

By: Senator(s) Bean, Thames

To: Public Health and
Welfare;
Appropriations

SENATE BILL NO. 2126

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO INCREASE THE AUTHORIZED NUMBER OF HOME LEAVE DAYS FOR ICFMR
3 SERVICES MEDICAID REIMBURSEMENT; 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;
17 however, before any recipient will be allowed more than fifteen
18 (15) days of inpatient hospital care in any one (1) year, he must
19 obtain prior approval therefor from the division. The division
20 shall be authorized to allow unlimited days in disproportionate
21 hospitals as defined by the division for eligible infants under
22 the age of six (6) years.

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

the Medicaid Program.

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

(3) Laboratory and X-ray services.

(4) Nursing facility services.

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

(b) From and after July 1, 1993, the division shall implement the integrated case-mix payment and quality monitoring system developed pursuant to Section 43-13-122, which includes the fair rental system for property costs and in which recapture of depreciation is eliminated. The division may revise the reimbursement methodology for the case-mix payment system by reducing payment for hospital leave and therapeutic home leave days to the lowest case-mix category for nursing facilities, modifying the current method of scoring residents so that only services provided at the nursing facility are considered in calculating a facility's per diem, and the division may limit administrative and operating costs, but in no case shall these costs be less than one hundred nine percent (109%) of the median administrative and operating costs for each class of facility, not to exceed the median used to calculate the nursing facility reimbursement for Fiscal Year 1996, to be applied uniformly to all long-term care facilities. This paragraph (b) shall stand repealed on July 1, 1997.

(c) From and after July 1, 1997, all state-owned

66 nursing facilities shall be reimbursed on a full reasonable costs
67 basis. From and after July 1, 1997, payments by the division to
68 nursing facilities for return on equity capital shall be made at
69 the rate paid under Medicare (Title XVIII of the Social Security
70 Act), but shall be no less than seven and one-half percent (7.5%)
71 nor greater than ten percent (10%).

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

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

76 (A) Matters relating to cost reports
77 including, but not limited to, allowable costs and cost
78 adjustments resulting from desk reviews and audits.

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

82 (ii) The Review Board shall be composed of six (6)
83 members, three (3) having expertise in one (1) of the two (2)
84 areas set forth above and three (3) having expertise in the other
85 area set forth above. Each panel of three (3) shall only review
86 appeals arising in its area of expertise. The members shall be
87 appointed as follows:

88 (A) In each of the areas of expertise defined
89 under subparagraphs (i)(A) and (i)(B), the Executive Director of
90 the Division of Medicaid shall appoint one (1) person chosen from
91 the private sector nursing home industry in the state, which may
92 include independent accountants and consultants serving the
93 industry;

94 (B) In each of the areas of expertise defined
95 under subparagraphs (i)(A) and (i)(B), the Executive Director of
96 the Division of Medicaid shall appoint one (1) person who is
97 employed by the state who does not participate directly in desk
98 reviews or audits of nursing facilities in the two (2) areas of
99 review;

100 (C) The two (2) members appointed by the
101 Executive Director of the Division of Medicaid in each area of
102 expertise shall appoint a third member in the same area of
103 expertise.

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

108 (iii) The Review Board panels shall have the power
109 to preserve and enforce order during hearings; to issue subpoenas;
110 to administer oaths; to compel attendance and testimony of
111 witnesses; or to compel the production of books, papers, documents
112 and other evidence; or the taking of depositions before any
113 designated individual competent to administer oaths; to examine
114 witnesses; and to do all things conformable to law that may be
115 necessary to enable it effectively to discharge its duties. The
116 Review Board panels may appoint such person or persons as they
117 shall deem proper to execute and return process in connection
118 therewith.

119 (iv) The Review Board shall promulgate, publish
120 and disseminate to nursing facility providers rules of procedure
121 for the efficient conduct of proceedings, subject to the approval
122 of the Executive Director of the Division of Medicaid and in
123 accordance with federal and state administrative hearing laws and
124 regulations.

125 (v) Proceedings of the Review Board shall be of
126 record.

127 (vi) Appeals to the Review Board shall be in
128 writing and shall set out the issues, a statement of alleged facts
129 and reasons supporting the provider's position. Relevant
130 documents may also be attached. The appeal shall be filed within
131 thirty (30) days from the date the provider is notified of the
132 action being appealed or, if informal review procedures are taken,
133 as provided by administrative regulations of the Division of

Medicaid, within thirty (30) days after a decision has been rendered through informal hearing procedures.

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

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

(ix) The Executive Director of the Division of Medicaid shall, upon review of the recommendation, the proceedings and the record, prepare a written decision which shall be mailed to the nursing facility provider no later than twenty (20) days after the submission of the recommendation by the panel. The decision of the executive director is final, subject only to judicial review.

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

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

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

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

(5) Periodic screening and diagnostic services for individuals under age twenty-one (21) years as are needed to identify physical and mental defects and to provide health care treatment and other measures designed to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services regardless of whether these services are included in the state plan. The division may include in its periodic screening and diagnostic program those discretionary services authorized under the federal regulations adopted to implement Title XIX of the federal Social Security Act, as amended. The division, in obtaining physical therapy services,

occupational therapy services, and services for individuals with speech, hearing and language disorders, may enter into a cooperative agreement with the State Department of Education for the provision of such services to handicapped students by public school districts using state funds which are provided from the appropriation to the Department of Education to obtain federal matching funds through the division. The division, in obtaining medical and psychological evaluations for children in the custody of the State Department of Human Services may enter into a cooperative agreement with the State Department of Human Services for the provision of such services using state funds which are provided from the appropriation to the Department of Human Services to obtain federal matching funds through the division.

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

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

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

(b) The division may revise reimbursement for home health services in order to establish equity between reimbursement for home health services and reimbursement for institutional services within the Medicaid program. This paragraph (b) shall stand repealed on July 1, 1997.

(8) Emergency medical transportation services. On January 1, 1994, emergency medical transportation services shall be reimbursed at seventy percent (70%) of the rate established under

Medicare (Title XVIII of the Social Security Act), as amended.

"Emergency medical transportation services" shall mean, but shall not be limited to, the following services by a properly permitted ambulance operated by a properly licensed provider in accordance with the Emergency Medical Services Act of 1974 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi) disposable supplies, (vii) similar services.

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

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

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

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

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

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

(11) Eyeglasses necessitated by reason of eye surgery, and as prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the patient may select.

(12) Intermediate care facility services.

(a) The division shall make full payment to all intermediate care facilities for the mentally retarded for each day, not exceeding seventy-two (72) days per year, that a patient is absent from the facility on home leave. However, before payment may be made for more than eighteen (18) home leave days in a year for a patient, the patient must have written authorization from a physician stating that the patient is physically and mentally able to be away from the facility on home leave. Such authorization must be filed with the division before it will be effective, and the authorization shall be effective for three (3) months from the date it is received by the division, unless it is

304 revoked earlier by the physician because of a change in the
305 condition of the patient.

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

309 (13) Family planning services, including drugs, supplies and
310 devices, when such services are under the supervision of a
311 physician.

312 (14) Clinic services. Such diagnostic, preventive,
313 therapeutic, rehabilitative or palliative services furnished to an
314 outpatient by or under the supervision of a physician or dentist
315 in a facility which is not a part of a hospital but which is
316 organized and operated to provide medical care to outpatients.
317 Clinic services shall include any services reimbursed as
318 outpatient hospital services which may be rendered in such a
319 facility, including those that become so after July 1, 1991. On
320 January 1, 1994, all fees for physicians' services reimbursed
321 under authority of this paragraph (14) shall be reimbursed at
322 seventy percent (70%) of the rate established on January 1, 1993,
323 under Medicare (Title XVIII of the Social Security Act), as
324 amended, or the amount that would have been paid under the
325 division's fee schedule that was in effect on December 31, 1993,
326 whichever is greater, and the division may adjust the physicians'
327 reimbursement schedule to reflect the differences in relative
328 value between Medicaid and Medicare. However, on January 1, 1994,
329 the division may increase any fee for physicians' services in the
330 division's fee schedule on December 31, 1993, that was greater
331 than seventy percent (70%) of the rate established under Medicare
332 by no more than ten percent (10%). On January 1, 1994, all fees
333 for dentists' services reimbursed under authority of this
334 paragraph (14) shall be increased by twenty percent (20%) of the
335 reimbursement rate as provided in the Dental Services Provider
336 Manual in effect on December 31, 1993.

337 (15) Home- and community-based services, as provided under

338 Title XIX of the federal Social Security Act, as amended, under
339 waivers, subject to the availability of funds specifically
340 appropriated therefor by the Legislature. Payment for such
341 services shall be limited to individuals who would be eligible for
342 and would otherwise require the level of care provided in a
343 nursing facility. The division shall certify case management
344 agencies to provide case management services and provide for home-
345 and community-based services for eligible individuals under this
346 paragraph. The home- and community-based services under this
347 paragraph and the activities performed by certified case
348 management agencies under this paragraph shall be funded using
349 state funds that are provided from the appropriation to the
350 Division of Medicaid and used to match federal funds under a
351 cooperative agreement between the division and the Department of
352 Human Services.

353 (16) Mental health services. Approved therapeutic and case
354 management services provided by (a) an approved regional mental
355 health/retardation center established under Sections 41-19-31
356 through 41-19-39, or by another community mental health service
357 provider meeting the requirements of the Department of Mental
358 Health to be an approved mental health/retardation center if
359 determined necessary by the Department of Mental Health, using
360 state funds which are provided from the appropriation to the State
361 Department of Mental Health and used to match federal funds under
362 a cooperative agreement between the division and the department,
363 or (b) a facility which is certified by the State Department of
364 Mental Health to provide therapeutic and case management services,
365 to be reimbursed on a fee for service basis. Any such services
366 provided by a facility described in paragraph (b) must have the
367 prior approval of the division to be reimbursable under this
368 section. After June 30, 1997, mental health services provided by
369 regional mental health/retardation centers established under
370 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
371 Section 41-9-3(a) and/or their subsidiaries and divisions, or by

psychiatric residential treatment facilities as defined in Section 43-11-1, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/retardation center if determined necessary by the Department of Mental Health, shall not be included in or provided under any capitated managed care pilot program provided for under paragraph (24) of this section.

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

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

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

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

406 The State Department of Health shall certify annually in writing
407 to the director of the division the dollar amount of state early
408 intervention funds available which shall be utilized as a
409 certified match for Medicaid matching funds. Those funds then
410 shall be used to provide expanded targeted case management
411 services for Medicaid eligible children with special needs who are
412 eligible for the state's early intervention system.

413 Qualifications for persons providing service coordination shall be
414 determined by the State Department of Health and the Division of
415 Medicaid.

416 (20) Home- and community-based services for physically
417 disabled approved services as allowed by a waiver from the U.S.
418 Department of Health and Human Services for home- and
419 community-based services for physically disabled people using
420 state funds which are provided from the appropriation to the State
421 Department of Rehabilitation Services and used to match federal
422 funds under a cooperative agreement between the division and the
423 department, provided that funds for these services are
424 specifically appropriated to the Department of Rehabilitation
425 Services.

426 (21) Nurse practitioner services. Services furnished by a
427 registered nurse who is licensed and certified by the Mississippi
428 Board of Nursing as a nurse practitioner including, but not
429 limited to, nurse anesthetists, nurse midwives, family nurse
430 practitioners, family planning nurse practitioners, pediatric
431 nurse practitioners, obstetrics-gynecology nurse practitioners and
432 neonatal nurse practitioners, under regulations adopted by the
433 division. Reimbursement for such services shall not exceed ninety
434 percent (90%) of the reimbursement rate for comparable services
435 rendered by a physician.

436 (22) Ambulatory services delivered in federally qualified
437 health centers and in clinics of the local health departments of
438 the State Department of Health for individuals eligible for
439 medical assistance under this article based on reasonable costs as

determined by the division.

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

(24) Managed care services in a program to be developed by the division by a public or private provider. Notwithstanding any other provision in this article to the contrary, the division shall establish rates of reimbursement to providers rendering care and services authorized under this section, and may revise such rates of reimbursement without amendment to this section by the Legislature for the purpose of achieving effective and accessible health services, and for responsible containment of costs. This shall include, but not be limited to, one (1) module of capitated managed care in a rural area, and one (1) module of capitated managed care in an urban area.

(25) Birthing center services.

(26) Hospice care. As used in this paragraph, the term "hospice care" means a coordinated program of active professional medical attention within the home and outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of

physical, psychological, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement and meets the Medicare requirements for participation as a hospice as provided in 42 CFR Part 418.

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

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

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

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

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

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

(33) Podiatrist services.

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

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

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

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

(38) Chiropractic services: a chiropractor's manual manipulation of the spine to correct a subluxation, if x-ray

demonstrates that a subluxation exists and if the subluxation has resulted in a neuromusculoskeletal condition for which manipulation is appropriate treatment. Reimbursement for chiropractic services shall not exceed Seven Hundred Dollars (\$700.00) per year per recipient.

Notwithstanding any provision of this article, except as authorized in the following paragraph and in Section 43-13-139, neither (a) the limitations on quantity or frequency of use of or the fees or charges for any of the care or services available to recipients under this section, nor (b) the payments or rates of reimbursement to providers rendering care or services authorized under this section to recipients, may be increased, decreased or otherwise changed from the levels in effect on July 1, 1986, unless such is authorized by an amendment to this section by the Legislature. However, the restriction in this paragraph shall not prevent the division from changing the payments or rates of reimbursement to providers without an amendment to this section whenever such changes are required by federal law or regulation, or whenever such changes are necessary to correct administrative errors or omissions in calculating such payments or rates of reimbursement.

Notwithstanding any provision of this article, no new groups or categories of recipients and new types of care and services may be added without enabling legislation from the Mississippi Legislature, except that the division may authorize such changes without enabling legislation when such addition of recipients or services is ordered by a court of proper authority. The director shall keep the Governor advised on a timely basis of the funds available for expenditure and the projected expenditures. In the event current or projected expenditures can be reasonably anticipated to exceed the amounts appropriated for any fiscal year, the Governor, after consultation with the director, shall discontinue any or all of the payment of the types of care and services as provided herein which are deemed to be optional

576 services under Title XIX of the federal Social Security Act, as
577 amended, for any period necessary to not exceed appropriated
578 funds, and when necessary shall institute any other cost
579 containment measures on any program or programs authorized under
580 the article to the extent allowed under the federal law governing
581 such program or programs, it being the intent of the Legislature
582 that expenditures during any fiscal year shall not exceed the
583 amounts appropriated for such fiscal year.

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