

By: Senator(s) Huggins, Simmons

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2914

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO AUTHORIZE MEDICAID REIMBURSEMENT FOR NURSING FACILITY SERVICES
3 FOR THE SEVERELY DISABLED; AND FOR RELATED PURPOSES.

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

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

7 43-13-117. Medical assistance as authorized by this article
8 shall include payment of part or all of the costs, at the
9 discretion of the division or its successor, with approval of the
10 Governor, of the following types of care and services rendered to
11 eligible applicants who shall have been determined to be eligible
12 for such care and services, within the limits of state
13 appropriations and federal matching funds:

14 (1) Inpatient hospital services.

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

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

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

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 This paragraph (c) shall stand repealed on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

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

46 (3) Laboratory and x-ray services.

47 (4) Nursing facility services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

229 (b) Repealed.

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

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

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

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

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

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

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

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

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

294 (12) Intermediate care facility services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

521 (25) Birthing center services.

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

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

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

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

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

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

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

562 (33) Podiatrist services.

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

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

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

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

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

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

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

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

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

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

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

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

626 (44) Nursing facility services for the severely
627 disabled. Severe disabilities include, but are not limited to,
628 spinal cord injuries, closed head injuries and ventilator
629 dependent patients. These services must be provided in a
630 long-term care nursing facility dedicated to the care and
631 treatment of persons with severe disabilities and shall be
632 reimbursed as a separate category of nursing facilities.

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

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

670 SECTION 2. This act shall take effect and be in force from
671 and after its passage.