

By: Senator(s) Bryan

To:

SENATE BILL NO. 2754

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE THAT PROGRAMMABLE, IMPLANTABLE PUMPS, WITH THE
3 EXCEPTION OF CERTAIN PUMPS USED TO TREAT SPASTICITY, SHALL BE
4 REIMBURSED BY THE DIVISION OF MEDICAID AS OTHER ALLOWABLE COSTS;
5 AND FOR RELATED PURPOSES.

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

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

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

16 (1) Inpatient hospital services.

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

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

28 (c) Hospitals will receive an additional payment
29 for the implantable programmable baclofen drug pump used to treat
30 spasticity which is implanted on an inpatient basis. The payment
31 pursuant to written invoice will be in addition to the facility's
32 per diem reimbursement and will represent a reduction of costs on
33 the facility's annual cost report, and shall not exceed Ten
34 Thousand Dollars (\$10,000.00) per year per recipient. * * *

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

643 Notwithstanding any provision of this article, no new groups
644 or categories of recipients and new types of care and services may
645 be added without enabling legislation from the Mississippi
646 Legislature, except that the division may authorize such changes
647 without enabling legislation when such addition of recipients or
648 services is ordered by a court of proper authority. The director
649 shall keep the Governor advised on a timely basis of the funds

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

664 SECTION 2. This act shall take effect and be in force from
665 and after June 30, 2001.