

By: Senator(s) Furniss, Thames, White (5th) To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2434 (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 NURSING
3 AND ICFMR FACILITIES MEDICAID REIMBURSEMENT; AND FOR RELATED
4 PURPOSES.

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

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

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

15 (1) Inpatient hospital services.

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

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

29 the Medicaid Program.

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

34 (3) Laboratory and X-ray services.

35 (4) Nursing facility services.

36 (a) The division shall make full payment to nursing  
37 facilities for each day, not exceeding fifty-two (52) days per  
38 year, that a patient is absent from the facility on home leave.  
39 However, before payment may be made for more than eighteen (18)  
40 home leave days in a year for a patient, the patient must have  
41 written authorization from a physician stating that the patient is  
42 physically and mentally able to be away from the facility on home  
43 leave. Such authorization must be filed with the division before  
44 it will be effective and the authorization shall be effective for  
45 three (3) months from the date it is received by the division,  
46 unless it is revoked earlier by the physician because of a change  
47 in the condition of the patient.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

234 (8) Emergency medical transportation services. On January  
235 1, 1994, emergency medical transportation services shall be  
236 reimbursed at seventy percent (70%) of the rate established under

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

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

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

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

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



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

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

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

293           (12) Intermediate care facility services.

294           (a) The division shall make full payment to all  
295 intermediate care facilities for the mentally retarded for each  
296 day, not exceeding eighty-four (84) days per year, that a patient  
297 is absent from the facility on home leave. Payment may be made  
298 for the following home leave days in addition to the 84-day  
299 limitation: Christmas, the day before Christmas, the day after  
300 Christmas, Thanksgiving, the day before Thanksgiving and the day  
301 after Thanksgiving. However, before payment may be made for more  
302 than eighteen (18) home leave days in a year for a patient, the  
303 patient must have written authorization from a physician stating  
304 that the patient is physically and mentally able to be away from

305 the facility on home leave. Such authorization must be filed with  
306 the division before it will be effective, and the authorization  
307 shall be effective for three (3) months from the date it is  
308 received by the division, unless it is revoked earlier by the  
309 physician because of a change in the condition of the patient.

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

313 (13) Family planning services, including drugs, supplies and  
314 devices, when such services are under the supervision of a  
315 physician.

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

339 reimbursement rate as provided in the Dental Services Provider  
340 Manual in effect on December 31, 1993.

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

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

373 regional mental health/retardation centers established under  
374 Sections 41-19-31 through 41-19-39, or by hospitals as defined in  
375 Section 41-9-3(a) and/or their subsidiaries and divisions, or by  
376 psychiatric residential treatment facilities as defined in Section  
377 43-11-1, or by another community mental health service provider  
378 meeting the requirements of the Department of Mental Health to be  
379 an approved mental health/retardation center if determined  
380 necessary by the Department of Mental Health, shall not be  
381 included in or provided under any capitated managed care pilot  
382 program provided for under paragraph (24) of this section.

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

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

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

405 (b) Early intervention system services. The division  
406 shall cooperate with the State Department of Health, acting as

407 lead agency, in the development and implementation of a statewide  
408 system of delivery of early intervention services, pursuant to  
409 Part H of the Individuals with Disabilities Education Act (IDEA).

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

417 Qualifications for persons providing service coordination shall be  
418 determined by the State Department of Health and the Division of  
419 Medicaid.

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

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

440 (22) Ambulatory services delivered in federally qualified

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

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

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

470 (25) Birthing center services.

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

475 employing a medically directed interdisciplinary team. The  
476 program provides relief of severe pain or other physical symptoms  
477 and supportive care to meet the special needs arising out of  
478 physical, psychological, spiritual, social and economic stresses  
479 which are experienced during the final stages of illness and  
480 during dying and bereavement and meets the Medicare requirements  
481 for participation as a hospice as provided in 42 CFR Part 418.

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

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

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

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

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

505 (32) Care and services provided in Christian Science  
506 Sanatoria operated by or listed and certified by The First Church  
507 of Christ Scientist, Boston, Massachusetts, rendered in connection  
508 with treatment by prayer or spiritual means to the extent that

509 such services are subject to reimbursement under Section 1903 of  
510 the Social Security Act.

511 (33) Podiatrist services.

512 (34) Personal care services provided in a pilot program to  
513 not more than forty (40) residents at a location or locations to  
514 be determined by the division and delivered by individuals  
515 qualified to provide such services, as allowed by waivers under  
516 Title XIX of the Social Security Act, as amended. The division  
517 shall not expend more than Three Hundred Thousand Dollars  
518 (\$300,000.00) annually to provide such personal care services.  
519 The division shall develop recommendations for the effective  
520 regulation of any facilities that would provide personal care  
521 services which may become eligible for Medicaid reimbursement  
522 under this section, and shall present such recommendations with  
523 any proposed legislation to the 1996 Regular Session of the  
524 Legislature on or before January 1, 1996.

525 (35) Services and activities authorized in Sections  
526 43-27-101 and 43-27-103, using state funds that are provided from  
527 the appropriation to the State Department of Human Services and  
528 used to match federal funds under a cooperative agreement between  
529 the division and the department.

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

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



543 for these services shall be provided from State General Funds.

544 (38) Chiropractic services: a chiropractor's manual  
545 manipulation of the spine to correct a subluxation, if x-ray  
546 demonstrates that a subluxation exists and if the subluxation has  
547 resulted in a neuromusculoskeletal condition for which  
548 manipulation is appropriate treatment. Reimbursement for  
549 chiropractic services shall not exceed Seven Hundred Dollars  
550 (\$700.00) per year per recipient.

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

567 Notwithstanding any provision of this article, no new groups  
568 or categories of recipients and new types of care and services may  
569 be added without enabling legislation from the Mississippi  
570 Legislature, except that the division may authorize such changes  
571 without enabling legislation when such addition of recipients or  
572 services is ordered by a court of proper authority. The director  
573 shall keep the Governor advised on a timely basis of the funds  
574 available for expenditure and the projected expenditures. In the  
575 event current or projected expenditures can be reasonably  
576 anticipated to exceed the amounts appropriated for any fiscal

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

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