By: Senator(s) Bean, Thames, Dearing, Posey, Harvey

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2126
(As Passed the Senate)

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

28 the Medicaid Program.

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

33 (3) Laboratory and X-ray services.

34 (4) Nursing facility services.

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

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64 repealed on July 1, 1997.

65 (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

134 Medicaid, within thirty (30) days after a decision has been
135 rendered through informal hearing procedures.
136 (vii) The provider shall be notified of the
137 hearing date by certified mail within thirty (30) days from the
138 date the Division of Medicaid receives the request for appeal.
139 Notification of the hearing date shall in no event be less than
140 thirty (30) days before the scheduled hearing date. The appeal
141 may be heard on shorter notice by written agreement between the
142 provider and the Division of Medicaid.
143 (viii) Within thirty (30) days from the date of
144 the hearing, the Review Board panel shall render a written
145 recommendation to the Executive Director of the Division of
146 Medicaid setting forth the issues, findings of fact and applicable
147 law, regulations or provisions.
148 (ix) The Executive Director of the Division of
149 Medicaid shall, upon review of the recommendation, the proceedings
150 and the record, prepare a written decision which shall be mailed
151 to the nursing facility provider no later than twenty (20) days
152 after the submission of the recommendation by the panel. The
153 decision of the executive director is final, subject only to
154 judicial review.
155 (x) Appeals from a final decision shall be made to
156 the Chancery Court of Hinds County. The appeal shall be filed
157 with the court within thirty (30) days from the date the decision
158 of the Executive Director of the Division of Medicaid becomes
159 final.
160 (xi) The action of the Division of Medicaid under
161 review shall be stayed until all administrative proceedings have
162 been exhausted.
163 (xii) Appeals by nursing facility providers
164 involving any issues other than those two (2) specified in
165 subparagraphs (i)(A) and (ii)(B) shall be taken in accordance with
166 the administrative hearing procedures established by the Division
167 of Medicaid.

168 (e) When a facility of a category that does not require
169 a certificate of need for construction and that could not be
170 eligible for Medicaid reimbursement is constructed to nursing
171 facility specifications for licensure and certification, and the
172 facility is subsequently converted to a nursing facility pursuant
173 to a certificate of need that authorizes conversion only and the
174 applicant for the certificate of need was assessed an application
175 review fee based on capital expenditures incurred in constructing
176 the facility, the division shall allow reimbursement for capital
177 expenditures necessary for construction of the facility that were
178 incurred within the twenty-four (24) consecutive calendar months
179 immediately preceding the date that the certificate of need
180 authorizing such conversion was issued, to the same extent that
181 reimbursement would be allowed for construction of a new nursing
182 facility pursuant to a certificate of need that authorizes such
183 construction. The reimbursement authorized in this subparagraph
184 (e) may be made only to facilities the construction of which was
185 completed after June 30, 1989. Before the division shall be
186 authorized to make the reimbursement authorized in this
187 subparagraph (e), the division first must have received approval
188 from the Health Care Financing Administration of the United States
189 Department of Health and Human Services of the change in the state
190 Medicaid plan providing for such reimbursement.
191 (5) Periodic screening and diagnostic services for
192 individuals under age twenty-one (21) years as are needed to
193 identify physical and mental defects and to provide health care
194 treatment and other measures designed to correct or ameliorate
195 defects and physical and mental illness and conditions discovered
196 by the screening services regardless of whether these services are
197 included in the state plan. The division may include in its
198 periodic screening and diagnostic program those discretionary
199 services authorized under the federal regulations adopted to
200 implement Title XIX of the federal Social Security Act, as
201 amended. The division, in obtaining physical therapy services,

202 occupational therapy services, and services for individuals with
203 speech, hearing and language disorders, may enter into a
204 cooperative agreement with the State Department of Education for
205 the provision of such services to handicapped students by public
206 school districts using state funds which are provided from the
207 appropriation to the Department of Education to obtain federal
208 matching funds through the division. The division, in obtaining
209 medical and psychological evaluations for children in the custody
210 of the State Department of Human Services may enter into a
211 cooperative agreement with the State Department of Human Services
212 for the provision of such services using state funds which are
213 provided from the appropriation to the Department of Human
214 Services to obtain federal matching funds through the division.
215 On July 1, 1993, all fees for periodic screening and
216 diagnostic services under this paragraph (5) shall be increased by
217 twenty-five percent (25%) of the reimbursement rate in effect on
218 June 30, 1993.
219 (6) Physicians' services. On January 1, 1996, all fees for
220 physicians' services shall be reimbursed at seventy percent (70%)
221 of the rate established on January 1, 1994, under Medicare (Title
222 XVIII of the Social Security Act), as amended, and the division
223 may adjust the physicians' reimbursement schedule to reflect the
224 differences in relative value between Medicaid and Medicare.
225 (7) (a) Home health services for eligible persons, not to
226 exceed in cost the prevailing cost of nursing facility services,
227 not to exceed sixty (60) visits per year.
228 (b) The division may revise reimbursement for home
229 health services in order to establish equity between reimbursement
230 for home health services and reimbursement for institutional
231 services within the Medicaid program. This paragraph (b) shall
232 stand repealed on July 1, 1997.
233 (8) Emergency medical transportation services. On January
234 1, 1994, emergency medical transportation services shall be
235 reimbursed at seventy percent (70%) of the rate established under

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

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

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

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

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

270 As used in this paragraph (9), "estimated acquisition cost"
271 means the division's best estimate of what price providers
272 generally are paying for a drug in the package size that providers
273 buy most frequently. Product selection shall be made in
274 compliance with existing state law; however, the division may
275 reimburse as if the prescription had been filled under the generic
276 name. The division may provide otherwise in the case of specified
277 drugs when the consensus of competent medical advice is that
278 trademarked drugs are substantially more effective.
279 (10) Dental care that is an adjunct to treatment of an acute
280 medical or surgical condition; services of oral surgeons and
281 dentists in connection with surgery related to the jaw or any
282 structure contiguous to the jaw or the reduction of any fracture
283 of the jaw or any facial bone; and emergency dental extractions
284 and treatment related thereto. On January 1, 1994, all fees for
285 dental care and surgery under authority of this paragraph (10)
286 shall be increased by twenty percent (20%) of the reimbursement
287 rate as provided in the Dental Services Provider Manual in effect
288 on December 31, 1993.
289 (11) Eyeglasses necessitated by reason of eye surgery, and
290 as prescribed by a physician skilled in diseases of the eye or an
291 optometrist, whichever the patient may select.
292 (12) Intermediate care facility services.
293 (a) The division shall make full payment to all
294 intermediate care facilities for the mentally retarded for each
295 day, not exceeding eighty-four (84) days per year, that a patient
296 is absent from the facility on home leave. Payment may be made
297 for the following home leave days in addition to the 84-day
298 limitation: Christmas, the day before Christmas, the day after
299 Christmas, Thanksgiving, the day before Thanksgiving and the day
300 after Thanksgiving. However, before payment may be made for more
301 than eighteen (18) home leave days in a year for a patient, the
302 patient must have written authorization from a physician stating
303 that the patient is physically and mentally able to be away from

304 the facility on home leave. Such authorization must be filed with
305 the division before it will be effective, and the authorization
306 shall be effective for three (3) months from the date it is
307 received by the division, unless it is revoked earlier by the
308 physician because of a change in the condition of the patient.
309 (b) All state-owned intermediate care facilities for
310 the mentally retarded shall be reimbursed on a full reasonable
311 cost basis.
312 (13) Family planning services, including drugs, supplies and
313 devices, when such services are under the supervision of a
314 physician.
315 (14) Clinic services. Such diagnostic, preventive,
316 therapeutic, rehabilitative or palliative services furnished to an
317 outpatient by or under the supervision of a physician or dentist
318 in a facility which is not a part of a hospital but which is
319 organized and operated to provide medical care to outpatients.
320 Clinic services shall include any services reimbursed as
321 outpatient hospital services which may be rendered in such a
322 facility, including those that become so after July 1, 1991. On
323 January 1, 1994, all fees for physicians' services reimbursed
324 under authority of this paragraph (14) shall be reimbursed at
325 seventy percent (70%) of the rate established on January 1, 1993,
326 under Medicare (Title XVIII of the Social Security Act), as
327 amended, or the amount that would have been paid under the
328 division's fee schedule that was in effect on December 31, 1993,
329 whichever is greater, and the division may adjust the physicians'
330 reimbursement schedule to reflect the differences in relative
331 value between Medicaid and Medicare. However, on January 1, 1994,
332 the division may increase any fee for physicians' services in the
333 division's fee schedule on December 31, 1993, that was greater
334 than seventy percent (70%) of the rate established under Medicare
335 by no more than ten percent (10%). On January 1, 1994, all fees
336 for dentists' services reimbursed under authority of this
337 paragraph (14) shall be increased by twenty percent (20%) of the

338 reimbursement rate as provided in the Dental Services Provider
339 Manual in effect on December 31, 1993.
340 (15) Home- and community-based services, as provided under
341 Title XIX of the federal Social Security Act, as amended, under
342 waivers, subject to the availability of funds specifically
343 appropriated therefor by the Legislature. Payment for such
344 services shall be limited to individuals who would be eligible for
345 and would otherwise require the level of care provided in a
346 nursing facility. The division shall certify case management
347 agencies to provide case management services and provide for home-
348 and community-based services for eligible individuals under this
349 paragraph. The home- and community-based services under this
350 paragraph and the activities performed by certified case
351 management agencies under this paragraph shall be funded using
352 state funds that are provided from the appropriation to the
353 Division of Medicaid and used to match federal funds under a
354 cooperative agreement between the division and the Department of
355 Human Services.
356 (16) Mental health services. Approved therapeutic and case
357 management services provided by (a) an approved regional mental
358 health/retardation center established under Sections 41-19-31
359 through 41-19-39, or by another community mental health service
360 provider meeting the requirements of the Department of Mental
361 Health to be an approved mental health/retardation center if
362 determined necessary by the Department of Mental Health, using
363 state funds which are provided from the appropriation to the State
364 Department of Mental Health and used to match federal funds under
365 a cooperative agreement between the division and the department,
366 or (b) a facility which is certified by the State Department of
367 Mental Health to provide therapeutic and case management services,
368 to be reimbursed on a fee for service basis. Any such services
369 provided by a facility described in paragraph (b) must have the
370 prior approval of the division to be reimbursable under this
371 section. After June 30, 1997, mental health services provided by

372 regional mental health/retardation centers established under
373 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
374 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
375 psychiatric residential treatment facilities as defined in Section
376 43-11-1, or by another community mental health service provider
377 meeting the requirements of the Department of Mental Health to be
378 an approved mental health/retardation center if determined
379 necessary by the Department of Mental Health, shall not be
380 included in or provided under any capitated managed care pilot
381 program provided for under paragraph (24) of this section.
382 (17) Durable medical equipment services and medical supplies
383 restricted to patients receiving home health services unless
384 waived on an individual basis by the division. The division shall
385 not expend more than Three Hundred Thousand Dollars ($300,000.00)
386 of state funds annually to pay for medical supplies authorized
387 under this paragraph.
388 (18) Notwithstanding any other provision of this section to
389 the contrary, the division shall make additional reimbursement to
390 hospitals which serve a disproportionate share of low-income
391 patients and which meet the federal requirements for such payments
392 as provided in Section 1923 of the federal Social Security Act and
393 any applicable regulations.
394 (19) (a) Perinatal risk management services. The division
395 shall promulgate regulations to be effective from and after
396 October 1, 1988, to establish a comprehensive perinatal system for
397 risk assessment of all pregnant and infant Medicaid recipients and
398 for management, education and follow-up for those who are
399 determined to be at risk. Services to be performed include case
400 management, nutrition assessment/counseling, psychosocial
401 assessment/counseling and health education. The division shall
402 set reimbursement rates for providers in conjunction with the
403 State Department of Health.
404 (b) Early intervention system services. The division
405 shall cooperate with the State Department of Health, acting as

406 lead agency, in the development and implementation of a statewide
407 system of delivery of early intervention services, pursuant to
408 Part H of the Individuals with Disabilities Education Act (IDEA).
409 The State Department of Health shall certify annually in writing
410 to the director of the division the dollar amount of state early
411 intervention funds available which shall be utilized as a
412 certified match for Medicaid matching funds. Those funds then
413 shall be used to provide expanded targeted case management
414 services for Medicaid eligible children with special needs who are
415 eligible for the state's early intervention system.
416 Qualifications for persons providing service coordination shall be
417 determined by the State Department of Health and the Division of
418 Medicaid.
419 (20) Home- and community-based services for physically
420 disabled approved services as allowed by a waiver from the U.S.
421 Department of Health and Human Services for home- and
422 community-based services for physically disabled people using
423 state funds which are provided from the appropriation to the State
424 Department of Rehabilitation Services and used to match federal
425 funds under a cooperative agreement between the division and the
426 department, provided that funds for these services are
427 specifically appropriated to the Department of Rehabilitation
428 Services.
429 (21) Nurse practitioner services. Services furnished by a
430 registered nurse who is licensed and certified by the Mississippi
431 Board of Nursing as a nurse practitioner including, but not
432 limited to, nurse anesthetists, nurse midwives, family nurse
433 practitioners, family planning nurse practitioners, pediatric
434 nurse practitioners, obstetrics-gynecology nurse practitioners and
435 neonatal nurse practitioners, under regulations adopted by the
436 division. Reimbursement for such services shall not exceed ninety
437 percent (90%) of the reimbursement rate for comparable services
438 rendered by a physician.
439 (22) Ambulatory services delivered in federally qualified

440 health centers and in clinics of the local health departments of
441 the State Department of Health for individuals eligible for
442 medical assistance under this article based on reasonable costs as
443 determined by the division.

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

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

469 (25) Birthing center services.

470 (26) Hospice care. As used in this paragraph, the term
471 "hospice care" means a coordinated program of active professional
472 medical attention within the home and outpatient and inpatient
473 care which treats the terminally ill patient and family as a unit,

474 employing a medically directed interdisciplinary team. The
475 program provides relief of severe pain or other physical symptoms
476 and supportive care to meet the special needs arising out of
477 physical, psychological, spiritual, social and economic stresses
478 which are experienced during the final stages of illness and
479 during dying and bereavement and meets the Medicare requirements
480 for participation as a hospice as provided in 42 CFR Part 418.
481 (27) Group health plan premiums and cost sharing if it is
482 cost effective as defined by the Secretary of Health and Human
483 Services.
484 (28) Other health insurance premiums which are cost
485 effective as defined by the Secretary of Health and Human
486 Services. Medicare eligible must have Medicare Part B before
487 other insurance premiums can be paid.
488 (29) The Division of Medicaid may apply for a waiver from
489 the Department of Health and Human Services for home- and
490 community-based services for developmentally disabled people using
491 state funds which are provided from the appropriation to the State
492 Department of Mental Health and used to match federal funds under
493 a cooperative agreement between the division and the department,
494 provided that funds for these services are specifically
495 appropriated to the Department of Mental Health.
496 (30) Pediatric skilled nursing services for eligible persons
497 under twenty-one (21) years of age.
498 (31) Targeted case management services for children with
499 special needs, under waivers from the U.S. Department of Health
500 and Human Services, using state funds that are provided from the
501 appropriation to the Mississippi Department of Human Services and
502 used to match federal funds under a cooperative agreement between
503 the division and the department.
504 (32) Care and services provided in Christian Science
505 Sanatoria operated by or listed and certified by The First Church
506 of Christ Scientist, Boston, Massachusetts, rendered in connection
507 with treatment by prayer or spiritual means to the extent that

508 such services are subject to reimbursement under Section 1903 of
509 the Social Security Act.
510 (33) Podiatrist services.
511 (34) Personal care services provided in a pilot program to
512 not more than forty (40) residents at a location or locations to
513 be determined by the division and delivered by individuals
514 qualified to provide such services, as allowed by waivers under
515 Title XIX of the Social Security Act, as amended. The division
516 shall not expend more than Three Hundred Thousand Dollars
517 ($300,000.00) annually to provide such personal care services.
518 The division shall develop recommendations for the effective
519 regulation of any facilities that would provide personal care
520 services which may become eligible for Medicaid reimbursement
521 under this section, and shall present such recommendations with
522 any proposed legislation to the 1996 Regular Session of the
523 Legislature on or before January 1, 1996.
524 (35) Services and activities authorized in Sections
525 43-27-101 and 43-27-103, using state funds that are provided from
526 the appropriation to the State Department of Human Services and
527 used to match federal funds under a cooperative agreement between
528 the division and the department.
529 (36) Nonemergency transportation services for
530 Medicaid-eligible persons, to be provided by the Department of
531 Human Services. The division may contract with additional
532 entities to administer nonemergency transportation services as it
533 deems necessary. All providers shall have a valid driver's
534 license, vehicle inspection sticker and a standard liability
535 insurance policy covering the vehicle.
536 (37) Targeted case management services for individuals with
537 chronic diseases, with expanded eligibility to cover services to
538 uninsured recipients, on a pilot program basis. This paragraph
539 (37) shall be contingent upon continued receipt of special funds
540 from the Health Care Financing Authority and private foundations
541 who have granted funds for planning these services. No funding

542 for these services shall be provided from State General Funds.
543 (38) Chiropractic services: a chiropractor's manual
544 manipulation of the spine to correct a subluxation, if x-ray
545 demonstrates that a subluxation exists and if the subluxation has
546 resulted in a neuromusculoskeletal condition for which
547 manipulation is appropriate treatment. Reimbursement for
548 chiropractic services shall not exceed Seven Hundred Dollars
549 ($700.00) per year per recipient.
550 Notwithstanding any provision of this article, except as
551 authorized in the following paragraph and in Section 43-13-139,
552 neither (a) the limitations on quantity or frequency of use of or
553 the fees or charges for any of the care or services available to
554 recipients under this section, nor (b) the payments or rates of
555 reimbursement to providers rendering care or services authorized
556 under this section to recipients, may be increased, decreased or
557 otherwise changed from the levels in effect on July 1, 1986,
558 unless such is authorized by an amendment to this section by the
559 Legislature. However, the restriction in this paragraph shall not
560 prevent the division from changing the payments or rates of
561 reimbursement to providers without an amendment to this section
562 whenever such changes are required by federal law or regulation,
563 or whenever such changes are necessary to correct administrative
564 errors or omissions in calculating such payments or rates of
565 reimbursement.
566 Notwithstanding any provision of this article, no new groups
567 or categories of recipients and new types of care and services may
568 be added without enabling legislation from the Mississippi
569 Legislature, except that the division may authorize such changes
570 without enabling legislation when such addition of recipients or
571 services is ordered by a court of proper authority. The director
572 shall keep the Governor advised on a timely basis of the funds
573 available for expenditure and the projected expenditures. In the
574 event current or projected expenditures can be reasonably
575 anticipated to exceed the amounts appropriated for any fiscal

576 year, the Governor, after consultation with the director, shall
577 discontinue any or all of the payment of the types of care and
578 services as provided herein which are deemed to be optional
579 services under Title XIX of the federal Social Security Act, as
580 amended, for any period necessary to not exceed appropriated
581 funds, and when necessary shall institute any other cost
582 containment measures on any program or programs authorized under
583 the article to the extent allowed under the federal law governing
584 such program or programs, it being the intent of the Legislature
585 that expenditures during any fiscal year shall not exceed the
586 amounts appropriated for such fiscal year.
587 SECTION 2. This act shall take effect and be in force from
588 and after its passage.