

By: Senator(s) Bryan

To: Public Health and
Welfare; Appropriations

SENATE BILL NO. 2754
(As Sent to Governor)

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO SPECIFY AND LIMIT THE TYPE OF IMPLANTABLE PROGRAMMABLE PUMP FOR
3 WHICH HOSPITALS WILL RECEIVE AN ADDITIONAL PAYMENT UNDER MEDICAID;
4 TO EXTEND THE REPEAL DATE ON THE PROVISION AUTHORIZING THAT
5 ADDITIONAL PAYMENT FROM JULY 1, 2001, TO JULY 1, 2005; AND FOR
6 RELATED PURPOSES.

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

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

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

17 (1) Inpatient hospital services.

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

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

29 (c) Hospitals will receive an additional payment
30 for the implantable programmable baclofen drug pump used to treat
31 spasticity which is implanted on an inpatient basis. The payment
32 pursuant to written invoice will be in addition to the facility's
33 per diem reimbursement and will represent a reduction of costs on
34 the facility's annual cost report, and shall not exceed Ten
35 Thousand Dollars (\$10,000.00) per year per recipient. This
36 paragraph (c) shall stand repealed on July 1, 2005.

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

49 (3) Laboratory and x-ray services.

50 (4) Nursing facility services.

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

62 leave. Such authorization must be filed with the division before
63 it will be effective and the authorization shall be effective for
64 three (3) months from the date it is received by the division,
65 unless it is revoked earlier by the physician because of a change
66 in the condition of the patient.

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

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

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

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

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

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

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

126 of additional cost. The division shall also develop and implement
127 as part of the fair rental reimbursement system for nursing
128 facility beds, an Alzheimer's resident bed depreciation enhanced
129 reimbursement system which will provide an incentive to encourage
130 nursing facilities to convert or construct beds for residents with
131 Alzheimer's or other related dementia.

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

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

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

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

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

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

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

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

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

188 (5) Periodic screening and diagnostic services for
189 individuals under age twenty-one (21) years as are needed to
190 identify physical and mental defects and to provide health care

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

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

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

224 at ten percent (10%) of the adjusted Medicare payment established
225 on January 1, 1999, and as adjusted each January thereafter, under
226 Medicare (Title XVIII of the Social Security Act, as amended), and
227 which shall in no event be less than seven percent (7%) of the
228 adjusted Medicare payment established on January 1, 1994.

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

232 (b) Repealed.

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

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

256 prescriptions per month shall be allowed, with the approval of the
257 director.

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

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

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

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

281 (10) Dental care that is an adjunct to treatment of an
282 acute medical or surgical condition; services of oral surgeons and
283 dentists in connection with surgery related to the jaw or any
284 structure contiguous to the jaw or the reduction of any fracture
285 of the jaw or any facial bone; and emergency dental extractions
286 and treatment related thereto. On July 1, 1999, all fees for
287 dental care and surgery under authority of this paragraph (10)
288 shall be increased to one hundred sixty percent (160%) of the

289 amount of the reimbursement rate that was in effect on June 30,
290 1999. It is the intent of the Legislature to encourage more
291 dentists to participate in the Medicaid program.

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

297 (12) Intermediate care facility services.

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

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

318 (c) The division is authorized to limit allowable
319 management fees and home office costs to either three percent
320 (3%), five percent (5%) or seven percent (7%) of other allowable

321 costs, including allowable therapy costs and property costs, based
322 on the types of management services provided, as follows:

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

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

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

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

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

354 Medicare (Title XVIII of the Social Security Act, as amended), and
355 which shall in no event be less than seven percent (7%) of the
356 adjusted Medicare payment established on January 1, 1994. On July
357 1, 1999, all fees for dentists' services reimbursed under
358 authority of this paragraph (14) shall be increased to one hundred
359 sixty percent (160%) of the amount of the reimbursement rate that
360 was in effect on June 30, 1999.

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

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

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

412 (17) Durable medical equipment services and medical
413 supplies. The Division of Medicaid may require durable medical
414 equipment providers to obtain a surety bond in the amount and to
415 the specifications as established by the Balanced Budget Act of
416 1997.

417 (18) Notwithstanding any other provision of this
418 section to the contrary, the division shall make additional
419 reimbursement to hospitals which serve a disproportionate share of

420 low-income patients and which meet the federal requirements for
421 such payments as provided in Section 1923 of the federal Social
422 Security Act and any applicable regulations. However, from and
423 after January 1, 2000, no public hospital shall participate in the
424 Medicaid disproportionate share program unless the public hospital
425 participates in an intergovernmental transfer program as provided
426 in Section 1903 of the federal Social Security Act and any
427 applicable regulations. Administration and support for
428 participating hospitals shall be provided by the Mississippi
429 Hospital Association.

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

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

452 Qualifications for persons providing service coordination shall be

453 determined by the State Department of Health and the Division of
454 Medicaid.

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

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

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

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

486 twenty-one (21) or, if the recipient was receiving the services
487 immediately before he reached age twenty-one (21), before the
488 earlier of the date he no longer requires the services or the date
489 he reaches age twenty-two (22), as provided by federal
490 regulations. Recipients shall be allowed forty-five (45) days per
491 year of psychiatric services provided in acute care psychiatric
492 facilities, and shall be allowed unlimited days of psychiatric
493 services provided in licensed psychiatric residential treatment
494 facilities. The division is authorized to limit allowable
495 management fees and home office costs to either three percent
496 (3%), five percent (5%) or seven percent (7%) of other allowable
497 costs, including allowable therapy costs and property costs, based
498 on the types of management services provided, as follows:

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

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

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

509 (24) Managed care services in a program to be developed
510 by the division by a public or private provider. If managed care
511 services are provided by the division to Medicaid recipients, and
512 those managed care services are operated, managed and controlled
513 by and under the authority of the division, the division shall be
514 responsible for educating the Medicaid recipients who are
515 participants in the managed care program regarding the manner in
516 which the participants should seek health care under the program.
517 Notwithstanding any other provision in this article to the
518 contrary, the division shall establish rates of reimbursement to

519 providers rendering care and services authorized under this
520 paragraph (24), and may revise such rates of reimbursement without
521 amendment to this section by the Legislature for the purpose of
522 achieving effective and accessible health services, and for
523 responsible containment of costs.

524 (25) Birthing center services.

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

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

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

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

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

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

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

565 (33) Podiatrist services.

566 (34) The division shall make application to the United
567 States Health Care Financing Administration for a waiver to
568 develop a program of services to personal care and assisted living
569 homes in Mississippi. This waiver shall be completed by December
570 1, 1999.

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

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

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

590 (38) Chiropractic services: a chiropractor's manual
591 manipulation of the spine to correct a subluxation, if x-ray
592 demonstrates that a subluxation exists and if the subluxation has
593 resulted in a neuromusculoskeletal condition for which
594 manipulation is appropriate treatment. Reimbursement for
595 chiropractic services shall not exceed Seven Hundred Dollars
596 (\$700.00) per year per recipient.

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

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

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

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

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

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 June 30, 2001.