MISSISSIPPI LEGISLATURE REGULAR SESSION 1999

By: Representative Scott (80th)

To: Public Health and Welfare; Appropriations

HOUSE BILL NO. 183

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO DIRECT THE DIVISION OF MEDICAID TO CONDUCT A STUDY OF MEDICAID
3 PROVIDERS TO DETERMINE THE EFFECT OF REIMBURSEMENT LEVELS ON
4 PROVIDER PARTICIPATION OR NONPARTICIPATION IN THE CAPITATED
5 MANAGED CARE PILOT PROGRAM; 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;
19 however, before any recipient will be allowed more than fifteen
20 (15) days of inpatient hospital care in any one (1) year, he must
21 obtain prior approval therefor from the division. The division
22 shall be authorized to allow unlimited days in disproportionate
23 hospitals as defined by the division for eligible infants under
24 the age of six (6) years.

25 (b) From and after July 1, 1994, the Executive Director
26 of the Division of Medicaid shall amend the Mississippi Title XIX
27 Inpatient Hospital Reimbursement Plan to remove the occupancy rate
28 penalty from the calculation of the Medicaid Capital Cost

29 Component utilized to determine total hospital costs allocated to
30 the Medicaid Program.
31 (2) Outpatient hospital services. Provided that where the
32 same services are reimbursed as clinic services, the division may
33 revise the rate or methodology of outpatient reimbursement to
34 maintain consistency, efficiency, economy and quality of care.
35 (3) Laboratory and X-ray services.
36 (4) Nursing facility services.
37 (a) The division shall make full payment to nursing
38 facilities for each day, not exceeding thirty-six (36) days per
39 year, that a patient is absent from the facility on home leave.
40 However, before payment may be made for more than eighteen (18)
41 home leave days in a year for a patient, the patient must have
42 written authorization from a physician stating that the patient is
43 physically and mentally able to be away from the facility on home
44 leave. Such authorization must be filed with the division before
45 it will be effective and the authorization shall be effective for
46 three (3) months from the date it is received by the division,
47 unless it is revoked earlier by the physician because of a change
48 in the condition of the patient.
49 (b) Repealed.
50 (c) From and after July 1, 1997, all state-owned
51 nursing facilities shall be reimbursed on a full reasonable costs
52 basis. From and after July 1, 1997, payments by the division to
53 nursing facilities for return on equity capital shall be made at
54 the rate paid under Medicare (Title XVIII of the Social Security
55 Act), but shall be no less than seven and one-half percent (7.5%)
56 nor greater than ten percent (10%).
57 (d) A Review Board for nursing facilities is
58 established to conduct reviews of the Division of Medicaid's
59 decision in the areas set forth below:
60 (i) Review shall be heard in the following areas:
61 (A) Matters relating to cost reports
62 including, but not limited to, allowable costs and cost
63 adjustments resulting from desk reviews and audits.
64 (B) Matters relating to the Minimum Data Set
65 Plus (MDS +) or successor assessment formats including but not
66 limited to audits, classifications and submissions.

67 (ii) The Review Board shall be composed of six (6)
68 members, three (3) having expertise in one (1) of the two (2)
69 areas set forth above and three (3) having expertise in the other
70 area set forth above. Each panel of three (3) shall only review
71 appeals arising in its area of expertise. The members shall be
72 appointed as follows:

73 (A) In each of the areas of expertise defined
74 under subparagraphs (i)(A) and (i)(B), the Executive Director of
75 the Division of Medicaid shall appoint one (1) person chosen from
76 the private sector nursing home industry in the state, which may
77 include independent accountants and consultants serving the
78 industry;

79 (B) In each of the areas of expertise defined
80 under subparagraphs (i)(A) and (i)(B), the Executive Director of
81 the Division of Medicaid shall appoint one (1) person who is
82 employed by the state who does not participate directly in desk
83 reviews or audits of nursing facilities in the two (2) areas of
84 review;

85 (C) The two (2) members appointed by the
86 Executive Director of the Division of Medicaid in each area of
87 expertise shall appoint a third member in the same area of
88 expertise.

89 In the event of a conflict of interest on the part of any
90 Review Board members, the Executive Director of the Division of
91 Medicaid or the other two (2) panel members, as applicable, shall
92 appoint a substitute member for conducting a specific review.

93 (iii) The Review Board panels shall have the power
94 to preserve and enforce order during hearings; to issue subpoenas;
95 to administer oaths; to compel attendance and testimony of
96 witnesses; or to compel the production of books, papers, documents
97 and other evidence; or the taking of depositions before any
98 designated individual competent to administer oaths; to examine
99 witnesses; and to do all things conformable to law that may be
100 necessary to enable it effectively to discharge its duties. The

101 Review Board panels may appoint such person or persons as they
102 shall deem proper to execute and return process in connection
103 therewith.
104 (iv) The Review Board shall promulgate, publish
105 and disseminate to nursing facility providers rules of procedure
106 for the efficient conduct of proceedings, subject to the approval
107 of the Executive Director of the Division of Medicaid and in
108 accordance with federal and state administrative hearing laws and
109 regulations.
110 (v) Proceedings of the Review Board shall be of
111 record.
112 (vi) Appeals to the Review Board shall be in
113 writing and shall set out the issues, a statement of alleged facts
114 and reasons supporting the provider's position. Relevant
115 documents may also be attached. The appeal shall be filed within
116 thirty (30) days from the date the provider is notified of the
117 action being appealed or, if informal review procedures are taken,
118 as provided by administrative regulations of the Division of
119 Medicaid, within thirty (30) days after a decision has been
120 rendered through informal hearing procedures.
121 (vii) The provider shall be notified of the
122 hearing date by certified mail within thirty (30) days from the
123 date the Division of Medicaid receives the request for appeal.
124 Notification of the hearing date shall in no event be less than
125 thirty (30) days before the scheduled hearing date. The appeal
126 may be heard on shorter notice by written agreement between the
127 provider and the Division of Medicaid.
128 (viii) Within thirty (30) days from the date of
129 the hearing, the Review Board panel shall render a written
130 recommendation to the Executive Director of the Division of
131 Medicaid setting forth the issues, findings of fact and applicable
132 law, regulations or provisions.
133 (ix) The Executive Director of the Division of
134 Medicaid shall, upon review of the recommendation, the proceedings

135 and the record, prepare a written decision which shall be mailed
136 to the nursing facility provider no later than twenty (20) days
137 after the submission of the recommendation by the panel. The
138 decision of the executive director is final, subject only to
139 judicial review.
140 (x) Appeals from a final decision shall be made to
141 the Chancery Court of Hinds County. The appeal shall be filed
142 with the court within thirty (30) days from the date the decision
143 of the Executive Director of the Division of Medicaid becomes
144 final.
145 (xi) The action of the Division of Medicaid under
146 review shall be stayed until all administrative proceedings have
147 been exhausted.
148 (xii) Appeals by nursing facility providers
149 involving any issues other than those two (2) specified in
150 subparagraphs (i)(A) and (ii)(B) shall be taken in accordance with
151 the administrative hearing procedures established by the Division
152 of Medicaid.
153 (e) When a facility of a category that does not require
154 a certificate of need for construction and that could not be
155 eligible for Medicaid reimbursement is constructed to nursing
156 facility specifications for licensure and certification, and the
157 facility is subsequently converted to a nursing facility pursuant
158 to a certificate of need that authorizes conversion only and the
159 applicant for the certificate of need was assessed an application
160 review fee based on capital expenditures incurred in constructing
161 the facility, the division shall allow reimbursement for capital
162 expenditures necessary for construction of the facility that were
163 incurred within the twenty-four (24) consecutive calendar months
164 immediately preceding the date that the certificate of need
165 authorizing such conversion was issued, to the same extent that
166 reimbursement would be allowed for construction of a new nursing
167 facility pursuant to a certificate of need that authorizes such
168 construction. The reimbursement authorized in this subparagraph

169 (e) may be made only to facilities the construction of which was
170 completed after June 30, 1989. Before the division shall be
171 authorized to make the reimbursement authorized in this
172 subparagraph (e), the division first must have received approval
173 from the Health Care Financing Administration of the United States
174 Department of Health and Human Services of the change in the state
175 Medicaid plan providing for such reimbursement.
176 (5) Periodic screening and diagnostic services for
177 individuals under age twenty-one (21) years as are needed to
178 identify physical and mental defects and to provide health care
179 treatment and other measures designed to correct or ameliorate
180 defects and physical and mental illness and conditions discovered
181 by the screening services regardless of whether these services are
182 included in the state plan. The division may include in its
183 periodic screening and diagnostic program those discretionary
184 services authorized under the federal regulations adopted to
185 implement Title XIX of the federal Social Security Act, as
186 amended. The division, in obtaining physical therapy services,
187 occupational therapy services, and services for individuals with
188 speech, hearing and language disorders, may enter into a
189 cooperative agreement with the State Department of Education for
190 the provision of such services to handicapped students by public
191 school districts using state funds which are provided from the
192 appropriation to the Department of Education to obtain federal
193 matching funds through the division. The division, in obtaining
194 medical and psychological evaluations for children in the custody
195 of the State Department of Human Services may enter into a
196 cooperative agreement with the State Department of Human Services
197 for the provision of such services using state funds which are
198 provided from the appropriation to the Department of Human
199 Services to obtain federal matching funds through the division.
200 On July 1, 1993, all fees for periodic screening and
201 diagnostic services under this paragraph (5) shall be increased by
202 twenty-five percent (25%) of the reimbursement rate in effect on

203 June 30, 1993.

204 (6) Physician's services. On January 1, 1996, all fees for
205 physicians' services shall be reimbursed at seventy percent (70%)
206 of the rate established on January 1, 1994, under Medicare (Title
207 XVIII of the Social Security Act), as amended, and the division
208 may adjust the physicians' reimbursement schedule to reflect the
209 differences in relative value between Medicaid and Medicare.

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

213 (b) Repealed.

214 (8) Emergency medical transportation services. On January
215 1, 1994, emergency medical transportation services shall be
216 reimbursed at seventy percent (70%) of the rate established under
217 Medicare (Title XVIII of the Social Security Act), as amended.
218 "Emergency medical transportation services" shall mean, but shall
219 not be limited to, the following services by a properly permitted
220 ambulance operated by a properly licensed provider in accordance
221 with the Emergency Medical Services Act of 1974 (Section 41-59-1
222 et seq.): (i) basic life support, (ii) advanced life support,
223 (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi)
224 disposable supplies, (vii) similar services.

225 (9) Legend and other drugs as may be determined by the
226 division. The division may implement a program of prior approval
227 for drugs to the extent permitted by law. Payment by the division
228 for covered multiple source drugs shall be limited to the lower of
229 the upper limits established and published by the Health Care
230 Financing Administration (HCFA) plus a dispensing fee of Four
231 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
232 cost (EAC) as determined by the division plus a dispensing fee of
233 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual
234 and customary charge to the general public. The division shall
235 allow five (5) prescriptions per month for noninstitutionalized
236 Medicaid recipients.

237 Payment for other covered drugs, other than multiple source
238 drugs with HCFA upper limits, shall not exceed the lower of the
239 estimated acquisition cost as determined by the division plus a
240 dispensing fee of Four Dollars and Ninety-one Cents ($4.91) or the
241 providers' usual and customary charge to the general public.
242 Payment for nonlegend or over-the-counter drugs covered on
243 the division's formulary shall be reimbursed at the lower of the
244 division's estimated shelf price or the providers' usual and
245 customary charge to the general public. No dispensing fee shall
246 be paid.
247 The division shall develop and implement a program of payment
248 for additional pharmacist services, with payment to be based on
249 demonstrated savings, but in no case shall the total payment
250 exceed twice the amount of the dispensing fee.
251 As used in this paragraph (9), "estimated acquisition cost"
252 means the division's best estimate of what price providers
253 generally are paying for a drug in the package size that providers
254 buy most frequently. Product selection shall be made in
255 compliance with existing state law; however, the division may
256 reimburse as if the prescription had been filled under the generic
257 name. The division may provide otherwise in the case of specified
258 drugs when the consensus of competent medical advice is that
259 trademarked drugs are substantially more effective.
260 (10) Dental care that is an adjunct to treatment of an acute
261 medical or surgical condition; services of oral surgeons and
262 dentists in connection with surgery related to the jaw or any
263 structure contiguous to the jaw or the reduction of any fracture
264 of the jaw or any facial bone; and emergency dental extractions
265 and treatment related thereto. On January 1, 1994, all fees for
266 dental care and surgery under authority of this paragraph (10)
267 shall be increased by twenty percent (20%) of the reimbursement
268 rate as provided in the Dental Services Provider Manual in effect
269 on December 31, 1993.
270 (11) Eyeglasses necessitated by reason of eye surgery, and

271 as prescribed by a physician skilled in diseases of the eye or an
272 optometrist, whichever the patient may select.
273 (12) Intermediate care facility services.
274 (a) The division shall make full payment to all
275 intermediate care facilities for the mentally retarded for each
276 day, not exceeding thirty-six (36) days per year, that a patient
277 is absent from the facility on home leave. However, before
278 payment may be made for more than eighteen (18) home leave days in
279 a year for a patient, the patient must have written authorization
280 from a physician stating that the patient is physically and
281 mentally able to be away from the facility on home leave. Such
282 authorization must be filed with the division before it will be
283 effective, and the authorization shall be effective for three (3)
284 months from the date it is received by the division, unless it is
285 revoked earlier by the physician because of a change in the
286 condition of the patient.
287 (b) All state-owned intermediate care facilities for
288 the mentally retarded shall be reimbursed on a full reasonable
289 cost basis.
290 (13) Family planning services, including drugs, supplies and
291 devices, when such services are under the supervision of a
292 physician.
293 (14) Clinic services. Such diagnostic, preventive,
294 therapeutic, rehabilitative or palliative services furnished to an
295 outpatient by or under the supervision of a physician or dentist
296 in a facility which is not a part of a hospital but which is
297 organized and operated to provide medical care to outpatients.
298 Clinic services shall include any services reimbursed as
299 outpatient hospital services which may be rendered in such a
300 facility, including those that become so after July 1, 1991. On
301 January 1, 1994, all fees for physicians' services reimbursed
302 under authority of this paragraph (14) shall be reimbursed at
303 seventy percent (70%) of the rate established on January 1, 1993,
304 under Medicare (Title XVIII of the Social Security Act), as

305 amended, or the amount that would have been paid under the
306 division's fee schedule that was in effect on December 31, 1993,
307 whichever is greater, and the division may adjust the physicians'
308 reimbursement schedule to reflect the differences in relative
309 value between Medicaid and Medicare. However, on January 1, 1994,
310 the division may increase any fee for physicians' services in the
311 division's fee schedule on December 31, 1993, that was greater
312 than seventy percent (70%) of the rate established under Medicare
313 by no more than ten percent (10%). On January 1, 1994, all fees
314 for dentists' services reimbursed under authority of this
315 paragraph (14) shall be increased by twenty percent (20%) of the
316 reimbursement rate as provided in the Dental Services Provider
317 Manual in effect on December 31, 1993.
318 (15) Home- and community-based services, as provided under
319 Title XIX of the federal Social Security Act, as amended, under
320 waivers, subject to the availability of funds specifically
321 appropriated therefor by the Legislature. Payment for such
322 services shall be limited to individuals who would be eligible for
323 and would otherwise require the level of care provided in a
324 nursing facility. The division shall certify case management
325 agencies to provide case management services and provide for home-
326 and community-based services for eligible individuals under this
327 paragraph. The home- and community-based services under this
328 paragraph and the activities performed by certified case
329 management agencies under this paragraph shall be funded using
330 state funds that are provided from the appropriation to the
331 Division of Medicaid and used to match federal funds under a
332 cooperative agreement between the division and the Department of
333 Human Services.
334 (16) Mental health services. Approved therapeutic and case
335 management services provided by (a) an approved regional mental
336 health/retardation center established under Sections 41-19-31
337 through 41-19-39, or by another community mental health service
338 provider meeting the requirements of the Department of Mental

339 Health to be an approved mental health/retardation center if
340 determined necessary by the Department of Mental Health, using
341 state funds which are provided from the appropriation to the State
342 Department of Mental Health and used to match federal funds under
343 a cooperative agreement between the division and the department,
344 or (b) a facility which is certified by the State Department of
345 Mental Health to provide therapeutic and case management services,
346 to be reimbursed on a fee for service basis. Any such services
347 provided by a facility described in paragraph (b) must have the
348 prior approval of the division to be reimbursable under this
349 section. After June 30, 1997, mental health services provided by
350 regional mental health/retardation centers established under
351 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
352 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
353 psychiatric residential treatment facilities as defined in Section
354 43-11-1, or by another community mental health service provider
355 meeting the requirements of the Department of Mental Health to be
356 an approved mental health/retardation center if determined
357 necessary by the Department of Mental Health, shall not be
358 included in or provided under any capitated managed care pilot
359 program provided for under paragraph (24) of this section.
360 (17) Durable medical equipment services and medical supplies
361 restricted to patients receiving home health services unless
362 waived on an individual basis by the division. The division shall
363 not expend more than Three Hundred Thousand Dollars ($300,000.00)
364 of state funds annually to pay for medical supplies authorized
365 under this paragraph.
366 (18) Notwithstanding any other provision of this section to
367 the contrary, the division shall make additional reimbursement to
368 hospitals which serve a disproportionate share of low-income
369 patients and which meet the federal requirements for such payments
370 as provided in Section 1923 of the federal Social Security Act and
371 any applicable regulations.
372 (19) (a) Perinatal risk management services. The division

373 shall promulgate regulations to be effective from and after
374 October 1, 1988, to establish a comprehensive perinatal system for
375 risk assessment of all pregnant and infant Medicaid recipients and
376 for management, education and follow-up for those who are
377 determined to be at risk. Services to be performed include case
378 management, nutrition assessment/counseling, psychosocial
379 assessment/counseling and health education. The division shall
380 set reimbursement rates for providers in conjunction with the
381 State Department of Health.
382 (b) Early intervention system services. The division
383 shall cooperate with the State Department of Health, acting as
384 lead agency, in the development and implementation of a statewide
385 system of delivery of early intervention services, pursuant to
386 Part H of the Individuals with Disabilities Education Act (IDEA).
387 The State Department of Health shall certify annually in writing
388 to the director of the division the dollar amount of state early
389 intervention funds available which shall be utilized as a
390 certified match for Medicaid matching funds. Those funds then
391 shall be used to provide expanded targeted case management
392 services for Medicaid eligible children with special needs who are
393 eligible for the state's early intervention system.
394 Qualifications for persons providing service coordination shall be
395 determined by the State Department of Health and the Division of
396 Medicaid.
397 (20) Home- and community-based services for physically
398 disabled approved services as allowed by a waiver from the U.S.
399 Department of Health and Human Services for home- and
400 community-based services for physically disabled people using
401 state funds which are provided from the appropriation to the State
402 Department of Rehabilitation Services and used to match federal
403 funds under a cooperative agreement between the division and the
404 department, provided that funds for these services are
405 specifically appropriated to the Department of Rehabilitation
406 Services.

407 (21) Nurse practitioner services. Services furnished by a
408 registered nurse who is licensed and certified by the Mississippi
409 Board of Nursing as a nurse practitioner including, but not
410 limited to, nurse anesthetists, nurse midwives, family nurse
411 practitioners, family planning nurse practitioners, pediatric
412 nurse practitioners, obstetrics-gynecology nurse practitioners and
413 neonatal nurse practitioners, under regulations adopted by the
414 division. Reimbursement for such services shall not exceed ninety
415 percent (90%) of the reimbursement rate for comparable services
416 rendered by a physician.
417 (22) Ambulatory services delivered in federally qualified
418 health centers and in clinics of the local health departments of
419 the State Department of Health for individuals eligible for
420 medical assistance under this article based on reasonable costs as
421 determined by the division.
422 (23) Inpatient psychiatric services. Inpatient psychiatric
423 services to be determined by the division for recipients under age
424 twenty-one (21) which are provided under the direction of a
425 physician in an inpatient program in a licensed acute care
426 psychiatric facility or in a licensed psychiatric residential
427 treatment facility, before the recipient reaches age twenty-one
428 (21) or, if the recipient was receiving the services immediately
429 before he reached age twenty-one (21), before the earlier of the
430 date he no longer requires the services or the date he reaches age
431 twenty-two (22), as provided by federal regulations. Recipients
432 shall be allowed forty-five (45) days per year of psychiatric
433 services provided in acute care psychiatric facilities, and shall
434 be allowed unlimited days of psychiatric services provided in
435 licensed psychiatric residential treatment facilities.
436 (24) Managed care services in a program to be developed by
437 the division by a public or private provider. Notwithstanding any
438 other provision in this article to the contrary, the division
439 shall establish rates of reimbursement to providers rendering care
440 and services authorized under this section, and may revise such

441 rates of reimbursement without amendment to this section by the
442 Legislature for the purpose of achieving effective and accessible
443 health services, and for responsible containment of costs. This
444 shall include, but not be limited to, one (1) module of capitated
445 managed care in a rural area, and one (1) module of capitated
446 managed care in an urban area. The division shall conduct a study
447 of those Medicaid providers who participate in the capitated
448 managed care pilot program and those Medicaid providers in the
449 same counties who do not participate in the pilot program, and the
450 levels of reimbursement made to each group of providers for
451 similar services, to determine the effect of the levels of
452 reimbursement on provider participation or nonparticipation in the
453 pilot program.
454 (25) Birthing center services.
455 (26) Hospice care. As used in this paragraph, the term
456 "hospice care" means a coordinated program of active professional
457 medical attention within the home and outpatient and inpatient
458 care which treats the terminally ill patient and family as a unit,
459 employing a medically directed interdisciplinary team. The
460 program provides relief of severe pain or other physical symptoms
461 and supportive care to meet the special needs arising out of
462 physical, psychological, spiritual, social and economic stresses
463 which are experienced during the final stages of illness and
464 during dying and bereavement and meets the Medicare requirements
465 for participation as a hospice as provided in 42 CFR Part 418.
466 (27) Group health plan premiums and cost sharing if it is
467 cost effective as defined by the Secretary of Health and Human
468 Services.
469 (28) Other health insurance premiums which are cost
470 effective as defined by the Secretary of Health and Human
471 Services. Medicare eligible must have Medicare Part B before
472 other insurance premiums can be paid.
473 (29) The Division of Medicaid may apply for a waiver from
474 the Department of Health and Human Services for home- and

475 community-based services for developmentally disabled people using
476 state funds which are provided from the appropriation to the State
477 Department of Mental Health and used to match federal funds under
478 a cooperative agreement between the division and the department,
479 provided that funds for these services are specifically
480 appropriated to the Department of Mental Health.

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

483 (31) Targeted case management services for children with
484 special needs, under waivers from the U.S. Department of Health
485 and Human Services, using state funds that are provided from the
486 appropriation to the Mississippi Department of Human Services and
487 used to match federal funds under a cooperative agreement between
488 the division and the department.

489 (32) Care and services provided in Christian Science
490 Sanatoria operated by or listed and certified by The First Church
491 of Christ Scientist, Boston, Massachusetts, rendered in connection
492 with treatment by prayer or spiritual means to the extent that
493 such services are subject to reimbursement under Section 1903 of
494 the Social Security Act.

495 (33) Podiatrist services.

496 (34) Personal care services provided in a pilot program to
497 not more than forty (40) residents at a location or locations to
498 be determined by the division and delivered by individuals
499 qualified to provide such services, as allowed by waivers under
500 Title XIX of the Social Security Act, as amended. The division
501 shall not expend more than Three Hundred Thousand Dollars
502 ($300,000.00) annually to provide such personal care services.
503 The division shall develop recommendations for the effective
504 regulation of any facilities that would provide personal care
505 services which may become eligible for Medicaid reimbursement
506 under this section, and shall present such recommendations with
507 any proposed legislation to the 1996 Regular Session of the
508 Legislature on or before January 1, 1996.

509 (35) Services and activities authorized in Sections
510 43-27-101 and 43-27-103, using state funds that are provided from
511 the appropriation to the State Department of Human Services and
512 used to match federal funds under a cooperative agreement between
513 the division and the department.
514 (36) Nonemergency transportation services for
515 Medicaid-eligible persons, to be provided by the Department of
516 Human Services. The division may contract with additional
517 entities to administer non-emergency transportation services as it
518 deems necessary. All providers shall have a valid driver's
519 license, vehicle inspection sticker and a standard liability
520 insurance policy covering the vehicle.
521 (37) Targeted case management services for individuals with
522 chronic diseases, with expanded eligibility to cover services to
523 uninsured recipients, on a pilot program basis. This paragraph
524 (37) shall be contingent upon continued receipt of special funds
525 from the Health Care Financing Authority and private foundations
526 who have granted funds for planning these services. No funding
527 for these services shall be provided from State General Funds.
528 (38) Chiropractic services: a chiropractor's manual
529 manipulation of the spine to correct a subluxation, if x-ray
530 demonstrates that a subluxation exists and if the subluxation has
531 resulted in a neuromusculoskeletal condition for which
532 manipulation is appropriate treatment. Reimbursement for
533 chiropractic services shall not exceed Seven Hundred Dollars
534 ($700.00) per year per recipient.
535 Notwithstanding any provision of this article, except as
536 authorized in the following paragraph and in Section 43-13-139,
537 neither (a) the limitations on quantity or frequency of use of or
538 the fees or charges for any of the care or services available to
539 recipients under this section, nor (b) the payments or rates of
540 reimbursement to providers rendering care or services authorized
541 under this section to recipients, may be increased, decreased or
542 otherwise changed from the levels in effect on July 1, 1986,

543 unless such is authorized by an amendment to this section by the
544 Legislature. However, the restriction in this paragraph shall not
545 prevent the division from changing the payments or rates of
546 reimbursement to providers without an amendment to this section
547 whenever such changes are required by federal law or regulation,
548 or whenever such changes are necessary to correct administrative
549 errors or omissions in calculating such payments or rates of
550 reimbursement.

551 Notwithstanding any provision of this article, no new groups
552 or categories of recipients and new types of care and services may
553 be added without enabling legislation from the Mississippi
554 Legislature, except that the division may authorize such changes
555 without enabling legislation when such addition of recipients or
556 services is ordered by a court of proper authority. The director
557 shall keep the Governor advised on a timely basis of the funds
558 available for expenditure and the projected expenditures. In the
559 event current or projected expenditures can be reasonably
560 anticipated to exceed the amounts appropriated for any fiscal
561 year, the Governor, after consultation with the director, shall
562 discontinue any or all of the payment of the types of care and
563 services as provided herein which are deemed to be optional
564 services under Title XIX of the federal Social Security Act, as
565 amended, for any period necessary to not exceed appropriated
566 funds, and when necessary shall institute any other cost
567 containment measures on any program or programs authorized under
568 the article to the extent allowed under the federal law governing
569 such program or programs, it being the intent of the Legislature
570 that expenditures during any fiscal year shall not exceed the
571 amounts appropriated for such fiscal year.

572 SECTION 2. This act shall take effect and be in force from
573 and after July 1, 1999.