MISSISSIPPI LEGISLATURE REGULAR SESSION 2007

By: Senator(s) Dawkins, Williamson

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2507

AN ACT RELATING TO NEWBORN SCREENING TESTS; TO AMEND SECTIONS 41-21-201 AND 41-21-203, MISSISSIPPI CODE OF 1972, TO DIRECT THE STATE BOARD OF HEALTH, HEALTH CARE PROVIDERS AND HEALTH CARE FACILITIES WHICH ATTEND INFANTS TO EXPLAIN TO THE PARENT OR GUARDIAN THE AVAILABILITY OF CERTAIN NEWBORN SCREENING TESTS TO DETECT HERITABLE AND GENETIC CONDITIONS; TO PROVIDE THAT UPON CONSENT OF THE PARENT OR GUARDIAN, THE HEALTH CARE FACILITY SHALL BE RESPONSIBLE FOR OBTAINING THE SPECIMEN, SENDING THE SPECIMEN TO A QUALIFIED LABORATORY AND PROVIDING DIAGNOSIS, TREATMENT AND EVALUATION AS NECESSARY; TO AUTHORIZE THE STATE BOARD OF HEALTH TO ENTER INTO AGREEMENTS WITH QUALIFIED LABORATORIES TO PERFORM NEWBORN SCREENING TESTS FOR SUCH ADDITIONAL TESTING; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO AUTHORIZE MEDICAID REIMBURSEMENT FOR CERTAIN NEWBORN SCREENING TESTS BEGINNING JANUARY 1, 2008; TO CODIFY SECTION 83-9-36, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT A HEALTH BENEFIT PLAN THAT PROVIDES COVERAGE FOR A FAMILY OR DEPENDENT SHALL PROVIDE COVERAGE FOR COMPREHENSIVE NEWBORN SCREENING; TO CODIFY SECTIONS 41-89-1 AND 41-89-3, MISSISSIPPI CODE OF 1972, AND TO AMEND SECTION 41-89-5, MISSISSIPPI CODE OF 1972, TO REENACT AND CONTINUE THE EXISTENCE OF THE INFANT MORTALITY TASK FORCE AND TO SPECIFICALLY CHARGE THE TASK FORCE WITH THE RESPONSIBILITY OF ADVISING THE STATE BOARD OF HEALTH ON MATTERS RELATING TO NEWBORN SCREENING; AND FOR RELATED PURPOSES.

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

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

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

(2) <u>(a) Beginning January 1, 2008,</u> the State Board of Health shall <u>develop information that explains the availability of</u>

additional newborn screening tests not specified in subsection (1) of this section that relate to heritable and genetic congenital disorders, and the risks and costs of these test. These tests shall include newborn screening tests utilizing tandem spectrometry mass recommended by the American College of Medical Genetics in a report commissioned by federal Health Resources and Services Administration. These recommendations shall be superseded by any future recommendations of the Advisory Committee on Heritable Disorders and Genetic Disease in Newborns and Children established by the United States Department for Health and Human Services. The State Board of Health shall make this information available on the Internet and shall distribute information regarding the availability of newborn screening information on the Internet to:

(i) All health care facilities that provide care for infants twenty-eight (28) days or less of age; and

(ii) All physicians in this state that have a primary responsibility for ordering screening tests to be performed.

(b) Each health care facility and physician shall inform the infant's parent or guardian of the availability of such comprehensive newborn screening tests. Information provided to the parent or guardian shall include, at a minimum, the content provided on the cabinet's Internet site. Upon consent of the parent or guardian, the health care facility shall be responsible for obtaining the specimen, sending the specimen to a qualified laboratory, and providing the appropriate follow-up to the newborn screening, including, but not limited to, diagnosis, treatment and evaluation as necessary. "Qualified laboratory" means a clinical laboratory that:

(i) Holds a current and valid certificate issued by the United States Department for Health and Human Services pursuant to 42 USC Section 236a;

(ii) Is licensed to perform newborn screening testing in any state;

(iii) Is not operated by the State Board of Health; and

(iv) Reports its screening results using normal pediatric reference ranges.

(c) The health care facility or physician shall not be required to assume the cost of additional testing.

(d) The State Board of Health may enter into agreements with public or private qualified laboratories to perform newborn screening tests for any additional testing conducted pursuant to this subsection. Any agreement entered into under this paragraph (d) shall not preclude a health care facility or physician from having newborn tests analyzed by other qualified laboratories.

(e) The State Board of Health shall receive and consider the recommendations of the Infant Mortality Task Force created in Section 41-89-1 et seq., relating to additional screening for newborn disorders.

SECTION 2. Section 41-21-203, Mississippi Code of 1972, is amended as follows:

41-21-203. (1) All newborn infants shall be screened by the physician or other health care provider attending the infant, using tests that have been approved by the State Board of Health, to detect those conditions listed in Section 41-21-201(1) and the other conditions specified under Section 41-21-201(2) for the comprehensive newborn screening program. However, no such tests shall be given to any child whose parents object thereto on the grounds that the test conflicts with his religious practices or tenets. The tests provided under the comprehensive newborn screening program shall be evaluated in laboratories located in the United States and qualified as provided in Section 41-21-201(2). The State Department of Health shall follow up all positive tests with the attending physician or other health care

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

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

(3) The State Department of Health shall deposit into the Mississippi Public Health Laboratory Construction and Underwood Building Repair, Renovation and Expansion Bond Sinking Fund created in Section 3 of Chapter 516, Laws of 2006, such amounts as specified in Section 3 of Chapter 516, Laws of 2006, from any fees received for newborn screening tests performed under this section that are evaluated in the public health laboratory of the department.

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

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

(1) Inpatient hospital services.

(a) The division shall allow thirty (30) days of inpatient hospital care annually for all Medicaid recipients. Precertification of inpatient days must be obtained as required by the division. The division may allow unlimited days in

disproportionate hospitals as defined by the division for eligible infants and children under the age of six (6) years if certified as medically necessary as required by the division.

(b) From and after July 1, 1994, the Executive Director of the Division of Medicaid shall amend the Mississippi Title XIX Inpatient Hospital Reimbursement Plan to remove the occupancy rate penalty from the calculation of the Medicaid Capital Cost Component utilized to determine total hospital costs allocated to the Medicaid program.

(c) Hospitals will receive an additional payment for the implantable programmable baclofen drug pump used to treat spasticity that is implanted on an inpatient basis. The payment pursuant to written invoice will be in addition to the facility's per diem reimbursement and will represent a reduction of costs on the facility's annual cost report, and shall not exceed Ten Thousand Dollars ($10,000.00) per year per recipient.

(2) Outpatient hospital services.

(a) Emergency services. The division shall allow six (6) medically necessary emergency room visits per beneficiary per fiscal year.

(b) Other outpatient hospital services. The division shall allow benefits for other medically necessary outpatient hospital services (such as chemotherapy, radiation, surgery and therapy). Where the same services are reimbursed as clinic services, the division may revise the rate or methodology of outpatient reimbursement to maintain consistency, efficiency, economy and quality of care.

(3) Laboratory and x-ray services.

(4) Nursing facility services.

(a) The division shall make full payment to nursing facilities for each day, not exceeding fifty-two (52) days per year, that a patient is absent from the facility on home leave. Payment may be made for the following home leave days in

addition to the fifty-two-day limitation: Christmas, the day before Christmas, the day after Christmas, Thanksgiving, the day before Thanksgiving and the day after Thanksgiving.

(b) From and after July 1, 1997, the division shall implement the integrated case-mix payment and quality monitoring system, which includes the fair rental system for property costs and in which recapture of depreciation is eliminated. The division may reduce the payment for hospital leave and therapeutic home leave days to the lower of the case-mix category as computed for the resident on leave using the assessment being utilized for payment at that point in time, or a case-mix score of 1.000 for nursing facilities, and shall compute case-mix scores of residents so that only services provided at the nursing facility are considered in calculating a facility's per diem.

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

(d) When a facility of a category that does not require a certificate of need for construction and that could not be eligible for Medicaid reimbursement is constructed to nursing facility specifications for licensure and certification, and the facility is subsequently converted to a nursing facility under a certificate of need that authorizes conversion only and the applicant for the certificate of need was assessed an application review fee based on capital expenditures incurred in constructing the facility, the division shall allow reimbursement for capital expenditures necessary for construction of the facility that were incurred within the twenty-four (24) consecutive calendar months immediately preceding the date that the certificate of need authorizing the conversion was issued, to the same extent that reimbursement would be allowed for construction of a new nursing facility under a certificate of need that authorizes that

construction. The reimbursement authorized in this subparagraph (d) may be made only to facilities the construction of which was completed after June 30, 1989. Before the division shall be authorized to make the reimbursement authorized in this subparagraph (d), the division first must have received approval from the Centers for Medicare and Medicaid Services (CMS) of the change in the state Medicaid plan providing for the reimbursement.

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

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

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

(5) Periodic screening and diagnostic services for individuals under age twenty-one (21) years as are needed to identify physical and mental defects and to provide health care treatment and other measures designed to correct or ameliorate defects and physical and mental illness and conditions discovered

by the screening services, regardless of whether these services are included in the state plan. The division may include in its periodic screening and diagnostic program those discretionary services authorized under the federal regulations adopted to implement Title XIX of the federal Social Security Act, as amended. The division, in obtaining physical therapy services, occupational therapy services, and services for individuals with speech, hearing and language disorders, may enter into a cooperative agreement with the State Department of Education for the provision of those services to handicapped students by public school districts using state funds that are provided from the appropriation to the Department of Education to obtain federal matching funds through the division. The division, in obtaining medical and psychological evaluations for children in the custody of the State Department of Human Services may enter into a cooperative agreement with the State Department of Human Services for the provision of those services using state funds that are provided from the appropriation to the Department of Human Services to obtain federal matching funds through the division.

(6) Physician's services. The division shall allow twelve (12) physician visits annually. All fees for physicians' services that are covered only by Medicaid shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as may be adjusted each July thereafter, under Medicare (Title XVIII of the federal Social Security Act, as amended). The division may develop and implement a different reimbursement model or schedule for physician's services provided by physicians based at an academic health care center and by physicians at rural health centers that are associated with an academic health care center.

(7) (a) Home health services for eligible persons, not to exceed in cost the prevailing cost of nursing facility services, not to exceed twenty-five (25) visits per year. All

home health visits must be precertified as required by the division.

(b) Repealed.

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

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

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

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

The division shall allow for a combination of prescriptions for single source and innovator multiple source drugs and generic drugs to meet the needs of the beneficiaries, not to exceed five (5) prescriptions per month for each noninstitutionalized Medicaid

beneficiary, with not more than two (2) of those prescriptions being for single source or innovator multiple source drugs.

The executive director may approve specific maintenance drugs for beneficiaries with certain medical conditions, which may be prescribed and dispensed in three-month supply increments. The executive director may allow a state agency or agencies to be the sole source purchaser and distributor of hemophilia factor medications, HIV/AIDS medications and other medications as determined by the executive director as allowed by federal regulations.

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

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

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

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

All claims for drugs for dually eligible Medicare/Medicaid beneficiaries that are paid for by Medicare must be submitted to Medicare for payment before they may be processed by the division's on-line payment system.

The division shall develop a pharmacy policy in which drugs in tamper-resistant packaging that are prescribed for a resident of a nursing facility but are not dispensed to the resident shall be returned to the pharmacy and not billed to Medicaid, in accordance with guidelines of the State Board of Pharmacy.

The division shall develop and implement a method or methods by which the division will provide on a regular basis to Medicaid providers who are authorized to prescribe drugs, information about the costs to the Medicaid program of single source drugs and innovator multiple source drugs, and information about other drugs that may be prescribed as alternatives to those single source drugs and innovator multiple source drugs and the costs to the Medicaid program of those alternative drugs.

Notwithstanding any law or regulation, information obtained or maintained by the division regarding the prescription drug program, including trade secrets and manufacturer or labeler pricing, is confidential and not subject to disclosure except to other state agencies.

(b) Payment by the division for covered multisource drugs shall be limited to the lower of the upper limits established and published by the Centers for Medicare and Medicaid Services (CMS) plus a dispensing fee, or the estimated acquisition cost (EAC) as determined by the division, plus a dispensing fee, or the providers' usual and customary charge to the general public.

Payment for other covered drugs, other than multisource drugs with CMS upper limits, shall not exceed the lower of the estimated acquisition cost as determined by the division, plus a dispensing fee or the providers' usual and customary charge to the general public.

Payment for nonlegend or over-the-counter drugs covered by the division shall be reimbursed at the lower of the division's estimated shelf price or the providers' usual and customary charge to the general public.

The dispensing fee for each new or refill prescription, including nonlegend or over-the-counter drugs covered by the division, shall be not less than Three Dollars and Ninety-one Cents ($3.91), as determined by the division.

The division shall not reimburse for single source or innovator multiple source drugs if there are equally effective generic equivalents available and if the generic equivalents are the least expensive.

It is the intent of the Legislature that the pharmacists providers be reimbursed for the reasonable costs of filling and dispensing prescriptions for Medicaid beneficiaries.

(10) Dental care that is an adjunct to treatment of an acute medical or surgical condition; services of oral surgeons and dentists in connection with surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone; and emergency dental extractions and treatment related thereto. On July 1, 1999, all fees for dental care and surgery under authority of this paragraph (10) shall be increased to one hundred sixty percent (160%) of the amount of the reimbursement rate that was in effect on June 30, 1999. It is the intent of the Legislature to encourage more dentists to participate in the Medicaid program.

(11) Eyeglasses for all Medicaid beneficiaries who have (a) had surgery on the eyeball or ocular muscle that results in a

vision change for which eyeglasses or a change in eyeglasses is medically indicated within six (6) months of the surgery and is in accordance with policies established by the division, or (b) one (1) pair every five (5) years and in accordance with policies established by the division. In either instance, the eyeglasses must be prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the beneficiary may select.

(12) Intermediate care facility services.

(a) The division shall make full payment to all intermediate care facilities for the mentally retarded for each day, not exceeding eighty-four (84) days per year, that a patient is absent from the facility on home leave. Payment may be made for the following home leave days in addition to the eighty-four-day limitation: Christmas, the day before Christmas, the day after Christmas, Thanksgiving, the day before Thanksgiving and the day after Thanksgiving.

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

(13) Family planning services, including drugs, supplies and devices, when those services are under the supervision of a physician or nurse practitioner.

(14) Clinic services. Such diagnostic, preventive, therapeutic, rehabilitative or palliative services furnished to an outpatient by or under the supervision of a physician or dentist in a facility that is not a part of a hospital but that is organized and operated to provide medical care to outpatients. Clinic services shall include any services reimbursed as outpatient hospital services that may be rendered in such a facility, including those that become so after July 1, 1991. On July 1, 1999, all fees for physicians' services reimbursed under authority of this paragraph (14) shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as

may be adjusted each July thereafter, under Medicare (Title XVIII of the federal Social Security Act, as amended). The division may develop and implement a different reimbursement model or schedule for physician's services provided by physicians based at an academic health care center and by physicians at rural health centers that are associated with an academic health care center. On July 1, 1999, all fees for dentists' services reimbursed under authority of this paragraph (14) shall be increased to one hundred sixty percent (160%) of the amount of the reimbursement rate that was in effect on June 30, 1999.

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

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

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

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

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

(b) The division shall establish a Medicare Upper Payment Limits Program, as defined in Section 1902(a)(30) of the federal Social Security Act and any applicable federal regulations, for hospitals, and may establish a Medicare Upper

Payments Limits Program for nursing facilities. The division shall assess each hospital and, if the program is established for nursing facilities, shall assess each nursing facility, based on Medicaid utilization or other appropriate method consistent with federal regulations. The assessment will remain in effect as long as the state participates in the Medicare Upper Payment Limits Program. The division shall make additional reimbursement to hospitals and, if the program is established for nursing facilities, shall make additional reimbursement to nursing facilities, for the Medicare Upper Payment Limits, as defined in Section 1902(a)(30) of the federal Social Security Act and any applicable federal regulations.

(19) (a) Perinatal risk management services. The division shall promulgate regulations to be effective from and after October 1, 1988, to establish a comprehensive perinatal system for risk assessment of all pregnant and infant Medicaid recipients and for management, education and follow-up for those who are determined to be at risk. Services to be performed include case management, nutrition assessment/counseling, psychosocial assessment/counseling and health education.

(b) Early intervention system services. The division shall cooperate with the State Department of Health, acting as lead agency, in the development and implementation of a statewide system of delivery of early intervention services, under Part C of the Individuals with Disabilities Education Act (IDEA). The State Department of Health shall certify annually in writing to the executive director of the division the dollar amount of state early intervention funds available that will be utilized as a certified match for Medicaid matching funds. Those funds then shall be used to provide expanded targeted case management services for Medicaid eligible children with special needs who are eligible for the state's early intervention system. Qualifications for persons providing service coordination shall be

determined by the State Department of Health and the Division of Medicaid.

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

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

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

(23) Inpatient psychiatric services. Inpatient psychiatric services to be determined by the division for recipients under age twenty-one (21) that are provided under the direction of a physician in an inpatient program in a licensed acute care psychiatric facility or in a licensed psychiatric residential treatment facility, before the recipient reaches age

twenty-one (21) or, if the recipient was receiving the services immediately before he or she reached age twenty-one (21), before the earlier of the date he or she no longer requires the services or the date he or she reaches age twenty-two (22), as provided by federal regulations. Precertification of inpatient days and residential treatment days must be obtained as required by the division.

(24) [Deleted]

(25) [Deleted]

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

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

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

(29) The Division of Medicaid may apply for a waiver from the United States Department of Health and Human Services for home- and community-based services for developmentally disabled people using state funds that are provided from the appropriation to the State Department of Mental Health and/or funds transferred to the department by a political subdivision or instrumentality of

the state and used to match federal funds under a cooperative agreement between the division and the department, provided that funds for these services are specifically appropriated to the Department of Mental Health and/or transferred to the department by a political subdivision or instrumentality of the state.

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

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

(32) Care and services provided in Christian Science Sanatoria listed and certified by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc., rendered in connection with treatment by prayer or spiritual means to the extent that those services are subject to reimbursement under Section 1903 of the federal Social Security Act.

(33) Podiatrist services.

(34) Assisted living services as provided through home- and community-based services under Title XIX of the federal Social Security Act, as amended, subject to the availability of funds specifically appropriated for that purpose by the Legislature.

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

(36) Nonemergency transportation services for Medicaid-eligible persons, to be provided by the Division of Medicaid. The division may contract with additional entities to administer nonemergency transportation services as it deems

necessary. All providers shall have a valid driver's license, vehicle inspection sticker, valid vehicle license tags and a standard liability insurance policy covering the vehicle. The division may pay providers a flat fee based on mileage tiers, or in the alternative, may reimburse on actual miles traveled. The division may apply to the Center for Medicare and Medicaid Services (CMS) for a waiver to draw federal matching funds for nonemergency transportation services as a covered service instead of an administrative cost.

(37) [Deleted]

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

(39) Dually eligible Medicare/Medicaid beneficiaries. The division shall pay the Medicare deductible and coinsurance amounts for services available under Medicare, as determined by the division.

(40) [Deleted]

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

(42) Notwithstanding any other provision in this article to the contrary, the division may develop a population health management program for women and children health services through the age of one (1) year. This program is primarily for obstetrical care associated with low birth weight and pre-term babies. The division may apply to the federal Centers for Medicare and Medicaid Services (CMS) for a Section 1115 waiver or any other waivers that may enhance the program. In order to effect cost savings, the division may develop a revised payment methodology that may include at-risk capitated payments, and may require member participation in accordance with the terms and conditions of an approved federal waiver.

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

(44) Nursing facility services for the severely disabled.

(a) Severe disabilities include, but are not limited to, spinal cord injuries, closed head injuries and ventilator dependent patients.

(b) Those services must be provided in a long-term care nursing facility dedicated to the care and treatment of persons with severe disabilities, and shall be reimbursed as a separate category of nursing facilities.

(45) Physician assistant services. Services furnished by a physician assistant who is licensed by the State Board of Medical Licensure and is practicing with physician supervision under regulations adopted by the board, under regulations adopted by the division. Reimbursement for those services shall not exceed ninety percent (90%) of the reimbursement rate for comparable services rendered by a physician.

(46) The division shall make application to the federal Centers for Medicare and Medicaid Services (CMS) for a waiver to develop and provide services for children with serious emotional disturbances as defined in Section 43-14-1(1), which may include home- and community-based services, case management services or managed care services through mental health providers certified by the Department of Mental Health. The division may implement and provide services under this waivered program only if funds for these services are specifically appropriated for this purpose by the Legislature, or if funds are voluntarily provided by affected agencies.

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

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

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

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

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

(f) Prescription drugs that are provided to individuals under the prescription drug home delivery component shall be limited only to those drugs that are used for the treatment, management or care of asthma, diabetes or hypertension.

(48) Pediatric long-term acute care hospital services.

(a) Pediatric long-term acute care hospital services means services provided to eligible persons under twenty-one (21) years of age by a freestanding Medicare-certified hospital that has an average length of inpatient stay greater than twenty-five (25) days and that is primarily engaged in providing chronic or long-term medical care to persons under twenty-one (21) years of age.

(b) The services under this paragraph (48) shall be reimbursed as a separate category of hospital services.

(49) The division shall establish co-payments and/or coinsurance for all Medicaid services for which co-payments and/or coinsurance are allowable under federal law or regulation, and shall set the amount of the co-payment and/or coinsurance for each of those services at the maximum amount allowable under federal law or regulation.

(50) Services provided by the State Department of Rehabilitation Services for the care and rehabilitation of persons who are deaf and blind, as allowed under waivers from the United States Department of Health and Human Services to provide home- and community-based services using state funds that are provided from the appropriation to the State Department of Rehabilitation Services or if funds are voluntarily provided by another agency.

(51) Upon determination of Medicaid eligibility and in association with annual redetermination of Medicaid eligibility, beneficiaries shall be encouraged to undertake a physical examination that will establish a base-line level of health and identification of a usual and customary source of care (a medical home) to aid utilization of disease management tools. This physical examination and utilization of these disease management tools shall be consistent with current United States Preventive Services Task Force or other recognized authority recommendations.

For persons who are determined ineligible for Medicaid, the division will provide information and direction for accessing medical care and services in the area of their residence.

(52) Notwithstanding any provisions of this article, the division may pay enhanced reimbursement fees related to trauma care, as determined by the division in conjunction with the State Department of Health, using funds appropriated to the State Department of Health for trauma care and services and used to match federal funds under a cooperative agreement between the division and the State Department of Health. The division, in conjunction with the State Department of Health, may use grants, waivers, demonstrations, or other projects as necessary in the development and implementation of this reimbursement program.

(53) Targeted case management services for high-cost beneficiaries shall be developed by the division for all services under this section.

(54) Beginning January 1, 2008, newborn screening tests recommended by the American College of Medical Genetics in a report commissioned by the federal Health Resources and Services Administration. These recommendations shall be superseded by any future recommendations of the Advisory Committee on Heritable Disorders and Genetic Disease in Newborns and Children established by the United States Department for Health and Human Services.

Notwithstanding any other provision of this article to the contrary, the division shall reduce the rate of reimbursement to providers for any service provided under this section by five percent (5%) of the allowed amount for that service. However, the reduction in the reimbursement rates required by this paragraph shall not apply to inpatient hospital services, nursing facility services, intermediate care facility services, psychiatric residential treatment facility services, pharmacy services provided under paragraph (9) of this section, or any service provided by the University of Mississippi Medical Center or a state agency, a state facility or a public agency that either provides its own state match through intergovernmental transfer or certification of funds to the division, or a service for which the federal government sets the reimbursement methodology and rate. In addition, the reduction in the reimbursement rates required by this paragraph shall not apply to case management services and home-delivered meals provided under the home- and community-based services program for the elderly and disabled by a planning and development district (PDD). Planning and development districts participating in the home- and community-based services program for the elderly and disabled as case management providers shall be reimbursed for case management services at the maximum rate approved by the Centers for Medicare and Medicaid Services (CMS).

The division may pay to those providers who participate in and accept patient referrals from the division's emergency room redirection program a percentage, as determined by the division, of savings achieved according to the performance measures and reduction of costs required of that program. Federally qualified health centers may participate in the emergency room redirection program, and the division may pay those centers a percentage of any savings to the Medicaid program achieved by the centers' accepting patient referrals through the program, as provided in this paragraph.

Notwithstanding any provision of this article, except as authorized in the following paragraph and in Section 43-13-139, neither (a) the limitations on quantity or frequency of use of or the fees or charges for any of the care or services available to recipients under this section, nor (b) the payments or rates of reimbursement to providers rendering care or services authorized under this section to recipients, may be increased, decreased or otherwise changed from the levels in effect on July 1, 1999, unless they are authorized by an amendment to this section by the Legislature. However, the restriction in this paragraph shall not prevent the division from changing the payments or rates of reimbursement to providers without an amendment to this section whenever those changes are required by federal law or regulation, or whenever those changes are necessary to correct administrative errors or omissions in calculating those payments or rates of reimbursement.

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

The executive director shall keep the Governor advised on a timely basis of the funds available for expenditure and the projected expenditures. If current or projected expenditures of the division are reasonably anticipated to exceed the amount of funds appropriated to the division for any fiscal year, the Governor, after consultation with the executive director, shall discontinue any or all of the payment of the types of care and services as provided in this section that are deemed to be optional services under Title XIX of the federal Social Security Act, as amended, and when necessary, shall institute any other cost containment measures on any program or programs authorized

under the article to the extent allowed under the federal law governing that program or programs. However, the Governor shall not be authorized to discontinue or eliminate any service under this section that is mandatory under federal law, or to discontinue or eliminate, or adjust income limits or resource limits for, any eligibility category or group under Section 43-13-115. It is the intent of the Legislature that the expenditures of the division during any fiscal year shall not exceed the amounts appropriated to the division for that fiscal year.

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

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

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

(2) The requirements of this section shall apply to all health benefit plans delivered on and after January 1, 2008.

SECTION 5. The following shall be codified as Section 41-89-1, Mississippi Code of 1972:

41-89-1. (1) There is created the Infant Mortality Task Force, the purpose of which is to foster the reduction of infant mortality and morbidity in Mississippi and to improve the health status of mothers and infants.

(2) The Infant Mortality Task Force is continued and reconstituted as follows: The task force shall be composed of eleven (11) voting members appointed as follows:

(a) The Governor shall appoint seven (7) members, with two (2) from each Mississippi Supreme Court district and one (1) from the state at large.

(b) The Lieutenant Governor shall appoint two (2) members from the state at large.

(c) The Speaker of the House of Representatives shall appoint two (2) members from the state at large.

(d) The task force shall be comprised of persons with a professional association with or special interest in maternal and infant health and well-being.

(e) Any member of the Infant Mortality Task Force appointed and serving prior to July 1, 1995, shall be eligible for reappointment to the task force.

(3) The Governor shall appoint two (2) members for initial terms that expire on June 30, 2008, two (2) members for initial terms that expire on June 30, 2009, and three (3) members for initial terms that expire on June 30, 2010. The Lieutenant Governor and Speaker of the House of Representatives shall appoint one (1) member for an initial term that expires on June 30, 2009, and one (1) member for an initial term that expires on June 30, 2010. Thereafter, all members shall be appointed for terms of three (3) years from the expiration of the previous term. No

member shall serve more than two (2) successive full terms. Any vacancy occurring other than by expiration of a term shall be filled for the unexpired term by the appropriate appointing authority. An appointment to fill an unexpired term shall not be considered as a full term.

(4) The administrative head of the following state agencies shall designate one (1) employee to serve in an advisory capacity as an ex officio, nonvoting member of the Infant Mortality Task Force: (a) Mississippi Department of Health; (b) State Department of Education; (c) Department of Human Services; (d) Mississippi Department of Mental Health; (e) Division of Medicaid; and (f) the University Medical Center. In addition there shall be one (1) member of the Mississippi Primary Health Care Association who shall serve in an advisory capacity as an ex officio nonvoting member.

(5) The Chairman of the Senate Public Health and Welfare Committee and one (1) member of the committee to be designated by the chairman, and the Chairman of the House Public Health and Welfare Committee and one (1) member of the committee to be designated by the chairman shall serve in an advisory capacity as ex officio nonvoting members of the Infant Mortality Task Force.

(6) This section shall stand repealed on July 1, 2008.

SECTION 6. The following shall be codified as Section 41-89-3, Mississippi Code of 1972:

41-89-3. (1) The Chairman of the Infant Mortality Task Force shall be elected annually by the task force membership. The task force shall adopt bylaws and rules for its efficient operation, which may include designation of its organizational structure including other officers and committees, duties of officers and committees, a process for selecting officers, quorum requirements for committees, provisions for special or ad hoc committees, staff policies and other such procedures as may be

necessary. The task force may establish committees responsible for conducting specific task force programs or activities.

(2) The task force shall be assigned to the State Department of Health for administrative purposes only, and the department shall designate staff to assist the task force. The task force shall have a line item in the budget of the State Department of Health and shall be financed through the department's annual appropriation. Members of the task force may receive, within the funds appropriated, reimbursement for travel expenses incurred while engaged in official business of the task force.

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

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

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

(6) The Infant Mortality Task Force shall conduct a study of the utility of oxygen saturation as a screening test for critical congenital heart disease in newborns, and shall make a report with recommendations to the Chairman of the Senate Public Health and

Welfare Committee and the Chairman of the House Public Health and Human Services Committee not later than December 1, 2005.

(7) This section shall stand repealed on July 1, 2008.

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

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

(a) Serve an advocacy and public awareness role with the general public regarding maternal and infant health issues;

(b) Conduct studies on maternal and infant health and related issues;

(c) Serve as the state's official liaison with the Southern Regional Project on Infant Mortality, a project of the Southern Governors' Association and the Southern Legislative Conference;

(d) Recommend to the Governor and the Legislature appropriate policies to reduce Mississippi's infant mortality and morbidity rates and to improve the status of maternal and infant health; *** * ***

(e) Report annually to the Governor and the Legislature regarding the progress made toward the goals outlined in subsection (1) of Section 41-89-1 and the actions taken with regard to recommendations previously made; and

(f) Recommend to the State Board of Health comprehensive newborn screening tests, procedures and protocol to be utilized in informing parents and guardians of the availability of screening tests for newborn disorders.

(2) In developing its recommendations, the task force may consult with experts and shall examine actions taken in other states and review the policy statement developed during the Southern Legislative Summit on Healthy Infants and Families sponsored by the Southern Regional Project on Infant Mortality.

SECTION 8. This act shall take effect and be in force from and after July 1, 2007.