (5%) shall be allowed where
623 centralized managerial and administrative services and limited
624 professional and consultant services are provided.
625 A maximum of up to seven percent (7%) shall be allowed where
626 a full spectrum of centralized managerial services, administrative
627 services, professional services and consultant services are
628 provided.
629 (24) Managed care services in a program to be developed
630 by the division by a public or private provider. If managed care
631 services are provided by the division to Medicaid recipients, and
632 those managed care services are operated, managed and controlled
633 by and under the authority of the division, the division shall be
634 responsible for educating the Medicaid recipients who are
635 participants in the managed care program regarding the manner in
636 which the participants should seek health care under the program.
637 Notwithstanding any other provision in this article to the
638 contrary, the division shall establish rates of reimbursement to
639 providers rendering care and services authorized under this
640 paragraph (24), and may revise such rates of reimbursement without
641 amendment to this section by the Legislature for the purpose of
642 achieving effective and accessible health services, and for
643 responsible containment of costs.
644 (25) Birthing center services.
645 (26) Hospice care. As used in this paragraph, the term
646 "hospice care" means a coordinated program of active professional
647 medical attention within the home and outpatient and inpatient
648 care which treats the terminally ill patient and family as a unit,
649 employing a medically directed interdisciplinary team. The
650 program provides relief of severe pain or other physical symptoms
651 and supportive care to meet the special needs arising out of
652 physical, psychological, spiritual, social and economic stresses
653 which are experienced during the final stages of illness and

654 during dying and bereavement and meets the Medicare requirements
655 for participation as a hospice as provided in federal regulations.
656 (27) Group health plan premiums and cost sharing if it
657 is cost effective as defined by the Secretary of Health and Human
658 Services.
659 (28) Other health insurance premiums which are cost
660 effective as defined by the Secretary of Health and Human
661 Services. Medicare eligible must have Medicare Part B before
662 other insurance premiums can be paid.
663 (29) The Division of Medicaid may apply for a waiver
664 from the Department of Health and Human Services for home- and
665 community-based services for developmentally disabled people using
666 state funds which are provided from the appropriation to the State
667 Department of Mental Health and used to match federal funds under
668 a cooperative agreement between the division and the department,
669 provided that funds for these services are specifically
670 appropriated to the Department of Mental Health.
671 (30) Pediatric skilled nursing services for eligible
672 persons under twenty-one (21) years of age.
673 (31) Targeted case management services for children
674 with special needs, under waivers from the United States
675 Department of Health and Human Services, using state funds that
676 are provided from the appropriation to the Mississippi Department
677 of Human Services and used to match federal funds under a
678 cooperative agreement between the division and the department.
679 (32) Care and services provided in Christian Science
680 Sanatoria operated by or listed and certified by The First Church
681 of Christ Scientist, Boston, Massachusetts, rendered in connection
682 with treatment by prayer or spiritual means to the extent that
683 such services are subject to reimbursement under Section 1903 of
684 the Social Security Act.
685 (33) Podiatrist services.

686 (34) The division shall make application to the United
687 States Health Care Financing Administration for a waiver to
688 develop a program of services to personal care and assisted living
689 homes in Mississippi. This waiver shall be completed by December
690 1, 1999.
691 (35) Services and activities authorized in Sections
692 43-27-101 and 43-27-103, using state funds that are provided from
693 the appropriation to the State Department of Human Services and
694 used to match federal funds under a cooperative agreement between
695 the division and the department.
696 (36) Nonemergency transportation services for
697 Medicaid-eligible persons, to be provided by the Division of
698 Medicaid. The division may contract with additional entities to
699 administer nonemergency transportation services as it deems
700 necessary. All providers shall have a valid driver's license,
701 vehicle inspection sticker, valid vehicle license tags and a
702 standard liability insurance policy covering the vehicle.
703 (37) Targeted case management services for individuals
704 with chronic diseases, with expanded eligibility to cover services
705 to uninsured recipients, on a pilot program basis. This paragraph
706 (37) shall be contingent upon continued receipt of special funds
707 from the Health Care Financing Authority and private foundations
708 who have granted funds for planning these services. No funding
709 for these services shall be provided from state general funds.
710 (38) Chiropractic services: a chiropractor's manual
711 manipulation of the spine to correct a subluxation, if x-ray
712 demonstrates that a subluxation exists and if the subluxation has
713 resulted in a neuromusculoskeletal condition for which
714 manipulation is appropriate treatment. Reimbursement for
715 chiropractic services shall not exceed Seven Hundred Dollars
716 ($700.00) per year per recipient.
717 (39) Dually eligible Medicare/Medicaid beneficiaries.
718 The division shall pay the Medicare deductible and ten percent

719 (10%) coinsurance amounts for services available under Medicare
720 for the duration and scope of services otherwise available under
721 the Medicaid program.

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

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

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

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

749 Notwithstanding any provision of this article, except as
750 authorized in the following paragraph and in Section 43-13-139,
751 neither (a) the limitations on quantity or frequency of use of or

752 the fees or charges for any of the care or services available to
753 recipients under this section, nor (b) the payments or rates of
754 reimbursement to providers rendering care or services authorized
755 under this section to recipients, may be increased, decreased or
756 otherwise changed from the levels in effect on July 1, 1999,
757 unless such is authorized by an amendment to this section by the
758 Legislature. However, the restriction in this paragraph shall not
759 prevent the division from changing the payments or rates of
760 reimbursement to providers without an amendment to this section
761 whenever such changes are required by federal law or regulation,
762 or whenever such changes are necessary to correct administrative
763 errors or omissions in calculating such payments or rates of
764 reimbursement.
765 Notwithstanding any provision of this article, no new groups
766 or categories of recipients and new types of care and services may
767 be added without enabling legislation from the Mississippi
768 Legislature, except that the division may authorize such changes
769 without enabling legislation when such addition of recipients or
770 services is ordered by a court of proper authority. The director
771 shall keep the Governor advised on a timely basis of the funds
772 available for expenditure and the projected expenditures. In the
773 event current or projected expenditures can be reasonably
774 anticipated to exceed the amounts appropriated for any fiscal
775 year, the Governor, after consultation with the director, shall
776 discontinue any or all of the payment of the types of care and
777 services as provided herein which are deemed to be optional
778 services under Title XIX of the federal Social Security Act, as
779 amended, for any period necessary to not exceed appropriated
780 funds, and when necessary shall institute any other cost
781 containment measures on any program or programs authorized under
782 the article to the extent allowed under the federal law governing
783 such program or programs, it being the intent of the Legislature

784 that expenditures during any fiscal year shall not exceed the
785 amounts appropriated for such fiscal year.
786 SECTION 3. This act shall take effect and be in force from
787 and after July 1, 2001.

ST: Medicaid; division must follow reimbursement guidelines for long-term care facilities.