

By: Senator(s) Dearing

To: Public Health and  
Welfare; Appropriations

SENATE BILL NO. 2254

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,  
2 TO PROVIDE THAT MENTAL HEALTH COUNSELING SERVICES PROVIDED BY A  
3 LICENSED PROFESSIONAL COUNSELOR (LPC) SHALL BE REIMBURSABLE UNDER  
4 THE MEDICAID PROGRAM; AND FOR RELATED PURPOSES.

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

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

8 43-13-117. Medical assistance as authorized by this article  
9 shall include payment of part or all of the costs, at the  
10 discretion of the division or its successor, with approval of the  
11 Governor, of the following types of care and services rendered to  
12 eligible applicants who shall have been determined to be eligible  
13 for such care and services, within the limits of state  
14 appropriations and federal matching funds:

15 (1) Inpatient hospital services.

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

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

27 (c) Hospitals will receive an additional payment  
28 for the implantable programmable pump implanted in an inpatient



29 basis. The payment pursuant to written invoice will be in  
30 addition to the facility's per diem reimbursement and will  
31 represent a reduction of costs on the facility's annual cost  
32 report, and shall not exceed Ten Thousand Dollars (\$10,000.00) per  
33 year per recipient. This paragraph (c) shall stand repealed on  
34 July 1, 2001.

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

47 (3) Laboratory and x-ray services.

48 (4) Nursing facility services.

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



62 three (3) months from the date it is received by the division,  
63 unless it is revoked earlier by the physician because of a change  
64 in the condition of the patient.

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

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

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

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

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



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

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



127 reimbursement system which will provide an incentive to encourage  
128 nursing facilities to convert or construct beds for residents with  
129 Alzheimer's or other related dementia.

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

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

156                   (ii) Provide a proposed care plan and inform  
157 the applicant or the applicant's legal representative regarding  
158 the degree to which the services in the care plan are available in



159 a home- or in other community-based setting rather than nursing  
160 facility care; and

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

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

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

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

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

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

186 (5) Periodic screening and diagnostic services for  
187 individuals under age twenty-one (21) years as are needed to  
188 identify physical and mental defects and to provide health care  
189 treatment and other measures designed to correct or ameliorate  
190 defects and physical and mental illness and conditions discovered  
191 by the screening services regardless of whether these services are



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

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

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



225 which shall in no event be less than seven percent (7%) of the  
226 adjusted Medicare payment established on January 1, 1994.

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

230 (b) Repealed.

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

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

256 Payment for other covered drugs, other than multiple source  
257 drugs with HCFA upper limits, shall not exceed the lower of the





258 estimated acquisition cost as determined by the division plus a  
259 dispensing fee of Four Dollars and Ninety-one Cents (\$4.91) or the  
260 providers' usual and customary charge to the general public.

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

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

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

279 (10) Dental care that is an adjunct to treatment of an  
280 acute medical or surgical condition; services of oral surgeons and  
281 dentists in connection with surgery related to the jaw or any  
282 structure contiguous to the jaw or the reduction of any fracture  
283 of the jaw or any facial bone; and emergency dental extractions  
284 and treatment related thereto. On July 1, 1999, all fees for  
285 dental care and surgery under authority of this paragraph (10)  
286 shall be increased to one hundred sixty percent (160%) of the  
287 amount of the reimbursement rate that was in effect on June 30,  
288 1999. It is the intent of the Legislature to encourage more  
289 dentists to participate in the Medicaid program.



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

295           (12) Intermediate care facility services.

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

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

316           (c) The division is authorized to limit allowable  
317 management fees and home office costs to either three percent  
318 (3%), five percent (5%) or seven percent (7%) of other allowable  
319 costs, including allowable therapy costs and property costs, based  
320 on the types of management services provided, as follows:



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

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

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

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

334 (14) Clinic services. Such diagnostic, preventive,  
335 therapeutic, rehabilitative or palliative services furnished to an  
336 outpatient by or under the supervision of a physician or dentist  
337 in a facility which is not a part of a hospital but which is  
338 organized and operated to provide medical care to outpatients.  
339 Clinic services shall include any services reimbursed as  
340 outpatient hospital services which may be rendered in such a  
341 facility, including those that become so after July 1, 1991. On  
342 July 1, 1999, all fees for physicians' services reimbursed under  
343 authority of this paragraph (14) shall be reimbursed at ninety  
344 percent (90%) of the rate established on January 1, 1999, and as  
345 adjusted each January thereafter, under Medicare (Title XVIII of  
346 the Social Security Act, as amended), and which shall in no event  
347 be less than seventy percent (70%) of the rate established on  
348 January 1, 1994. All fees for physicians' services that are  
349 covered by both Medicare and Medicaid shall be reimbursed at ten  
350 percent (10%) of the adjusted Medicare payment established on  
351 January 1, 1999, and as adjusted each January thereafter, under  
352 Medicare (Title XVIII of the Social Security Act, as amended), and  
353 which shall in no event be less than seven percent (7%) of the



354 adjusted Medicare payment established on January 1, 1994. On July  
355 1, 1999, all fees for dentists' services reimbursed under  
356 authority of this paragraph (14) shall be increased to one hundred  
357 sixty percent (160%) of the amount of the reimbursement rate that  
358 was in effect on June 30, 1999.

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

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



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

410 (17) Durable medical equipment services and medical  
411 supplies. The Division of Medicaid may require durable medical  
412 equipment providers to obtain a surety bond in the amount and to  
413 the specifications as established by the Balanced Budget Act of  
414 1997.

415 (18) Notwithstanding any other provision of this  
416 section to the contrary, the division shall make additional  
417 reimbursement to hospitals which serve a disproportionate share of  
418 low-income patients and which meet the federal requirements for  
419 such payments as provided in Section 1923 of the federal Social



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

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

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



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

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

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

478           (23) Inpatient psychiatric services. Inpatient  
479 psychiatric services to be determined by the division for  
480 recipients under age twenty-one (21) which are provided under the  
481 direction of a physician in an inpatient program in a licensed  
482 acute care psychiatric facility or in a licensed psychiatric  
483 residential treatment facility, before the recipient reaches age  
484 twenty-one (21) or, if the recipient was receiving the services  
485 immediately before he reached age twenty-one (21), before the



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

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

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

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

507         (24) Managed care services in a program to be developed  
508 by the division by a public or private provider. If managed care  
509 services are provided by the division to Medicaid recipients, and  
510 those managed care services are operated, managed and controlled  
511 by and under the authority of the division, the division shall be  
512 responsible for educating the Medicaid recipients who are  
513 participants in the managed care program regarding the manner in  
514 which the participants should seek health care under the program.  
515 Notwithstanding any other provision in this article to the  
516 contrary, the division shall establish rates of reimbursement to  
517 providers rendering care and services authorized under this  
518 paragraph (24), and may revise such rates of reimbursement without





519 amendment to this section by the Legislature for the purpose of  
520 achieving effective and accessible health services, and for  
521 responsible containment of costs.

522 (25) Birthing center services.

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

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

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

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

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



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

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

563           (33) Podiatrist services.

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

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

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

581           (37) Targeted case management services for individuals  
582 with chronic diseases, with expanded eligibility to cover services  
583 to uninsured recipients, on a pilot program basis. This paragraph



584 (37) shall be contingent upon continued receipt of special funds  
585 from the Health Care Financing Authority and private foundations  
586 who have granted funds for planning these services. No funding  
587 for these services shall be provided from state general funds.

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

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

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

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

614 (42) Notwithstanding any other provision in this  
615 article to the contrary, the division is hereby authorized to  
616 develop a population health management program for women and



617 children health services through the age of two (2). This program  
618 is primarily for obstetrical care associated with low birth weight  
619 and pre-term babies. In order to effect cost savings, the  
620 division may develop a revised payment methodology which may  
621 include at-risk capitated payments.

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

627 (44) Mental health counseling services provided by a  
628 duly licensed professional counselor (LPC).

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

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



650 services is ordered by a court of proper authority. The director  
651 shall keep the Governor advised on a timely basis of the funds  
652 available for expenditure and the projected expenditures. In the  
653 event current or projected expenditures can be reasonably  
654 anticipated to exceed the amounts appropriated for any fiscal  
655 year, the Governor, after consultation with the director, shall  
656 discontinue any or all of the payment of the types of care and  
657 services as provided herein which are deemed to be optional  
658 services under Title XIX of the federal Social Security Act, as  
659 amended, for any period necessary to not exceed appropriated  
660 funds, and when necessary shall institute any other cost  
661 containment measures on any program or programs authorized under  
662 the article to the extent allowed under the federal law governing  
663 such program or programs, it being the intent of the Legislature  
664 that expenditures during any fiscal year shall not exceed the  
665 amounts appropriated for such fiscal year.

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

