MISSISSIPPI LEGISLATURE REGULAR SESSION 2000

By: Simmons, Blackmon, Turner, Johnson (38th)

To: Juvenile Justice; Appropriations

SENATE BILL NO. 2347

AN ACT TO AMEND SECTIONS 43-27-301 THROUGH 43-27-307, MISSISSIPPI CODE OF 1972, TO ESTABLISH THE JUVENILE HEALTH RECOVERY CENTERS OF MISSISSIPPI PILOT PROGRAM, TO CREATE FIVE RESIDENTIAL FACILITIES FOR THE TREATMENT AND TRAINING OF COMPULSORY-SCHOOL-AGE CHILDREN WHO HAVE BEEN EXPELLED OR SUSPENDED FROM SCHOOL FOR SERIOUS AND CHRONIC MISCONDUCT PURSUANT TO ORDER OF THE YOUTH COURT OR VOLUNTARY COMMITMENT, TO ESTABLISH AND EMPOWER THE JUVENILE HEALTH RECOVERY BOARD, TO PROVIDE FOR THE CONSTRUCTION, EQUIPPING, SUPPORT AND MAINTENANCE OF THE FACILITIES, TO PROVIDE FOR THE OPERATION OF THE CENTERS, TO DEFINE THOSE CHILDREN ELIGIBLE FOR SERVICE AT THE CENTERS AND TO DEFINE THOSE SERVICES TO BE PROVIDED AT THE CENTERS; TO CODIFY SECTION 43-27-308, MISSISSIPPI CODE OF 1972, TO CREATE A SPECIAL FUND IN THE STATE TREASURY FOR SUPPORT OF THE PROGRAM TO BE ADMINISTERED BY THE JUVENILE HEALTH RECOVERY BOARD; TO AMEND SECTION 43-21-605, MISSISSIPPI CODE OF 1972, TO AUTHORIZE YOUTH COURT PLACEMENT ORDERS TO THE FACILITIES; TO AMEND SECTION 37-13-92, MISSISSIPPI CODE OF 1972, TO AUTHORIZE LOCAL SCHOOL BOARDS TO REFER SUCH CHILDREN TO THE YOUTH COURT FOR PLACEMENT IN THESE FACILITIES IF THE ALTERNATIVE SCHOOL PROGRAM IS NOT APPROPRIATE AND TO CLARIFY THE DISCRETION OF SCHOOL SUPERINTENDENTS IN ASSIGNING STUDENTS TO ALTERNATIVE SCHOOLS; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO AUTHORIZE MEDICAID REIMBURSEMENT FOR SERVICES AT THESE FACILITIES ESTABLISHED UNDER THE PROGRAM; AND FOR RELATED PURPOSES.

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

SECTION 1. Section 43-27-301, Mississippi Code of 1972, is amended as follows:

43-27-301. The purpose of this chapter is to <u>create, equip and maintain</u> a comprehensive system of a multidisciplinary continuum of care and services for compulsory-school-age children, including, but not limited to, in-home treatment, family-based

programs, therapeutic foster care, community-based programs, residential therapeutic facilities or rescue centers for certain categories of compulsory-school-age children. These facilities shall be known as * * * "Juvenile Health Recovery Centers of Mississippi." These facilities shall offer a full range of recommended treatment options for children in the following categories:

(a) Children suspended or expelled from a local school district for serious and chronic misconduct;

(b) Children diagnosed to have severe mental health problems who have been voluntarily placed in a program or facility by the child's parent(s) or guardian(s); or

(c) Neglected, abused or delinquent children with serious emotional or behavioral problems that would be subject to the jurisdiction of the Department of Human Services or the youth court; * * * or other categories of children not expressly provided above * * * as provided by law.

SECTION 2. Section 43-27-303, Mississippi Code of 1972, is amended as follows:

43-27-303. The Juvenile Health Recovery Facilities of Mississippi shall be established and operated on a phased-in pilot program basis, and shall be under the administrative authority of a Juvenile Health Recovery * * * Board consisting of the following members:

(a) The Attorney General;

(b) The Medical Director of the Division of Medicaid;

(c) The Director of the Division of Family and Children's Services, Department of Human Services;

(d) A representative from the Department of Mental Health;

(e) The Associate State Superintendent of Education,

Office of Academic Education;

(f) The Public Policy Chair, Mississippi Early Childhood Association;

(g) The Executive Director of the Mississippi Association of School Superintendents;

(h) The Executive Director of the Public Education Forum of Mississippi;

(i) A pediatric specialist representative from the University Medical Center Children's Hospital;

(j) A representative from the Mississippi Economic Council; and

(k) Up to six (6) persons appointed by the chairman, of whom not less than three (3) shall have special expertise in working with children and youth special needs.

The Chairmen of the House Juvenile Justice Committee and the Senate Juvenile Justice Committee shall serve as ex-officio nonvoting members of the board. The board may accept grants, contributions or other funds from any other sources, either public or private, to employ consultants or other professionals as may be necessary to carry out the duties and responsibilities of the board.

No later than September 30, 1999, the Juvenile Health Recovery Advisory Board shall have an organizational meeting upon the call of the Attorney General, who shall serve as chairman of the board. A vice chairman shall also be selected by the membership of the advisory board. Board members may designate other appropriate representatives of their offices to attend and fully act for and on behalf of the board member. The chairman of

the advisory board shall be responsible for establishing a calendar and notices of meetings.

SECTION 3. Section 43-27-305, Mississippi Code of 1972, is amended as follows:

43-27-305. The Juvenile Health Recovery * * * Board shall have the following powers and responsibilities:

(a) The board shall promulgate rules and regulations as necessary to implement and administer a Juvenile Health Recovery Program;

(b) The board shall develop a long-term comprehensive plan for implementation of a coordinated array of Juvenile Health Recovery Programs which may include in-home treatment, family-based programs, therapeutic foster care, community-based programs, regional family resource and youth services centers, rescue centers and residential therapeutic facilities;

(c) The board shall select the location for five (5) pilot Juvenile Health Recovery Programs, one (1) to be in each of the five (5) Mississippi congressional districts;

(d) The board shall coordinate the delivery and funding of services at such facilities, utilizing whatever funding form state, local, federal and private sources may be made available to the board;

(e) The board shall * * * establish or utilize local interagency coordinating entities and multidisciplinary assessment and planning (MAP) teams as local advisory councils for each Juvenile Health Recovery Program. Such local advisory councils may assist in the coordination and provision of services to the children, and shall consist of the local school superintendent,

local law enforcement officers, the director of the regional mental health/retardation center, school guidance counselors and other members as deemed appropriate by the board;

(f) The board shall conduct empirical and theoretical research to develop an appropriate cost/benefit analysis of the recommended programs upon full implementation, including a comparison of alternative societal costs which may be incurred without the recommended programs. Such costs may include estimates of incarceration in correctional institutions, law enforcement efforts, social services, legal services, judicial services and human suffering.

(g) * * * The Juvenile Health Recovery * * * Board * * * may contract with providers of health, education and other residential services to the children to be served by such programs, provided * * * that such programs are consistent with the recommendations of the Juvenile Health Recovery * * * Board.

SECTION 4. Section 43-27-307, Mississippi Code of 1972, is amended as follows:

43-27-307. (1) The Juvenile Health Recovery * * * Board shall submit to the Governor and the Legislature, on or before February 1, 2000, a recommendation for a comprehensive, multidisciplinary plan for the care, treatment and placement of children identified in Section 43-27-303.

(2) The Juvenile Health Record Board shall submit to the Governor and the Legislature, on or before September 15, 2000, recommended rules and regulations for the operation of the Juvenile Health Recovery Pilot Program, and shall submit a report with recommendations for full implementation of the program on or

before July 1, 2002.

SECTION 5. The following provision shall be codified as Section 43-27-308, Mississippi Code of 1972.

43-27-308. There is created in the State Treasury a special fund into which shall be deposited all funds contributed by the Department of Human Services, Department of Mental Health, State Department of Education, Division of Medicaid, or from any other source of state, local, federal or private funds which may be available for the operation of the Juvenile Health Recovery Centers of Mississippi pilot program. By the first quarter of the 2001 fiscal year, and the three (3) fiscal years thereafter, each agency named in this section shall pay into the special fund out of its annual appropriation a sum equal to the amount determined by the Juvenile Health Recovery Board to be necessary for the operation of the pilot Juvenile Health Recovery Centers, and subject to such funds as may have been otherwise made available to such agencies by legislative appropriation or otherwise. The Division of Medicaid shall use all unmatched funds not committed for another purpose to match federal Medicaid funds for any Medicaid approved services that will be used in the Juvenile Health Recovery pilot program for Medicaid eligible children served at the centers, or through any other of the continuum of services provided, including therapeutic foster care, in-home treatment and community-based programs.

SECTION 6. Section 43-21-605, Mississippi Code of 1972, is amended as follows:

43-21-605. (1) In delinquency cases, the disposition order may include any of the following alternatives:

(a) Release the child without further action;

(b) Place the child in the custody of the parents, a relative or other persons subject to any conditions and limitations, including restitution, as the youth court may prescribe;

(c) Place the child on probation subject to any reasonable and appropriate conditions and limitations, including restitution, as the youth court may prescribe;

(d) Order terms of treatment calculated to assist the child and the child's parents or guardian which are within the ability of the parent or guardian to perform;

(e) Order terms of supervision which may include participation in a constructive program of service or education or civil fines not in excess of Five Hundred Dollars ($500.00), or restitution not in excess of actual damages caused by the child to be paid out of his own assets or by performance of services acceptable to the victims and approved by the youth court and reasonably capable of performance within one (1) year;

(f) Suspend the child's driver's license by taking and keeping it in custody of the court for not more than one (1) year;

(g) Give legal custody of the child to any of the following:

(i) The Department of Human Services for appropriate placement; or

(ii) Any public or private organization, preferably community-based, able to assume the education, care and maintenance of the child, which has been found suitable by the court; or

(iii) The Department of Human Services for placement in a wilderness training program or a state-supported training school, except that no child under the age of ten (10) years shall be committed to a state training school. The training school may retain custody of the child until the child's twentieth birthday but for no longer. The superintendent of a state training school may parole a child at any time he may deem it in the best interest and welfare of such child. Twenty (20) days prior to such parole, the training school shall notify the committing court of the pending release. The youth court may then arrange subsequent placement after a reconvened disposition hearing except that the youth court may not recommit the child to the training school or any other secure facility without an adjudication of a new offense or probation or parole violation. Prior to assigning the custody of any child to any private institution or agency, the youth court through its designee shall first inspect the physical facilities to determine that they provide a reasonable standard of health and safety for the child. The youth court shall not place a child in the custody of a state training school for truancy, unless such child has been adjudicated to have committed an act of delinquency in addition to truancy;

(h) Recommend to the child and the child's parents or guardian that the child attend and participate in the Youth Challenge Program under the Mississippi National Guard, as created in Section 43-27-203, subject to the selection of the child for the program by the National Guard; however, the child must volunteer to participate in the program. The youth court may not

order any child to apply or attend the program;

(i) (i) Adjudicate the juvenile to the Statewide Juvenile Work Program if the program is established in the court's jurisdiction. The juvenile and his parents or guardians must sign a waiver of liability in order to participate in the work program. The judge will coordinate with the youth services counselors as to placing participants in the work program;

(ii) The severity of the crime, whether or not the juvenile is a repeat offender or is a felony offender will be taken into consideration by the judge when adjudicating a juvenile to the work program. The juveniles adjudicated to the work program will be supervised by police officers or reserve officers. The term of service will be from twenty-four (24) to one hundred twenty (120) hours of community service. A juvenile will work the hours to which he was adjudicated on the weekends during school and week days during the summer. Parents are responsible for a juvenile reporting for work. Noncompliance with an order to perform community service will result in a heavier adjudication. A juvenile may be adjudicated to the community service program only two (2) times;

(iii) The judge shall assess an additional fine on the juvenile which will be used to pay the costs of implementation of the program and to pay for supervision by police officers and reserve officers. The amount of the fine will be based on the number of hours to which the juvenile has been adjudicated;

(j) Order the child to participate in a youth court work program as provided in Section 43-21-627; * * *

(k) Order the child into a juvenile detention center

operated by the county or into a juvenile detention center operated by any county with which the county in which the court is located has entered into a contract for the purpose of housing delinquents. The time period for such detention cannot exceed ninety (90) days. The youth court judge may order that the number of days specified in the detention order be served either throughout the week or on weekends only; or

(l) Upon recommendation of the local school superintendent or local law enforcement officers, adjudicate the child to a Mississippi Juvenile Health Recovery Program facility if such facility or facilities are established under Senate Bill NO. ____, 2000 Regular Session.

(2) In addition to any of the disposition alternatives authorized under subsection (1) of this section, the disposition order in any case in which the child is adjudicated delinquent for an offense under Section 63-11-30 shall include an order denying the driver's license and driving privileges of the child as required under subsection (8) of Section 63-11-30.

(3) Fines levied under this chapter shall be paid into the general fund of the county but, in those counties wherein the youth court is a branch of the municipal government, it shall be paid into the municipal treasury.

(4) Any institution or agency to which a child has been committed shall give to the youth court any information concerning the child as the youth court may at any time require.

(5) The youth court shall not place a child in another school district who has been expelled from a school district for the commission of a violent act. For the purpose of this

subsection, "violent act" means any action which results in death or physical harm to another or an attempt to cause death or physical harm to another.

SECTION 7. Section 37-13-92, Mississippi Code of 1972, is amended as follows:

37-13-92. (1) Beginning with the school year 1993-1994, the school boards of all school districts shall establish, maintain and operate, in connection with the regular programs of the school district, an alternative school program for, but not limited to, the following categories of compulsory-school-age students:

(a) Any compulsory-school-age child who has been suspended for more than ten (10) days or expelled from school, except as provided in subsection (2);

(b) Any compulsory-school-age child referred to such alternative school based upon a documented need for placement in the alternative school program by the parent, legal guardian or custodian of such child due to disciplinary problems; and

(c) Any compulsory-school-age child referred to such alternative school program by the dispositive order of a chancellor or youth court judge, with the consent of the superintendent of the child's school district.

(2) Notwithstanding any other provisions to the contrary, no school district shall be required to enroll any compulsory-school-age child in an alternative school program if such student (a) is suspended or expelled for possession of a weapon or other felonious conduct or any other violation set forth in Section 37-11-18, Mississippi Code of 1972; (b) poses a threat to the safety of himself or to others; or (c) is disruptive to the

educational process being provided to other students, subject to review by and the approval of the school board taking under consideration recommendations by the administrator of the alternative school and the appropriate guidance counselor. In such cases the local school superintendent may recommend to the youth court of the residence of the child that the child should be placed in a Mississippi Juvenile Health Recovery Facility Program pursuant to Senate Bill No. ____, 2000 Regular Session.

(3) The principal or program administrator of any such alternative school program shall require verification from the appropriate guidance counselor of any such child referred to the alternative school program regarding the suitability of such child for attendance at the alternative school program. Before a student may be removed to an alternative school education program, the superintendent of the student's school district must determine that the written and distributed disciplinary policy of the local district is being followed. The policy shall include standards for:

(a) The removal of a student to an alternative education program that will include a process of educational review to develop the student's individual instruction plan and the evaluation at regular intervals of the student's educational progress; the process shall include classroom teachers and/or other appropriate professional personnel, as defined in the district policy, to ensure a continuing educational program for the removed student;

(b) The duration of alternative placement; and

(c) The notification of parents or guardians, and their

appropriate inclusion in the removal and evaluation process, as defined in the district policy. Nothing in this paragraph should be defined in a manner to circumvent the principal's or the superintendent's authority to remove a student to alternative education.

(4) The local school board or the superintendent shall provide for the continuing education of a student who has been removed to an alternative school program.

(5) A school district, in its discretion, may provide a program of general educational development (GED) preparatory instruction in the alternative school program. However, any GED preparation program offered in an alternative school program must be administered in compliance with the rules and regulations established for such programs under Sections 37-35-1 through 37-35-11 and by the State Board for Community and Junior Colleges. The school district may administer the General Educational Development (GED) Testing Program under the policies and guidelines of the GED Testing Service of the American Council on Education in the alternative school program or may authorize the test to be administered through the community/junior college district in which the alternative school is situated.

(6) Any such alternative school program operated under the authority of this section shall meet all appropriate accreditation requirements of the State Department of Education.

(7) The alternative school program may be held within such school district or may be operated by two (2) or more adjacent school districts, pursuant to a contract approved by the State Board of Education. When two (2) or more school districts

contract to operate an alternative school program, the school board of a district designated to be the lead district shall serve as the governing board of the alternative school program. Transportation for students attending the alternative school program shall be the responsibility of the local school district. The expense of establishing, maintaining and operating such alternative school program may be paid from funds contributed or otherwise made available to the school district for such purpose or from local district maintenance funds.

(8) The State Board of Education shall promulgate minimum guidelines for alternative school programs. The guidelines shall require, at a minimum, the formulation of an individual instruction plan for each student referred to the alternative school program and, upon a determination that it is in a student's best interest for that student to receive general educational development (GED) preparatory instruction, that the local school board assign the student to a GED preparatory program established under subsection (4) of this section. The minimum guidelines for alternative school programs shall also require the following components:

(a) Clear guidelines and procedures for placement of students into alternative education programs which at a minimum shall prescribe due process procedures for disciplinary and general educational development (GED) placement;

(b) Clear and consistent goals for students and parents;

(c) Curricula addressing cultural and learning style differences;

(d) Direct supervision of all activities on a closed campus;

(e) Full-day attendance with a rigorous workload and minimal time off;

(f) Selection of program from options provided by the local school district, Division of Youth Services or the youth court, including transfer to a community-based alternative school;

(g) Continual monitoring and evaluation and formalized passage from one step or program to another;

(h) A motivated and culturally diverse staff;

(i) Counseling for parents and students;

(j) Administrative and community support for the program; and

(k) Clear procedures for annual alternative school program review and evaluation.

(9) On request of a school district, the State Department of Education shall provide the district informational material on developing an alternative school program that takes into consideration size, wealth and existing facilities in determining a program best suited to a district.

(10) Any compulsory-school-age child who becomes involved in any criminal or violent behavior shall be removed from such alternative school program and, if probable cause exists, a case shall be referred to the youth court.

(11) The State Board of Education, in its discretion, may exempt not more than four (4) school district alternative school programs in the state from any compulsory standard of accreditation for a period of three (3) years. During this

period, the State Department of Education shall conduct a study of all alternative school programs in the state, and on or before January 1, 2000, shall develop and promulgate accreditation standards for all alternative school programs, including any recommendations for necessary legislation relating to such alternative school programs.

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

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

(1) Inpatient hospital services.

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

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

Component utilized to determine total hospital costs allocated to the Medicaid program.

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

(3) Laboratory and x-ray services.

(4) Nursing facility services.

(a) The division shall make full payment to nursing facilities for each day, not exceeding fifty-two (52) days per year, that a patient is absent from the facility on home leave. Payment may be made for the following home leave days in addition to the 52-day limitation: Christmas, the day before Christmas, the day after Christmas, Thanksgiving, the day before Thanksgiving and the day after Thanksgiving. However, before payment may be made for more than eighteen (18) home leave days in a year for a patient, the patient must have written authorization from a physician stating that the patient is physically and mentally able to be away from the facility on home leave. Such authorization must be filed with the division before it will be effective and the authorization shall be effective for three (3) months from the date it is received by the division, unless it is revoked earlier by the physician because of a change in the condition of the patient.

(b) From and after July 1, 1993, the division shall implement the integrated case-mix payment and quality monitoring system developed pursuant to Section 43-13-122, which includes the fair rental system for property costs and in which recapture of

depreciation is eliminated. The division may revise the reimbursement methodology for the case-mix payment system by reducing payment for hospital leave and therapeutic home leave days to the lowest case-mix category for nursing facilities, modifying the current method of scoring residents so that only services provided at the nursing facility are considered in calculating a facility's per diem, and the division may limit administrative and operating costs, but in no case shall these costs be less than one hundred nine percent (109%) of the median administrative and operating costs for each class of facility, not to exceed the median used to calculate the nursing facility reimbursement for fiscal year 1996, to be applied uniformly to all long-term care facilities.

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

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

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

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

(B) Matters relating to the Minimum Data Set

Plus (MDS +) or successor assessment formats including but not limited to audits, classifications and submissions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(xii) Appeals by nursing facility providers

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

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

(f) The division shall develop and implement a case-mix

payment add-on determined by time studies and other valid statistical data which will reimburse a nursing facility for the additional cost of caring for a resident who has a diagnosis of Alzheimer's or other related dementia and exhibits symptoms that require special care. Any such case-mix add-on payment shall be supported by a determination of additional cost. The division shall also develop and implement as part of the fair rental reimbursement system for nursing facility beds, an Alzheimer's resident bed depreciation enhanced reimbursement system which will provide an incentive to encourage nursing facilities to convert or construct beds for residents with Alzheimer's or other related dementia.

(g) The Division of Medicaid shall develop and implement a referral process for long-term care alternatives for Medicaid beneficiaries and applicants. No Medicaid beneficiary shall be admitted to a Medicaid-certified nursing facility unless a licensed physician certifies that nursing facility care is appropriate for that person on a standardized form to be prepared and provided to nursing facilities by the Division of Medicaid. The physician shall forward a copy of that certification to the Division of Medicaid within twenty-four (24) hours after it is signed by the physician. Any physician who fails to forward the certification to the Division of Medicaid within the time period specified in this paragraph shall be ineligible for Medicaid reimbursement for any physician's services performed for the applicant. The Division of Medicaid shall determine, through an assessment of the applicant conducted within two (2) business days after receipt of the physician's certification, whether the

applicant also could live appropriately and cost-effectively at home or in some other community-based setting if home- or community-based services were available to the applicant. The time limitation prescribed in this paragraph shall be waived in cases of emergency. If the Division of Medicaid determines that a home- or other community-based setting is appropriate and cost-effective, the division shall:

(i) Advise the applicant or the applicant's legal representative that a home- or other community-based setting is appropriate;

(ii) Provide a proposed care plan and inform the applicant or the applicant's legal representative regarding the degree to which the services in the care plan are available in a home- or in other community-based setting rather than nursing facility care; and

(iii) Explain that such plan and services are available only if the applicant or the applicant's legal representative chooses a home- or community-based alternative to nursing facility care, and that the applicant is free to choose nursing facility care.

The Division of Medicaid may provide the services described in this paragraph (g) directly or through contract with case managers from the local Area Agencies on Aging, and shall coordinate long-term care alternatives to avoid duplication with hospital discharge planning procedures.

Placement in a nursing facility may not be denied by the division if home- or community-based services that would be more appropriate than nursing facility care are not actually available,

or if the applicant chooses not to receive the appropriate home- or community-based services.

The division shall provide an opportunity for a fair hearing under federal regulations to any applicant who is not given the choice of home- or community-based services as an alternative to institutional care.

The division shall make full payment for long-term care alternative services.

The division shall apply for necessary federal waivers to assure that additional services providing alternatives to nursing facility care are made available to applicants for nursing facility care.

(5) Periodic screening and diagnostic services for individuals under age twenty-one (21) years as are needed to identify physical and mental defects and to provide health care treatment and other measures designed to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services regardless of whether these services are included in the state plan. The division may include in its periodic screening and diagnostic program those discretionary services authorized under the federal regulations adopted to implement Title XIX of the federal Social Security Act, as amended. The division, in obtaining physical therapy services, occupational therapy services, and services for individuals with speech, hearing and language disorders, may enter into a cooperative agreement with the State Department of Education for the provision of such services to handicapped students by public school districts using state funds which are provided from the

appropriation to the Department of Education to obtain federal matching funds through the division. The division, in obtaining medical and psychological evaluations for children in the custody of the State Department of Human Services may enter into a cooperative agreement with the State Department of Human Services for the provision of such services using state funds which are provided from the appropriation to the Department of Human Services to obtain federal matching funds through the division.

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

(6) Physician's services. All fees for physicians' services that are covered only by Medicaid shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act), as amended, and which shall in no event be less than seventy percent (70%) of the rate established on January 1, 1994. All fees for physicians' services that are covered by both Medicare and Medicaid shall be reimbursed at ten percent (10%) of the adjusted Medicare payment established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act), as amended, and which shall in no event be less than seven percent (7%) of the adjusted Medicare payment established on January 1, 1994.

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

(b) Repealed.

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

(9) Legend and other drugs as may be determined by the division. The division may implement a program of prior approval for drugs to the extent permitted by law. Payment by the division for covered multiple source drugs shall be limited to the lower of the upper limits established and published by the Health Care Financing Administration (HCFA) plus a dispensing fee of Four Dollars and Ninety-one Cents ($4.91), or the estimated acquisition cost (EAC) as determined by the division plus a dispensing fee of Four Dollars and Ninety-one Cents ($4.91), or the providers' usual and customary charge to the general public. The division shall allow five (5) prescriptions per month for noninstitutionalized Medicaid recipients; however, exceptions for up to ten (10) prescriptions per month shall be allowed, with the approval of the director.

Payment for other covered drugs, other than multiple source drugs with HCFA upper limits, shall not exceed the lower of the

estimated acquisition cost as determined by the division plus a dispensing fee of Four Dollars and Ninety-one Cents ($4.91) or the providers' usual and customary charge to the general public.

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

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

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

(10) Dental care that is an adjunct to treatment of an acute medical or surgical condition; services of oral surgeons and dentists in connection with surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone; and emergency dental extractions and treatment related thereto. On July 1, 1999, all fees for dental care and surgery under authority of this paragraph (10)

shall be increased to one hundred sixty percent (160%) of the amount of the reimbursement rate that was in effect on June 30, 1999. It is the intent of the Legislature to encourage more dentists to participate in the Medicaid program.

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

(12) Intermediate care facility services.

(a) The division shall make full payment to all intermediate care facilities for the mentally retarded for each day, not exceeding eighty-four (84) days per year, that a patient is absent from the facility on home leave. Payment may be made for the following home leave days in addition to the 84-day limitation: Christmas, the day before Christmas, the day after Christmas, Thanksgiving, the day before Thanksgiving and the day after Thanksgiving. However, before payment may be made for more than eighteen (18) home leave days in a year for a patient, the patient must have written authorization from a physician stating that the patient is physically and mentally able to be away from the facility on home leave. Such authorization must be filed with the division before it will be effective, and the authorization shall be effective for three (3) months from the date it is received by the division, unless it is revoked earlier by the physician because of a change in the condition of the patient.

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

(13) Family planning services, including drugs, supplies and

devices, when such services are under the supervision of a physician.

(14) Clinic services. Such diagnostic, preventive, therapeutic, rehabilitative or palliative services furnished to an outpatient by or under the supervision of a physician or dentist in a facility which is not a part of a hospital but which is organized and operated to provide medical care to outpatients. Clinic services shall include any services reimbursed as outpatient hospital services which may be rendered in such a facility, including those that become so after July 1, 1991. On July 1, 1999, all fees for physicians' services reimbursed under authority of this paragraph (14) shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act), as amended, and which shall in no event be less than seventy percent (70%) of the rate established on January 1, 1994. All fees for physicians' services that are covered by both Medicare and Medicaid shall be reimbursed at ten percent (10%) of the adjusted Medicare payment established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act), as amended, and which shall in no event be less than seven percent (7%) of the adjusted Medicare payment established on January 1, 1994. On July 1, 1999, all fees for dentists' services reimbursed under authority of this paragraph (14) shall be increased to one hundred sixty percent (160%) of the amount of the reimbursement rate that was in effect on June 30, 1999.

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

Title XIX of the federal Social Security Act, as amended, under waivers, subject to the availability of funds specifically appropriated therefor by the Legislature. Payment for such services shall be limited to individuals who would be eligible for and would otherwise require the level of care provided in a nursing facility. The home- and community-based services authorized under this paragraph shall be expanded over a five-year period beginning July 1, 1999. The division shall certify case management agencies to provide case management services and provide for home- and community-based services for eligible individuals under this paragraph. The home- and community-based services under this paragraph and the activities performed by certified case management agencies under this paragraph shall be funded using state funds that are provided from the appropriation to the Division of Medicaid and used to match federal funds.

(16) Mental health services. Approved therapeutic and case management services provided by (a) an approved regional mental health/retardation center established under Sections 41-19-31 through 41-19-39, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/retardation center if determined necessary by the Department of Mental Health, using state funds which are provided from the appropriation to the State Department of Mental Health and used to match federal funds under a cooperative agreement between the division and the department, or (b) a facility which is certified by the State Department of Mental Health to provide therapeutic and case management services, to be reimbursed on a fee for service basis. Any such services

provided by a facility described in paragraph (b) must have the prior approval of the division to be reimbursable under this section. After June 30, 1997, mental health services provided by regional mental health/retardation centers established under Sections 41-19-31 through 41-19-39, or by hospitals as defined in Section 41-9-3(a) and/or their subsidiaries and divisions, or by psychiatric residential treatment facilities as defined in Section 43-11-1, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/retardation center if determined necessary by the Department of Mental Health, shall not be included in or provided under any capitated managed care pilot program provided for under paragraph (24) of this section.

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

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

(19) (a) Perinatal risk management services. The division shall promulgate regulations to be effective from and after October 1, 1988, to establish a comprehensive perinatal system for

risk assessment of all pregnant and infant Medicaid recipients and for management, education and follow-up for those who are determined to be at risk. Services to be performed include case management, nutrition assessment/counseling, psychosocial assessment/counseling and health education. The division shall set reimbursement rates for providers in conjunction with the State Department of Health.

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

The State Department of Health shall certify annually in writing to the director of the division the dollar amount of state early intervention funds available which shall be utilized as a certified match for Medicaid matching funds. Those funds then shall be used to provide expanded targeted case management services for Medicaid eligible children with special needs who are eligible for the state's early intervention system. Qualifications for persons providing service coordination shall be determined by the State Department of Health and the Division of Medicaid.

(20) Home- and community-based services for physically disabled approved services as allowed by a waiver from the U.S. Department of Health and Human Services for home- and community-based services for physically disabled people using state funds which are provided from the appropriation to the State Department of Rehabilitation Services and used to match federal

funds under a cooperative agreement between the division and the department, provided that funds for these services are specifically appropriated to the Department of Rehabilitation Services.

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

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

(23) Inpatient psychiatric services. Inpatient psychiatric services to be determined by the division for recipients under age twenty-one (21) which are provided under the direction of a physician in an inpatient program in a licensed acute care psychiatric facility or in a licensed psychiatric residential treatment facility, before the recipient reaches age twenty-one (21) or, if the recipient was receiving the services immediately before he reached age twenty-one (21), before the earlier of the date he no longer requires the services or the date he reaches age

twenty-two (22), as provided by federal regulations. Recipients shall be allowed forty-five (45) days per year of psychiatric services provided in acute care psychiatric facilities, and shall be allowed unlimited days of psychiatric services provided in licensed psychiatric residential treatment facilities.

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

(25) Birthing center services.

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

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

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

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

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

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

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

the Social Security Act.

(33) Podiatrist services.

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

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

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

(37) Targeted case management services for individuals with

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

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

Services for children placed in a Mississippi Juvenile Health Recovery Facility by the youth court, using state funds that are provided from appropriations to the Department of Human Services, the Department of Mental Health, the State Department of Education and the Division of Medicaid and used to match federal funds under a cooperative agreement with the Juvenile Health Recovery Board pursuant to Senate Bill No. ____, 2000 Regular Session.

Notwithstanding any provision of this article, except as authorized in the following paragraph and in Section 43-13-139, neither (a) the limitations on quantity or frequency of use of or the fees or charges for any of the care or services available to recipients under this section, nor (b) the payments or rates of reimbursement to providers rendering care or services authorized under this section to recipients, may be increased, decreased or otherwise changed from the levels in effect on July 1, 1986,

unless such is authorized by an amendment to this section by the Legislature. However, the restriction in this paragraph shall not prevent the division from changing the payments or rates of reimbursement to providers without an amendment to this section whenever such changes are required by federal law or regulation, or whenever such changes are necessary to correct administrative errors or omissions in calculating such payments or rates of reimbursement.

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

amounts appropriated for such fiscal year.

SECTION 9. Section 43-27-309, which repeals the chapter establishing a Juvenile Health Recovery Review and Advisory Board, is hereby repealed.

SECTION 10. This act shall take effect and be in force from and after July 1, 2000.