*****Adopted*****

AMENDMENT No. 1 PROPOSED TO

House Bill NO. 1275

By Senator(s) Committee

Amend by striking all after the enacting clause and inserting in lieu thereof the following:

24 SECTION 1. Section 43-14-1, Mississippi Code of 1972, is
25 amended as follows:
26 43-14-1. (1) The purpose of this chapter is to provide for
27 the development and implementation of a coordinated interagency
28 system of necessary services and care * * * for children and youth
29 up to age twenty-one (21) with serious emotional/behavioral
30 disorders, including, but not limited to, conduct disorders, or
31 mental illness who require services from a multiple services and
32 multiple programs system, and who can be successfully diverted
33 from inappropriate institutional placement. This program is to be
34 done in the most fiscally responsible (cost efficient) manner
35 possible, based on an individualized plan of care which takes into
36 account other available interagency programs, including, but not
37 limited to, Early Intervention Act of Infants and Toddlers,
38 Section 41-87-1 et seq., Early Periodic Screening Diagnosis and
39 Treatment, Section 43-13-117(5), waivered program for home- and
40 community-based services for developmentally disabled people,

41 Section 43-13-117(29), and waivered program for targeted case
42 management services for children with special needs, Section
43 43-13-117(31), those children identified through the federal
44 Individuals with Disabilities Education Act of 1997 as having a
45 serious emotional disorder (EMD), the Mississippi Children's
46 Health Insurance Program Phase I and Phase II and waivered
47 programs for children with serious emotional disturbances, Section
48 43-13-117(44), and is tied to clinically appropriate outcomes.
49 Some of the outcomes are to reduce the number of inappropriate
50 out-of-home placements inclusive of those out-of-state and to
51 reduce the number of inappropriate school suspensions and
52 expulsions for this population of children. From and after July
53 1, 2001, this coordinated interagency system of necessary services
54 and care shall be named the System of Care program. Children to
55 be served by this chapter who are eligible for Medicaid shall be
56 screened through the Medicaid Early Periodic Screening Diagnosis
57 and Treatment (EPSDT) and their needs for medically necessary
58 services shall be certified through the EPSDT process. For
59 purposes of this chapter, a "System of Care" is defined as a
60 coordinated network of agencies and providers working as a team to
61 make a full range of mental health and other necessary services
62 available as needed by children with mental health problems and
63 their families. The System of Care shall be:
64 (a) Child centered, family focused and family driven;
65 (b) Community based;
66 (c) Culturally competent and responsive; and shall
67 provide for:
68 (i) Service coordination or case management;
69 (ii) Prevention and early identification and
70 intervention;

71 (iii) Smooth transitions among agencies,
72 providers, and to the adult service system;
73 (iv) Human rights protection and advocacy;
74 (v) Nondiscrimination in access to services;
75 (vi) A comprehensive array of services;
76 (vii) Individualized service planning;
77 (viii) Services in the least restrictive
78 environment;
79 (ix) Family participation in all aspects of
80 planning, service delivery and evaluation; and
81 (x) Integrated services with coordinated planning
82 across child-serving agencies.
83 (2) There is established the Interagency Coordinating
84 Council for Children and Youth (hereinafter referred to as the
85 "ICCCY"). The ICCCY shall consist of the following membership:
86 (a) the State Superintendent of Public Education; (b) the
87 Executive Director of the Mississippi Department of Mental Health;
88 (c) the Executive Director of the State Department of Health; (d)
89 the Executive Director of the Department of Human Services; (e)
90 the Executive Director of the Division of Medicaid, Office of the
91 Governor; and (f) the Executive Director of the State Department
92 of Rehabilitation Services. The council shall meet before August
93 1, 2001, and shall organize for business by selecting a chairman,
94 who shall serve for a one-year term and may not serve consecutive
95 terms. The council shall adopt internal organizational procedures
96 necessary for efficient operation of the council. Each member of
97 the council shall designate necessary staff of their departments
98 to assist the ICCCY in performing its duties and responsibilities.
99 The ICCCY shall meet and conduct business at least twice
100 annually. The chairman of the ICCCY shall notify all persons who

101 request such notice as to the date, time and place of each
102 meeting.
103 (3) The Interagency System of Care Council is created to
104 serve as the state management team for the ICCCY, with the
105 responsibility of collecting and analyzing data and funding
106 strategies necessary to improve the operation of the System of
107 Care programs, and to make recommendations to the ICCCY and to the
108 Legislature concerning such strategies on or before December 31,
109 2002. The System of Care Council also has the responsibility of
110 coordinating the local Multidisciplinary Assessment and Planning
111 (MAP) teams and may apply for grants from public and private
112 sources necessary to carry out its responsibilities. The
113 Interagency System of Care Council shall be comprised of one (1)
114 member from each of the appropriate child-serving divisions or
115 sections of the State Department of Health, the Department of
116 Human Services, the State Department of Mental Health, the State
117 Department of Education, the Division of Medicaid of the
118 Governor's Office, the Department of Rehabilitation Services, a
119 family member representing a family education and support 501(c)3
120 organization, a representative from the Council of Administrators
121 for Special Education/Mississippi Organization of Special
122 Education Supervisors (CASE/MOSES) and a family member designated
123 by Mississippi Families as Allies for Children's Mental Health,
124 Inc. * * * Appointments to the Interagency System of Care Council
125 shall be made within sixty (60) days after the effective date of
126 this act. The council shall organize by selecting a chairman from
127 its membership to serve on an annual basis, and the chairman may
128 not serve consecutive terms.
129 (4) There is established a statewide system of local
130 Multidisciplinary Assessment and Planning Resource (MAP) teams.

131 The MAP teams shall be comprised of one (1) representative each at
132 the county level from the major child-serving public agencies for
133 education, human services, health, mental health and
134 rehabilitative services approved by respective state agencies of
135 the Department of Education, the Department of Human Services, the
136 Department of Health, the Department of Mental Health and the
137 Department of Rehabilitation Services. Three (3) additional
138 members may be added to each team, one (1) of which may be a
139 representative of a family education/support 501(c)3 organization
140 with statewide recognition and specifically established for the
141 population of children defined in Section 43-14-1. The remaining
142 two (2) members will be representatives of significant
143 community-level stakeholders with resources that can benefit the
144 population of children defined in Section 43-14-1.

145 (5) The Interagency Coordinating Council for Children and
146 Youth may provide input relative to how each agency utilizes its
147 federal and state statutes, policy requirements and funding
148 streams to identify and/or serve children and youth in the
149 population defined in Section 43-14-1. The ICCCY shall support
150 the implementation of the plans of the respective state agencies
151 for comprehensive multidisciplinary care, treatment and placement
152 of these children.

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

161 (7) The local coordinating care MAP team will facilitate the
162 development of the individualized System of Care programs for the
163 population targeted in Section 43-14-1. * * *
164 (8) Each local MAP team shall serve as the single point of
165 entry to ensure that comprehensive diagnosis and assessment occur
166 and shall coordinate needed services through the local
167 coordinating care entity for the children named in subsection (1).
168 Local children in crisis shall have first priority for access to
169 the MAP team processes and local System of Care programs.
170 (9) The Interagency Coordinating Council for Children and
171 Youth shall facilitate monitoring of the performance of local MAP
172 teams.
173 (10) Each state agency named in subsection (2) of this
174 section shall enter into a binding interagency agreement to
175 participate in the oversight of the statewide System of Care
176 programs for the children and youth described in this section.
177 The agreement shall be signed and in effect by July 1 of each
178 year * * *.
179 (11) This section shall stand repealed from and after July
180 1, 2005.
181 SECTION 2. Section 43-14-3, Mississippi Code of 1972, is
182 amended as follows:
183 43-14-3. In addition to the specific authority provided in
184 Section 43-14-1, the powers and responsibilities of the
185 Interagency Coordinating Council for Children and Youth shall be
186 as follows:
187 * * *
188 (a) To serve in an advisory capacity and to provide
189 state level leadership and oversight to the development of
190 the * * * System of Care programs; and

191 (b) To insure the creation and availability of an
192 annual pool of funds from each participating agency member of the
193 ICCCY that includes the amount to be contributed by each agency
194 and a process for utilization of those funds.
195 * * *
196 This section shall stand repealed from and after July 1,
197 2005.
198 SECTION 3. Section 43-14-5, Mississippi Code of 1972, is
199 amended as follows:
200 43-14-5. There is created in the State Treasury a special
201 fund into which shall be deposited all funds contributed by the
202 Department of Human Services, State Department of Health,
203 Department of Mental Health, State Department of Rehabilitation
204 Services and State Department of Education for the operation of a
205 statewide System of Care by MAP teams utilizing such funds as may
206 be made available to those MAP teams through a Request for
207 Proposal (RFP) approved by the ICCCY. * * *
208 This section shall stand repealed from and after July 1,
209 2005.
210 SECTION 4. Section 43-13-117, Mississippi Code of 1972, is
211 amended as follows:
212 43-13-117. Medical assistance as authorized by this article
213 shall include payment of part or all of the costs, at the
214 discretion of the division or its successor, with approval of the
215 Governor, of the following types of care and services rendered to
216 eligible applicants who shall have been determined to be eligible
217 for such care and services, within the limits of state
218 appropriations and federal matching funds:
219 (1) Inpatient hospital services.
220 (a) The division shall allow thirty (30) days of

221 inpatient hospital care annually for all Medicaid recipients. The
222 division shall be authorized to allow unlimited days in
223 disproportionate hospitals as defined by the division for eligible
224 infants under the age of six (6) years.
225 (b) From and after July 1, 1994, the Executive
226 Director of the Division of Medicaid shall amend the Mississippi
227 Title XIX Inpatient Hospital Reimbursement Plan to remove the
228 occupancy rate penalty from the calculation of the Medicaid
229 Capital Cost Component utilized to determine total hospital costs
230 allocated to the Medicaid program.
231 (c) Hospitals will receive an additional payment
232 for the implantable programmable pump implanted in an inpatient
233 basis. The payment pursuant to written invoice will be in
234 addition to the facility's per diem reimbursement and will
235 represent a reduction of costs on the facility's annual cost
236 report, and shall not exceed Ten Thousand Dollars ($10,000.00) per
237 year per recipient. This paragraph (c) shall stand repealed on
238 July 1, 2001.
239 (2) Outpatient hospital services. Provided that where
240 the same services are reimbursed as clinic services, the division
241 may revise the rate or methodology of outpatient reimbursement to
242 maintain consistency, efficiency, economy and quality of care.
243 The division shall develop a Medicaid-specific cost-to-charge
244 ratio calculation from data provided by hospitals to determine an
245 allowable rate payment for outpatient hospital services, and shall
246 submit a report thereon to the Medical Advisory Committee on or
247 before December 1, 1999. The committee shall make a
248 recommendation on the specific cost-to-charge reimbursement method
249 for outpatient hospital services to the 2000 Regular Session of
250 the Legislature.

251 (3) Laboratory and x-ray services.
252 (4) Nursing facility services.
253 (a) The division shall make full payment to
254 nursing facilities for each day, not exceeding fifty-two (52) days
255 per year, that a patient is absent from the facility on home
256 leave. Payment may be made for the following home leave days in
257 addition to the fifty-two-day limitation: Christmas, the day
258 before Christmas, the day after Christmas, Thanksgiving, the day
259 before Thanksgiving and the day after Thanksgiving. However,
260 before payment may be made for more than eighteen (18) home leave
261 days in a year for a patient, the patient must have written
262 authorization from a physician stating that the patient is
263 physically and mentally able to be away from the facility on home
264 leave. Such authorization must be filed with the division before
265 it will be effective and the authorization shall be effective for
266 three (3) months from the date it is received by the division,
267 unless it is revoked earlier by the physician because of a change
268 in the condition of the patient.
269 (b) From and after July 1, 1997, the division
270 shall implement the integrated case-mix payment and quality
271 monitoring system, which includes the fair rental system for
272 property costs and in which recapture of depreciation is
273 eliminated. The division may reduce the payment for hospital
274 leave and therapeutic home leave days to the lower of the case-mix
275 category as computed for the resident on leave using the
276 assessment being utilized for payment at that point in time, or a
277 case-mix score of 1.000 for nursing facilities, and shall compute
278 case-mix scores of residents so that only services provided at the
279 nursing facility are considered in calculating a facility's per
280 diem. The division is authorized to limit allowable management

281 fees and home office costs to either three percent (3%), five
282 percent (5%) or seven percent (7%) of other allowable costs,
283 including allowable therapy costs and property costs, based on the
284 types of management services provided, as follows:
285 A maximum of up to three percent (3%) shall be allowed where
286 centralized managerial and administrative services are provided by
287 the management company or home office.
288 A maximum of up to five percent (5%) shall be allowed where
289 centralized managerial and administrative services and limited
290 professional and consultant services are provided.
291 A maximum of up to seven percent (7%) shall be allowed where
292 a full spectrum of centralized managerial services, administrative
293 services, professional services and consultant services are
294 provided.
295 (c) From and after July 1, 1997, all state-owned
296 nursing facilities shall be reimbursed on a full reasonable cost
297 basis.
298 (d) When a facility of a category that does not
299 require a certificate of need for construction and that could not
300 be eligible for Medicaid reimbursement is constructed to nursing
301 facility specifications for licensure and certification, and the
302 facility is subsequently converted to a nursing facility pursuant
303 to a certificate of need that authorizes conversion only and the
304 applicant for the certificate of need was assessed an application
305 review fee based on capital expenditures incurred in constructing
306 the facility, the division shall allow reimbursement for capital
307 expenditures necessary for construction of the facility that were
308 incurred within the twenty-four (24) consecutive calendar months
309 immediately preceding the date that the certificate of need
310 authorizing such conversion was issued, to the same extent that

311 reimbursement would be allowed for construction of a new nursing
312 facility pursuant to a certificate of need that authorizes such
313 construction. The reimbursement authorized in this subparagraph
314 (d) may be made only to facilities the construction of which was
315 completed after June 30, 1989. Before the division shall be
316 authorized to make the reimbursement authorized in this
317 subparagraph (d), the division first must have received approval
318 from the Health Care Financing Administration of the United States
319 Department of Health and Human Services of the change in the state
320 Medicaid plan providing for such reimbursement.

321 (e) The division shall develop and implement, not
322 later than January 1, 2001, a case-mix payment add-on determined
323 by time studies and other valid statistical data which will
324 reimburse a nursing facility for the additional cost of caring for
325 a resident who has a diagnosis of Alzheimer's or other related
326 dementia and exhibits symptoms that require special care. Any
327 such case-mix add-on payment shall be supported by a determination
328 of additional cost. The division shall also develop and implement
329 as part of the fair rental reimbursement system for nursing
330 facility beds, an Alzheimer's resident bed depreciation enhanced
331 reimbursement system which will provide an incentive to encourage
332 nursing facilities to convert or construct beds for residents with
333 Alzheimer's or other related dementia.

334 (f) The Division of Medicaid shall develop and
335 implement a referral process for long-term care alternatives for
336 Medicaid beneficiaries and applicants. No Medicaid beneficiary
337 shall be admitted to a Medicaid-certified nursing facility unless
338 a licensed physician certifies that nursing facility care is
339 appropriate for that person on a standardized form to be prepared
340 and provided to nursing facilities by the Division of Medicaid.

341 The physician shall forward a copy of that certification to the
342 Division of Medicaid within twenty-four (24) hours after it is
343 signed by the physician. Any physician who fails to forward the
344 certification to the Division of Medicaid within the time period
345 specified in this paragraph shall be ineligible for Medicaid
346 reimbursement for any physician's services performed for the
347 applicant. The Division of Medicaid shall determine, through an
348 assessment of the applicant conducted within two (2) business days
349 after receipt of the physician's certification, whether the
350 applicant also could live appropriately and cost-effectively at
351 home or in some other community-based setting if home- or
352 community-based services were available to the applicant. The
353 time limitation prescribed in this paragraph shall be waived in
354 cases of emergency. If the Division of Medicaid determines that a
355 home- or other community-based setting is appropriate and
356 cost-effective, the division shall:
357 (i) Advise the applicant or the applicant's
358 legal representative that a home- or other community-based setting
359 is appropriate;
360 (ii) Provide a proposed care plan and inform
361 the applicant or the applicant's legal representative regarding
362 the degree to which the services in the care plan are available in
363 a home- or in other community-based setting rather than nursing
364 facility care; and
365 (iii) Explain that such plan and services are
366 available only if the applicant or the applicant's legal
367 representative chooses a home- or community-based alternative to
368 nursing facility care, and that the applicant is free to choose
369 nursing facility care.
370 The Division of Medicaid may provide the services described

371 in this paragraph (f) directly or through contract with case
372 managers from the local Area Agencies on Aging, and shall
373 coordinate long-term care alternatives to avoid duplication with
374 hospital discharge planning procedures.
375 Placement in a nursing facility may not be denied by the
376 division if home- or community-based services that would be more
377 appropriate than nursing facility care are not actually available,
378 or if the applicant chooses not to receive the appropriate home-
379 or community-based services.
380 The division shall provide an opportunity for a fair hearing
381 under federal regulations to any applicant who is not given the
382 choice of home- or community-based services as an alternative to
383 institutional care.
384 The division shall make full payment for long-term care
385 alternative services.
386 The division shall apply for necessary federal waivers to
387 assure that additional services providing alternatives to nursing
388 facility care are made available to applicants for nursing
389 facility care.
390 (5) Periodic screening and diagnostic services for
391 individuals under age twenty-one (21) years as are needed to
392 identify physical and mental defects and to provide health care
393 treatment and other measures designed to correct or ameliorate
394 defects and physical and mental illness and conditions discovered
395 by the screening services regardless of whether these services are
396 included in the state plan. The division may include in its
397 periodic screening and diagnostic program those discretionary
398 services authorized under the federal regulations adopted to
399 implement Title XIX of the federal Social Security Act, as
400 amended. The division, in obtaining physical therapy services,

401 occupational therapy services, and services for individuals with
402 speech, hearing and language disorders, may enter into a
403 cooperative agreement with the State Department of Education for
404 the provision of such services to handicapped students by public
405 school districts using state funds which are provided from the
406 appropriation to the Department of Education to obtain federal
407 matching funds through the division. The division, in obtaining
408 medical and psychological evaluations for children in the custody
409 of the State Department of Human Services may enter into a
410 cooperative agreement with the State Department of Human Services
411 for the provision of such services using state funds which are
412 provided from the appropriation to the Department of Human
413 Services to obtain federal matching funds through the division.
414 On July 1, 1993, all fees for periodic screening and
415 diagnostic services under this paragraph (5) shall be increased by
416 twenty-five percent (25%) of the reimbursement rate in effect on
417 June 30, 1993.
418 (6) Physician's services. All fees for physicians'
419 services that are covered only by Medicaid shall be reimbursed at
420 ninety percent (90%) of the rate established on January 1, 1999,
421 and as adjusted each January thereafter, under Medicare (Title
422 XVIII of the Social Security Act, as amended), and which shall in
423 no event be less than seventy percent (70%) of the rate
424 established on January 1, 1994. All fees for physicians' services
425 that are covered by both Medicare and Medicaid shall be reimbursed
426 at ten percent (10%) of the adjusted Medicare payment established
427 on January 1, 1999, and as adjusted each January thereafter, under
428 Medicare (Title XVIII of the Social Security Act, as amended), and
429 which shall in no event be less than seven percent (7%) of the
430 adjusted Medicare payment established on January 1, 1994.

431 (7) (a) Home health services for eligible persons, not
432 to exceed in cost the prevailing cost of nursing facility
433 services, not to exceed sixty (60) visits per year.
434 (b) Repealed.
435 (8) Emergency medical transportation services. On
436 January 1, 1994, emergency medical transportation services shall
437 be reimbursed at seventy percent (70%) of the rate established
438 under Medicare (Title XVIII of the Social Security Act, as
439 amended). "Emergency medical transportation services" shall mean,
440 but shall not be limited to, the following services by a properly
441 permitted ambulance operated by a properly licensed provider in
442 accordance with the Emergency Medical Services Act of 1974
443 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
444 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
445 (vi) disposable supplies, (vii) similar services.
446 (9) Legend and other drugs as may be determined by the
447 division. The division may implement a program of prior approval
448 for drugs to the extent permitted by law. Payment by the division
449 for covered multiple source drugs shall be limited to the lower of
450 the upper limits established and published by the Health Care
451 Financing Administration (HCFA) plus a dispensing fee of Four
452 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
453 cost (EAC) as determined by the division plus a dispensing fee of
454 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual
455 and customary charge to the general public. The division shall
456 allow five (5) prescriptions per month for noninstitutionalized
457 Medicaid recipients; however, exceptions for up to ten (10)
458 prescriptions per month shall be allowed, with the approval of the
459 director.
460 Payment for other covered drugs, other than multiple source

461 drugs with HCFA upper limits, shall not exceed the lower of the
462 estimated acquisition cost as determined by the division plus a
463 dispensing fee of Four Dollars and Ninety-one Cents ($4.91) or the
464 providers' usual and customary charge to the general public.
465 Payment for nonlegend or over-the-counter drugs covered on
466 the division's formulary shall be reimbursed at the lower of the
467 division's estimated shelf price or the providers' usual and
468 customary charge to the general public. No dispensing fee shall
469 be paid.
470 The division shall develop and implement a program of payment
471 for additional pharmacist services, with payment to be based on
472 demonstrated savings, but in no case shall the total payment
473 exceed twice the amount of the dispensing fee.
474 As used in this paragraph (9), "estimated acquisition cost"
475 means the division's best estimate of what price providers
476 generally are paying for a drug in the package size that providers
477 buy most frequently. Product selection shall be made in
478 compliance with existing state law; however, the division may
479 reimburse as if the prescription had been filled under the generic
480 name. The division may provide otherwise in the case of specified
481 drugs when the consensus of competent medical advice is that
482 trademarked drugs are substantially more effective.
483 (10) Dental care that is an adjunct to treatment of an
484 acute medical or surgical condition; services of oral surgeons and
485 dentists in connection with surgery related to the jaw or any
486 structure contiguous to the jaw or the reduction of any fracture
487 of the jaw or any facial bone; and emergency dental extractions
488 and treatment related thereto. On July 1, 1999, all fees for
489 dental care and surgery under authority of this paragraph (10)
490 shall be increased to one hundred sixty percent (160%) of the

491 amount of the reimbursement rate that was in effect on June 30,
492 1999. It is the intent of the Legislature to encourage more
493 dentists to participate in the Medicaid program.
494 (11) Eyeglasses necessitated by reason of eye surgery,
495 and as prescribed by a physician skilled in diseases of the eye or
496 an optometrist, whichever the patient may select, or one (1) pair
497 every three (3) years as prescribed by a physician or an
498 optometrist, whichever the patient may select.
499 (12) Intermediate care facility services.
500 (a) The division shall make full payment to all
501 intermediate care facilities for the mentally retarded for each
502 day, not exceeding eighty-four (84) days per year, that a patient
503 is absent from the facility on home leave. Payment may be made
504 for the following home leave days in addition to the
505 eighty-four-day limitation: Christmas, the day before Christmas,
506 the day after Christmas, Thanksgiving, the day before Thanksgiving
507 and the day after Thanksgiving. However, before payment may be
508 made for more than eighteen (18) home leave days in a year for a
509 patient, the patient must have written authorization from a
510 physician stating that the patient is physically and mentally able
511 to be away from the facility on home leave. Such authorization
512 must be filed with the division before it will be effective, and
513 the authorization shall be effective for three (3) months from the
514 date it is received by the division, unless it is revoked earlier
515 by the physician because of a change in the condition of the
516 patient.
517 (b) All state-owned intermediate care facilities
518 for the mentally retarded shall be reimbursed on a full reasonable
519 cost basis.
520 (c) The division is authorized to limit allowable

521 management fees and home office costs to either three percent
522 (3%), five percent (5%) or seven percent (7%) of other allowable
523 costs, including allowable therapy costs and property costs, based
524 on the types of management services provided, as follows:
525 A maximum of up to three percent (3%) shall be allowed where
526 centralized managerial and administrative services are provided by
527 the management company or home office.
528 A maximum of up to five percent (5%) shall be allowed where
529 centralized managerial and administrative services and limited
530 professional and consultant services are provided.
531 A maximum of up to seven percent (7%) shall be allowed where
532 a full spectrum of centralized managerial services, administrative
533 services, professional services and consultant services are
534 provided.
535 (13) Family planning services, including drugs,
536 supplies and devices, when such services are under the supervision
537 of a physician.
538 (14) Clinic services. Such diagnostic, preventive,
539 therapeutic, rehabilitative or palliative services furnished to an
540 outpatient by or under the supervision of a physician or dentist
541 in a facility which is not a part of a hospital but which is
542 organized and operated to provide medical care to outpatients.
543 Clinic services shall include any services reimbursed as
544 outpatient hospital services which may be rendered in such a
545 facility, including those that become so after July 1, 1991. On
546 July 1, 1999, all fees for physicians' services reimbursed under
547 authority of this paragraph (14) shall be reimbursed at ninety
548 percent (90%) of the rate established on January 1, 1999, and as
549 adjusted each January thereafter, under Medicare (Title XVIII of
550 the Social Security Act, as amended), and which shall in no event

551 be less than seventy percent (70%) of the rate established on
552 January 1, 1994. All fees for physicians' services that are
553 covered by both Medicare and Medicaid shall be reimbursed at ten
554 percent (10%) of the adjusted Medicare payment established on
555 January 1, 1999, and as adjusted each January thereafter, under
556 Medicare (Title XVIII of the Social Security Act, as amended), and
557 which shall in no event be less than seven percent (7%) of the
558 adjusted Medicare payment established on January 1, 1994. On July
559 1, 1999, all fees for dentists' services reimbursed under
560 authority of this paragraph (14) shall be increased to one hundred
561 sixty percent (160%) of the amount of the reimbursement rate that
562 was in effect on June 30, 1999.
563 (15) Home- and community-based services, as provided
564 under Title XIX of the federal Social Security Act, as amended,
565 under waivers, subject to the availability of funds specifically
566 appropriated therefor by the Legislature. Payment for such
567 services shall be limited to individuals who would be eligible for
568 and would otherwise require the level of care provided in a
569 nursing facility. The home- and community-based services
570 authorized under this paragraph shall be expanded over a five-year
571 period beginning July 1, 1999. The division shall certify case
572 management agencies to provide case management services and
573 provide for home- and community-based services for eligible
574 individuals under this paragraph. The home- and community-based
575 services under this paragraph and the activities performed by
576 certified case management agencies under this paragraph shall be
577 funded using state funds that are provided from the appropriation
578 to the Division of Medicaid and used to match federal funds.
579 (16) Mental health services. Approved therapeutic and
580 case management services provided by (a) an approved regional

581 mental health/retardation center established under Sections
582 41-19-31 through 41-19-39, or by another community mental health
583 service provider meeting the requirements of the Department of
584 Mental Health to be an approved mental health/retardation center
585 if determined necessary by the Department of Mental Health, using
586 state funds which are provided from the appropriation to the State
587 Department of Mental Health and used to match federal funds under
588 a cooperative agreement between the division and the department,
589 or (b) a facility which is certified by the State Department of
590 Mental Health to provide therapeutic and case management services,
591 to be reimbursed on a fee for service basis. Any such services
592 provided by a facility described in paragraph (b) must have the
593 prior approval of the division to be reimbursable under this
594 section. After June 30, 1997, mental health services provided by
595 regional mental health/retardation centers established under
596 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
597 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
598 psychiatric residential treatment facilities as defined in Section
599 43-11-1, or by another community mental health service provider
600 meeting the requirements of the Department of Mental Health to be
601 an approved mental health/retardation center if determined
602 necessary by the Department of Mental Health, shall not be
603 included in or provided under any capitated managed care pilot
604 program provided for under paragraph (24) of this section. From
605 and after July 1, 2000, the division is authorized to contract
606 with a 134-bed specialty hospital located on Highway 39 North in
607 Lauderdale County for the use of not more than sixty (60) beds at
608 the facility to provide mental health services for children and
609 adolescents and for crisis intervention services for emotionally
610 disturbed children with behavioral problems, with priority to be

611 given to children in the custody of the Department of Human
612 Services who are, or otherwise will be, receiving such services
613 out-of-state.
614 (17) Durable medical equipment services and medical
615 supplies. The Division of Medicaid may require durable medical
616 equipment providers to obtain a surety bond in the amount and to
617 the specifications as established by the Balanced Budget Act of
618 1997.
619 (18) Notwithstanding any other provision of this
620 section to the contrary, the division shall make additional
621 reimbursement to hospitals which serve a disproportionate share of
622 low-income patients and which meet the federal requirements for
623 such payments as provided in Section 1923 of the federal Social
624 Security Act and any applicable regulations. However, from and
625 after January 1, 2000, no public hospital shall participate in the
626 Medicaid disproportionate share program unless the public hospital
627 participates in an intergovernmental transfer program as provided
628 in Section 1903 of the federal Social Security Act and any
629 applicable regulations. Administration and support for
630 participating hospitals shall be provided by the Mississippi
631 Hospital Association.
632 (19) (a) Perinatal risk management services. The
633 division shall promulgate regulations to be effective from and
634 after October 1, 1988, to establish a comprehensive perinatal
635 system for risk assessment of all pregnant and infant Medicaid
636 recipients and for management, education and follow-up for those
637 who are determined to be at risk. Services to be performed
638 include case management, nutrition assessment/counseling,
639 psychosocial assessment/counseling and health education. The
640 division shall set reimbursement rates for providers in

641 conjunction with the State Department of Health.

642 (b) Early intervention system services. The
643 division shall cooperate with the State Department of Health,
644 acting as lead agency, in the development and implementation of a
645 statewide system of delivery of early intervention services,
646 pursuant to Part H of the Individuals with Disabilities Education
647 Act (IDEA). The State Department of Health shall certify annually
648 in writing to the director of the division the dollar amount of
649 state early intervention funds available which shall be utilized
650 as a certified match for Medicaid matching funds. Those funds
651 then shall be used to provide expanded targeted case management
652 services for Medicaid eligible children with special needs who are
653 eligible for the state's early intervention system.
654 Qualifications for persons providing service coordination shall be
655 determined by the State Department of Health and the Division of
656 Medicaid.

657 (20) Home- and community-based services for physically
658 disabled approved services as allowed by a waiver from the United
659 States Department of Health and Human Services for home- and
660 community-based services for physically disabled people using
661 state funds which are provided from the appropriation to the State
662 Department of Rehabilitation Services and used to match federal
663 funds under a cooperative agreement between the division and the
664 department, provided that funds for these services are
665 specifically appropriated to the Department of Rehabilitation
666 Services.

667 (21) Nurse practitioner services. Services furnished
668 by a registered nurse who is licensed and certified by the
669 Mississippi Board of Nursing as a nurse practitioner including,
670 but not limited to, nurse anesthetists, nurse midwives, family

671 nurse practitioners, family planning nurse practitioners,
672 pediatric nurse practitioners, obstetrics-gynecology nurse
673 practitioners and neonatal nurse practitioners, under regulations
674 adopted by the division. Reimbursement for such services shall
675 not exceed ninety percent (90%) of the reimbursement rate for
676 comparable services rendered by a physician.
677 (22) Ambulatory services delivered in federally
678 qualified health centers and in clinics of the local health
679 departments of the State Department of Health for individuals
680 eligible for medical assistance under this article based on
681 reasonable costs as determined by the division.
682 (23) Inpatient psychiatric services. Inpatient
683 psychiatric services to be determined by the division for
684 recipients under age twenty-one (21) which are provided under the
685 direction of a physician in an inpatient program in a licensed
686 acute care psychiatric facility or in a licensed psychiatric
687 residential treatment facility, before the recipient reaches age
688 twenty-one (21) or, if the recipient was receiving the services
689 immediately before he reached age twenty-one (21), before the
690 earlier of the date he no longer requires the services or the date
691 he reaches age twenty-two (22), as provided by federal
692 regulations. Recipients shall be allowed forty-five (45) days per
693 year of psychiatric services provided in acute care psychiatric
694 facilities, and shall be allowed unlimited days of psychiatric
695 services provided in licensed psychiatric residential treatment
696 facilities. The division is authorized to limit allowable
697 management fees and home office costs to either three percent
698 (3%), five percent (5%) or seven percent (7%) of other allowable
699 costs, including allowable therapy costs and property costs, based
700 on the types of management services provided, as follows:

701 A maximum of up to three percent (3%) shall be allowed where
702 centralized managerial and administrative services are provided by
703 the management company or home office.
704 A maximum of up to five percent (5%) shall be allowed where
705 centralized managerial and administrative services and limited
706 professional and consultant services are provided.
707 A maximum of up to seven percent (7%) shall be allowed where
708 a full spectrum of centralized managerial services, administrative
709 services, professional services and consultant services are
710 provided.
711 (24) Managed care services in a program to be developed
712 by the division by a public or private provider. If managed care
713 services are provided by the division to Medicaid recipients, and
714 those managed care services are operated, managed and controlled
715 by and under the authority of the division, the division shall be
716 responsible for educating the Medicaid recipients who are
717 participants in the managed care program regarding the manner in
718 which the participants should seek health care under the program.
719 Notwithstanding any other provision in this article to the
720 contrary, the division shall establish rates of reimbursement to
721 providers rendering care and services authorized under this
722 paragraph (24), and may revise such rates of reimbursement without
723 amendment to this section by the Legislature for the purpose of
724 achieving effective and accessible health services, and for
725 responsible containment of costs.
726 (25) Birthing center services.
727 (26) Hospice care. As used in this paragraph, the term
728 "hospice care" means a coordinated program of active professional
729 medical attention within the home and outpatient and inpatient
730 care which treats the terminally ill patient and family as a unit,

731 employing a medically directed interdisciplinary team. The
732 program provides relief of severe pain or other physical symptoms
733 and supportive care to meet the special needs arising out of
734 physical, psychological, spiritual, social and economic stresses
735 which are experienced during the final stages of illness and
736 during dying and bereavement and meets the Medicare requirements
737 for participation as a hospice as provided in federal regulations.
738 (27) Group health plan premiums and cost sharing if it
739 is cost effective as defined by the Secretary of Health and Human
740 Services.
741 (28) Other health insurance premiums which are cost
742 effective as defined by the Secretary of Health and Human
743 Services. Medicare eligible must have Medicare Part B before
744 other insurance premiums can be paid.
745 (29) The Division of Medicaid may apply for a waiver
746 from the Department of Health and Human Services for home- and
747 community-based services for developmentally disabled people using
748 state funds which are provided from the appropriation to the State
749 Department of Mental Health and used to match federal funds under
750 a cooperative agreement between the division and the department,
751 provided that funds for these services are specifically
752 appropriated to the Department of Mental Health.
753 (30) Pediatric skilled nursing services for eligible
754 persons under twenty-one (21) years of age.
755 (31) Targeted case management services for children
756 with special needs, under waivers from the United States
757 Department of Health and Human Services, using state funds that
758 are provided from the appropriation to the Mississippi Department
759 of Human Services and used to match federal funds under a
760 cooperative agreement between the division and the department.

761 (32) Care and services provided in Christian Science
762 Sanatoria operated by or listed and certified by The First Church
763 of Christ Scientist, Boston, Massachusetts, rendered in connection
764 with treatment by prayer or spiritual means to the extent that
765 such services are subject to reimbursement under Section 1903 of
766 the Social Security Act.
767 (33) Podiatrist services.
768 (34) The division shall make application to the United
769 States Health Care Financing Administration for a waiver to
770 develop a program of services to personal care and assisted living
771 homes in Mississippi. This waiver shall be completed by December
772 1, 1999.
773 (35) Services and activities authorized in Sections
774 43-27-101 and 43-27-103, using state funds that are provided from
775 the appropriation to the State Department of Human Services and
776 used to match federal funds under a cooperative agreement between
777 the division and the department.
778 (36) Nonemergency transportation services for
779 Medicaid-eligible persons, to be provided by the Division of
780 Medicaid. The division may contract with additional entities to
781 administer nonemergency transportation services as it deems
782 necessary. All providers shall have a valid driver's license,
783 vehicle inspection sticker, valid vehicle license tags and a
784 standard liability insurance policy covering the vehicle.
785 (37) Targeted case management services for individuals
786 with chronic diseases, with expanded eligibility to cover services
787 to uninsured recipients, on a pilot program basis. This paragraph
788 (37) shall be contingent upon continued receipt of special funds
789 from the Health Care Financing Authority and private foundations
790 who have granted funds for planning these services. No funding

791 for these services shall be provided from state general funds.

792 (38) Chiropractic services: a chiropractor's manual
793 manipulation of the spine to correct a subluxation, if x-ray
794 demonstrates that a subluxation exists and if the subluxation has
795 resulted in a neuromusculoskeletal condition for which
796 manipulation is appropriate treatment. Reimbursement for
797 chiropractic services shall not exceed Seven Hundred Dollars
798 ($700.00) per year per recipient.

799 (39) Dually eligible Medicare/Medicaid beneficiaries.
800 The division shall pay the Medicare deductible and ten percent
801 (10%) coinsurance amounts for services available under Medicare
802 for the duration and scope of services otherwise available under
803 the Medicaid program.

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

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

818 (42) Notwithstanding any other provision in this
819 article to the contrary, the division is hereby authorized to
820 develop a population health management program for women and

821 children health services through the age of two (2). This program
822 is primarily for obstetrical care associated with low birth weight
823 and pre-term babies. In order to effect cost savings, the
824 division may develop a revised payment methodology which may
825 include at-risk capitated payments.

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

831 <u>(44) The division shall make application to the federal</u>
832 <u>Health Care Financing Administration for a waiver to develop and</u>
833 <u>provide services for children with serious emotional disturbances</u>
834 <u>as defined in Section 43-14-1(1), which may include home- and</u>
835 <u>community-based services, case management services or managed care</u>
836 <u>services through mental health providers certified by the</u>
837 <u>Department of Mental Health. The division may implement and</u>
838 <u>provide services under this waivered program only if funds for</u>
839 <u>these services are specifically appropriated for this purpose by</u>
840 <u>the Legislature, or if funds are voluntarily provided by affected</u>
841 <u>agencies.</u>

842 Notwithstanding any provision of this article, except as
843 authorized in the following paragraph and in Section 43-13-139,
844 neither (a) the limitations on quantity or frequency of use of or
845 the fees or charges for any of the care or services available to
846 recipients under this section, nor (b) the payments or rates of
847 reimbursement to providers rendering care or services authorized
848 under this section to recipients, may be increased, decreased or
849 otherwise changed from the levels in effect on July 1, 1999,
850 unless such is authorized by an amendment to this section by the

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

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

879 SECTION 5. Section 43-14-7, Mississippi Code of 1972, which
880 provides for services and eligibility under the blended funding

881 formula formerly administered by the Children's Advisory Council,

882 and Section 43-14-9, Mississippi Code of 1972, which is the

883 automatic repealer on Sections 43-14-1 through 43-14-7, are hereby

884 repealed.

885 SECTION 6. This act shall take effect and be in force from

886 and after June 30, 2001.

Further, amend by striking the title in its entirety and inserting in lieu thereof the following:

1 AN ACT TO AMEND SECTIONS 43-14-1, 43-14-3 and 43-14-5,
2 MISSISSIPPI CODE OF 1972, TO ESTABLISH AN INTERAGENCY COORDINATING
3 COUNCIL FOR CHILDREN AND YOUTH, TO EMPOWER THE INTERAGENCY COUNCIL
4 TO IMPLEMENT A PLANNING PROCESS FOR EACH CHILD SERVICE AGENCY TO
5 UTILIZE FEDERAL AND STATE FUNDS, TO DEFINE CHILDREN ELIGIBLE FOR
6 SERVICES WHICH ARE TO BE COORDINATED UNDER THIS ACT, TO ESTABLISH
7 AN INTERAGENCY SYSTEM OF CARE COUNCIL TO PERFORM CERTAIN FUNCTIONS
8 AND ADVISE THE INTERAGENCY COORDINATING COUNCIL, TO ESTABLISH A
9 STATEWIDE SYSTEM OF LOCAL MULTIDISCIPLINARY ASSESSMENT AND
10 PLANNING RESOURCE (MAP) TEAMS, TO EMPOWER THE INTERAGENCY
11 COORDINATING COUNCIL TO COORDINATE A POOL OF FUNDS FROM THESE
12 STATE AGENCIES TO SERVE THIS POPULATION OF CHILDREN THROUGH LOCAL
13 MAP TEAMS AND TO CHARGE THE LOCAL MAP TEAMS WITH CERTAIN
14 RESPONSIBILITIES; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF
15 1972, TO DIRECT THE DIVISION OF MEDICAID TO APPLY FOR FEDERAL
16 WAIVERS TO PROVIDE SERVICES FOR CHILDREN WITH SERIOUS EMOTIONAL
17 DISTURBANCES; TO REPEAL SECTION 43-14-7, MISSISSIPPI CODE OF 1972,
18 WHICH PROVIDES FOR SERVICES AND ELIGIBILITY UNDER THE BLENDED
19 FUNDING PROGRAM FORMERLY ADMINISTERED BY THE CHILDREN'S ADVISORY
20 COUNCIL AND TO REPEAL SECTION 43-14-9, MISSISSIPPI CODE OF 1972,
21 WHICH IS THE AUTOMATIC REPEALER ON SECTIONS 43-14-1 THROUGH
22 43-14-7, MISSISSIPPI CODE OF 1972; AND FOR RELATED PURPOSES.