

By: Representatives Scott (80th), Bailey, Banks, Broomfield, Evans, Gibbs, Middleton, Myers, Smith (27th), Thomas, Thornton, Watson

To: Public Health and Welfare; Appropriations

HOUSE BILL NO. 1402

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO AUTHORIZE THE DIVISION OF MEDICAID TO REQUEST A WAIVER FOR
3 EXPANDED COVERAGE OF THE CHRONICALLY ILL; TO TARGET THE WAIVERED
4 PROGRAM AT PERSONS WITH POORLY CONTROLLED HYPERTENSION AND
5 DIABETES; AND FOR RELATED PURPOSES. BE IT ENACTED BY THE
6 LEGISLATURE OF THE STATE OF MISSISSIPPI:
7

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

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

17 (1) Inpatient hospital services.

18 (a) The division shall allow thirty (30) days of
19 inpatient hospital care annually for all Medicaid recipients;
20 however, before any recipient will be allowed more than fifteen
21 (15) days of inpatient hospital care in any one (1) year, he must
22 obtain prior approval therefor from the division. The division
23 shall be authorized to allow unlimited days in disproportionate
24 hospitals as defined by the division for eligible infants under
25 the age of six (6) years.

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

30 Component utilized to determine total hospital costs allocated to
31 the Medicaid Program.

32 (2) Outpatient hospital services. Provided that where the
33 same services are reimbursed as clinic services, the division may
34 revise the rate or methodology of outpatient reimbursement to
35 maintain consistency, efficiency, economy and quality of care.

36 (3) Laboratory and X-ray services.

37 (4) Nursing facility services.

38 (a) The division shall make full payment to nursing
39 facilities for each day, not exceeding thirty-six (36) days per
40 year, that a patient is absent from the facility on home leave.
41 However, before payment may be made for more than eighteen (18)
42 home leave days in a year for a patient, the patient must have
43 written authorization from a physician stating that the patient is
44 physically and mentally able to be away from the facility on home
45 leave. Such authorization must be filed with the division before
46 it will be effective and the authorization shall be effective for
47 three (3) months from the date it is received by the division,
48 unless it is revoked earlier by the physician because of a change
49 in the condition of the patient.

50 (b) Repealed.

51 (c) From and after July 1, 1997, all state-owned
52 nursing facilities shall be reimbursed on a full reasonable costs
53 basis. From and after July 1, 1997, payments by the division to
54 nursing facilities for return on equity capital shall be made at
55 the rate paid under Medicare (Title XVIII of the Social Security
56 Act), but shall be no less than seven and one-half percent (7.5%)
57 nor greater than ten percent (10%).

58 (d) A Review Board for nursing facilities is
59 established to conduct reviews of the Division of Medicaid's
60 decision in the areas set forth below:

61 (i) Review shall be heard in the following areas:

62 (A) Matters relating to cost reports
63 including, but not limited to, allowable costs and cost
64 adjustments resulting from desk reviews and audits.

65 (B) Matters relating to the Minimum Data Set
66 Plus (MDS +) or successor assessment formats including but not
67 limited to audits, classifications and submissions.

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

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

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

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

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

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

102 Review Board panels may appoint such person or persons as they
103 shall deem proper to execute and return process in connection
104 therewith.

105 (iv) The Review Board shall promulgate, publish
106 and disseminate to nursing facility providers rules of procedure
107 for the efficient conduct of proceedings, subject to the approval
108 of the Executive Director of the Division of Medicaid and in
109 accordance with federal and state administrative hearing laws and
110 regulations.

111 (v) Proceedings of the Review Board shall be of
112 record.

113 (vi) Appeals to the Review Board shall be in
114 writing and shall set out the issues, a statement of alleged facts
115 and reasons supporting the provider's position. Relevant
116 documents may also be attached. The appeal shall be filed within
117 thirty (30) days from the date the provider is notified of the
118 action being appealed or, if informal review procedures are taken,
119 as provided by administrative regulations of the Division of
120 Medicaid, within thirty (30) days after a decision has been
121 rendered through informal hearing procedures.

122 (vii) The provider shall be notified of the
123 hearing date by certified mail within thirty (30) days from the
124 date the Division of Medicaid receives the request for appeal.
125 Notification of the hearing date shall in no event be less than
126 thirty (30) days before the scheduled hearing date. The appeal
127 may be heard on shorter notice by written agreement between the
128 provider and the Division of Medicaid.

129 (viii) Within thirty (30) days from the date of
130 the hearing, the Review Board panel shall render a written
131 recommendation to the Executive Director of the Division of
132 Medicaid setting forth the issues, findings of fact and applicable
133 law, regulations or provisions.

134 (ix) The Executive Director of the Division of
135 Medicaid shall, upon review of the recommendation, the proceedings

136 and the record, prepare a written decision which shall be mailed
137 to the nursing facility provider no later than twenty (20) days
138 after the submission of the recommendation by the panel. The
139 decision of the executive director is final, subject only to
140 judicial review.

141 (x) Appeals from a final decision shall be made to
142 the Chancery Court of Hinds County. The appeal shall be filed
143 with the court within thirty (30) days from the date the decision
144 of the Executive Director of the Division of Medicaid becomes
145 final.

146 (xi) The action of the Division of Medicaid under
147 review shall be stayed until all administrative proceedings have
148 been exhausted.

149 (xii) Appeals by nursing facility providers
150 involving any issues other than those two (2) specified in
151 subparagraphs (i)(A) and (ii)(B) shall be taken in accordance with
152 the administrative hearing procedures established by the Division
153 of Medicaid.

154 (e) When a facility of a category that does not require
155 a certificate of need for construction and that could not be
156 eligible for Medicaid reimbursement is constructed to nursing
157 facility specifications for licensure and certification, and the
158 facility is subsequently converted to a nursing facility pursuant
159 to a certificate of need that authorizes conversion only and the
160 applicant for the certificate of need was assessed an application
161 review fee based on capital expenditures incurred in constructing
162 the facility, the division shall allow reimbursement for capital
163 expenditures necessary for construction of the facility that were
164 incurred within the twenty-four (24) consecutive calendar months
165 immediately preceding the date that the certificate of need
166 authorizing such conversion was issued, to the same extent that
167 reimbursement would be allowed for construction of a new nursing
168 facility pursuant to a certificate of need that authorizes such
169 construction. The reimbursement authorized in this subparagraph

170 (e) may be made only to facilities the construction of which was
171 completed after June 30, 1989. Before the division shall be
172 authorized to make the reimbursement authorized in this
173 subparagraph (e), the division first must have received approval
174 from the Health Care Financing Administration of the United States
175 Department of Health and Human Services of the change in the state
176 Medicaid plan providing for such reimbursement.

177 (5) Periodic screening and diagnostic services for
178 individuals under age twenty-one (21) years as are needed to
179 identify physical and mental defects and to provide health care
180 treatment and other measures designed to correct or ameliorate
181 defects and physical and mental illness and conditions discovered
182 by the screening services regardless of whether these services are
183 included in the state plan. The division may include in its
184 periodic screening and diagnostic program those discretionary
185 services authorized under the federal regulations adopted to
186 implement Title XIX of the federal Social Security Act, as
187 amended. The division, in obtaining physical therapy services,
188 occupational therapy services, and services for individuals with
189 speech, hearing and language disorders, may enter into a
190 cooperative agreement with the State Department of Education for
191 the provision of such services to handicapped students by public
192 school districts using state funds which are provided from the
193 appropriation to the Department of Education to obtain federal
194 matching funds through the division. The division, in obtaining
195 medical and psychological evaluations for children in the custody
196 of the State Department of Human Services may enter into a
197 cooperative agreement with the State Department of Human Services
198 for the provision of such services using state funds which are
199 provided from the appropriation to the Department of Human
200 Services to obtain federal matching funds through the division.

201 On July 1, 1993, all fees for periodic screening and
202 diagnostic services under this paragraph (5) shall be increased by
203 twenty-five percent (25%) of the reimbursement rate in effect on

204 June 30, 1993.

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

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

214 (b) Repealed.

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

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

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

243 Payment for nonlegend or over-the-counter drugs covered on
244 the division's formulary shall be reimbursed at the lower of the
245 division's estimated shelf price or the providers' usual and
246 customary charge to the general public. No dispensing fee shall
247 be paid.

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

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

261 (10) Dental care that is an adjunct to treatment of an acute
262 medical or surgical condition; services of oral surgeons and
263 dentists in connection with surgery related to the jaw or any
264 structure contiguous to the jaw or the reduction of any fracture
265 of the jaw or any facial bone; and emergency dental extractions
266 and treatment related thereto. On January 1, 1994, all fees for
267 dental care and surgery under authority of this paragraph (10)
268 shall be increased by twenty percent (20%) of the reimbursement
269 rate as provided in the Dental Services Provider Manual in effect
270 on December 31, 1993.

271 (11) Eyeglasses necessitated by reason of eye surgery, and

272 as prescribed by a physician skilled in diseases of the eye or an
273 optometrist, whichever the patient may select.

274 (12) Intermediate care facility services.

275 (a) The division shall make full payment to all
276 intermediate care facilities for the mentally retarded for each
277 day, not exceeding thirty-six (36) days per year, that a patient
278 is absent from the facility on home leave. However, before
279 payment may be made for more than eighteen (18) home leave days in
280 a year for a patient, the patient must have written authorization
281 from a physician stating that the patient is physically and
282 mentally able to be away from the facility on home leave. Such
283 authorization must be filed with the division before it will be
284 effective, and the authorization shall be effective for three (3)
285 months from the date it is received by the division, unless it is
286 revoked earlier by the physician because of a change in the
287 condition of the patient.

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

291 (13) Family planning services, including drugs, supplies and
292 devices, when such services are under the supervision of a
293 physician.

294 (14) Clinic services. Such diagnostic, preventive,
295 therapeutic, rehabilitative or palliative services furnished to an
296 outpatient by or under the supervision of a physician or dentist
297 in a facility which is not a part of a hospital but which is
298 organized and operated to provide medical care to outpatients.
299 Clinic services shall include any services reimbursed as
300 outpatient hospital services which may be rendered in such a
301 facility, including those that become so after July 1, 1991. On
302 January 1, 1994, all fees for physicians' services reimbursed
303 under authority of this paragraph (14) shall be reimbursed at
304 seventy percent (70%) of the rate established on January 1, 1993,
305 under Medicare (Title XVIII of the Social Security Act), as

306 amended, or the amount that would have been paid under the
307 division's fee schedule that was in effect on December 31, 1993,
308 whichever is greater, and the division may adjust the physicians'
309 reimbursement schedule to reflect the differences in relative
310 value between Medicaid and Medicare. However, on January 1, 1994,
311 the division may increase any fee for physicians' services in the
312 division's fee schedule on December 31, 1993, that was greater
313 than seventy percent (70%) of the rate established under Medicare
314 by no more than ten percent (10%). On January 1, 1994, all fees
315 for dentists' services reimbursed under authority of this
316 paragraph (14) shall be increased by twenty percent (20%) of the
317 reimbursement rate as provided in the Dental Services Provider
318 Manual in effect on December 31, 1993.

319 (15) Home- and community-based services, as provided under
320 Title XIX of the federal Social Security Act, as amended, under
321 waivers, subject to the availability of funds specifically
322 appropriated therefor by the Legislature. Payment for such
323 services shall be limited to individuals who would be eligible for
324 and would otherwise require the level of care provided in a
325 nursing facility. The division shall certify case management
326 agencies to provide case management services and provide for home-
327 and community-based services for eligible individuals under this
328 paragraph. The home- and community-based services under this
329 paragraph and the activities performed by certified case
330 management agencies under this paragraph shall be funded using
331 state funds that are provided from the appropriation to the
332 Division of Medicaid and used to match federal funds under a
333 cooperative agreement between the division and the Department of
334 Human Services.

335 (16) Mental health services. Approved therapeutic and case
336 management services provided by (a) an approved regional mental
337 health/retardation center established under Sections 41-19-31
338 through 41-19-39, or by another community mental health service
339 provider meeting the requirements of the Department of Mental

340 Health to be an approved mental health/retardation center if
341 determined necessary by the Department of Mental Health, using
342 state funds which are provided from the appropriation to the State
343 Department of Mental Health and used to match federal funds under
344 a cooperative agreement between the division and the department,
345 or (b) a facility which is certified by the State Department of
346 Mental Health to provide therapeutic and case management services,
347 to be reimbursed on a fee for service basis. Any such services
348 provided by a facility described in paragraph (b) must have the
349 prior approval of the division to be reimbursable under this
350 section. After June 30, 1997, mental health services provided by
351 regional mental health/retardation centers established under
352 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
353 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
354 psychiatric residential treatment facilities as defined in Section
355 43-11-1, or by another community mental health service provider
356 meeting the requirements of the Department of Mental Health to be
357 an approved mental health/retardation center if determined
358 necessary by the Department of Mental Health, shall not be
359 included in or provided under any capitated managed care pilot
360 program provided for under paragraph (24) of this section.

361 (17) Durable medical equipment services and medical supplies
362 restricted to patients receiving home health services unless
363 waived on an individual basis by the division. The division shall
364 not expend more than Three Hundred Thousand Dollars (\$300,000.00)
365 of state funds annually to pay for medical supplies authorized
366 under this paragraph.

367 (18) Notwithstanding any other provision of this section to
368 the contrary, the division shall make additional reimbursement to
369 hospitals which serve a disproportionate share of low-income
370 patients and which meet the federal requirements for such payments
371 as provided in Section 1923 of the federal Social Security Act and
372 any applicable regulations.

373 (19) (a) Perinatal risk management services. The division

374 shall promulgate regulations to be effective from and after
375 October 1, 1988, to establish a comprehensive perinatal system for
376 risk assessment of all pregnant and infant Medicaid recipients and
377 for management, education and follow-up for those who are
378 determined to be at risk. Services to be performed include case
379 management, nutrition assessment/counseling, psychosocial
380 assessment/counseling and health education. The division shall
381 set reimbursement rates for providers in conjunction with the
382 State Department of Health.

383 (b) Early intervention system services. The division
384 shall cooperate with the State Department of Health, acting as
385 lead agency, in the development and implementation of a statewide
386 system of delivery of early intervention services, pursuant to
387 Part H of the Individuals with Disabilities Education Act (IDEA).

388 The State Department of Health shall certify annually in writing
389 to the director of the division the dollar amount of state early
390 intervention funds available which shall be utilized as a
391 certified match for Medicaid matching funds. Those funds then
392 shall be used to provide expanded targeted case management
393 services for Medicaid eligible children with special needs who are
394 eligible for the state's early intervention system.

395 Qualifications for persons providing service coordination shall be
396 determined by the State Department of Health and the Division of
397 Medicaid.

398 (20) Home- and community-based services for physically
399 disabled approved services as allowed by a waiver from the U.S.
400 Department of Health and Human Services for home- and
401 community-based services for physically disabled people using
402 state funds which are provided from the appropriation to the State
403 Department of Rehabilitation Services and used to match federal
404 funds under a cooperative agreement between the division and the
405 department, provided that funds for these services are
406 specifically appropriated to the Department of Rehabilitation
407 Services.

408 (21) Nurse practitioner services. Services furnished by a
409 registered nurse who is licensed and certified by the Mississippi
410 Board of Nursing as a nurse practitioner including, but not
411 limited to, nurse anesthetists, nurse midwives, family nurse
412 practitioners, family planning nurse practitioners, pediatric
413 nurse practitioners, obstetrics-gynecology nurse practitioners and
414 neonatal nurse practitioners, under regulations adopted by the
415 division. Reimbursement for such services shall not exceed ninety
416 percent (90%) of the reimbursement rate for comparable services
417 rendered by a physician.

418 (22) Ambulatory services delivered in federally qualified
419 health centers and in clinics of the local health departments of
420 the State Department of Health for individuals eligible for
421 medical assistance under this article based on reasonable costs as
422 determined by the division.

423 (23) Inpatient psychiatric services. Inpatient psychiatric
424 services to be determined by the division for recipients under age
425 twenty-one (21) which are provided under the direction of a
426 physician in an inpatient program in a licensed acute care
427 psychiatric facility or in a licensed psychiatric residential
428 treatment facility, before the recipient reaches age twenty-one
429 (21) or, if the recipient was receiving the services immediately
430 before he reached age twenty-one (21), before the earlier of the
431 date he no longer requires the services or the date he reaches age
432 twenty-two (22), as provided by federal regulations. Recipients
433 shall be allowed forty-five (45) days per year of psychiatric
434 services provided in acute care psychiatric facilities, and shall
435 be allowed unlimited days of psychiatric services provided in
436 licensed psychiatric residential treatment facilities.

437 (24) Managed care services in a program to be developed by
438 the division by a public or private provider. Notwithstanding any
439 other provision in this article to the contrary, the division
440 shall establish rates of reimbursement to providers rendering care
441 and services authorized under this section, and may revise such

442 rates of reimbursement without amendment to this section by the
443 Legislature for the purpose of achieving effective and accessible
444 health services, and for responsible containment of costs. This
445 shall include, but not be limited to, one (1) module of capitated
446 managed care in a rural area, and one (1) module of capitated
447 managed care in an urban area.

448 (25) Birthing center services.

449 (26) Hospice care. As used in this paragraph, the term
450 "hospice care" means a coordinated program of active professional
451 medical attention within the home and outpatient and inpatient
452 care which treats the terminally ill patient and family as a unit,
453 employing a medically directed interdisciplinary team. The
454 program provides relief of severe pain or other physical symptoms
455 and supportive care to meet the special needs arising out of
456 physical, psychological, spiritual, social and economic stresses
457 which are experienced during the final stages of illness and
458 during dying and bereavement and meets the Medicare requirements
459 for participation as a hospice as provided in 42 CFR Part 418.

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

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

467 (29) The Division of Medicaid may apply for a waiver from
468 the Department of Health and Human Services for home- and
469 community-based services for developmentally disabled people using
470 state funds which are provided from the appropriation to the State
471 Department of Mental Health and used to match federal funds under
472 a cooperative agreement between the division and the department,
473 provided that funds for these services are specifically
474 appropriated to the Department of Mental Health.

475 (30) Pediatric skilled nursing services for eligible persons

476 under twenty-one (21) years of age.

477 (31) Targeted case management services for children with
478 special needs, under waivers from the U.S. Department of Health
479 and Human Services, using state funds that are provided from the
480 appropriation to the Mississippi Department of Human Services and
481 used to match federal funds under a cooperative agreement between
482 the division and the department.

483 (32) Care and services provided in Christian Science
484 Sanatoria operated by or listed and certified by The First Church
485 of Christ Scientist, Boston, Massachusetts, rendered in connection
486 with treatment by prayer or spiritual means to the extent that
487 such services are subject to reimbursement under Section 1903 of
488 the Social Security Act.

489 (33) Podiatrist services.

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

503 (35) Services and activities authorized in Sections
504 43-27-101 and 43-27-103, using state funds that are provided from
505 the appropriation to the State Department of Human Services and
506 used to match federal funds under a cooperative agreement between
507 the division and the department.

508 (36) Nonemergency transportation services for
509 Medicaid-eligible persons, to be provided by the Department of

510 Human Services. The division may contract with additional
511 entities to administer non-emergency transportation services as it
512 deems necessary. All providers shall have a valid driver's
513 license, vehicle inspection sticker and a standard liability
514 insurance policy covering the vehicle.

515 (37) Targeted case management services for individuals with
516 chronic diseases, with expanded eligibility to cover services to
517 uninsured recipients, on a pilot program basis. This paragraph
518 (37) shall be contingent upon continued receipt of special funds
519 from the Health Care Financing Authority and private foundations
520 who have granted funds for planning these services. No funding
521 for these services shall be provided from State General Funds.

522 (38) Chiropractic services: a chiropractor's manual
523 manipulation of the spine to correct a subluxation, if x-ray
524 demonstrates that a subluxation exists and if the subluxation has
525 resulted in a neuromusculoskeletal condition for which
526 manipulation is appropriate treatment. Reimbursement for
527 chiropractic services shall not exceed Seven Hundred Dollars
528 (\$700.00) per year per recipient.

529 (39) The Division of Medicaid may apply for a waiver from
530 the U. S. Department of Health and Human Services for chronically
531 ill people, which shall be targeted at persons with poorly
532 controlled hypertension and diabetes. The waived program shall
533 provide reimbursement for insulin (Humulin) for patients who are
534 adult-onset diabetics and shall include reimbursement for newer
535 medicines for blood pressure which have protective effects on
536 kidney function in diabetics.

537 Notwithstanding any provision of this article, except as
538 authorized in the following paragraph and in Section 43-13-139,
539 neither (a) the limitations on quantity or frequency of use of or
540 the fees or charges for any of the care or services available to
541 recipients under this section, nor (b) the payments or rates of
542 reimbursement to providers rendering care or services authorized
543 under this section to recipients, may be increased, decreased or

544 otherwise changed from the levels in effect on July 1, 1986,
545 unless such is authorized by an amendment to this section by the
546 Legislature. However, the restriction in this paragraph shall not
547 prevent the division from changing the payments or rates of
548 reimbursement to providers without an amendment to this section
549 whenever such changes are required by federal law or regulation,
550 or whenever such changes are necessary to correct administrative
551 errors or omissions in calculating such payments or rates of
552 reimbursement.

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

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