By: Senator(s) Dawkins, Williamson, Harden, Hyde-Smith, Nunnelee

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2375

1 AN ACT RELATING TO NEWBORN SCREENING TESTS; TO AMEND SECTIONS
2 41-21-201 AND 41-21-203, MISSISSIPPI CODE OF 1972, TO DIRECT THE
3 STATE BOARD OF HEALTH, HEALTH CARE PROVIDERS AND HEALTH CARE
4 FACILITIES WHICH ATTEND INFANTS TO EXPLAIN TO THE PARENT OR
5 GUARDIAN THE AVAILABILITY OF CERTAIN NEWBORN SCREENING TESTS TO
6 DETECT HERITABLE AND GENETIC CONDITIONS; TO PROVIDE THAT UPON
7 CONSENT OF THE PARENT OR GUARDIAN, THE HEALTH CARE FACILITY SHALL
8 BE RESPONSIBLE FOR OBTAINING THE SPECIMEN, SENDING THE SPECIMEN TO
9 A QUALIFIED LABORATORY AND PROVIDING DIAGNOSIS, TREATMENT AND
10 EVALUATION AS NECESSARY; TO AUTHORIZE THE STATE BOARD OF HEALTH TO
11 ENTER INTO AGREEMENTS WITH QUALIFIED LABORATORIES TO PERFORM
12 NEWBORN SCREENING TESTS FOR SUCH ADDITIONAL TESTING; TO AMEND
13 SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO AUTHORIZE MEDICAID
14 REIMBURSEMENT FOR CERTAIN NEWBORN SCREENING TESTS BEGINNING
15 JANUARY 1, 2007; TO CODIFY SECTION 83-9-36, MISSISSIPPI CODE OF
16 1972, TO PROVIDE THAT A HEALTH BENEFIT PLAN THAT PROVIDES COVERAGE
17 FOR A FAMILY OR DEPENDENT SHALL PROVIDE COVERAGE FOR COMPREHENSIVE
18 NEWBORN SCREENING; TO AMEND SECTIONS 41-89-1, 41-89-3 AND 41-89-5,
19 MISSISSIPPI CODE OF 1972, TO REENACT AND CONTINUE THE EXISTENCE OF
20 THE INFANT MORTALITY TASK FORCE AND TO SPECIFICALLY CHARGE THE
21 TASK FORCE WITH THE RESPONSIBILITY OF ADVISING THE STATE BOARD OF
22 HEALTH ON MATTERS RELATING TO NEWBORN SCREENING; AND FOR RELATED
23 PURPOSES.

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

25 **SECTION 1.** Section 41-21-201, Mississippi Code of 1972, is
26 amended as follows:

27 41-21-201. (1) The State Department of Health shall
28 establish, maintain and carry out a comprehensive newborn
29 screening program designed to detect hypothyroidism,
30 phenylketonuria (PKU), hemoglobinopathy, congenital adrenal
31 hyperplasia (CAH), galactosemia, and such other conditions as
32 specified by the State Board of Health and as recommended by the
33 American Academy of Pediatrics. The State Board of Health shall
34 adopt any rules and regulations necessary to accomplish the
35 program.

36 (2) (a) Beginning January 1, 2007, the State Board of
37 Health shall develop information that explains the availability of

38 additional newborn screening tests not specified in subsection (1)
39 of this section that relate to heritable and genetic congenital
40 disorders, and the risks and costs of these test. These tests
41 shall include newborn screening tests utilizing tandem
42 spectrometry mass recommended by the American College of Medical
43 Genetics in a report commissioned by federal Health Resources and
44 Services Administration. These recommendations shall be
45 superseded by any future recommendations of the Advisory Committee
46 on Heritable Disorders and Genetic Disease in Newborns and
47 Children established by the United States Department for Health
48 and Human Services. The State Board of Health shall make this
49 information available on the Internet and shall distribute
50 information regarding the availability of newborn screening
51 information on the Internet to:
52 (i) All health care facilities that provide care
53 for infants twenty-eight (28) days or less of age; and
54 (ii) All physicians in this state that have a
55 primary responsibility for ordering screening tests to be
56 performed.
57 (b) Each health care facility and physician shall
58 inform the infant's parent or guardian of the availability of such
59 comprehensive newborn screening tests. Information provided to
60 the parent or guardian shall include, at a minimum, the content
61 provided on the cabinet's Internet site. Upon consent of the
62 parent or guardian, the health care facility shall be responsible
63 for obtaining the specimen, sending the specimen to a qualified
64 laboratory, and providing the appropriate follow-up to the newborn
65 screening, including, but not limited to, diagnosis, treatment and
66 evaluation as necessary. "Qualified laboratory" means a clinical
67 laboratory that:
68 (i) Holds a current and valid certificate issued
69 by the United States Department for Health and Human Services
70 pursuant to 42 USC Section 236a;

71 (ii) Is licensed to perform newborn screening
72 testing in any state;
73 (iii) Is not operated by the State Board of
74 Health; and
75 (iv) Reports its screening results using normal
76 pediatric reference ranges.
77 (c) The health care facility or physician shall not be
78 required to assume the cost of additional testing.
79 (d) The State Board of Health may enter into agreements
80 with public or private qualified laboratories to perform newborn
81 screening tests for any additional testing conducted pursuant to
82 this subsection. Any agreement entered into under this paragraph
83 (d) shall not preclude a health care facility or physician from
84 having newborn tests analyzed by other qualified laboratories.
85 (e) The State Board of Health shall receive and
86 consider the recommendations of the Infant Mortality Task Force
87 created in Section 41-89-1 et seq., relating to additional
88 screening for newborn disorders.
89 **SECTION 2.** Section 41-21-203, Mississippi Code of 1972, is
90 amended as follows:
91 41-21-203. (1) All newborn infants shall be screened by the
92 physician or other health care provider attending the infant,
93 using tests that have been approved by the State Board of Health,
94 to detect those conditions listed in Section 41-21-201(1) and the
95 other conditions specified under Section 41-21-201(2) for the
96 comprehensive newborn screening program. However, no such tests
97 shall be given to any child whose parents object thereto on the
98 grounds that the test conflicts with his religious practices or
99 tenets. The tests provided under the comprehensive newborn
100 screening program shall be evaluated in laboratories located in
101 the United States and qualified as provided in Section
102 41-21-201(2). The State Department of Health shall follow up all
103 positive tests with the attending physician or other health care

104 provider who notified the department thereof, and with the parents
105 of the newborn child. The services and facilities of the State
106 Department of Health and those of other state boards, departments
107 and agencies cooperating with the State Department of Health in
108 carrying out the comprehensive newborn screening program shall be
109 made available to all newborn infants with abnormal screening
110 tests.

111 (2) The State Department of Health shall provide ongoing
112 epidemiologic surveillance of the comprehensive newborn screening
113 program to determine the efficacy and cost effectiveness of
114 screening newborn infants.

115 **SECTION 3.** Section 43-13-117, Mississippi Code of 1972, is
116 amended as follows:

117 43-13-117. Medicaid as authorized by this article shall
118 include payment of part or all of the costs, at the discretion of
119 the division, with approval of the Governor, of the following
120 types of care and services rendered to eligible applicants who
121 have been determined to be eligible for that care and services,
122 within the limits of state appropriations and federal matching
123 funds:

124 (1) Inpatient hospital services.

125 (a) The division shall allow thirty (30) days of
126 inpatient hospital care annually for all Medicaid recipients.
127 Precertification of inpatient days must be obtained as required by
128 the division. The division may allow unlimited days in
129 disproportionate hospitals as defined by the division for eligible
130 infants and children under the age of six (6) years if certified
131 as medically necessary as required by the division.

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

136 Capital Cost Component utilized to determine total hospital costs
137 allocated to the Medicaid program.
138 (c) Hospitals will receive an additional payment
139 for the implantable programmable baclofen drug pump used to treat
140 spasticity that is implanted on an inpatient basis. The payment
141 pursuant to written invoice will be in addition to the facility's
142 per diem reimbursement and will represent a reduction of costs on
143 the facility's annual cost report, and shall not exceed Ten
144 Thousand Dollars ($10,000.00) per year per recipient.
145 (2) Outpatient hospital services.
146 (a) Emergency services. The division shall allow
147 six (6) medically necessary emergency room visits per beneficiary
148 per fiscal year.
149 (b) Other outpatient hospital services. The
150 division shall allow benefits for other medically necessary
151 outpatient hospital services (such as chemotherapy, radiation,
152 surgery and therapy). Where the same services are reimbursed as
153 clinic services, the division may revise the rate or methodology
154 of outpatient reimbursement to maintain consistency, efficiency,
155 economy and quality of care.
156 (3) Laboratory and x-ray services.
157 (4) Nursing facility services.
158 (a) The division shall make full payment to
159 nursing facilities for each day, not exceeding fifty-two (52) days
160 per year, that a patient is absent from the facility on home
161 leave. Payment may be made for the following home leave days in
162 addition to the fifty-two-day limitation: Christmas, the day
163 before Christmas, the day after Christmas, Thanksgiving, the day
164 before Thanksgiving and the day after Thanksgiving.
165 (b) From and after July 1, 1997, the division
166 shall implement the integrated case-mix payment and quality
167 monitoring system, which includes the fair rental system for
168 property costs and in which recapture of depreciation is

169 eliminated. The division may reduce the payment for hospital
170 leave and therapeutic home leave days to the lower of the case-mix
171 category as computed for the resident on leave using the
172 assessment being utilized for payment at that point in time, or a
173 case-mix score of 1.000 for nursing facilities, and shall compute
174 case-mix scores of residents so that only services provided at the
175 nursing facility are considered in calculating a facility's per
176 diem.

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

180 (d) When a facility of a category that does not
181 require a certificate of need for construction and that could not
182 be eligible for Medicaid reimbursement is constructed to nursing
183 facility specifications for licensure and certification, and the
184 facility is subsequently converted to a nursing facility under a
185 certificate of need that authorizes conversion only and the
186 applicant for the certificate of need was assessed an application
187 review fee based on capital expenditures incurred in constructing
188 the facility, the division shall allow reimbursement for capital
189 expenditures necessary for construction of the facility that were
190 incurred within the twenty-four (24) consecutive calendar months
191 immediately preceding the date that the certificate of need
192 authorizing the conversion was issued, to the same extent that
193 reimbursement would be allowed for construction of a new nursing
194 facility under a certificate of need that authorizes that
195 construction. The reimbursement authorized in this subparagraph
196 (d) may be made only to facilities the construction of which was
197 completed after June 30, 1989. Before the division shall be
198 authorized to make the reimbursement authorized in this
199 subparagraph (d), the division first must have received approval
200 from the Centers for Medicare and Medicaid Services (CMS) of the
201 change in the state Medicaid plan providing for the reimbursement.

202 (e) The division shall develop and implement, not
203 later than January 1, 2001, a case-mix payment add-on determined
204 by time studies and other valid statistical data that will
205 reimburse a nursing facility for the additional cost of caring for
206 a resident who has a diagnosis of Alzheimer's or other related
207 dementia and exhibits symptoms that require special care. Any
208 such case-mix add-on payment shall be supported by a determination
209 of additional cost. The division shall also develop and implement
210 as part of the fair rental reimbursement system for nursing
211 facility beds, an Alzheimer's resident bed depreciation enhanced
212 reimbursement system that will provide an incentive to encourage
213 nursing facilities to convert or construct beds for residents with
214 Alzheimer's or other related dementia.

215 (f) The division shall develop and implement an
216 assessment process for long-term care services. The division may
217 provide the assessment and related functions directly or through
218 contract with the area agencies on aging.

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

223 (5) Periodic screening and diagnostic services for
224 individuals under age twenty-one (21) years as are needed to
225 identify physical and mental defects and to provide health care
226 treatment and other measures designed to correct or ameliorate
227 defects and physical and mental illness and conditions discovered
228 by the screening services, regardless of whether these services
229 are included in the state plan. The division may include in its
230 periodic screening and diagnostic program those discretionary
231 services authorized under the federal regulations adopted to
232 implement Title XIX of the federal Social Security Act, as
233 amended. The division, in obtaining physical therapy services,
234 occupational therapy services, and services for individuals with

235 speech, hearing and language disorders, may enter into a
236 cooperative agreement with the State Department of Education for
237 the provision of those services to handicapped students by public
238 school districts using state funds that are provided from the
239 appropriation to the Department of Education to obtain federal
240 matching funds through the division. The division, in obtaining
241 medical and psychological evaluations for children in the custody
242 of the State Department of Human Services may enter into a
243 cooperative agreement with the State Department of Human Services
244 for the provision of those services using state funds that are
245 provided from the appropriation to the Department of Human
246 Services to obtain federal matching funds through the division.
247 (6) Physician's services. The division shall allow
248 twelve (12) physician visits annually. All fees for physicians'
249 services that are covered only by Medicaid shall be reimbursed at
250 ninety percent (90%) of the rate established on January 1, 1999,
251 and as may be adjusted each July thereafter, under Medicare (Title
252 XVIII of the federal Social Security Act, as amended). The
253 division may develop and implement a different reimbursement model
254 or schedule for physician's services provided by physicians based
255 at an academic health care center and by physicians at rural
256 health centers that are associated with an academic health care
257 center.
258 (7) (a) Home health services for eligible persons, not
259 to exceed in cost the prevailing cost of nursing facility
260 services, not to exceed twenty-five (25) visits per year. All
261 home health visits must be precertified as required by the
262 division.
263 (b) Repealed.
264 (8) Emergency medical transportation services. On
265 January 1, 1994, emergency medical transportation services shall
266 be reimbursed at seventy percent (70%) of the rate established
267 under Medicare (Title XVIII of the federal Social Security Act, as

268 amended). "Emergency medical transportation services" shall mean,
269 but shall not be limited to, the following services by a properly
270 permitted ambulance operated by a properly licensed provider in
271 accordance with the Emergency Medical Services Act of 1974
272 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
273 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
274 (vi) disposable supplies, (vii) similar services.

275 (9) (a) Legend and other drugs as may be determined by
276 the division.

277 The division shall establish a mandatory preferred drug list.
278 Drugs not on the mandatory preferred drug list shall be made
279 available by utilizing prior authorization procedures established
280 by the division.

281 The division may seek to establish relationships with other
282 states in order to lower acquisition costs of prescription drugs
283 to include single source and innovator multiple source drugs or
284 generic drugs. In addition, if allowed by federal law or
285 regulation, the division may seek to establish relationships with
286 and negotiate with other countries to facilitate the acquisition
287 of prescription drugs to include single source and innovator
288 multiple source drugs or generic drugs, if that will lower the
289 acquisition costs of those prescription drugs.

290 The division shall allow for a combination of prescriptions
291 for single source and innovator multiple source drugs and generic
292 drugs to meet the needs of the beneficiaries, not to exceed five
293 (5) prescriptions per month for each noninstitutionalized Medicaid
294 beneficiary, with not more than two (2) of those prescriptions
295 being for single source or innovator multiple source drugs.

296 The executive director may approve specific maintenance drugs
297 for beneficiaries with certain medical conditions, which may be
298 prescribed and dispensed in three-month supply increments. The
299 executive director may allow a state agency or agencies to be the
300 sole source purchaser and distributor of hemophilia factor

301 medications, HIV/AIDS medications and other medications as
302 determined by the executive director as allowed by federal
303 regulations.

304 Drugs prescribed for a resident of a psychiatric residential
305 treatment facility must be provided in true unit doses when
306 available. The division may require that drugs not covered by
307 Medicare Part D for a resident of a long-term care facility be
308 provided in true unit doses when available. Those drugs that were
309 originally billed to the division but are not used by a resident
310 in any of those facilities shall be returned to the billing
311 pharmacy for credit to the division, in accordance with the
312 guidelines of the State Board of Pharmacy and any requirements of
313 federal law and regulation. Drugs shall be dispensed to a
314 recipient and only one (1) dispensing fee per month may be
315 charged. The division shall develop a methodology for reimbursing
316 for restocked drugs, which shall include a restock fee as
317 determined by the division not exceeding Seven Dollars and
318 Eighty-two Cents ($7.82).

319 The voluntary preferred drug list shall be expanded to
320 function in the interim in order to have a manageable prior
321 authorization system, thereby minimizing disruption of service to
322 beneficiaries.

323 Except for those specific maintenance drugs approved by the
324 executive director, the division shall not reimburse for any
325 portion of a prescription that exceeds a thirty-one-day supply of
326 the drug based on the daily dosage.

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

331 All claims for drugs for dually eligible Medicare/Medicaid
332 beneficiaries that are paid for by Medicare must be submitted to

333 Medicare for payment before they may be processed by the
334 division's on-line payment system.
335 The division shall develop a pharmacy policy in which drugs
336 in tamper-resistant packaging that are prescribed for a resident
337 of a nursing facility but are not dispensed to the resident shall
338 be returned to the pharmacy and not billed to Medicaid, in
339 accordance with guidelines of the State Board of Pharmacy.
340 The division shall develop and implement a method or methods
341 by which the division will provide on a regular basis to Medicaid
342 providers who are authorized to prescribe drugs, information about
343 the costs to the Medicaid program of single source drugs and
344 innovator multiple source drugs, and information about other drugs
345 that may be prescribed as alternatives to those single source
346 drugs and innovator multiple source drugs and the costs to the
347 Medicaid program of those alternative drugs.
348 Notwithstanding any law or regulation, information obtained
349 or maintained by the division regarding the prescription drug
350 program, including trade secrets and manufacturer or labeler
351 pricing, is confidential and not subject to disclosure except to
352 other state agencies.
353 (b) Payment by the division for covered
354 multisource drugs shall be limited to the lower of the upper
355 limits established and published by the Centers for Medicare and
356 Medicaid Services (CMS) plus a dispensing fee, or the estimated
357 acquisition cost (EAC) as determined by the division, plus a
358 dispensing fee, or the providers' usual and customary charge to
359 the general public.
360 Payment for other covered drugs, other than multisource drugs
361 with CMS upper limits, shall not exceed the lower of the estimated
362 acquisition cost as determined by the division, plus a dispensing
363 fee or the providers' usual and customary charge to the general
364 public.

365 Payment for nonlegend or over-the-counter drugs covered by
366 the division shall be reimbursed at the lower of the division's
367 estimated shelf price or the providers' usual and customary charge
368 to the general public.
369 The dispensing fee for each new or refill prescription,
370 including nonlegend or over-the-counter drugs covered by the
371 division, shall be not less than Three Dollars and Ninety-one
372 Cents ($3.91), as determined by the division.
373 The division shall not reimburse for single source or
374 innovator multiple source drugs if there are equally effective
375 generic equivalents available and if the generic equivalents are
376 the least expensive.
377 It is the intent of the Legislature that the pharmacists
378 providers be reimbursed for the reasonable costs of filling and
379 dispensing prescriptions for Medicaid beneficiaries.
380 (10) Dental care that is an adjunct to treatment of an
381 acute medical or surgical condition; services of oral surgeons and
382 dentists in connection with surgery related to the jaw or any
383 structure contiguous to the jaw or the reduction of any fracture
384 of the jaw or any facial bone; and emergency dental extractions
385 and treatment related thereto. On July 1, 1999, all fees for
386 dental care and surgery under authority of this paragraph (10)
387 shall be increased to one hundred sixty percent (160%) of the
388 amount of the reimbursement rate that was in effect on June 30,
389 1999. It is the intent of the Legislature to encourage more
390 dentists to participate in the Medicaid program.
391 (11) Eyeglasses for all Medicaid beneficiaries who have
392 (a) had surgery on the eyeball or ocular muscle that results in a
393 vision change for which eyeglasses or a change in eyeglasses is
394 medically indicated within six (6) months of the surgery and is in
395 accordance with policies established by the division, or (b) one
396 (1) pair every five (5) years and in accordance with policies
397 established by the division. In either instance, the eyeglasses

398 must be prescribed by a physician skilled in diseases of the eye
399 or an optometrist, whichever the beneficiary may select.
400 (12) Intermediate care facility services.
401 (a) The division shall make full payment to all
402 intermediate care facilities for the mentally retarded for each
403 day, not exceeding eighty-four (84) days per year, that a patient
404 is absent from the facility on home leave. Payment may be made
405 for the following home leave days in addition to the
406 eighty-four-day limitation: Christmas, the day before Christmas,
407 the day after Christmas, Thanksgiving, the day before Thanksgiving
408 and the day after Thanksgiving.
409 (b) All state-owned intermediate care facilities
410 for the mentally retarded shall be reimbursed on a full reasonable
411 cost basis.
412 (13) Family planning services, including drugs,
413 supplies and devices, when those services are under the
414 supervision of a physician or nurse practitioner.
415 (14) Clinic services. Such diagnostic, preventive,
416 therapeutic, rehabilitative or palliative services furnished to an
417 outpatient by or under the supervision of a physician or dentist
418 in a facility that is not a part of a hospital but that is
419 organized and operated to provide medical care to outpatients.
420 Clinic services shall include any services reimbursed as
421 outpatient hospital services that may be rendered in such a
422 facility, including those that become so after July 1, 1991. On
423 July 1, 1999, all fees for physicians' services reimbursed under
424 authority of this paragraph (14) shall be reimbursed at ninety
425 percent (90%) of the rate established on January 1, 1999, and as
426 may be adjusted each July thereafter, under Medicare (Title XVIII
427 of the federal Social Security Act, as amended). The division may
428 develop and implement a different reimbursement model or schedule
429 for physician's services provided by physicians based at an
430 academic health care center and by physicians at rural health

431 centers that are associated with an academic health care center.
432 On July 1, 1999, all fees for dentists' services reimbursed under
433 authority of this paragraph (14) shall be increased to one hundred
434 sixty percent (160%) of the amount of the reimbursement rate that
435 was in effect on June 30, 1999.

436 (15) Home- and community-based services for the elderly
437 and disabled, as provided under Title XIX of the federal Social
438 Security Act, as amended, under waivers, subject to the
439 availability of funds specifically appropriated for that purpose
440 by the Legislature.

441 (16) Mental health services. Approved therapeutic and
442 case management services (a) provided by an approved regional
443 mental health/retardation center established under Sections
444 41-19-31 through 41-19-39, or by another community mental health
445 service provider meeting the requirements of the Department of
446 Mental Health to be an approved mental health/retardation center
447 if determined necessary by the Department of Mental Health, using
448 state funds that are provided from the appropriation to the State
449 Department of Mental Health and/or funds transferred to the
450 department by a political subdivision or instrumentality of the
451 state and used to match federal funds under a cooperative
452 agreement between the division and the department, or (b) provided
453 by a facility that is certified by the State Department of Mental
454 Health to provide therapeutic and case management services, to be
455 reimbursed on a fee for service basis, or (c) provided in the
456 community by a facility or program operated by the Department of
457 Mental Health. Any such services provided by a facility described
458 in subparagraph (b) must have the prior approval of the division
459 to be reimbursable under this section. After June 30, 1997,
460 mental health services provided by regional mental
461 health/retardation centers established under Sections 41-19-31
462 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
463 and/or their subsidiaries and divisions, or by psychiatric

464 residential treatment facilities as defined in Section 43-11-1, or
465 by another community mental health service provider meeting the
466 requirements of the Department of Mental Health to be an approved
467 mental health/retardation center if determined necessary by the
468 Department of Mental Health, shall not be included in or provided
469 under any capitated managed care pilot program provided for under
470 paragraph (24) of this section.

471 (17) Durable medical equipment services and medical
472 supplies. Precertification of durable medical equipment and
473 medical supplies must be obtained as required by the division.
474 The Division of Medicaid may require durable medical equipment
475 providers to obtain a surety bond in the amount and to the
476 specifications as established by the Balanced Budget Act of 1997.

477 (18) (a) Notwithstanding any other provision of this
478 section to the contrary, the division shall make additional
479 reimbursement to hospitals that serve a disproportionate share of
480 low-income patients and that meet the federal requirements for
481 those payments as provided in Section 1923 of the federal Social
482 Security Act and any applicable regulations. However, from and
483 after January 1, 1999, no public hospital shall participate in the
484 Medicaid disproportionate share program unless the public hospital
485 participates in an intergovernmental transfer program as provided
486 in Section 1903 of the federal Social Security Act and any
487 applicable regulations.

488 (b) The division shall establish a Medicare Upper
489 Payment Limits Program, as defined in Section 1902(a)(30) of the
490 federal Social Security Act and any applicable federal
491 regulations, for hospitals, and may establish a Medicare Upper
492 Payments Limits Program for nursing facilities. The division
493 shall assess each hospital and, if the program is established for
494 nursing facilities, shall assess each nursing facility, based on
495 Medicaid utilization or other appropriate method consistent with
496 federal regulations. The assessment will remain in effect as long

497 as the state participates in the Medicare Upper Payment Limits
498 Program. The division shall make additional reimbursement to
499 hospitals and, if the program is established for nursing
500 facilities, shall make additional reimbursement to nursing
501 facilities, for the Medicare Upper Payment Limits, as defined in
502 Section 1902(a)(30) of the federal Social Security Act and any
503 applicable federal regulations.
504 (19) (a) Perinatal risk management services. The
505 division shall promulgate regulations to be effective from and
506 after October 1, 1988, to establish a comprehensive perinatal
507 system for risk assessment of all pregnant and infant Medicaid
508 recipients and for management, education and follow-up for those
509 who are determined to be at risk. Services to be performed
510 include case management, nutrition assessment/counseling,
511 psychosocial assessment/counseling and health education.
512 (b) Early intervention system services. The
513 division shall cooperate with the State Department of Health,
514 acting as lead agency, in the development and implementation of a
515 statewide system of delivery of early intervention services, under
516 Part C of the Individuals with Disabilities Education Act (IDEA).
517 The State Department of Health shall certify annually in writing
518 to the executive director of the division the dollar amount of
519 state early intervention funds available that will be utilized as
520 a certified match for Medicaid matching funds. Those funds then
521 shall be used to provide expanded targeted case management
522 services for Medicaid eligible children with special needs who are
523 eligible for the state's early intervention system.
524 Qualifications for persons providing service coordination shall be
525 determined by the State Department of Health and the Division of
526 Medicaid.
527 (20) Home- and community-based services for physically
528 disabled approved services as allowed by a waiver from the United
529 States Department of Health and Human Services for home- and

530 community-based services for physically disabled people using
531 state funds that are provided from the appropriation to the State
532 Department of Rehabilitation Services and used to match federal
533 funds under a cooperative agreement between the division and the
534 department, provided that funds for these services are
535 specifically appropriated to the Department of Rehabilitation
536 Services.

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

547 (22) Ambulatory services delivered in federally
548 qualified health centers, rural health centers and clinics of the
549 local health departments of the State Department of Health for
550 individuals eligible for Medicaid under this article based on
551 reasonable costs as determined by the division.

552 (23) Inpatient psychiatric services. Inpatient
553 psychiatric services to be determined by the division for
554 recipients under age twenty-one (21) that are provided under the
555 direction of a physician in an inpatient program in a licensed
556 acute care psychiatric facility or in a licensed psychiatric
557 residential treatment facility, before the recipient reaches age
558 twenty-one (21) or, if the recipient was receiving the services
559 immediately before he or she reached age twenty-one (21), before
560 the earlier of the date he or she no longer requires the services
561 or the date he or she reaches age twenty-two (22), as provided by
562 federal regulations. Precertification of inpatient days and

563 residential treatment days must be obtained as required by the
564 division.

565 (24) [Deleted]

566 (25) [Deleted]

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

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

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

585 (29) The Division of Medicaid may apply for a waiver
586 from the United States Department of Health and Human Services for
587 home- and community-based services for developmentally disabled
588 people using state funds that are provided from the appropriation
589 to the State Department of Mental Health and/or funds transferred
590 to the department by a political subdivision or instrumentality of
591 the state and used to match federal funds under a cooperative
592 agreement between the division and the department, provided that
593 funds for these services are specifically appropriated to the
594 Department of Mental Health and/or transferred to the department
595 by a political subdivision or instrumentality of the state.

596 (30) Pediatric skilled nursing services for eligible
597 persons under twenty-one (21) years of age.
598 (31) Targeted case management services for children
599 with special needs, under waivers from the United States
600 Department of Health and Human Services, using state funds that
601 are provided from the appropriation to the Mississippi Department
602 of Human Services and used to match federal funds under a
603 cooperative agreement between the division and the department.
604 (32) Care and services provided in Christian Science
605 Sanatoria listed and certified by the Commission for Accreditation
606 of Christian Science Nursing Organizations/Facilities, Inc.,
607 rendered in connection with treatment by prayer or spiritual means
608 to the extent that those services are subject to reimbursement
609 under Section 1903 of the federal Social Security Act.
610 (33) Podiatrist services.
611 (34) Assisted living services as provided through home-
612 and community-based services under Title XIX of the federal Social
613 Security Act, as amended, subject to the availability of funds
614 specifically appropriated for that purpose by the Legislature.
615 (35) Services and activities authorized in Sections
616 43-27-101 and 43-27-103, using state funds that are provided from
617 the appropriation to the State Department of Human Services and
618 used to match federal funds under a cooperative agreement between
619 the division and the department.
620 (36) Nonemergency transportation services for
621 Medicaid-eligible persons, to be provided by the Division of
622 Medicaid. The division may contract with additional entities to
623 administer nonemergency transportation services as it deems
624 necessary. All providers shall have a valid driver's license,
625 vehicle inspection sticker, valid vehicle license tags and a
626 standard liability insurance policy covering the vehicle. The
627 division may pay providers a flat fee based on mileage tiers, or
628 in the alternative, may reimburse on actual miles traveled. The

629 division may apply to the Center for Medicare and Medicaid
630 Services (CMS) for a waiver to draw federal matching funds for
631 nonemergency transportation services as a covered service instead
632 of an administrative cost.
633 (37) [Deleted]
634 (38) Chiropractic services. A chiropractor's manual
635 manipulation of the spine to correct a subluxation, if x-ray
636 demonstrates that a subluxation exists and if the subluxation has
637 resulted in a neuromusculoskeletal condition for which
638 manipulation is appropriate treatment, and related spinal x-rays
639 performed to document these conditions. Reimbursement for
640 chiropractic services shall not exceed Seven Hundred Dollars
641 ($700.00) per year per beneficiary.
642 (39) Dually eligible Medicare/Medicaid beneficiaries.
643 The division shall pay the Medicare deductible and coinsurance
644 amounts for services available under Medicare, as determined by
645 the division.
646 (40) [Deleted]
647 (41) Services provided by the State Department of
648 Rehabilitation Services for the care and rehabilitation of persons
649 with spinal cord injuries or traumatic brain injuries, as allowed
650 under waivers from the United States Department of Health and
651 Human Services, using up to seventy-five percent (75%) of the
652 funds that are appropriated to the Department of Rehabilitation
653 Services from the Spinal Cord and Head Injury Trust Fund
654 established under Section 37-33-261 and used to match federal
655 funds under a cooperative agreement between the division and the
656 department.
657 (42) Notwithstanding any other provision in this
658 article to the contrary, the division may develop a population
659 health management program for women and children health services
660 through the age of one (1) year. This program is primarily for
661 obstetrical care associated with low birth weight and pre-term

662 babies. The division may apply to the federal Centers for
663 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
664 any other waivers that may enhance the program. In order to
665 effect cost savings, the division may develop a revised payment
666 methodology that may include at-risk capitated payments, and may
667 require member participation in accordance with the terms and
668 conditions of an approved federal waiver.
669 (43) The division shall provide reimbursement,
670 according to a payment schedule developed by the division, for
671 smoking cessation medications for pregnant women during their
672 pregnancy and other Medicaid-eligible women who are of
673 child-bearing age.
674 (44) Nursing facility services for the severely
675 disabled.
676 (a) Severe disabilities include, but are not
677 limited to, spinal cord injuries, closed head injuries and
678 ventilator dependent patients.
679 (b) Those services must be provided in a long-term
680 care nursing facility dedicated to the care and treatment of
681 persons with severe disabilities, and shall be reimbursed as a
682 separate category of nursing facilities.
683 (45) Physician assistant services. Services furnished
684 by a physician assistant who is licensed by the State Board of
685 Medical Licensure and is practicing with physician supervision
686 under regulations adopted by the board, under regulations adopted
687 by the division. Reimbursement for those services shall not
688 exceed ninety percent (90%) of the reimbursement rate for
689 comparable services rendered by a physician.
690 (46) The division shall make application to the federal
691 Centers for Medicare and Medicaid Services (CMS) for a waiver to
692 develop and provide services for children with serious emotional
693 disturbances as defined in Section 43-14-1(1), which may include
694 home- and community-based services, case management services or

695 managed care services through mental health providers certified by
696 the Department of Mental Health. The division may implement and
697 provide services under this waivered program only if funds for
698 these services are specifically appropriated for this purpose by
699 the Legislature, or if funds are voluntarily provided by affected
700 agencies.

701 (47) (a) Notwithstanding any other provision in this
702 article to the contrary, the division, in conjunction with the
703 State Department of Health, may develop and implement disease
704 management programs for individuals with high-cost chronic
705 diseases and conditions, including the use of grants, waivers,
706 demonstrations or other projects as necessary.

707 (b) Participation in any disease management
708 program implemented under this paragraph (47) is optional with the
709 individual. An individual must affirmatively elect to participate
710 in the disease management program in order to participate.

711 (c) An individual who participates in the disease
712 management program has the option of participating in the
713 prescription drug home delivery component of the program at any
714 time while participating in the program. An individual must
715 affirmatively elect to participate in the prescription drug home
716 delivery component in order to participate.

717 (d) An individual who participates in the disease
718 management program may elect to discontinue participation in the
719 program at any time. An individual who participates in the
720 prescription drug home delivery component may elect to discontinue
721 participation in the prescription drug home delivery component at
722 any time.

723 (e) The division shall send written notice to all
724 individuals who participate in the disease management program
725 informing them that they may continue using their local pharmacy
726 or any other pharmacy of their choice to obtain their prescription
727 drugs while participating in the program.

728 (f) Prescription drugs that are provided to
729 individuals under the prescription drug home delivery component
730 shall be limited only to those drugs that are used for the
731 treatment, management or care of asthma, diabetes or hypertension.
732 (48) Pediatric long-term acute care hospital services.
733 (a) Pediatric long-term acute care hospital
734 services means services provided to eligible persons under
735 twenty-one (21) years of age by a freestanding Medicare-certified
736 hospital that has an average length of inpatient stay greater than
737 twenty-five (25) days and that is primarily engaged in providing
738 chronic or long-term medical care to persons under twenty-one (21)
739 years of age.
740 (b) The services under this paragraph (48) shall
741 be reimbursed as a separate category of hospital services.
742 (49) The division shall establish co-payments and/or
743 coinsurance for all Medicaid services for which co-payments and/or
744 coinsurance are allowable under federal law or regulation, and
745 shall set the amount of the co-payment and/or coinsurance for each
746 of those services at the maximum amount allowable under federal
747 law or regulation.
748 (50) Services provided by the State Department of
749 Rehabilitation Services for the care and rehabilitation of persons
750 who are deaf and blind, as allowed under waivers from the United
751 States Department of Health and Human Services to provide home-
752 and community-based services using state funds that are provided
753 from the appropriation to the State Department of Rehabilitation
754 Services or if funds are voluntarily provided by another agency.
755 (51) Upon determination of Medicaid eligibility and in
756 association with annual redetermination of Medicaid eligibility,
757 beneficiaries shall be encouraged to undertake a physical
758 examination that will establish a base-line level of health and
759 identification of a usual and customary source of care (a medical
760 home) to aid utilization of disease management tools. This

761 physical examination and utilization of these disease management
762 tools shall be consistent with current United States Preventive
763 Services Task Force or other recognized authority recommendations.
764 For persons who are determined ineligible for Medicaid, the
765 division will provide information and direction for accessing
766 medical care and services in the area of their residence.
767 (52) Notwithstanding any provisions of this article,
768 the division may pay enhanced reimbursement fees related to trauma
769 care, as determined by the division in conjunction with the State
770 Department of Health, using funds appropriated to the State
771 Department of Health for trauma care and services and used to
772 match federal funds under a cooperative agreement between the
773 division and the State Department of Health. The division, in
774 conjunction with the State Department of Health, may use grants,
775 waivers, demonstrations, or other projects as necessary in the
776 development and implementation of this reimbursement program.
777 (53) Targeted case management services for high-cost
778 beneficiaries shall be developed by the division for all services
779 under this section.
780 (54) Beginning January 1, 2007, newborn screening tests
781 recommended by the American College of Medical Genetics in a
782 report commissioned by the federal Health Resources and Services
783 Administration. These recommendations shall be superseded by any
784 future recommendations of the Advisory Committee on Heritable
785 Disorders and Genetic Disease in Newborns and Children established
786 by the United States Department for Health and Human Services.
787 Notwithstanding any other provision of this article to the
788 contrary, the division shall reduce the rate of reimbursement to
789 providers for any service provided under this section by five
790 percent (5%) of the allowed amount for that service. However, the
791 reduction in the reimbursement rates required by this paragraph
792 shall not apply to inpatient hospital services, nursing facility
793 services, intermediate care facility services, psychiatric

794 residential treatment facility services, pharmacy services
795 provided under paragraph (9) of this section, or any service
796 provided by the University of Mississippi Medical Center or a
797 state agency, a state facility or a public agency that either
798 provides its own state match through intergovernmental transfer or
799 certification of funds to the division, or a service for which the
800 federal government sets the reimbursement methodology and rate.
801 In addition, the reduction in the reimbursement rates required by
802 this paragraph shall not apply to case management services and
803 home-delivered meals provided under the home- and community-based
804 services program for the elderly and disabled by a planning and
805 development district (PDD). Planning and development districts
806 participating in the home- and community-based services program
807 for the elderly and disabled as case management providers shall be
808 reimbursed for case management services at the maximum rate
809 approved by the Centers for Medicare and Medicaid Services (CMS).
810 The division may pay to those providers who participate in
811 and accept patient referrals from the division's emergency room
812 redirection program a percentage, as determined by the division,
813 of savings achieved according to the performance measures and
814 reduction of costs required of that program. Federally qualified
815 health centers may participate in the emergency room redirection
816 program, and the division may pay those centers a percentage of
817 any savings to the Medicaid program achieved by the centers'
818 accepting patient referrals through the program, as provided in
819 this paragraph.
820 Notwithstanding any provision of this article, except as
821 authorized in the following paragraph and in Section 43-13-139,
822 neither (a) the limitations on quantity or frequency of use of or
823 the fees or charges for any of the care or services available to
824 recipients under this section, nor (b) the payments or rates of
825 reimbursement to providers rendering care or services authorized
826 under this section to recipients, may be increased, decreased or

827 otherwise changed from the levels in effect on July 1, 1999,
828 unless they are authorized by an amendment to this section by the
829 Legislature. However, the restriction in this paragraph shall not
830 prevent the division from changing the payments or rates of
831 reimbursement to providers without an amendment to this section
832 whenever those changes are required by federal law or regulation,
833 or whenever those changes are necessary to correct administrative
834 errors or omissions in calculating those payments or rates of
835 reimbursement.

836 Notwithstanding any provision of this article, no new groups
837 or categories of recipients and new types of care and services may
838 be added without enabling legislation from the Mississippi
839 Legislature, except that the division may authorize those changes
840 without enabling legislation when the addition of recipients or
841 services is ordered by a court of proper authority.

842 The executive director shall keep the Governor advised on a
843 timely basis of the funds available for expenditure and the
844 projected expenditures. If current or projected expenditures of
845 the division are reasonably anticipated to exceed the amount of
846 funds appropriated to the division for any fiscal year, the
847 Governor, after consultation with the executive director, shall
848 discontinue any or all of the payment of the types of care and
849 services as provided in this section that are deemed to be
850 optional services under Title XIX of the federal Social Security
851 Act, as amended, and when necessary, shall institute any other
852 cost containment measures on any program or programs authorized
853 under the article to the extent allowed under the federal law
854 governing that program or programs. However, the Governor shall
855 not be authorized to discontinue or eliminate any service under
856 this section that is mandatory under federal law, or to
857 discontinue or eliminate, or adjust income limits or resource
858 limits for, any eligibility category or group under Section
859 43-13-115. It is the intent of the Legislature that the

860 expenditures of the division during any fiscal year shall not
861 exceed the amounts appropriated to the division for that fiscal
862 year.

863 Notwithstanding any other provision of this article, it shall
864 be the duty of each nursing facility, intermediate care facility
865 for the mentally retarded, psychiatric residential treatment
866 facility, and nursing facility for the severely disabled that is
867 participating in the Medicaid program to keep and maintain books,
868 documents and other records as prescribed by the Division of
869 Medicaid in substantiation of its cost reports for a period of
870 three (3) years after the date of submission to the Division of
871 Medicaid of an original cost report, or three (3) years after the
872 date of submission to the Division of Medicaid of an amended cost
873 report.

874 **SECTION 4.** The following provision shall be codified as
875 Section 83-9-36, Mississippi Code of 1972:

876 83-9-36. (1) A health benefit plan that provides coverage
877 for a family or dependent shall provide coverage for a newborn of
878 the insured and shall include coverage for comprehensive newborn
879 screening, including all tests recommended by the American College
880 of Medical Genetics in a report commissioned by federal Health
881 Resources and Services Administration. These recommendations
882 shall be superseded by any future recommendations of the Advisory
883 Committee on Heritable Disorders and Genetic Disease in Newborns
884 and Children established by the United States Department for
885 Health and Human Services.

886 (2) The requirements of this section shall apply to all
887 health benefit plans delivered on and after January 1, 2007.

888 **SECTION 5.** Section 41-89-1, Mississippi Code of 1972, is
889 amended as follows:

890 41-89-1. (1) There is created the Infant Mortality Task
891 Force, the purpose of which is to foster the reduction of infant

892 mortality and morbidity in Mississippi and to improve the health
893 status of mothers and infants.
894 (2) The Infant Mortality Task Force is continued and
895 reconstituted as follows: The task force shall be composed of
896 eleven (11) voting members appointed as follows:
897 (a) The Governor shall appoint seven (7) members, with
898 two (2) from each Mississippi Supreme Court district and one (1)
899 from the state at large.
900 (b) The Lieutenant Governor shall appoint two (2)
901 members from the state at large.
902 (c) The Speaker of the House of Representatives shall
903 appoint two (2) members from the state at large.
904 (d) The task force shall be comprised of persons with a
905 professional association with or special interest in maternal and
906 infant health and well-being.
907 (e) Any member of the Infant Mortality Task Force
908 appointed and serving prior to July 1, 1995, shall be eligible for
909 reappointment to the task force.
910 (3) The Governor shall appoint two (2) members for initial
911 terms that expire on June 30, 1996, two (2) members for initial
912 terms that expire on June 30, 1997, and three (3) members for
913 initial terms that expire on June 30, 1998. The Lieutenant
914 Governor and Speaker of the House of Representatives shall appoint
915 one (1) member for an initial term that expires on June 30, 1997,
916 and one (1) member for an initial term that expires on June 30,
917 1998. Thereafter, all members shall be appointed for terms of
918 three (3) years from the expiration of the previous term. No
919 member shall serve more than two (2) successive full terms. Any
920 vacancy occurring other than by expiration of a term shall be
921 filled for the unexpired term by the appropriate appointing
922 authority. An appointment to fill an unexpired term shall not be
923 considered as a full term.

924 (4) The administrative head of the following state agencies
925 shall designate one (1) employee to serve in an advisory capacity
926 as an ex officio, nonvoting member of the Infant Mortality Task
927 Force: (a) Mississippi Department of Health; (b) State Department
928 of Education; (c) Department of Human Services; (d) Mississippi
929 Department of Mental Health; (e) Division of Medicaid; and (f) the
930 University Medical Center. In addition there shall be one (1)
931 member of the Mississippi Primary Health Care Association who
932 shall serve in an advisory capacity as an ex officio nonvoting
933 member.
934 (5) The Chairman of the Senate Public Health and Welfare
935 Committee and one (1) member of the committee to be designated by
936 the chairman, and the Chairman of the House Public Health and
937 Welfare Committee and one (1) member of the committee to be
938 designated by the chairman shall serve in an advisory capacity as
939 ex officio nonvoting members of the Infant Mortality Task Force.
940 (6) This section shall stand repealed on July 1, 2007.
941 **SECTION 6.** Section 41-89-3, Mississippi Code of 1972, is
942 amended as follows:
943 41-89-3. (1) The Chairman of the Infant Mortality Task
944 Force shall be elected annually by the task force membership. The
945 task force shall adopt bylaws and rules for its efficient
946 operation, which may include designation of its organizational
947 structure including other officers and committees, duties of
948 officers and committees, a process for selecting officers, quorum
949 requirements for committees, provisions for special or ad hoc
950 committees, staff policies and other such procedures as may be
951 necessary. The task force may establish committees responsible
952 for conducting specific task force programs or activities.
953 (2) The task force shall be assigned to the State Department
954 of Health for administrative purposes only, and the department
955 shall designate staff to assist the task force. The task force
956 shall have a line item in the budget of the State Department of

957 Health and shall be financed through the department's annual
958 appropriation. Members of the task force may receive, within the
959 funds appropriated, reimbursement for travel expenses incurred
960 while engaged in official business of the task force.

961 (3) The task force shall meet and conduct business at least
962 quarterly. All meetings of the task force and any committees of
963 the task force shall be open to the public, with opportunities for
964 public comment provided on a regular basis. Notice of all
965 meetings shall be given as provided in the Open Meetings Act
966 (Section 25-41-1 et seq.) and appropriate notice also shall be
967 given to all persons so requesting of the date, time and place of
968 each meeting.

969 (4) The Infant Mortality Task Force, in conjunction with the
970 State Department of Health, the Department of Human Services, the
971 State Department of Education and the Division of Medicaid, shall
972 develop and implement a campaign for intensive outreach to high
973 risk populations in Mississippi to encourage them to avail
974 themselves of family planning, prenatal care and infant health
975 services.

976 (5) The Infant Mortality Task Force may apply for and expend
977 grants or other contributions for the purpose of promoting
978 maternal and infant health in Mississippi.

979 (6) The Infant Mortality Task Force shall conduct a study of
980 the utility of oxygen saturation as a screening test for critical
981 congenital heart disease in newborns, and shall make a report with
982 recommendations to the Chairman of the Senate Public Health and
983 Welfare Committee and the Chairman of the House Public Health and
984 Human Services Committee not later than December 1, 2005.

985 (7) This section shall stand repealed on July 1, 2007.

986 **SECTION 7.** Section 41-89-5, Mississippi Code of 1972, is
987 amended as follows:

988 41-89-5. (1) The task force shall:

989 (a) Serve an advocacy and public awareness role with
990 the general public regarding maternal and infant health issues;
991 (b) Conduct studies on maternal and infant health and
992 related issues;
993 (c) Serve as the state's official liaison with the
994 Southern Regional Project on Infant Mortality, a project of the
995 Southern Governors' Association and the Southern Legislative
996 Conference;
997 (d) Recommend to the Governor and the Legislature
998 appropriate policies to reduce Mississippi's infant mortality and
999 morbidity rates and to improve the status of maternal and infant
1000 health; and
1001 (e) Report annually to the Governor and the Legislature
1002 regarding the progress made toward the goals outlined in
1003 subsection (1) of Section 41-89-1 and the actions taken with
1004 regard to recommendations previously made.
1005 (f) Recommend to the State Board of Health
1006 comprehensive newborn screening tests, procedures and protocol to
1007 be utilized in informing parents and guardians of the availability
1008 of screening tests for newborn disorders.
1009 (2) In developing its recommendations, the task force may
1010 consult with experts and shall examine actions taken in other
1011 states and review the policy statement developed during the
1012 Southern Legislative Summit on Healthy Infants and Families
1013 sponsored by the Southern Regional Project on Infant Mortality.
1014 **SECTION 8.** This act shall take effect and be in force from
1015 and after July 1, 2006.

ST: Screening for newborn disorders; add additional tests and authorize Medicaid and private insurance reimbursement.