By: Senator(s) Burton

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2416
(As Passed the Senate)

AN ACT TO AMEND SECTION 43-11-1, MISSISSIPPI CODE OF 1972, TO DEFINE THE TERM "ADULT FOSTER CARE FACILITY" TO PROVIDE PROTECTIVE SERVICES FOR VULNERABLE ADULTS FOR PURPOSES OF LICENSURE BY THE STATE DEPARTMENT OF HEALTH; TO AMEND SECTION 43-11-13, MISSISSIPPI CODE OF 1972, TO DIRECT THE STATE BOARD OF HEALTH TO PROMULGATE RULES, REGULATIONS AND STANDARDS REGARDING THE OPERATION OF ADULT FOSTER CARE FACILITIES; TO CODIFY SECTION 43-11-8, MISSISSIPPI CODE OF 1972, TO PRESCRIBE FEES FOR ADULT FOSTER CARE FACILITY LICENSURE; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO AUTHORIZE THE DIVISION OF MEDICAID-OFFICE OF THE GOVERNOR TO APPLY FOR WAIVERS FOR ADULTS TO RECEIVE CARE IN ADULT FOSTER CARE UNDER THE MEDICAID PROGRAM; TO ESTABLISH A LONG-TERM CARE ADVISORY COUNCIL TO STUDY AND DEVELOP RECOMMENDATIONS TO THE GOVERNOR AND THE 2008 REGULAR SESSION OF THE LEGISLATURE RELATING TO THE SERVICES PROVIDED TO THE AGED AND DISABLED UNDER RECENT AMENDMENTS TO FEDERAL LAW; TO PROVIDE DEFINITIONS; TO SPECIFICALLY PROVIDE THAT THE ADVISORY COUNCIL SHALL MAKE RECOMMENDATIONS RELATING TO COORDINATION OF HOME- AND COMMUNITY-BASED SERVICES FOR THE AGED AND DISABLED AND THE ESTABLISHMENT OF A COORDINATING UNIT OF GOVERNMENT; TO DIRECT THE DEPARTMENT OF HUMAN SERVICES TO PROVIDE SUPPORT FOR THE WORK OF THE ADVISORY COUNCIL; TO AMEND SECTION 43-7-7, MISSISSIPPI CODE OF 1972, TO PRESCRIBE THE RESPONSIBILITIES OF THE DEPARTMENT OF HUMAN SERVICES AS LEAD AGENCY FOR FEDERAL OLD AGE ASSISTANCE PROGRAMS IN FISCAL YEAR 2009; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO PROVIDE FOR AN EXPANSION OF HOME- AND COMMUNITY-BASED SERVICES BY THE DIVISION OF MEDICAID, OFFICE OF THE GOVERNOR, IN FISCAL YEAR 2009; AND FOR RELATED PURPOSES.

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

SECTION 1. Section 43-11-1, Mississippi Code of 1972, is amended as follows:

43-11-1. When used in this chapter, the following words shall have the following meaning:

(a) "Institutions for the aged or infirm" means a place either governmental or private which provides group living arrangements for four (4) or more persons who are unrelated to the operator and who are being provided food, shelter and personal care whether any such place be organized or operated for profit or not. The term "institution for aged or infirm" includes nursing homes, pediatric skilled nursing facilities, psychiatric

41 residential treatment facilities, convalescent homes, homes for
42 the aged and adult foster care facilities, provided that these
43 institutions fall within the scope of the definitions set forth
44 above. The term "institution for the aged or infirm" does not
45 include hospitals, clinics or mental institutions devoted
46 primarily to providing medical service.

47 (b) "Person" means any individual, firm, partnership,
48 corporation, company, association or joint stock association, or
49 any licensee herein or the legal successor thereof.

50 (c) "Personal care" means assistance rendered by
51 personnel of the home to aged or infirm residents in performing
52 one or more of the activities of daily living, which includes, but
53 is not limited to, the bathing, walking, excretory functions,
54 feeding, personal grooming and dressing of such residents.

55 (d) "Psychiatric residential treatment facility" means
56 any nonhospital establishment with permanent facilities which
57 provides a twenty-four-hour program of care by qualified
58 therapists, including, but not limited to, duly licensed mental
59 health professionals, psychiatrists, psychologists,
60 psychotherapists and licensed certified social workers, for
61 emotionally disturbed children and adolescents referred to such
62 facility by a court, local school district or by the Department of
63 Human Services, who are not in an acute phase of illness requiring
64 the services of a psychiatric hospital, and are in need of such
65 restorative treatment services. For purposes of this paragraph,
66 the term "emotionally disturbed" means a condition exhibiting one
67 or more of the following characteristics over a long period of
68 time and to a marked degree, which adversely affects educational
69 performance:

70 1. An inability to learn which cannot be explained
71 by intellectual, sensory or health factors;

72 2. An inability to build or maintain satisfactory
73 relationships with peers and teachers;

74 3. Inappropriate types of behavior or feelings
75 under normal circumstances;
76 4. A general pervasive mood of unhappiness or
77 depression; or
78 5. A tendency to develop physical symptoms or
79 fears associated with personal or school problems. An
80 establishment furnishing primarily domiciliary care is not within
81 this definition.
82 (e) "Pediatric skilled nursing facility" means an
83 institution or a distinct part of an institution that is primarily
84 engaged in providing to inpatients skilled nursing care and
85 related services for persons under twenty-one (21) years of age
86 who require medical or nursing care or rehabilitation services for
87 the rehabilitation of injured, disabled or sick persons.
88 (f) "Licensing agency" means the State Department of
89 Health.
90 (g) "Medical records" mean, without restriction, those
91 medical histories, records, reports, summaries, diagnoses and
92 prognoses, records of treatment and medication ordered and given,
93 notes, entries, x-rays and other written or graphic data prepared,
94 kept, made or maintained in institutions for the aged or infirm
95 that pertain to residency in, or services rendered to residents
96 of, an institution for the aged or infirm.
97 (h) "Adult foster care facility" means a home setting
98 for vulnerable adults in the community who are unable to live
99 independently due to physical, emotional, developmental or mental
100 impairments, or in need of emergency and continuing protective
101 social services for purposes of preventing further abuse or
102 neglect and for safeguarding and enhancing the welfare of the
103 abused or neglected vulnerable adult. Adult foster care programs
104 shall be designed to meet the needs of vulnerable adults with
105 impairments through individual plans of care, which provide a
106 variety of health, social and related support services in a

107 protective setting, enabling participants to live in the
108 community. Adult foster care programs may be (i) traditional,
109 where the foster care provider lives in the residence and is the
110 primary caregiver to clients in the home; (ii) corporate, where
111 the foster care home is operated by a corporation with shift staff
112 delivery services to clients; or (iii) shelter, where the foster
113 care home accepts clients on an emergency short-term basis for up
114 to thirty (30) days.

115 **SECTION 2.** Section 43-11-13, Mississippi Code of 1972, is
116 amended as follows:

117 43-11-13. (1) The licensing agency shall adopt, amend,
118 promulgate and enforce such rules, regulations and standards,
119 including classifications, with respect to all institutions for
120 the aged or infirm to be licensed under this chapter as may be
121 designed to further the accomplishment of the purpose of this
122 chapter in promoting adequate care of individuals in those
123 institutions in the interest of public health, safety and welfare.
124 Those rules, regulations and standards shall be adopted and
125 promulgated by the licensing agency and shall be recorded and
126 indexed in a book to be maintained by the licensing agency in its
127 main office in the State of Mississippi, entitled "Rules,
128 Regulations and Minimum Standards for Institutions for the Aged or
129 Infirm" and the book shall be open and available to all
130 institutions for the aged or infirm and the public generally at
131 all reasonable times. Upon the adoption of those rules,
132 regulations and standards, the licensing agency shall mail copies
133 thereof to all those institutions in the state that have filed
134 with the agency their names and addresses for this purpose, but
135 the failure to mail the same or the failure of the institutions to
136 receive the same shall in no way affect the validity thereof. The
137 rules, regulations and standards may be amended by the licensing
138 agency, from time to time, as necessary to promote the health,
139 safety and welfare of persons living in those institutions.

140 (2) The licensee shall keep posted in a conspicuous place on
141 the licensed premises all current rules, regulations and minimum
142 standards applicable to fire protection measures as adopted by the
143 licensing agency. The licensee shall furnish to the licensing
144 agency at least once each six (6) months a certificate of approval
145 and inspection by state or local fire authorities. Failure to
146 comply with state laws and/or municipal ordinances and current
147 rules, regulations and minimum standards as adopted by the
148 licensing agency, relative to fire prevention measures, shall be
149 prima facie evidence for revocation of license.
150 (3) The State Board of Health shall promulgate rules and
151 regulations restricting the storage, quantity and classes of drugs
152 allowed in personal care homes <u>and adult foster care facilities</u>.
153 Residents requiring administration of Schedule II Narcotics as
154 defined in the Uniform Controlled Substances Law may be admitted
155 to a personal care home. Schedule drugs may only be allowed in a
156 personal care home if they are administered or stored utilizing
157 proper procedures under the direct supervision of a licensed
158 physician or nurse.
159 (4) (a) Notwithstanding any determination by the licensing
160 agency that skilled nursing services would be appropriate for a
161 resident of a personal care home, that resident, the resident's
162 guardian or the legally recognized responsible party for the
163 resident may consent in writing for the resident to continue to
164 reside in the personal care home, if approved in writing by a
165 licensed physician. However, no personal care home shall allow
166 more than two (2) residents, or ten percent (10%) of the total
167 number of residents in the facility, whichever is greater, to
168 remain in the personal care home under the provisions of this
169 subsection (4). This consent shall be deemed to be appropriately
170 informed consent as described in the regulations promulgated by
171 the licensing agency. After that written consent has been
172 obtained, the resident shall have the right to continue to reside

173 in the personal care home for as long as the resident meets the
174 other conditions for residing in the personal care home. A copy
175 of the written consent and the physician's approval shall be
176 forwarded by the personal care home to the licensing agency.
177 (b) The State Board of Health shall promulgate rules
178 and regulations restricting the handling of a resident's personal
179 deposits by the director of a personal care home. Any funds given
180 or provided for the purpose of supplying extra comforts,
181 conveniences or services to any resident in any personal care
182 home, and any funds otherwise received and held from, for or on
183 behalf of any such resident, shall be deposited by the director or
184 other proper officer of the personal care home to the credit of
185 that resident in an account that shall be known as the Resident's
186 Personal Deposit Fund. No more than one (1) month's charge for
187 the care, support, maintenance and medical attention of the
188 resident shall be applied from the account at any one time. After
189 the death, discharge or transfer of any resident for whose benefit
190 any such fund has been provided, any unexpended balance remaining
191 in his personal deposit fund shall be applied for the payment of
192 care, cost of support, maintenance and medical attention that is
193 accrued. If any unexpended balance remains in that resident's
194 personal deposit fund after complete reimbursement has been made
195 for payment of care, support, maintenance and medical attention,
196 and the director or other proper officer of the personal care home
197 has been or shall be unable to locate the person or persons
198 entitled to the unexpended balance, the director or other proper
199 officer may, after the lapse of one (1) year from the date of that
200 death, discharge or transfer, deposit the unexpended balance to
201 the credit of the personal care home's operating fund.
202 (c) The State Board of Health shall promulgate rules
203 and regulations requiring personal care homes to maintain records
204 relating to health condition, medicine dispensed and administered,
205 and any reaction to that medicine. The director of the personal

206 care home shall be responsible for explaining the availability of
207 those records to the family of the resident at any time upon
208 reasonable request.

209 (d) The State Board of Health shall evaluate the
210 effects of this section as it promotes adequate care of
211 individuals in personal care homes in the interest of public
212 health, safety and welfare. It shall report its findings to the
213 Chairmen of the Public Health and Welfare Committees of the House
214 and Senate by January 1, 2003. This subsection (4) shall stand
215 repealed on June 30, 2008.

216 (5) (a) For the purposes of this subsection (5):

217 (i) "Licensed entity" means a hospital, nursing
218 home, personal care home, home health agency or hospice;

219 (ii) "Covered entity" means a licensed entity or a
220 health care professional staffing agency;

221 (iii) "Employee" means any individual employed by
222 a covered entity, and also includes any individual who by contract
223 provides to the patients, residents or clients being served by the
224 covered entity direct, hands-on, medical patient care in a
225 patient's, resident's or client's room or in treatment or recovery
226 rooms. The term "employee" does not include health care
227 professional/vocational technical students, as defined in Section
228 37-29-232, performing clinical training in a licensed entity under
229 contracts between their schools and the licensed entity, and does
230 not include students at high schools located in Mississippi who
231 observe the treatment and care of patients in a licensed entity as
232 part of the requirements of an allied-health course taught in the
233 high school, if:

234 1. The student is under the supervision of a
235 licensed health care provider; and

236 2. The student has signed an affidavit that
237 is on file at the student's school stating that he or she has not
238 been convicted of or pleaded guilty or nolo contendere to a felony

239 listed in paragraph (d) of this subsection (5), or that any such
240 conviction or plea was reversed on appeal or a pardon was granted
241 for the conviction or plea. Before any student may sign such an
242 affidavit, the student's school shall provide information to the
243 student explaining what a felony is and the nature of the felonies
244 listed in paragraph (d) of this subsection (5).

245 However, the health care professional/vocational technical
246 academic program in which the student is enrolled may require the
247 student to obtain criminal history record checks under the
248 provisions of Section 37-29-232.

249 (b) Under regulations promulgated by the State Board of
250 Health, the licensing agency shall require to be performed a
251 criminal history record check on (i) every new employee of a
252 covered entity who provides direct patient care or services and
253 who is employed on or after July 1, 2003, and (ii) every employee
254 of a covered entity employed before July 1, 2003, who has a
255 documented disciplinary action by his or her present employer. In
256 addition, the licensing agency shall require the covered entity to
257 perform a disciplinary check with the professional licensing
258 agency of each employee, if any, to determine if any disciplinary
259 action has been taken against the employee by that agency.

260 Except as otherwise provided in paragraph (c) of this
261 subsection (5), no such employee hired on or after July 1, 2003,
262 shall be permitted to provide direct patient care until the
263 results of the criminal history record check have revealed no
264 disqualifying record or the employee has been granted a waiver.
265 In order to determine the employee applicant's suitability for
266 employment, the applicant shall be fingerprinted. Fingerprints
267 shall be submitted to the licensing agency from scanning, with the
268 results processed through the Department of Public Safety's
269 Criminal Information Center. If no disqualifying record is
270 identified at the state level, the fingerprints shall be forwarded
271 by the Department of Public Safety to the Federal Bureau of

272 Investigation for a national criminal history record check. The
273 licensing agency shall notify the covered entity of the results of
274 an employee applicant's criminal history record check. If the
275 criminal history record check discloses a felony conviction,
276 guilty plea or plea of nolo contendere to a felony of possession
277 or sale of drugs, murder, manslaughter, armed robbery, rape,
278 sexual battery, sex offense listed in Section 45-33-23(g), child
279 abuse, arson, grand larceny, burglary, gratification of lust or
280 aggravated assault, or felonious abuse and/or battery of a
281 vulnerable adult that has not been reversed on appeal or for which
282 a pardon has not been granted, the employee applicant shall not be
283 eligible to be employed by the covered entity.
284 (c) Any such new employee applicant may, however, be
285 employed on a temporary basis pending the results of the criminal
286 history record check, but any employment contract with the new
287 employee shall be voidable if the new employee receives a
288 disqualifying criminal history record check and no waiver is
289 granted as provided in this subsection (5).
290 (d) Under regulations promulgated by the State Board of
291 Health, the licensing agency shall require every employee of a
292 covered entity employed before July 1, 2003, to sign an affidavit
293 stating that he or she has not been convicted of or pleaded guilty
294 or nolo contendere to a felony of possession or sale of drugs,
295 murder, manslaughter, armed robbery, rape, sexual battery, any sex
296 offense listed in Section 45-33-23(g), child abuse, arson, grand
297 larceny, burglary, gratification of lust, aggravated assault, or
298 felonious abuse and/or battery of a vulnerable adult, or that any
299 such conviction or plea was reversed on appeal or a pardon was
300 granted for the conviction or plea. No such employee of a covered
301 entity hired before July 1, 2003, shall be permitted to provide
302 direct patient care until the employee has signed the affidavit
303 required by this paragraph (d). All such existing employees of
304 covered entities must sign the affidavit required by this

305 paragraph (d) within six (6) months of the final adoption of the
306 regulations promulgated by the State Board of Health. If a person
307 signs the affidavit required by this paragraph (d), and it is
308 later determined that the person actually had been convicted of or
309 pleaded guilty or nolo contendere to any of the offenses listed in
310 this paragraph (d) and the conviction or plea has not been
311 reversed on appeal or a pardon has not been granted for the
312 conviction or plea, the person is guilty of perjury. If the
313 offense that the person was convicted of or pleaded guilty or nolo
314 contendere to was a violent offense, the person, upon a conviction
315 of perjury under this paragraph, shall be punished as provided in
316 Section 97-9-61. If the offense that the person was convicted of
317 or pleaded guilty or nolo contendere to was a nonviolent offense,
318 the person, upon a conviction of perjury under this paragraph,
319 shall be punished by a fine of not more than Five Hundred Dollars
320 ($500.00), or by imprisonment in the county jail for not more than
321 six (6) months, or by both such fine and imprisonment.
322 (e) The covered entity may, in its discretion, allow
323 any employee who is unable to sign the affidavit required by
324 paragraph (d) of this subsection (5) or any employee applicant
325 aggrieved by an employment decision under this subsection (5) to
326 appear before the covered entity's hiring officer, or his or her
327 designee, to show mitigating circumstances that may exist and
328 allow the employee or employee applicant to be employed by the
329 covered entity. The covered entity, upon report and
330 recommendation of the hiring officer, may grant waivers for those
331 mitigating circumstances, which shall include, but not be limited
332 to: (i) age at which the crime was committed; (ii) circumstances
333 surrounding the crime; (iii) length of time since the conviction
334 and criminal history since the conviction; (iv) work history; (v)
335 current employment and character references; and (vi) other
336 evidence demonstrating the ability of the individual to perform
337 the employment responsibilities competently and that the

338 individual does not pose a threat to the health or safety of the
339 patients of the covered entity.
340 (f) The licensing agency may charge the covered entity
341 submitting the fingerprints a fee not to exceed Fifty Dollars
342 ($50.00), which covered entity may, in its discretion, charge the
343 same fee, or a portion thereof, to the employee applicant. Any
344 costs incurred by a covered entity implementing this subsection
345 (5) shall be reimbursed as an allowable cost under Section
346 43-13-116.
347 (g) If the results of an employee applicant's criminal
348 history record check reveals no disqualifying event, then the
349 covered entity shall, within two (2) weeks of the notification of
350 no disqualifying event, provide the employee applicant with a
351 notarized letter signed by the chief executive officer of the
352 covered entity, or his or her authorized designee, confirming the
353 employee applicant's suitability for employment based on his or
354 her criminal history record check. An employee applicant may use
355 that letter for a period of two (2) years from the date of the
356 letter to seek employment with any covered entity without the
357 necessity of an additional criminal history record check. Any
358 covered entity presented with the letter may rely on the letter
359 with respect to an employee applicant's criminal background and is
360 not required for a period of two (2) years from the date of the
361 letter to conduct or have conducted a criminal history record
362 check as required in this subsection (5).
363 (h) The licensing agency, the covered entity, and their
364 agents, officers, employees, attorneys and representatives, shall
365 be presumed to be acting in good faith for any employment decision
366 or action taken under this subsection (5). The presumption of
367 good faith may be overcome by a preponderance of the evidence in
368 any civil action. No licensing agency, covered entity, nor their
369 agents, officers, employees, attorneys and representatives shall
370 be held liable in any employment decision or action based in whole

371 or in part on compliance with or attempts to comply with the
372 requirements of this subsection (5).

373 (i) The licensing agency shall promulgate regulations
374 to implement this subsection (5).

375 (j) The provisions of this subsection (5) shall not
376 apply to:

377 (i) Applicants and employees of the University of
378 Mississippi Medical Center for whom criminal history record checks
379 and fingerprinting are obtained in accordance with Section
380 37-115-41; or

381 (ii) Health care professional/vocational technical
382 students for whom criminal history record checks and
383 fingerprinting are obtained in accordance with Section 37-29-232.

384 (6) The State Board of Health shall promulgate rules,
385 regulations and standards regarding the operation of adult foster
386 care facilities.

387 **SECTION 3.** The following provision shall be codified as
388 Section 43-11-8, Mississippi Code of 1972:

389 43-11-8. (1) An application for a license for an adult
390 foster care facility shall be made to the licensing agency upon
391 forms provided by it and shall contain such information as the
392 licensing agency reasonably requires, which may include
393 affirmative evidence of ability to comply with such reasonable
394 standards, rules and regulations as are lawfully prescribed
395 hereunder. Each application for a license for an adult foster
396 care facility shall be accompanied by a license fee of Ten Dollars
397 ($10.00) for each person or bed of licensed capacity, with a
398 minimum fee per home or institution of Fifty Dollars ($50.00),
399 which shall be paid to the licensing agency.

400 (2) A license, unless suspended or revoked, shall be
401 renewable annually upon payment by the licensee of an adult foster
402 care facility, except for personal care homes, of a renewal fee of
403 Ten Dollars ($10.00) for each person or bed of licensed capacity

404 in the institution, with a minimum renewal fee per institution of
405 Fifty Dollars ($50.00), which shall be paid to the licensing
406 agency, and upon filing by the licensee and approval by the
407 licensing agency of an annual report upon such uniform dates and
408 containing such information in such form as the licensing agency
409 prescribes by regulation. Each license shall be issued only for
410 the premises and person or persons or other legal entity or
411 entities named in the application and shall not be transferable or
412 assignable except with the written approval of the licensing
413 agency. Licenses shall be posted in a conspicuous place on the
414 licensed premises.

415 **SECTION 4.** (1) The Legislature finds and declares that:

416 (a) The current population of adults sixty (60) years
417 of age and older in Mississippi is expected to double in size over
418 the next twenty-five (25) years;

419 (b) A primary objective of public policy governing
420 access to long-term care in this state shall be to promote the
421 independence, dignity and lifestyle choice of older adults and
422 persons with physical disabilities or Alzheimer's disease and
423 related disorders;

424 (c) Many states are actively seeking to "rebalance"
425 their long-term care programs and budgets in order to support
426 consumer choice and offer more choices for older adults and
427 persons with disabilities to live in their homes and communities;

428 (d) The federal "New Freedom Initiative" was launched
429 in 2001 for the purpose of promoting the goal of independent
430 living for persons with disabilities; and Executive Order No.
431 13217, issued by the President of the United States on June 18,
432 2001, called upon the federal government to assist states and
433 localities to swiftly implement the 1999 United States Supreme
434 Court decision in *Olmstead v. L.C.* and directed federal agencies
435 to evaluate their policies, programs, statutes and regulations to
436 determine whether any should be revised or modified to improve the

437 availability of home- and community-based services for qualified
438 persons with disabilities;
439 (e) The federal "Older Americans Act Amendments of
440 2006" (Public Law 109-365) and the Deficit Reduction Act (DRA)
441 provided states with much flexibility to make significant reforms
442 to pursue innovative ideas in health care, Medicaid services for
443 the aging and disabled, consumer directed health care and
444 rebalancing long-term care. These amendments defined the
445 functions of Aging and Disability Resource Centers to provide
446 comprehensive information on long-term care program options and
447 directed states to create a state system of long-term care to
448 enable older individuals to receive long-term care in home- and
449 community-based settings and to provide counseling services
450 relating to such long-term care; and
451 (f) Older adults and those with physical disabilities
452 or Alzheimer's disease and related disorders that require a
453 nursing facility level of care should not be forced to choose
454 between going into a nursing home or giving up the medical
455 assistance that pays for their needed services, and thereby be
456 denied the right to choose where they receive those services;
457 their eligibility for home- and community-based long-term care
458 services under Medicaid should be based upon the same income and
459 asset standards as those used to determine eligibility for
460 long-term care in an institutional setting.
461 (2) As used in this act:
462 (a) The term "Aging and Disability Resource Center"
463 means a program established by a state as part of the state system
464 of long-term care, to provide a coordinated system for providing:
465 (i) Comprehensive information on the full range of
466 available public and private long-term care programs, options,
467 service providers and resources within a community, including
468 information on the availability of integrated long-term care;

469 (ii) Personal counseling to assist individuals in
470 assessing their existing or anticipated long-term care needs, and
471 developing and implementing a plan for long-term care designed to
472 meet their specific needs and circumstances; and
473 (iii) Consumers' access to the range of publicly
474 supported long-term care programs for which consumers may be
475 eligible, by serving as a convenient point of entry for such
476 programs.
477 (b) The term "at risk for institutional placement"
478 means, with respect to an older individual, that such individual
479 is unable to perform at least two (2) activities of daily living
480 without substantial assistance (including verbal reminding,
481 physical cuing or supervision) and is determined by the state
482 involved to be in need of placement in a long-term care facility.
483 (c) The term "long-term care services" means any
484 service, care or item:
485 (i) Intended to assist individuals in coping with,
486 and to the extent practicable compensate for, a functional
487 impairment in carrying out activities of daily living;
488 (ii) Furnished at home, in a community care
489 setting (including a small community care setting as defined in
490 subsection (g)(1), and a large community care setting as defined
491 in subsection (h)(1) of Section 1929 of the Social Security Act
492 (42 USC 1396t), or in a long-term care facility; and
493 (iii) Not furnished to prevent, diagnose, treat or
494 cure a medical disease or condition.
495 The term "state system of long-term care" means the federal,
496 state and local programs and activities administered by a state
497 that provide, support or facilitate access to long-term care to
498 individuals in such state.
499 (d) "Home- and community-based services" means Medicaid
500 home- and community-based long-term care options available in this
501 state, including, but not limited to, the Community Care Program

502 for the Elderly and Disabled, Assisted Living, Adult Family Care,
503 Caregiver Assistance Program, Adult Day Health Services, Traumatic
504 Brain Injury, AIDS Community Care Alternatives Program, Community
505 Resources for People with Disabilities, and Community Resources
506 for People with Disabilities Private Duty Nursing.

507 (3) (a) There is hereby established the Long-Term Care
508 Advisory Council within the Mississippi Department of Human
509 Services. The advisory council shall be entitled to receive such
510 information from the Department of Human Services, the Division of
511 Medicaid, the State Department of Rehabilitation Services and
512 other agencies relating to services for the aged and disabled, as
513 the advisory council deems necessary to carry out its
514 responsibilities under this act.

515 (b) The advisory council shall be provided a copy of
516 the Division of Medicaid's study titled Comprehensive Review of
517 Long-Term Services Money Follows the Person Program in response to
518 RFP #2006505-01 and shall assess and develop a recommendation no
519 later than December 1, 2007, to the Governor, the Lieutenant
520 Governor and Speaker of the House of Representatives on the impact
521 this study and of federal amendments to the "Older Americans Act"
522 and the Deficit Reduction Act of 2005 on Mississippi's public and
523 private system of programs and care for the aged and disabled.

524 (c) The advisory council shall comprise fifteen (15)
525 members as follows:

526 (i) The Executive Director of the Department of
527 Human Services, the Executive Director of the Division of
528 Medicaid-Office of the Governor, the Executive Directors of the
529 State Department of Rehabilitation Services and the State
530 Department of Mental Health, or their designees, as ex officio
531 members;

532 (ii) The Public Health Policy Advisor to the
533 Governor; and

534 (iii) Ten (10) public members to be appointed by
535 the Governor as follows: one (1) person appointed upon the
536 recommendation of AARP; one (1) person upon the recommendation of
537 the Mississippi Association of Area Agencies on Aging; one (1)
538 person upon the recommendation of the Mississippi Association for
539 the Rights of Citizens with Disabilities (The ARC); one (1) person
540 upon the recommendation of the Mississippi Health Care
541 Association; one (1) person upon the recommendation of the
542 Mississippi Hospital Association; one (1) person that represents
543 the independent nursing home industry; one (1) person who is a
544 representative of the home care industry; one (1) person upon the
545 recommendation of the Coalition for Citizens with Disabilities;
546 one (1) person upon the recommendation of the Living Independently
547 for Everyone (L.I.F.E.) organization; and one (1) person appointed
548 upon the recommendation of the Mississippi Department of
549 Transportation.
550 (d) The advisory council shall organize as soon as
551 possible after the appointment of its members upon call of the
552 Governor and shall select from its membership a chairman and a
553 secretary.
554 (e) The Department of Human Services and the Division
555 of Medicaid shall provide such staff and administrative support to
556 the advisory council as it requires to carry out its
557 responsibilities.
558 (f) The advisory council shall identify home- and
559 community-based long-term care service models that are determined
560 by the division to be efficient and cost-effective alternatives to
561 nursing home care, and develop clear and concise performance
562 standards for those services for which standards are not already
563 available in a home- and community-based services waiver.
564 (4) Upon presentation of its recommendation to the Governor,
565 the Lieutenant Governor and the Speaker of the House of

566 Representatives, the Long-Term Care Advisory Council shall be
567 dissolved.
568 **SECTION 5.** Section 43-7-7, Mississippi Code of 1972, is
569 amended as follows:
570 43-7-7. (1) The Department of Human Services shall be
571 responsible for the collection of data and statistics and for
572 making a continuing study of conditions affecting the general
573 welfare of the aging population; for providing for an inter-agency
574 and inter-departmental exchange of ideas; for encouraging and
575 assisting in the development of programs for the aging in
576 municipalities and counties of the state; for cooperation with
577 public and private agencies and departments in coordinating
578 programs for the aging; for encouraging and promoting biological,
579 physiological and sociological research; for making
580 recommendations for residential housing and needed nursing and
581 custodial care facilities.
582 (2) Beginning with the 2009 fiscal year, the Department of
583 Human Services may, consistent with federal law and regulations,
584 promote the development and implementation of a state system of
585 long-term care that is a comprehensive, coordinated system that
586 enables older individuals to receive long-term care in home-and
587 community-based settings, in a manner responsive to the needs and
588 preferences of older individuals and their family caregivers by:
589 (a) Collaborating, coordinating and consulting with
590 other agencies in such state responsible for formulating,
591 implementing and administering programs, benefits and services
592 related to providing long-term care;
593 (b) Conducting analyses and making recommendations with
594 respect to strategies for modifying the state system of long-term
595 care to:
596 (i) Respond to the needs and preference of older
597 individuals and family caregivers;

598 (ii) Facilitate the provision, by service
599 providers, of long-term care in home- and community-based
600 settings; and
601 (iii) Target services to individuals at risk for
602 institutional placement, to permit such individuals to remain in
603 home- and community-based settings where appropriate and
604 available;
605 (c) Implementing (through area agencies on aging,
606 service providers and such other entities as the state determines
607 to be appropriate) evidence-based programs to assist older
608 individuals and their family caregivers in learning about and
609 making behavioral changes intended to reduce the risk of injury,
610 disease and disability among older individuals;
611 (d) Providing for the availability and distribution
612 (through public education campaigns, Aging and Disability Resource
613 Centers, area agencies on aging and other appropriate means) of
614 information relating to:
615 (i) The need to plan in advance for long-term
616 care; and
617 (ii) The full range of available public and
618 private long-term care (including integrated long-term care)
619 programs, options, services providers and resources; and
620 (e) Nothing in this section shall conflict with the
621 authority of another state agency.
622 **SECTION 6.** Section 43-13-117, Mississippi Code of 1972, is
623 amended as follows:
624 43-13-117. Medicaid as authorized by this article shall
625 include payment of part or all of the costs, at the discretion of
626 the division, with approval of the Governor, of the following
627 types of care and services rendered to eligible applicants who
628 have been determined to be eligible for that care and services,
629 within the limits of state appropriations and federal matching
630 funds:

631 (1) Inpatient hospital services.

632 (a) The division shall allow thirty (30) days of
633 inpatient hospital care annually for all Medicaid recipients.
634 Precertification of inpatient days must be obtained as required by
635 the division. The division may allow unlimited days in
636 disproportionate hospitals as defined by the division for eligible
637 infants and children under the age of six (6) years if certified
638 as medically necessary as required by the division.

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

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

652 (2) Outpatient hospital services.

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

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

663 (3) Laboratory and x-ray services.

664 (4) Nursing facility services.
665 (a) The division shall make full payment to
666 nursing facilities for each day, not exceeding fifty-two (52) days
667 per year, that a patient is absent from the facility on home
668 leave. Payment may be made for the following home leave days in
669 addition to the fifty-two-day limitation: Christmas, the day
670 before Christmas, the day after Christmas, Thanksgiving, the day
671 before Thanksgiving and the day after Thanksgiving.
672 (b) From and after July 1, 1997, the division
673 shall implement the integrated case-mix payment and quality
674 monitoring system, which includes the fair rental system for
675 property costs and in which recapture of depreciation is
676 eliminated. The division may reduce the payment for hospital
677 leave and therapeutic home leave days to the lower of the case-mix
678 category as computed for the resident on leave using the
679 assessment being utilized for payment at that point in time, or a
680 case-mix score of 1.000 for nursing facilities, and shall compute
681 case-mix scores of residents so that only services provided at the
682 nursing facility are considered in calculating a facility's per
683 diem.
684 (c) From and after July 1, 1997, all state-owned
685 nursing facilities shall be reimbursed on a full reasonable cost
686 basis.
687 (d) When a facility of a category that does not
688 require a certificate of need for construction and that could not
689 be eligible for Medicaid reimbursement is constructed to nursing
690 facility specifications for licensure and certification, and the
691 facility is subsequently converted to a nursing facility under a
692 certificate of need that authorizes conversion only and the
693 applicant for the certificate of need was assessed an application
694 review fee based on capital expenditures incurred in constructing
695 the facility, the division shall allow reimbursement for capital
696 expenditures necessary for construction of the facility that were

697 incurred within the twenty-four (24) consecutive calendar months
698 immediately preceding the date that the certificate of need
699 authorizing the conversion was issued, to the same extent that
700 reimbursement would be allowed for construction of a new nursing
701 facility under a certificate of need that authorizes that
702 construction. The reimbursement authorized in this subparagraph
703 (d) may be made only to facilities the construction of which was
704 completed after June 30, 1989. Before the division shall be
705 authorized to make the reimbursement authorized in this
706 subparagraph (d), the division first must have received approval
707 from the Centers for Medicare and Medicaid Services (CMS) of the
708 change in the state Medicaid plan providing for the reimbursement.
709 (e) The division shall develop and implement, not
710 later than January 1, 2001, a case-mix payment add-on determined
711 by time studies and other valid statistical data that will
712 reimburse a nursing facility for the additional cost of caring for
713 a resident who has a diagnosis of Alzheimer's or other related
714 dementia and exhibits symptoms that require special care. Any
715 such case-mix add-on payment shall be supported by a determination
716 of additional cost. The division shall also develop and implement
717 as part of the fair rental reimbursement system for nursing
718 facility beds, an Alzheimer's resident bed depreciation enhanced
719 reimbursement system that will provide an incentive to encourage
720 nursing facilities to convert or construct beds for residents with
721 Alzheimer's or other related dementia.
722 (f) The division shall develop and implement an
723 assessment process for long-term care services. The division may
724 provide the assessment and related functions directly or through
725 contract with the area agencies on aging.
726 The division shall apply for necessary federal waivers to
727 assure that additional services providing alternatives to nursing
728 facility care are made available to applicants for nursing
729 facility care.

730 (5) Periodic screening and diagnostic services for
731 individuals under age twenty-one (21) years as are needed to
732 identify physical and mental defects and to provide health care
733 treatment and other measures designed to correct or ameliorate
734 defects and physical and mental illness and conditions discovered
735 by the screening services, regardless of whether these services
736 are included in the state plan. The division may include in its
737 periodic screening and diagnostic program those discretionary
738 services authorized under the federal regulations adopted to
739 implement Title XIX of the federal Social Security Act, as
740 amended. The division, in obtaining physical therapy services,
741 occupational therapy services, and services for individuals with
742 speech, hearing and language disorders, may enter into a
743 cooperative agreement with the State Department of Education for
744 the provision of those services to handicapped students by public
745 school districts using state funds that are provided from the
746 appropriation to the Department of Education to obtain federal
747 matching funds through the division. The division, in obtaining
748 medical and psychological evaluations for children in the custody
749 of the State Department of Human Services may enter into a
750 cooperative agreement with the State Department of Human Services
751 for the provision of those services using state funds that are
752 provided from the appropriation to the Department of Human
753 Services to obtain federal matching funds through the division.
754 (6) Physician's services. The division shall allow
755 twelve (12) physician visits annually. All fees for physicians'
756 services that are covered only by Medicaid shall be reimbursed at
757 ninety percent (90%) of the rate established on January 1, 1999,
758 and as may be adjusted each July thereafter, under Medicare (Title
759 XVIII of the federal Social Security Act, as amended). The
760 division may develop and implement a different reimbursement model
761 or schedule for physician's services provided by physicians based
762 at an academic health care center and by physicians at rural

763 health centers that are associated with an academic health care
764 center.
765 (7) (a) Home health services for eligible persons, not
766 to exceed in cost the prevailing cost of nursing facility
767 services, not to exceed twenty-five (25) visits per year. All
768 home health visits must be precertified as required by the
769 division.
770 (b) Repealed.
771 (8) Emergency medical transportation services. On
772 January 1, 1994, emergency medical transportation services shall
773 be reimbursed at seventy percent (70%) of the rate established
774 under Medicare (Title XVIII of the federal Social Security Act, as
775 amended). "Emergency medical transportation services" shall mean,
776 but shall not be limited to, the following services by a properly
777 permitted ambulance operated by a properly licensed provider in
778 accordance with the Emergency Medical Services Act of 1974
779 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
780 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
781 (vi) disposable supplies, (vii) similar services.
782 (9) (a) Legend and other drugs as may be determined by
783 the division.
784 The division shall establish a mandatory preferred drug list.
785 Drugs not on the mandatory preferred drug list shall be made
786 available by utilizing prior authorization procedures established
787 by the division.
788 The division may seek to establish relationships with other
789 states in order to lower acquisition costs of prescription drugs
790 to include single source and innovator multiple source drugs or
791 generic drugs. In addition, if allowed by federal law or
792 regulation, the division may seek to establish relationships with
793 and negotiate with other countries to facilitate the acquisition
794 of prescription drugs to include single source and innovator

795 multiple source drugs or generic drugs, if that will lower the
796 acquisition costs of those prescription drugs.
797 The division shall allow for a combination of prescriptions
798 for single source and innovator multiple source drugs and generic
799 drugs to meet the needs of the beneficiaries, not to exceed five
800 (5) prescriptions per month for each noninstitutionalized Medicaid
801 beneficiary, with not more than two (2) of those prescriptions
802 being for single source or innovator multiple source drugs.
803 The executive director may approve specific maintenance drugs
804 for beneficiaries with certain medical conditions, which may be
805 prescribed and dispensed in three-month supply increments. The
806 executive director may allow a state agency or agencies to be the
807 sole source purchaser and distributor of hemophilia factor
808 medications, HIV/AIDS medications and other medications as
809 determined by the executive director as allowed by federal
810 regulations.
811 Drugs prescribed for a resident of a psychiatric residential
812 treatment facility must be provided in true unit doses when
813 available. The division may require that drugs not covered by
814 Medicare Part D for a resident of a long-term care facility be
815 provided in true unit doses when available. Those drugs that were
816 originally billed to the division but are not used by a resident
817 in any of those facilities shall be returned to the billing
818 pharmacy for credit to the division, in accordance with the
819 guidelines of the State Board of Pharmacy and any requirements of
820 federal law and regulation. Drugs shall be dispensed to a
821 recipient and only one (1) dispensing fee per month may be
822 charged. The division shall develop a methodology for reimbursing
823 for restocked drugs, which shall include a restock fee as
824 determined by the division not exceeding Seven Dollars and
825 Eighty-two Cents ($7.82).
826 The voluntary preferred drug list shall be expanded to
827 function in the interim in order to have a manageable prior

828 authorization system, thereby minimizing disruption of service to
829 beneficiaries.

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

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

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

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

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

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

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

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

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

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

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

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

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

893 dental care and surgery under authority of this paragraph (10)
894 shall be increased to one hundred sixty percent (160%) of the
895 amount of the reimbursement rate that was in effect on June 30,
896 1999. It is the intent of the Legislature to encourage more
897 dentists to participate in the Medicaid program.
898 (11) Eyeglasses for all Medicaid beneficiaries who have
899 (a) had surgery on the eyeball or ocular muscle that results in a
900 vision change for which eyeglasses or a change in eyeglasses is
901 medically indicated within six (6) months of the surgery and is in
902 accordance with policies established by the division, or (b) one
903 (1) pair every five (5) years and in accordance with policies
904 established by the division. In either instance, the eyeglasses
905 must be prescribed by a physician skilled in diseases of the eye
906 or an optometrist, whichever the beneficiary may select.
907 (12) Intermediate care facility services.
908 (a) The division shall make full payment to all
909 intermediate care facilities for the mentally retarded for each
910 day, not exceeding eighty-four (84) days per year, that a patient
911 is absent from the facility on home leave. Payment may be made
912 for the following home leave days in addition to the
913 eighty-four-day limitation: Christmas, the day before Christmas,
914 the day after Christmas, Thanksgiving, the day before Thanksgiving
915 and the day after Thanksgiving.
916 (b) All state-owned intermediate care facilities
917 for the mentally retarded shall be reimbursed on a full reasonable
918 cost basis.
919 (13) Family planning services, including drugs,
920 supplies and devices, when those services are under the
921 supervision of a physician or nurse practitioner.
922 (14) Clinic services. Such diagnostic, preventive,
923 therapeutic, rehabilitative or palliative services furnished to an
924 outpatient by or under the supervision of a physician or dentist
925 in a facility that is not a part of a hospital but that is

926 organized and operated to provide medical care to outpatients.
927 Clinic services shall include any services reimbursed as
928 outpatient hospital services that may be rendered in such a
929 facility, including those that become so after July 1, 1991. On
930 July 1, 1999, all fees for physicians' services reimbursed under
931 authority of this paragraph (14) shall be reimbursed at ninety
932 percent (90%) of the rate established on January 1, 1999, and as
933 may be adjusted each July thereafter, under Medicare (Title XVIII
934 of the federal Social Security Act, as amended). The division may
935 develop and implement a different reimbursement model or schedule
936 for physician's services provided by physicians based at an
937 academic health care center and by physicians at rural health
938 centers that are associated with an academic health care center.
939 On July 1, 1999, all fees for dentists' services reimbursed under
940 authority of this paragraph (14) shall be increased to one hundred
941 sixty percent (160%) of the amount of the reimbursement rate that
942 was in effect on June 30, 1999.

943 *(15) Home- and community-based services for the elderly*
944 *and disabled, as provided under Title XIX of the federal Social*
945 *Security Act, as amended, under waivers, subject to the*
946 *availability of funds specifically appropriated for that purpose*
947 *by the Legislature.* Beginning in fiscal year 2009, and in each
948 succeeding fiscal year through fiscal year 2013, the division may
949 implement a process that promotes a rebalancing of the overall
950 allocation of Medicaid funding for long-term care services through
951 the expansion of home- and community-based services for persons
952 eligible for long-term care as defined by regulation of the
953 division, consistent with federal law and regulation. The
954 expansion of home- and community-based services may occur by the
955 voluntary migration of persons in need of long-term care from
956 nursing home placements to home- and community-based services
957 where appropriate and available to these persons. The Division of
958 Medicaid may apply to the federal Centers for Medicare and

959 Medicaid Services for any waiver of federal requirements, or for
960 any state plan amendments or home- and community-based services
961 waiver amendments, which may be necessary to obtain federal
962 financial participation for state Medicaid expenditures in order
963 to effectuate the purposes of this act. Provided, however, that
964 any programs proposed or implemented by the Division of Medicaid
965 under this paragraph (15) shall be in compliance and shall not
966 interfere with any federal court order regarding the rights of
967 disabled citizens.
968 (16) Mental health services. Approved therapeutic and
969 case management services (a) provided by an approved regional
970 mental health/retardation center established under Sections
971 41-19-31 through 41-19-39, or by another community mental health
972 service provider meeting the requirements of the Department of
973 Mental Health to be an approved mental health/retardation center
974 if determined necessary by the Department of Mental Health, using
975 state funds that are provided from the appropriation to the State
976 Department of Mental Health and/or funds transferred to the
977 department by a political subdivision or instrumentality of the
978 state and used to match federal funds under a cooperative
979 agreement between the division and the department, or (b) provided
980 by a facility that is certified by the State Department of Mental
981 Health to provide therapeutic and case management services, to be
982 reimbursed on a fee for service basis, or (c) provided in the
983 community by a facility or program operated by the Department of
984 Mental Health. Any such services provided by a facility described
985 in subparagraph (b) must have the prior approval of the division
986 to be reimbursable under this section. After June 30, 1997,
987 mental health services provided by regional mental
988 health/retardation centers established under Sections 41-19-31
989 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
990 and/or their subsidiaries and divisions, or by psychiatric
991 residential treatment facilities as defined in Section 43-11-1, or

992 by another community mental health service provider meeting the
993 requirements of the Department of Mental Health to be an approved
994 mental health/retardation center if determined necessary by the
995 Department of Mental Health, shall not be included in or provided
996 under any capitated managed care pilot program provided for under
997 paragraph (24) of this section.

998 (17) Durable medical equipment services and medical
999 supplies. Precertification of durable medical equipment and
1000 medical supplies must be obtained as required by the division.
1001 The Division of Medicaid may require durable medical equipment
1002 providers to obtain a surety bond in the amount and to the
1003 specifications as established by the Balanced Budget Act of 1997.

1004 (18) (a) Notwithstanding any other provision of this
1005 section to the contrary, the division shall make additional
1006 reimbursement to hospitals that serve a disproportionate share of
1007 low-income patients and that meet the federal requirements for
1008 those payments as provided in Section 1923 of the federal Social
1009 Security Act and any applicable regulations. However, from and
1010 after January 1, 1999, no public hospital shall participate in the
1011 Medicaid disproportionate share program unless the public hospital
1012 participates in an intergovernmental transfer program as provided
1013 in Section 1903 of the federal Social Security Act and any
1014 applicable regulations.

1015 (b) The division shall establish a Medicare Upper
1016 Payment Limits Program, as defined in Section 1902(a)(30) of the
1017 federal Social Security Act and any applicable federal
1018 regulations, for hospitals, and may establish a Medicare Upper
1019 Payments Limits Program for nursing facilities. The division
1020 shall assess each hospital and, if the program is established for
1021 nursing facilities, shall assess each nursing facility, based on
1022 Medicaid utilization or other appropriate method consistent with
1023 federal regulations. The assessment will remain in effect as long
1024 as the state participates in the Medicare Upper Payment Limits

1025 Program. The division shall make additional reimbursement to
1026 hospitals and, if the program is established for nursing
1027 facilities, shall make additional reimbursement to nursing
1028 facilities, for the Medicare Upper Payment Limits, as defined in
1029 Section 1902(a)(30) of the federal Social Security Act and any
1030 applicable federal regulations.
1031 (19) (a) Perinatal risk management services. The
1032 division shall promulgate regulations to be effective from and
1033 after October 1, 1988, to establish a comprehensive perinatal
1034 system for risk assessment of all pregnant and infant Medicaid
1035 recipients and for management, education and follow-up for those
1036 who are determined to be at risk. Services to be performed
1037 include case management, nutrition assessment/counseling,
1038 psychosocial assessment/counseling and health education.
1039 (b) Early intervention system services. The
1040 division shall cooperate with the State Department of Health,
1041 acting as lead agency, in the development and implementation of a
1042 statewide system of delivery of early intervention services, under
1043 Part C of the Individuals with Disabilities Education Act (IDEA).
1044 The State Department of Health shall certify annually in writing
1045 to the executive director of the division the dollar amount of
1046 state early intervention funds available that will be utilized as
1047 a certified match for Medicaid matching funds. Those funds then
1048 shall be used to provide expanded targeted case management
1049 services for Medicaid eligible children with special needs who are
1050 eligible for the state's early intervention system.
1051 Qualifications for persons providing service coordination shall be
1052 determined by the State Department of Health and the Division of
1053 Medicaid.
1054 (20) Home- and community-based services for physically
1055 disabled approved services as allowed by a waiver from the United
1056 States Department of Health and Human Services for home- and
1057 community-based services for physically disabled people using

1058 state funds that are provided from the appropriation to the State
1059 Department of Rehabilitation Services and used to match federal
1060 funds under a cooperative agreement between the division and the
1061 department, provided that funds for these services are
1062 specifically appropriated to the Department of Rehabilitation
1063 Services.
1064 (21) Nurse practitioner services. Services furnished
1065 by a registered nurse who is licensed and certified by the
1066 Mississippi Board of Nursing as a nurse practitioner, including,
1067 but not limited to, nurse anesthetists, nurse midwives, family
1068 nurse practitioners, family planning nurse practitioners,
1069 pediatric nurse practitioners, obstetrics-gynecology nurse
1070 practitioners and neonatal nurse practitioners, under regulations
1071 adopted by the division. Reimbursement for those services shall
1072 not exceed ninety percent (90%) of the reimbursement rate for
1073 comparable services rendered by a physician.
1074 (22) Ambulatory services delivered in federally
1075 qualified health centers, rural health centers and clinics of the
1076 local health departments of the State Department of Health for
1077 individuals eligible for Medicaid under this article based on
1078 reasonable costs as determined by the division.
1079 (23) Inpatient psychiatric services. Inpatient
1080 psychiatric services to be determined by the division for
1081 recipients under age twenty-one (21) that are provided under the
1082 direction of a physician in an inpatient program in a licensed
1083 acute care psychiatric facility or in a licensed psychiatric
1084 residential treatment facility, before the recipient reaches age
1085 twenty-one (21) or, if the recipient was receiving the services
1086 immediately before he or she reached age twenty-one (21), before
1087 the earlier of the date he or she no longer requires the services
1088 or the date he or she reaches age twenty-two (22), as provided by
1089 federal regulations. Precertification of inpatient days and

1090 residential treatment days must be obtained as required by the
1091 division.
1092 (24) [Deleted]
1093 (25) [Deleted]
1094 (26) Hospice care. As used in this paragraph, the term
1095 "hospice care" means a coordinated program of active professional
1096 medical attention within the home and outpatient and inpatient
1097 care that treats the terminally ill patient and family as a unit,
1098 employing a medically directed interdisciplinary team. The
1099 program provides relief of severe pain or other physical symptoms
1100 and supportive care to meet the special needs arising out of
1101 physical, psychological, spiritual, social and economic stresses
1102 that are experienced during the final stages of illness and during
1103 dying and bereavement and meets the Medicare requirements for
1104 participation as a hospice as provided in federal regulations.
1105 (27) Group health plan premiums and cost sharing if it
1106 is cost effective as defined by the United States Secretary of
1107 Health and Human Services.
1108 (28) Other health insurance premiums that are cost
1109 effective as defined by the United States Secretary of Health and
1110 Human Services. Medicare eligible must have Medicare Part B
1111 before other insurance premiums can be paid.
1112 (29) The Division of Medicaid may apply for a waiver
1113 from the United States Department of Health and Human Services for
1114 home- and community-based services for developmentally disabled
1115 people using state funds that are provided from the appropriation
1116 to the State Department of Mental Health and/or funds transferred
1117 to the department by a political subdivision or instrumentality of
1118 the state and used to match federal funds under a cooperative
1119 agreement between the division and the department, provided that
1120 funds for these services are specifically appropriated to the
1121 Department of Mental Health and/or transferred to the department
1122 by a political subdivision or instrumentality of the state.

1123 (30) Pediatric skilled nursing services for eligible
1124 persons under twenty-one (21) years of age.
1125 (31) Targeted case management services for children
1126 with special needs, under waivers from the United States
1127 Department of Health and Human Services, using state funds that
1128 are provided from the appropriation to the Mississippi Department
1129 of Human Services and used to match federal funds under a
1130 cooperative agreement between the division and the department.
1131 (32) Care and services provided in Christian Science
1132 Sanatoria listed and certified by the Commission for Accreditation
1133 of Christian Science Nursing Organizations/Facilities, Inc.,
1134 rendered in connection with treatment by prayer or spiritual means
1135 to the extent that those services are subject to reimbursement
1136 under Section 1903 of the federal Social Security Act.
1137 (33) Podiatrist services.
1138 (34) Assisted living services as provided through home-
1139 and community-based services under Title XIX of the federal Social
1140 Security Act, as amended, subject to the availability of funds
1141 specifically appropriated for that purpose by the Legislature.
1142 (35) Services and activities authorized in Sections
1143 43-27-101 and 43-27-103, using state funds that are provided from
1144 the appropriation to the State Department of Human Services and
1145 used to match federal funds under a cooperative agreement between
1146 the division and the department.
1147 (36) Nonemergency transportation services for
1148 Medicaid-eligible persons, to be provided by the Division of
1149 Medicaid. The division may contract with additional entities to
1150 administer nonemergency transportation services as it deems
1151 necessary. All providers shall have a valid driver's license,
1152 vehicle inspection sticker, valid vehicle license tags and a
1153 standard liability insurance policy covering the vehicle. The
1154 division may pay providers a flat fee based on mileage tiers, or
1155 in the alternative, may reimburse on actual miles traveled. The

1156 division may apply to the Center for Medicare and Medicaid
1157 Services (CMS) for a waiver to draw federal matching funds for
1158 nonemergency transportation services as a covered service instead
1159 of an administrative cost.
1160 (37) [Deleted]
1161 (38) Chiropractic services. A chiropractor's manual
1162 manipulation of the spine to correct a subluxation, if x-ray
1163 demonstrates that a subluxation exists and if the subluxation has
1164 resulted in a neuromusculoskeletal condition for which
1165 manipulation is appropriate treatment, and related spinal x-rays
1166 performed to document these conditions. Reimbursement for
1167 chiropractic services shall not exceed Seven Hundred Dollars
1168 ($700.00) per year per beneficiary.
1169 (39) Dually eligible Medicare/Medicaid beneficiaries.
1170 The division shall pay the Medicare deductible and coinsurance
1171 amounts for services available under Medicare, as determined by
1172 the division.
1173 (40) [Deleted]
1174 (41) Services provided by the State Department of
1175 Rehabilitation Services for the care and rehabilitation of persons
1176 with spinal cord injuries or traumatic brain injuries, as allowed
1177 under waivers from the United States Department of Health and
1178 Human Services, using up to seventy-five percent (75%) of the
1179 funds that are appropriated to the Department of Rehabilitation
1180 Services from the Spinal Cord and Head Injury Trust Fund
1181 established under Section 37-33-261 and used to match federal
1182 funds under a cooperative agreement between the division and the
1183 department.
1184 (42) Notwithstanding any other provision in this
1185 article to the contrary, the division may develop a population
1186 health management program for women and children health services
1187 through the age of one (1) year. This program is primarily for
1188 obstetrical care associated with low birth weight and pre-term

1189 babies. The division may apply to the federal Centers for
1190 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
1191 any other waivers that may enhance the program. In order to
1192 effect cost savings, the division may develop a revised payment
1193 methodology that may include at-risk capitated payments, and may
1194 require member participation in accordance with the terms and
1195 conditions of an approved federal waiver.

1196 (43) The division shall provide reimbursement,
1197 according to a payment schedule developed by the division, for
1198 smoking cessation medications for pregnant women during their
1199 pregnancy and other Medicaid-eligible women who are of
1200 child-bearing age.

1201 (44) Nursing facility services for the severely
1202 disabled.

1203 (a) Severe disabilities include, but are not
1204 limited to, spinal cord injuries, closed head injuries and
1205 ventilator dependent patients.

1206 (b) Those services must be provided in a long-term
1207 care nursing facility dedicated to the care and treatment of
1208 persons with severe disabilities, and shall be reimbursed as a
1209 separate category of nursing facilities.

1210 (45) Physician assistant services. Services furnished
1211 by a physician assistant who is licensed by the State Board of
1212 Medical Licensure and is practicing with physician supervision
1213 under regulations adopted by the board, under regulations adopted
1214 by the division. Reimbursement for those services shall not
1215 exceed ninety percent (90%) of the reimbursement rate for
1216 comparable services rendered by a physician.

1217 (46) The division shall make application to the federal
1218 Centers for Medicare and Medicaid Services (CMS) for a waiver to
1219 develop and provide services for children with serious emotional
1220 disturbances as defined in Section 43-14-1(1), which may include
1221 home- and community-based services, case management services or

1222 managed care services through mental health providers certified by
1223 the Department of Mental Health. The division may implement and
1224 provide services under this waivered program only if funds for
1225 these services are specifically appropriated for this purpose by
1226 the Legislature, or if funds are voluntarily provided by affected
1227 agencies.

1228 (47) (a) Notwithstanding any other provision in this
1229 article to the contrary, the division, in conjunction with the
1230 State Department of Health, may develop and implement disease
1231 management programs for individuals with high-cost chronic
1232 diseases and conditions, including the use of grants, waivers,
1233 demonstrations or other projects as necessary.

1234 (b) Participation in any disease management
1235 program implemented under this paragraph (47) is optional with the
1236 individual. An individual must affirmatively elect to participate
1237 in the disease management program in order to participate.

1238 (c) An individual who participates in the disease
1239 management program has the option of participating in the
1240 prescription drug home delivery component of the program at any
1241 time while participating in the program. An individual must
1242 affirmatively elect to participate in the prescription drug home
1243 delivery component in order to participate.

1244 (d) An individual who participates in the disease
1245 management program may elect to discontinue participation in the
1246 program at any time. An individual who participates in the
1247 prescription drug home delivery component may elect to discontinue
1248 participation in the prescription drug home delivery component at
1249 any time.

1250 (e) The division shall send written notice to all
1251 individuals who participate in the disease management program
1252 informing them that they may continue using their local pharmacy
1253 or any other pharmacy of their choice to obtain their prescription
1254 drugs while participating in the program.

1255 (f) Prescription drugs that are provided to
1256 individuals under the prescription drug home delivery component
1257 shall be limited only to those drugs that are used for the
1258 treatment, management or care of asthma, diabetes or hypertension.
1259 (48) Pediatric long-term acute care hospital services.
1260 (a) Pediatric long-term acute care hospital
1261 services means services provided to eligible persons under
1262 twenty-one (21) years of age by a freestanding Medicare-certified
1263 hospital that has an average length of inpatient stay greater than
1264 twenty-five (25) days and that is primarily engaged in providing
1265 chronic or long-term medical care to persons under twenty-one (21)
1266 years of age.
1267 (b) The services under this paragraph (48) shall
1268 be reimbursed as a separate category of hospital services.
1269 (49) The division shall establish co-payments and/or
1270 coinsurance for all Medicaid services for which co-payments and/or
1271 coinsurance are allowable under federal law or regulation, and
1272 shall set the amount of the co-payment and/or coinsurance for each
1273 of those services at the maximum amount allowable under federal
1274 law or regulation.
1275 (50) Services provided by the State Department of
1276 Rehabilitation Services for the care and rehabilitation of persons
1277 who are deaf and blind, as allowed under waivers from the United
1278 States Department of Health and Human Services to provide home-
1279 and community-based services using state funds that are provided
1280 from the appropriation to the State Department of Rehabilitation
1281 Services or if funds are voluntarily provided by another agency.
1282 (51) Upon determination of Medicaid eligibility and in
1283 association with annual redetermination of Medicaid eligibility,
1284 beneficiaries shall be encouraged to undertake a physical
1285 examination that will establish a base-line level of health and
1286 identification of a usual and customary source of care (a medical
1287 home) to aid utilization of disease management tools. This

1288 physical examination and utilization of these disease management
1289 tools shall be consistent with current United States Preventive
1290 Services Task Force or other recognized authority recommendations.
1291 For persons who are determined ineligible for Medicaid, the
1292 division will provide information and direction for accessing
1293 medical care and services in the area of their residence.
1294 (52) Notwithstanding any provisions of this article,
1295 the division may pay enhanced reimbursement fees related to trauma
1296 care, as determined by the division in conjunction with the State
1297 Department of Health, using funds appropriated to the State
1298 Department of Health for trauma care and services and used to
1299 match federal funds under a cooperative agreement between the
1300 division and the State Department of Health. The division, in
1301 conjunction with the State Department of Health, may use grants,
1302 waivers, demonstrations, or other projects as necessary in the
1303 development and implementation of this reimbursement program.
1304 (53) Targeted case management services for high-cost
1305 beneficiaries shall be developed by the division for all services
1306 under this section.
1307 <u>(54) Adult foster care services pilot program. Social</u>
1308 <u>and protective services on a pilot program basis in an approved</u>
1309 <u>foster care facility for vulnerable adults who would otherwise</u>
1310 <u>need care in a long-term care facility, under the Medicaid Waivers</u>
1311 <u>for the Elderly and Disabled program or an assisted living waiver.</u>
1312 <u>The division may use grants, waivers, demonstrations or other</u>
1313 <u>projects as necessary in the development and implementation of</u>
1314 <u>this adult foster care services pilot program.</u>
1315 Notwithstanding any other provision of this article to the
1316 contrary, the division shall reduce the rate of reimbursement to
1317 providers for any service provided under this section by five
1318 percent (5%) of the allowed amount for that service. However, the
1319 reduction in the reimbursement rates required by this paragraph
1320 shall not apply to inpatient hospital services, nursing facility

1321 services, intermediate care facility services, psychiatric
1322 residential treatment facility services, pharmacy services
1323 provided under paragraph (9) of this section, or any service
1324 provided by the University of Mississippi Medical Center or a
1325 state agency, a state facility or a public agency that either
1326 provides its own state match through intergovernmental transfer or
1327 certification of funds to the division, or a service for which the
1328 federal government sets the reimbursement methodology and rate.
1329 In addition, the reduction in the reimbursement rates required by
1330 this paragraph shall not apply to case management services and
1331 home-delivered meals provided under the home- and community-based
1332 services program for the elderly and disabled by a planning and
1333 development district (PDD). Planning and development districts
1334 participating in the home- and community-based services program
1335 for the elderly and disabled as case management providers shall be
1336 reimbursed for case management services at the maximum rate
1337 approved by the Centers for Medicare and Medicaid Services (CMS).
1338 The division may pay to those providers who participate in
1339 and accept patient referrals from the division's emergency room
1340 redirection program a percentage, as determined by the division,
1341 of savings achieved according to the performance measures and
1342 reduction of costs required of that program. Federally qualified
1343 health centers may participate in the emergency room redirection
1344 program, and the division may pay those centers a percentage of
1345 any savings to the Medicaid program achieved by the centers'
1346 accepting patient referrals through the program, as provided in
1347 this paragraph.
1348 Notwithstanding any provision of this article, except as
1349 authorized in the following paragraph and in Section 43-13-139,
1350 neither (a) the limitations on quantity or frequency of use of or
1351 the fees or charges for any of the care or services available to
1352 recipients under this section, nor (b) the payments or rates of
1353 reimbursement to providers rendering care or services authorized

1354 under this section to recipients, may be increased, decreased or
1355 otherwise changed from the levels in effect on July 1, 1999,
1356 unless they are authorized by an amendment to this section by the
1357 Legislature. However, the restriction in this paragraph shall not
1358 prevent the division from changing the payments or rates of
1359 reimbursement to providers without an amendment to this section
1360 whenever those changes are required by federal law or regulation,
1361 or whenever those changes are necessary to correct administrative
1362 errors or omissions in calculating those payments or rates of
1363 reimbursement.

1364 Notwithstanding any provision of this article, no new groups
1365 or categories of recipients and new types of care and services may
1366 be added without enabling legislation from the Mississippi
1367 Legislature, except that the division may authorize those changes
1368 without enabling legislation when the addition of recipients or
1369 services is ordered by a court of proper authority.

1370 The executive director shall keep the Governor advised on a
1371 timely basis of the funds available for expenditure and the
1372 projected expenditures. If current or projected expenditures of
1373 the division are reasonably anticipated to exceed the amount of
1374 funds appropriated to the division for any fiscal year, the
1375 Governor, after consultation with the executive director, shall
1376 discontinue any or all of the payment of the types of care and
1377 services as provided in this section that are deemed to be
1378 optional services under Title XIX of the federal Social Security
1379 Act, as amended, and when necessary, shall institute any other
1380 cost containment measures on any program or programs authorized
1381 under the article to the extent allowed under the federal law
1382 governing that program or programs. However, the Governor shall
1383 not be authorized to discontinue or eliminate any service under
1384 this section that is mandatory under federal law, or to
1385 discontinue or eliminate, or adjust income limits or resource
1386 limits for, any eligibility category or group under Section

1387 43-13-115. It is the intent of the Legislature that the
1388 expenditures of the division during any fiscal year shall not
1389 exceed the amounts appropriated to the division for that fiscal
1390 year.

1391 Notwithstanding any other provision of this article, it shall
1392 be the duty of each nursing facility, intermediate care facility
1393 for the mentally retarded, psychiatric residential treatment
1394 facility, and nursing facility for the severely disabled that is
1395 participating in the Medicaid program to keep and maintain books,
1396 documents and other records as prescribed by the Division of
1397 Medicaid in substantiation of its cost reports for a period of
1398 three (3) years after the date of submission to the Division of
1399 Medicaid of an original cost report, or three (3) years after the
1400 date of submission to the Division of Medicaid of an amended cost
1401 report.

1402 **SECTION 7.** This act shall take effect and be in force from
1403 and after July 1, 2007.

ST: Adult foster care facilities; define for licensure purposes and authorize Medicaid pilot program.