By: Senator(s) Jordan, Simmons, Frazier, Jackson, Harden, Williamson

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2999

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO AUTHORIZE THE DIVISION OF MEDICAID TO REQUEST APPLICABLE
3 WAIVERS FOR EXPANDED COVERAGE OF THE CHRONICALLY ILL; TO TARGET
4 THE WAIVERED PROGRAM AT PERSONS WITH POORLY CONTROLLED
5 HYPERTENSION AND DIABETES; 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 pump implanted in an inpatient
30 basis. The payment pursuant to written invoice will be in
31 addition to the facility's per diem reimbursement and will
32 represent a reduction of costs on the facility's annual cost
33 report, and shall not exceed Ten Thousand Dollars ($10,000.00) per
34 year per recipient. This paragraph (c) shall stand repealed on
35 July 1, 2001.
36 (2) Outpatient hospital services. Provided that where
37 the same services are reimbursed as clinic services, the division
38 may revise the rate or methodology of outpatient reimbursement to
39 maintain consistency, efficiency, economy and quality of care.
40 The division shall develop a Medicaid-specific cost-to-charge
41 ratio calculation from data provided by hospitals to determine an
42 allowable rate payment for outpatient hospital services, and shall
43 submit a report thereon to the Medical Advisory Committee on or
44 before December 1, 1999. The committee shall make a
45 recommendation on the specific cost-to-charge reimbursement method
46 for outpatient hospital services to the 2000 Regular Session of
47 the Legislature.
48 (3) Laboratory and x-ray services.
49 (4) Nursing facility services.
50 (a) The division shall make full payment to
51 nursing facilities for each day, not exceeding fifty-two (52) days
52 per year, that a patient is absent from the facility on home
53 leave. Payment may be made for the following home leave days in
54 addition to the fifty-two-day limitation: Christmas, the day
55 before Christmas, the day after Christmas, Thanksgiving, the day
56 before Thanksgiving and the day after Thanksgiving. However,
57 before payment may be made for more than eighteen (18) home leave
58 days in a year for a patient, the patient must have written
59 authorization from a physician stating that the patient is
60 physically and mentally able to be away from the facility on home

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

190 treatment and other measures designed to correct or ameliorate
191 defects and physical and mental illness and conditions discovered
192 by the screening services regardless of whether these services are
193 included in the state plan. The division may include in its
194 periodic screening and diagnostic program those discretionary
195 services authorized under the federal regulations adopted to
196 implement Title XIX of the federal Social Security Act, as
197 amended. The division, in obtaining physical therapy services,
198 occupational therapy services, and services for individuals with
199 speech, hearing and language disorders, may enter into a
200 cooperative agreement with the State Department of Education for
201 the provision of such services to handicapped students by public
202 school districts using state funds which are provided from the
203 appropriation to the Department of Education to obtain federal
204 matching funds through the division. The division, in obtaining
205 medical and psychological evaluations for children in the custody
206 of the State Department of Human Services may enter into a
207 cooperative agreement with the State Department of Human Services
208 for the provision of such services using state funds which are
209 provided from the appropriation to the Department of Human
210 Services to obtain federal matching funds through the division.
211 On July 1, 1993, all fees for periodic screening and
212 diagnostic services under this paragraph (5) shall be increased by
213 twenty-five percent (25%) of the reimbursement rate in effect on
214 June 30, 1993.
215 (6) Physician's services. All fees for physicians'
216 services that are covered only by Medicaid shall be reimbursed at
217 ninety percent (90%) of the rate established on January 1, 1999,
218 and as adjusted each January thereafter, under Medicare (Title
219 XVIII of the Social Security Act, as amended), and which shall in
220 no event be less than seventy percent (70%) of the rate
221 established on January 1, 1994. All fees for physicians' services
222 that are covered by both Medicare and Medicaid shall be reimbursed

223 at ten percent (10%) of the adjusted Medicare payment established
224 on January 1, 1999, and as adjusted each January thereafter, under
225 Medicare (Title XVIII of the Social Security Act, as amended), and
226 which shall in no event be less than seven percent (7%) of the
227 adjusted Medicare payment established on January 1, 1994.
228 (7) (a) Home health services for eligible persons, not
229 to exceed in cost the prevailing cost of nursing facility
230 services, not to exceed sixty (60) visits per year.
231 (b) Repealed.
232 (8) Emergency medical transportation services. On
233 January 1, 1994, emergency medical transportation services shall
234 be reimbursed at seventy percent (70%) of the rate established
235 under Medicare (Title XVIII of the Social Security Act, as
236 amended). "Emergency medical transportation services" shall mean,
237 but shall not be limited to, the following services by a properly
238 permitted ambulance operated by a properly licensed provider in
239 accordance with the Emergency Medical Services Act of 1974
240 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
241 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
242 (vi) disposable supplies, (vii) similar services.
243 (9) Legend and other drugs as may be determined by the
244 division. The division may implement a program of prior approval
245 for drugs to the extent permitted by law. Payment by the division
246 for covered multiple source drugs shall be limited to the lower of
247 the upper limits established and published by the Health Care
248 Financing Administration (HCFA) plus a dispensing fee of Four
249 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
250 cost (EAC) as determined by the division plus a dispensing fee of
251 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual
252 and customary charge to the general public. The division shall
253 allow five (5) prescriptions per month for noninstitutionalized
254 Medicaid recipients; however, exceptions for up to ten (10)

255 prescriptions per month shall be allowed, with the approval of the
256 director.
257 Payment for other covered drugs, other than multiple source
258 drugs with HCFA upper limits, shall not exceed the lower of the
259 estimated acquisition cost as determined by the division plus a
260 dispensing fee of Four Dollars and Ninety-one Cents ($4.91) or the
261 providers' usual and customary charge to the general public.
262 Payment for nonlegend or over-the-counter drugs covered on
263 the division's formulary shall be reimbursed at the lower of the
264 division's estimated shelf price or the providers' usual and
265 customary charge to the general public. No dispensing fee shall
266 be paid.
267 The division shall develop and implement a program of payment
268 for additional pharmacist services, with payment to be based on
269 demonstrated savings, but in no case shall the total payment
270 exceed twice the amount of the dispensing fee.
271 As used in this paragraph (9), "estimated acquisition cost"
272 means the division's best estimate of what price providers
273 generally are paying for a drug in the package size that providers
274 buy most frequently. Product selection shall be made in
275 compliance with existing state law; however, the division may
276 reimburse as if the prescription had been filled under the generic
277 name. The division may provide otherwise in the case of specified
278 drugs when the consensus of competent medical advice is that
279 trademarked drugs are substantially more effective.
280 (10) Dental care that is an adjunct to treatment of an
281 acute medical or surgical condition; services of oral surgeons and
282 dentists in connection with surgery related to the jaw or any
283 structure contiguous to the jaw or the reduction of any fracture
284 of the jaw or any facial bone; and emergency dental extractions
285 and treatment related thereto. On July 1, 1999, all fees for
286 dental care and surgery under authority of this paragraph (10)
287 shall be increased to one hundred sixty percent (160%) of the

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

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

296 (12) Intermediate care facility services.

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

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

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

320 costs, including allowable therapy costs and property costs, based
321 on the types of management services provided, as follows:
322 A maximum of up to three percent (3%) shall be allowed where
323 centralized managerial and administrative services are provided by
324 the management company or home office.
325 A maximum of up to five percent (5%) shall be allowed where
326 centralized managerial and administrative services and limited
327 professional and consultant services are provided.
328 A maximum of up to seven percent (7%) shall be allowed where
329 a full spectrum of centralized managerial services, administrative
330 services, professional services and consultant services are
331 provided.
332 (13) Family planning services, including drugs,
333 supplies and devices, when such services are under the supervision
334 of a physician.
335 (14) Clinic services. Such diagnostic, preventive,
336 therapeutic, rehabilitative or palliative services furnished to an
337 outpatient by or under the supervision of a physician or dentist
338 in a facility which is not a part of a hospital but which is
339 organized and operated to provide medical care to outpatients.
340 Clinic services shall include any services reimbursed as
341 outpatient hospital services which may be rendered in such a
342 facility, including those that become so after July 1, 1991. On
343 July 1, 1999, all fees for physicians' services reimbursed under
344 authority of this paragraph (14) shall be reimbursed at ninety
345 percent (90%) of the rate established on January 1, 1999, and as
346 adjusted each January thereafter, under Medicare (Title XVIII of
347 the Social Security Act, as amended), and which shall in no event
348 be less than seventy percent (70%) of the rate established on
349 January 1, 1994. All fees for physicians' services that are
350 covered by both Medicare and Medicaid shall be reimbursed at ten
351 percent (10%) of the adjusted Medicare payment established on
352 January 1, 1999, and as adjusted each January thereafter, under

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

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

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

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

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

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

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

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

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

452 determined by the State Department of Health and the Division of
453 Medicaid.
454 (20) Home- and community-based services for physically
455 disabled approved services as allowed by a waiver from the United
456 States Department of Health and Human Services for home- and
457 community-based services for physically disabled people using
458 state funds which are provided from the appropriation to the State
459 Department of Rehabilitation Services and used to match federal
460 funds under a cooperative agreement between the division and the
461 department, provided that funds for these services are
462 specifically appropriated to the Department of Rehabilitation
463 Services.
464 (21) Nurse practitioner services. Services furnished
465 by a registered nurse who is licensed and certified by the
466 Mississippi Board of Nursing as a nurse practitioner including,
467 but not limited to, nurse anesthetists, nurse midwives, family
468 nurse practitioners, family planning nurse practitioners,
469 pediatric nurse practitioners, obstetrics-gynecology nurse
470 practitioners and neonatal nurse practitioners, under regulations
471 adopted by the division. Reimbursement for such services shall
472 not exceed ninety percent (90%) of the reimbursement rate for
473 comparable services rendered by a physician.
474 (22) Ambulatory services delivered in federally
475 qualified health centers and in clinics of the local health
476 departments of the State Department of Health for individuals
477 eligible for medical assistance under this article based on
478 reasonable costs as determined by the division.
479 (23) Inpatient psychiatric services. Inpatient
480 psychiatric services to be determined by the division for
481 recipients under age twenty-one (21) which are provided under the
482 direction of a physician in an inpatient program in a licensed
483 acute care psychiatric facility or in a licensed psychiatric
484 residential treatment facility, before the recipient reaches age

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

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

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

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

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

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

523 (25) Birthing center services.

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

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

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

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

550 (30) Pediatric skilled nursing services for eligible
551 persons under twenty-one (21) years of age.
552 (31) Targeted case management services for children
553 with special needs, under waivers from the United States
554 Department of Health and Human Services, using state funds that
555 are provided from the appropriation to the Mississippi Department
556 of Human Services and used to match federal funds under a
557 cooperative agreement between the division and the department.
558 (32) Care and services provided in Christian Science
559 Sanatoria operated by or listed and certified by The First Church
560 of Christ Scientist, Boston, Massachusetts, rendered in connection
561 with treatment by prayer or spiritual means to the extent that
562 such services are subject to reimbursement under Section 1903 of
563 the Social Security Act.
564 (33) Podiatrist services.
565 (34) The division shall make application to the United
566 States Health Care Financing Administration for a waiver to
567 develop a program of services to personal care and assisted living
568 homes in Mississippi. This waiver shall be completed by December
569 1, 1999.
570 (35) Services and activities authorized in Sections
571 43-27-101 and 43-27-103, using state funds that are provided from
572 the appropriation to the State Department of Human Services and
573 used to match federal funds under a cooperative agreement between
574 the division and the department.
575 (36) Nonemergency transportation services for
576 Medicaid-eligible persons, to be provided by the Division of
577 Medicaid. The division may contract with additional entities to
578 administer nonemergency transportation services as it deems
579 necessary. All providers shall have a valid driver's license,
580 vehicle inspection sticker, valid vehicle license tags and a
581 standard liability insurance policy covering the vehicle.

582 (37) Targeted case management services for individuals
583 with chronic diseases, with expanded eligibility to cover services
584 to uninsured recipients, on a pilot program basis. This paragraph
585 (37) shall be contingent upon continued receipt of special funds
586 from the Health Care Financing Authority and private foundations
587 who have granted funds for planning these services. No funding
588 for these services shall be provided from state general funds.
589 (38) Chiropractic services: a chiropractor's manual
590 manipulation of the spine to correct a subluxation, if x-ray
591 demonstrates that a subluxation exists and if the subluxation has
592 resulted in a neuromusculoskeletal condition for which
593 manipulation is appropriate treatment. Reimbursement for
594 chiropractic services shall not exceed Seven Hundred Dollars
595 ($700.00) per year per recipient.
596 (39) Dually eligible Medicare/Medicaid beneficiaries.
597 The division shall pay the Medicare deductible and ten percent
598 (10%) coinsurance amounts for services available under Medicare
599 for the duration and scope of services otherwise available under
600 the Medicaid program.
601 (40) The division shall prepare an application for a
602 waiver to provide prescription drug benefits to as many
603 Mississippians as permitted under Title XIX of the Social Security
604 Act.
605 (41) Services provided by the State Department of
606 Rehabilitation Services for the care and rehabilitation of persons
607 with spinal cord injuries or traumatic brain injuries, as allowed
608 under waivers from the United States Department of Health and
609 Human Services, using up to seventy-five percent (75%) of the
610 funds that are appropriated to the Department of Rehabilitation
611 Services from the Spinal Cord and Head Injury Trust Fund
612 established under Section 37-33-261 and used to match federal
613 funds under a cooperative agreement between the division and the
614 department.

615 (42) Notwithstanding any other provision in this
616 article to the contrary, the division is hereby authorized to
617 develop a population health management program for women and
618 children health services through the age of two (2). This program
619 is primarily for obstetrical care associated with low birth weight
620 and pre-term babies. In order to effect cost savings, the
621 division may develop a revised payment methodology which may
622 include at-risk capitated payments.
623 (43) The division shall provide reimbursement,
624 according to a payment schedule developed by the division, for
625 smoking cessation medications for pregnant women during their
626 pregnancy and other Medicaid-eligible women who are of
627 child-bearing age.
628 (44) The Division of Medicaid may apply for a waiver from
629 the Department of Health and Human Services for chronically ill
630 people, which shall be targeted at persons with poorly controlled
631 hypertension and diabetes. The waivered program shall provide
632 reimbursement for insulin (Humulin) for patients who are
633 adult-onset diabetics and shall include reimbursement for newer
634 medicines for blood pressure which have protective effects on
635 kidney function in diabetics.
636 Notwithstanding any provision of this article, except as
637 authorized in the following paragraph and in Section 43-13-139,
638 neither (a) the limitations on quantity or frequency of use of or
639 the fees or charges for any of the care or services available to
640 recipients under this section, nor (b) the payments or rates of
641 reimbursement to providers rendering care or services authorized
642 under this section to recipients, may be increased, decreased or
643 otherwise changed from the levels in effect on July 1, 1999,
644 unless such is authorized by an amendment to this section by the
645 Legislature. However, the restriction in this paragraph shall not
646 prevent the division from changing the payments or rates of
647 reimbursement to providers without an amendment to this section

648 whenever such changes are required by federal law or regulation,
649 or whenever such changes are necessary to correct administrative
650 errors or omissions in calculating such payments or rates of
651 reimbursement.

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

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

ST: Medicaid waiver for coverage of the chronically ill with hypertension and diabetes; authorize.