MISSISSIPPI LEGISLATURE REGULAR SESSION 2001

By: Senator(s) Thames, Smith, Huggins, Dawkins

To: Public Health and Welfare; Appropriations

COMMITTEE SUBSTITUTE
FOR
SENATE BILL NO. 2342

AN ACT TO AMEND SECTIONS 43-14-1, 43-14-3 and 43-14-5, MISSISSIPPI CODE OF 1972, TO ESTABLISH AN INTERAGENCY COORDINATING COUNCIL FOR CHILDREN AND YOUTH, TO EMPOWER THE INTERAGENCY COUNCIL TO IMPLEMENT A PLANNING PROCESS FOR EACH CHILD SERVICE AGENCY TO UTILIZE FEDERAL AND STATE FUNDS, TO DEFINE CHILDREN ELIGIBLE FOR SERVICES WHICH ARE TO BE COORDINATED UNDER THIS ACT, TO ESTABLISH AN INTERAGENCY SYSTEM OF CARE COUNCIL TO ADVISE THE INTERAGENCY COUNCIL IN ITS RESPONSIBILITIES, TO ESTABLISH AN INTERAGENCY SYSTEM OF CARE COUNCIL TO PERFORM CERTAIN FUNCTIONS AND ADVISE THE INTERAGENCY COORDINATING COUNCIL, TO AUTHORIZE THE INTERAGENCY COUNCIL TO DIRECT THE MEMBER AGENCIES TO SEEK NECESSARY FUNDS TO SERVE THIS POPULATION OF CHILDREN, TO EMPOWER THE INTERAGENCY COORDINATING COUNCIL TO COORDINATE A POOL OF FUNDS FROM THESE STATE AGENCIES TO SERVE THIS POPULATION OF CHILDREN THROUGH LOCAL COORDINATING CARE ENTITIES DESIGNATED BY THE INTERAGENCY COORDINATING COUNCIL, TO CHARGE THE LOCAL COORDINATING CARE ENTITIES WITH CERTAIN RESPONSIBILITIES, TO PROVIDE CERTAIN PENALTIES FOR STATE AGENCIES WHICH DO NOT CONTRIBUTE OR PARTICIPATE IN THIS COORDINATED PROGRAM, TO AUTHORIZE THE INTERAGENCY COORDINATING COUNCIL TO ASSUME THE RESPONSIBILITIES OF THE JUVENILE HEALTH RECOVERY BOARD AND TO SPECIFY THE DUTIES AND RESPONSIBILITIES OF THE INTERAGENCY COORDINATING COUNCIL; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO DIRECT THE DIVISION OF MEDICAID TO APPLY FOR FEDERAL WAIVERS TO PROVIDE SERVICES FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCES; TO REPEAL SECTION 43-14-7, MISSISSIPPI CODE OF 1972, WHICH PROVIDES FOR SERVICES AND ELIGIBILITY UNDER THE BLENDED FUNDING PROGRAM FORMERLY ADMINISTERED BY THE CHILDREN'S ADVISORY COUNCIL AND TO REPEAL SECTION 43-14-9, MISSISSIPPI CODE OF 1972, WHICH IS THE AUTOMATIC REPEALER ON SECTIONS 43-14-1 THROUGH 43-14-7, MISSISSIPPI CODE OF 1972; AND FOR RELATED PURPOSES.

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

SECTION 1. Section 43-14-1, Mississippi Code of 1972, is amended as follows:

43-14-1. (1) The purpose of this chapter is to provide for the development and implementation of a coordinated interagency system of necessary services and care * * * for (a) children and youth up to age twenty-one (21) with serious emotional/behavioral disorders, including, but not limited to, conduct disorders, or mental illness who require services from a multiple services and multiple programs system; (b) children suspended or expelled from

a local school district for serious and chronic misconduct; (c) children with alcohol and drug abuse problems; (d) children with co-occurring disorders (mental illness and alcohol and drug abuse problems); (e) 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; and (f) those children with special mental health needs, including, but not limited to, those who are sexually reactive, for whom the necessary array of specialized services and support is not available in the state, in the most fiscally responsible (cost efficient) manner possible, based on an individualized plan of care which takes into account other available interagency programs, including, but not limited to, Early Intervention Act of Infants and Toddlers, Section 41-87-1 et seq., Early Periodic Screening Diagnosis and Treatment, Section 43-13-117(5), waivered program for home- and community-based services for developmentally disabled people, Section 43-13-117(29), and waivered program for targeted case management services for children with special needs, Section 43-13-117(31), those children identified through the federal Individuals with Disabilities Education Act of 1997 as having a serious emotional disorder (EMD), the Mississippi Children's Health Insurance Program Phase I and Phase II and waivered programs for children with serious emotional disturbances, Section 43-13-117(44), and is tied to clinically appropriate outcomes. Some of the outcomes are to reduce the number of inappropriate out-of-home placements inclusive of those out-of-state and to reduce the number of inappropriate school suspensions and expulsions for this population of children. From and after July 1, 2001, this coordinated interagency system of necessary services and care shall be named the System of Care program. Children to be served by this chapter who are eligible for Medicaid shall be screened through the Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) and their needs for

medically necessary services shall be certified through the EPSDT process. Children who are not Medicaid-eligible shall have access to their necessary services in the System of Care program through the funding formula determined by the Interagency Coordinating Council for Children and Youth and funded through the operating fund provided in Section 43-14-5. For purposes of this chapter, a "System of Care" is defined as a coordinated network of agencies and providers working as a team to make a full range of mental health and other necessary services available as needed by children with mental health problems and their families. The System of Care shall be:

(a) Child centered, family focused and family driven;

(b) Community based;

(c) Culturally competent and responsive; and shall provide for:

(i) Service coordination or case management;

(ii) Prevention and early identification and intervention;

(iii) Smooth transitions among agencies, providers, and to the adult service system;

(iv) Human rights protection and advocacy;

(v) Nondiscrimination in access to services;

(vi) A comprehensive array of services;

(vii) Individualized service planning;

(viii) Services in the least restrictive environment;

(ix) Family participation in all aspects of planning, service delivery and evaluation; and

(x) Integrated services with coordinated planning across child-serving agencies.

(2) There is established the Interagency Coordinating Council for Children and Youth (hereinafter referred to as the "ICCCY") which shall assume the responsibilities of the Children's

Advisory Council established under Section 43-14-1 et seq. and the Juvenile Health Recovery Advisory Board established under Section 43-27-301 et seq., and implement the interagency System of Care authorized under this chapter. The ICCCY shall consist of the following membership: (a) the Attorney General; (b) the State Superintendent of Public Education; (c) the Executive Director of the State Department of Mental Health; (d) the Executive Director of the State Department of Health; (e) the Executive Director of the Department of Human Services; (f) the Executive Director of the Division of Medicaid, Office of the Governor; (g) the Executive Director of the State Department of Rehabilitation Services; and (h) the Executive Director of Mississippi Families as Allies for Children's Mental Health, Inc. The council shall meet upon the call of the Attorney General before August 1, 2001, and shall organize for business by selecting a chairman, who shall serve for a one-year term and may be selected for subsequent terms. The council shall adopt internal organizational procedures necessary for efficient operation of the council. Each member of the council shall designate necessary staff of their departments to assist the ICCCY in performing its duties and responsibilities. The ICCCY shall meet and conduct business at least twice annually. The chairman of the ICCCY shall notify all persons who request such notice as to the date, time and place of each meeting.

(3) The Interagency System of Care Council is created to develop and make recommendations to the ICCCY established under subsection (2) as deemed necessary to implement the ICCCY's responsibilities relating to all programs serving the children described herein. The Interagency System of Care Council is authorized to serve as the state management team with the responsibility of overseeing the local Multidisciplinary Assessment and Planning (MAP) teams, the collection and analysis of data necessary to implement and operate the System of Care, and to develop necessary financing strategies, and may apply for

grants from public and private sources necessary to carry out its responsibilities. The Interagency System of Care Council shall be comprised of one (1) member from each of the appropriate child-serving divisions or sections of the State Department of Health, the Department of Human Services, the State Department of Mental Health, the State Department of Education, the Division of Medicaid of the Governor's Office, the Department of Rehabilitation Services, the Attorney General's Office, the Executive Director of the Mississippi Association of School Superintendents, the Executive Director of the Public Education Forum of Mississippi, a representative from the Council of Administrators for Special Education/Mississippi Organization of Special Education Supervisors (CASE/MOSES), a family member designated by Mississippi Families as Allies for Children's Mental Health, Inc., a family member designated by the Foster Family Association of Mississippi, a representative from the Mississippi Council of Youth Court Judges, a representative from the Governor's Office, three (3) persons appointed by the Speaker of the House of Representatives and three (3) persons appointed by the Lieutenant Governor, who, to the extent possible, shall have special expertise in working with children and youth with special mental health needs. Appointments to the Interagency System of Care Council shall be made within sixty (60) days after the effective date of this act. The council shall organize by selecting a chairman from its membership to serve on an annual basis, and the chairman may be re-elected. The Interagency System of Care Council shall appoint an executive committee to meet as needed in carrying out its functions and to meet with the ICCCY.

(4) The Interagency Coordinating Council for Children and Youth is so authorized and shall oversee a planning process that mandates that each child and/or youth-serving state agency define in writing how each agency utilizes its federal and state statutes, policy requirements and funding streams to identify

and/or serve children and youth with emotional disabilities or disorders, and mandate further that each define any additional federal statutes, state statutes and/or other agency regulations, processes or guidelines that are now being or could be used to identify and serve this population of children and youth. The ICCCY shall review and implement the plan for comprehensive, multidisciplinary care, treatment and placement of children developed by the Juvenile Health Recovery Board established under Section 43-27-303, Mississippi Code of 1972, and shall make necessary recommendations for legislation to the Legislature.

(5) The ICCCY shall oversee a pool of state funds contributed by each participating state agency and additional funds from the Mississippi Tobacco Health Care Expenditure Fund, subject to specific appropriation therefor by the Legislature. Part of this pool of funds shall be available for increasing the present funding levels by matching Medicaid funds in order to increase the existing resources available for necessary community-based services for Medicaid beneficiaries. * * *

(6) The local coordinating care entities to administer the System of Care programs * * * shall be designated by the ICCCY using a Request for Proposal (RFP) process. Each local coordinating care entity shall be an administrative body capable of securing and insuring the delivery of services and care across all necessary agencies and/or any other appropriate service provider(s) to meet each child or youth's authorized plan of care. After June 30, 2001, the ICCCY will add * * * additional coordinating care entities in each congressional district of the state so that all of the children in the State of Mississippi served by this chapter will be covered by June 30, 2011. Those local coordinating care entities designated by the ICCCY shall be those that clearly reflect their capability to select and secure appropriate services and care in the most cost-efficient and

timely manner for the children and youth who are to be served by this chapter.

(7) Each local coordinating care entity shall work with a local Multidisciplinary Assessment and Planning Team (MAP) which shall be made up of local interagency administrators and others who have special interest in and expertise with the population of children named in subsection (1) who shall provide policy oversight and community commitment to the local System of Care programs. Each local MAP team shall serve as the single point of entry to ensure that comprehensive diagnosis and assessment occur and shall coordinate needed services through the local coordinating care entity for the children named in subsection (1). Local children in crisis shall have first priority for access to the MAP team processes and local System of Care programs.

(8) The Interagency Coordinating Council for Children and Youth shall contract with the selected local coordinating care entity in the additional designated System of Care regions, and these entities shall administer the program according to the terms of the contract with the ICCCY.

(9) Each state agency named in subsection (2) of this section shall enter into a binding interagency agreement to participate in the oversight of the statewide System of Care programs for the children and youth described in this section. The agreement shall be signed and in effect by July 1 of each year * * *.

SECTION 2. Section 43-14-3, Mississippi Code of 1972, is amended as follows:

43-14-3. In addition to the specific authority provided in Section 43-14-1, the powers and responsibilities of the Interagency Coordinating Council for Children and Youth shall be as follows:

(a) To expand * * * the System of Care programs into each congressional district from a minimum of one (1) per congressional district;

(b) To implement a Request for Proposal process through which * * * local coordinating care entities will be selected in each congressional district to perform the functions provided in Section 43-14-7;

(c) To serve in an advisory capacity and to provide state level leadership and oversight to the development of the * * * System of Care programs;

(d) To insure the creation and availability of an annual pool of funds from each participating agency member of the ICCCY that includes the amount to be contributed by each agency and a process for utilization of those funds;

(e) To contract and expend funds for any contractual technical assistance and consultation necessary to the System of Care programs; and

(f) To implement and operate the Plan for Comprehensive, Multidisciplinary Care, Treatment and Placement submitted by the Juvenile Health Recovery Board pursuant to Section 43-27-301 et seq., and make any necessary recommendations to the Legislature.

SECTION 3. Section 43-14-5, Mississippi Code of 1972, is amended as follows:

43-14-5. There is created in the State Treasury a special fund into which shall be deposited all funds contributed by the Department of Human Services, State Department of Health, Department of Mental Health and State Department of Education for the operation of the * * * System of Care programs. By the first quarter of each state fiscal year, 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 ICCCY * * *. The ICCCY shall designate the agency of the state

that will be the administering agency for the System of Care program authorized under this chapter with full authority to adopt rules and regulations for the implementation of the program, the access of funds and for the coordination of the System of Care program with the state's other assistance programs. If the Division of Medicaid is designated as the administering agency for the System of Care program, the division shall have all of the authority set forth in Section 43-13-1-1 et seq. Payment for services dictated by the plan of care shall be made to the providers of the services by the selected local coordinating care entity in each of the designated System of Care regions utilizing the blended fund pool established under this section for the System of Care program.

SECTION 4. 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. 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.

(c) Hospitals will receive an additional payment for the implantable programmable pump implanted in an inpatient basis. The payment pursuant to written invoice will be in addition to the facility's per diem reimbursement and will represent a reduction of costs on the facility's annual cost report, and shall not exceed Ten Thousand Dollars ($10,000.00) per year per recipient. This paragraph (c) shall stand repealed on July 1, 2001.

(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. The division shall develop a Medicaid-specific cost-to-charge ratio calculation from data provided by hospitals to determine an allowable rate payment for outpatient hospital services, and shall submit a report thereon to the Medical Advisory Committee on or before December 1, 1999. The committee shall make a recommendation on the specific cost-to-charge reimbursement method for outpatient hospital services to the 2000 Regular Session of the Legislature.

(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 fifty-two-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, 1997, the division shall implement the integrated case-mix payment and quality monitoring system, which includes the fair rental system for property costs and in which recapture of depreciation is eliminated. The division may reduce the payment for hospital leave and therapeutic home leave days to the lower of the case-mix category as computed for the resident on leave using the assessment being utilized for payment at that point in time, or a case-mix score of 1.000 for nursing facilities, and shall compute case-mix scores of residents so that only services provided at the nursing facility are considered in calculating a facility's per diem. The division is authorized to limit allowable management fees and home office costs to either three percent (3%), five percent (5%) or seven percent (7%) of other allowable costs, including allowable therapy costs and property costs, based on the types of management services provided, as follows:

A maximum of up to three percent (3%) shall be allowed where centralized managerial and administrative services are provided by the management company or home office.

A maximum of up to five percent (5%) shall be allowed where centralized managerial and administrative services and limited professional and consultant services are provided.

A maximum of up to seven percent (7%) shall be allowed where a full spectrum of centralized managerial services, administrative services, professional services and consultant services are provided.

(c) From and after July 1, 1997, all state-owned nursing facilities shall be reimbursed on a full reasonable cost basis.

(d) 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 (d) 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 (d), 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.

(e) The division shall develop and implement, not later than January 1, 2001, 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.

(f) 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 (f) 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, or one (1) pair every three (3) years as prescribed by a physician 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 eighty-four-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.

(c) The division is authorized to limit allowable management fees and home office costs to either three percent (3%), five percent (5%) or seven percent (7%) of other allowable

costs, including allowable therapy costs and property costs, based on the types of management services provided, as follows:

A maximum of up to three percent (3%) shall be allowed where centralized managerial and administrative services are provided by the management company or home office.

A maximum of up to five percent (5%) shall be allowed where centralized managerial and administrative services and limited professional and consultant services are provided.

A maximum of up to seven percent (7%) shall be allowed where a full spectrum of centralized managerial services, administrative services, professional services and consultant services are provided.

(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. From and after July 1, 2000, the division is authorized to contract with a 134-bed specialty hospital located on Highway 39 North in Lauderdale County for the use of not more than sixty (60) beds at the facility to provide mental health services for children and adolescents and for crisis intervention services for emotionally disturbed children with behavioral problems, with priority to be given to children in the custody of the Department of Human Services who are, or otherwise will be, receiving such services out-of-state.

(17) Durable medical equipment services and medical supplies. The Division of Medicaid may require durable medical equipment providers to obtain a surety bond in the amount and to the specifications as established by the Balanced Budget Act of 1997.

(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. However, from and after January 1, 2000, no public hospital shall participate in the Medicaid disproportionate share program unless the public hospital participates in an intergovernmental transfer program as provided in Section 1903 of the federal Social Security Act and any applicable regulations. Administration and support for participating hospitals shall be provided by the Mississippi Hospital Association.

(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 United States 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. The division is authorized to limit allowable management fees and home office costs to either three percent (3%), five percent (5%) or seven percent (7%) of other allowable costs, including allowable therapy costs and property costs, based on the types of management services provided, as follows:

A maximum of up to three percent (3%) shall be allowed where centralized managerial and administrative services are provided by the management company or home office.

A maximum of up to five percent (5%) shall be allowed where centralized managerial and administrative services and limited professional and consultant services are provided.

A maximum of up to seven percent (7%) shall be allowed where a full spectrum of centralized managerial services, administrative services, professional services and consultant services are provided.

(24) Managed care services in a program to be developed by the division by a public or private provider. If managed care services are provided by the division to Medicaid recipients, and those managed care services are operated, managed and controlled by and under the authority of the division, the division shall be responsible for educating the Medicaid recipients who are participants in the managed care program regarding the manner in which the participants should seek health care under the program. 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 paragraph (24), 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.

(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 federal regulations.

(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 United States 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) The division shall make application to the United States Health Care Financing Administration for a waiver to develop a program of services to personal care and assisted living homes in Mississippi. This waiver shall be completed by December 1, 1999.

(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 Division of Medicaid. 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, valid vehicle license tags 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.

(39) Dually eligible Medicare/Medicaid beneficiaries. The division shall pay the Medicare deductible and ten percent (10%) coinsurance amounts for services available under Medicare for the duration and scope of services otherwise available under the Medicaid program.

(40) The division shall prepare an application for a waiver to provide prescription drug benefits to as many Mississippians as permitted under Title XIX of the Social Security Act.

(41) Services provided by the State Department of Rehabilitation Services for the care and rehabilitation of persons with spinal cord injuries or traumatic brain injuries, as allowed under waivers from the United States Department of Health and Human Services, using up to seventy-five percent (75%) of the funds that are appropriated to the Department of Rehabilitation Services from the Spinal Cord and Head Injury Trust Fund established under Section 37-33-261 and used to match federal funds under a cooperative agreement between the division and the department.

(42) Notwithstanding any other provision in this article to the contrary, the division is hereby authorized to develop a population health management program for women and children health services through the age of two (2). This program is primarily for obstetrical care associated with low birth weight and pre-term babies. In order to effect cost savings, the division may develop a revised payment methodology which may include at-risk capitated payments.

(43) The division shall provide reimbursement, according to a payment schedule developed by the division, for smoking cessation medications for pregnant women during their pregnancy and other Medicaid-eligible women who are of child-bearing age.

(44) The division shall make application to the federal Health Care Financing Administration for a waiver to develop and provide services for children with serious emotional disturbances.

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, 1999, 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 5. Section 43-14-7, Mississippi Code of 1972, which provides for services and eligibility under the blended funding formula formerly administered by the Children's Advisory Council, and Section 43-14-9, Mississippi Code of 1972, which is the automatic repealer on Sections 43-14-1 through 43-14-7, are hereby repealed.

SECTION 6. This act shall take effect and be in force from and after June 30, 2001.