By: Representative Bourdeaux

To: Public Health and Welfare; Appropriations

HOUSE BILL NO. 1016

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO AUTHORIZE MEDICAID REIMBURSEMENT FOR IMPLANTABLE INFUSION PUMPS
3 FOR RECIPIENTS WITH CERTAIN DIAGNOSES; 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) Repealed.

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

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

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

59 (A) Matters relating to cost reports
60 including, but not limited to, allowable costs and cost
61 adjustments resulting from desk reviews and audits.

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

65 (ii) The Review Board shall be composed of six (6)

66 members, three (3) having expertise in one (1) of the two (2)
67 areas set forth above and three (3) having expertise in the other
68 area set forth above. Each panel of three (3) shall only review
69 appeals arising in its area of expertise. The members shall be
70 appointed as follows:
71 (A) In each of the areas of expertise defined
72 under subparagraphs (i)(A) and (i)(B), the Executive Director of
73 the Division of Medicaid shall appoint one (1) person chosen from
74 the private sector nursing home industry in the state, which may
75 include independent accountants and consultants serving the
76 industry;
77 (B) In each of the areas of expertise defined
78 under subparagraphs (i)(A) and (i)(B), the Executive Director of
79 the Division of Medicaid shall appoint one (1) person who is
80 employed by the state who does not participate directly in desk
81 reviews or audits of nursing facilities in the two (2) areas of
82 review;
83 (C) The two (2) members appointed by the
84 Executive Director of the Division of Medicaid in each area of
85 expertise shall appoint a third member in the same area of
86 expertise.
87 In the event of a conflict of interest on the part of any
88 Review Board members, the Executive Director of the Division of
89 Medicaid or the other two (2) panel members, as applicable, shall
90 appoint a substitute member for conducting a specific review.
91 (iii) The Review Board panels shall have the power
92 to preserve and enforce order during hearings; to issue subpoenas;
93 to administer oaths; to compel attendance and testimony of
94 witnesses; or to compel the production of books, papers, documents
95 and other evidence; or the taking of depositions before any
96 designated individual competent to administer oaths; to examine
97 witnesses; and to do all things conformable to law that may be
98 necessary to enable it effectively to discharge its duties. The
99 Review Board panels may appoint such person or persons as they

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

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

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

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

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

211 (b) Repealed.

212 (8) Emergency medical transportation services. On January
213 1, 1994, emergency medical transportation services shall be
214 reimbursed at seventy percent (70%) of the rate established under
215 Medicare (Title XVIII of the Social Security Act), as amended.
216 "Emergency medical transportation services" shall mean, but shall
217 not be limited to, the following services by a properly permitted
218 ambulance operated by a properly licensed provider in accordance
219 with the Emergency Medical Services Act of 1974 (Section 41-59-1
220 et seq.): (i) basic life support, (ii) advanced life support,
221 (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi)
222 disposable supplies, (vii) similar services.

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

235 Payment for other covered drugs, other than multiple source

236 drugs with HCFA upper limits, shall not exceed the lower of the
237 estimated acquisition cost as determined by the division plus a
238 dispensing fee of Four Dollars and Ninety-one Cents ($4.91) or the
239 providers' usual and customary charge to the general public.

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

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

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

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

268 (11) Eyeglasses necessitated by reason of eye surgery, and
269 as prescribed by a physician skilled in diseases of the eye or an

270 optometrist, whichever the patient may select.

271 (12) Intermediate care facility services.

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

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

288 (13) Family planning services, including drugs, supplies and
289 devices, when such services are under the supervision of a
290 physician.

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

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

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

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

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

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

380 (b) Early intervention system services. The division
381 shall cooperate with the State Department of Health, acting as
382 lead agency, in the development and implementation of a statewide
383 system of delivery of early intervention services, pursuant to
384 Part H of the Individuals with Disabilities Education Act (IDEA).
385 The State Department of Health shall certify annually in writing
386 to the director of the division the dollar amount of state early
387 intervention funds available which shall be utilized as a
388 certified match for Medicaid matching funds. Those funds then
389 shall be used to provide expanded targeted case management
390 services for Medicaid eligible children with special needs who are
391 eligible for the state's early intervention system.
392 Qualifications for persons providing service coordination shall be
393 determined by the State Department of Health and the Division of
394 Medicaid.

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

405 (21) Nurse practitioner services. Services furnished by a

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

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

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

434 (24) Managed care services in a program to be developed by
435 the division by a public or private provider. Notwithstanding any
436 other provision in this article to the contrary, the division
437 shall establish rates of reimbursement to providers rendering care
438 and services authorized under this section, and may revise such
439 rates of reimbursement without amendment to this section by the

440 Legislature for the purpose of achieving effective and accessible
441 health services, and for responsible containment of costs. This
442 shall include, but not be limited to, one (1) module of capitated
443 managed care in a rural area, and one (1) module of capitated
444 managed care in an urban area.
445 (25) Birthing center services.
446 (26) Hospice care. As used in this paragraph, the term
447 "hospice care" means a coordinated program of active professional
448 medical attention within the home and outpatient and inpatient
449 care which treats the terminally ill patient and family as a unit,
450 employing a medically directed interdisciplinary team. The
451 program provides relief of severe pain or other physical symptoms
452 and supportive care to meet the special needs arising out of
453 physical, psychological, spiritual, social and economic stresses
454 which are experienced during the final stages of illness and
455 during dying and bereavement and meets the Medicare requirements
456 for participation as a hospice as provided in 42 CFR Part 418.
457 (27) Group health plan premiums and cost sharing if it is
458 cost effective as defined by the Secretary of Health and Human
459 Services.
460 (28) Other health insurance premiums which are cost
461 effective as defined by the Secretary of Health and Human
462 Services. Medicare eligible must have Medicare Part B before
463 other insurance premiums can be paid.
464 (29) The Division of Medicaid may apply for a waiver from
465 the Department of Health and Human Services for home- and
466 community-based services for developmentally disabled people using
467 state funds which are provided from the appropriation to the State
468 Department of Mental Health and used to match federal funds under
469 a cooperative agreement between the division and the department,
470 provided that funds for these services are specifically
471 appropriated to the Department of Mental Health.
472 (30) Pediatric skilled nursing services for eligible persons
473 under twenty-one (21) years of age.

474 (31) Targeted case management services for children with
475 special needs, under waivers from the U.S. Department of Health
476 and Human Services, using state funds that are provided from the
477 appropriation to the Mississippi Department of Human Services and
478 used to match federal funds under a cooperative agreement between
479 the division and the department.
480 (32) Care and services provided in Christian Science
481 Sanatoria operated by or listed and certified by The First Church
482 of Christ Scientist, Boston, Massachusetts, rendered in connection
483 with treatment by prayer or spiritual means to the extent that
484 such services are subject to reimbursement under Section 1903 of
485 the Social Security Act.
486 (33) Podiatrist services.
487 (34) Personal care services provided in a pilot program to
488 not more than forty (40) residents at a location or locations to
489 be determined by the division and delivered by individuals
490 qualified to provide such services, as allowed by waivers under
491 Title XIX of the Social Security Act, as amended. The division
492 shall not expend more than Three Hundred Thousand Dollars
493 ($300,000.00) annually to provide such personal care services.
494 The division shall develop recommendations for the effective
495 regulation of any facilities that would provide personal care
496 services which may become eligible for Medicaid reimbursement
497 under this section, and shall present such recommendations with
498 any proposed legislation to the 1996 Regular Session of the
499 Legislature on or before January 1, 1996.
500 (35) Services and activities authorized in Sections
501 43-27-101 and 43-27-103, using state funds that are provided from
502 the appropriation to the State Department of Human Services and
503 used to match federal funds under a cooperative agreement between
504 the division and the department.
505 (36) Nonemergency transportation services for
506 Medicaid-eligible persons, to be provided by the Department of
507 Human Services. The division may contract with additional

508 entities to administer non-emergency transportation services as it
509 deems necessary. All providers shall have a valid driver's
510 license, vehicle inspection sticker and a standard liability
511 insurance policy covering the vehicle.
512 (37) Targeted case management services for individuals with
513 chronic diseases, with expanded eligibility to cover services to
514 uninsured recipients, on a pilot program basis. This paragraph
515 (37) shall be contingent upon continued receipt of special funds
516 from the Health Care Financing Authority and private foundations
517 who have granted funds for planning these services. No funding
518 for these services shall be provided from State General Funds.
519 (38) Chiropractic services: a chiropractor's manual
520 manipulation of the spine to correct a subluxation, if x-ray
521 demonstrates that a subluxation exists and if the subluxation has
522 resulted in a neuromusculoskeletal condition for which
523 manipulation is appropriate treatment. Reimbursement for
524 chiropractic services shall not exceed Seven Hundred Dollars
525 ($700.00) per year per recipient.
526 (39) Implantable infusion pumps for recipients with cerebral
527 palsy, traumatic brain injury, spinal cord injury, multiple
528 sclerosis and other cerebral and spinal diagnoses by a licensed
529 physician. Reimbursement for implantable infusion pumps will be
530 paid to facilities outside per diem at manufacturer's invoice, not
531 to exceed Ten Thousand Dollars ($10,000.00) per year. The drug
532 used in the pump will be reimburseable at ninety-five percent
533 (95%) of the average wholesale price to physicians or at the
534 facility's outpatient rate.
535 Notwithstanding any provision of this article, except as
536 authorized in the following paragraph and in Section 43-13-139,
537 neither (a) the limitations on quantity or frequency of use of or
538 the fees or charges for any of the care or services available to
539 recipients under this section, nor (b) the payments or rates of
540 reimbursement to providers rendering care or services authorized
541 under this section to recipients, may be increased, decreased or

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

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

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