By: Senator(s) Dawkins

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2432

1 AN ACT ENTITLED THE "MISSISSIPPI INDEPENDENCE, DIGNITY AND
2 CHOICE IN LONG-TERM CARE ACT OF 2007" TO SUPPORT CHOICES FOR OLDER
3 ADULTS AND PERSONS WITH DISABILITIES TO LIVE IN THEIR HOMES AND
4 COMMUNITIES; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
5 TO DIRECT THE DIVISION OF MEDICAID, OFFICE OF THE GOVERNOR, TO
6 IMPLEMENT A FUNDING PARITY FORMULA BETWEEN NURSING HOME CARE
7 SERVICES AND HOME- AND COMMUNITY-BASED CARE SERVICES FOR MEDICAID
8 RECIPIENTS; TO PROVIDE FOR AN EXPANSION OF HOME- AND
9 COMMUNITY-BASED SERVICES BY DIVERTING PERSONS IN NEED OF LONG-TERM
10 CARE FROM NURSING HOME PLACEMENT TO HOME- AND COMMUNITY-BASED
11 SERVICES; TO PROVIDE FOR FAST-TRACK MEDICAID ELIGIBILITY
12 DETERMINATIONS AND CLINICAL ASSESSMENT INSTRUCTIONS FOR MEDICAID
13 LONG-TERM CARE EXPENDITURES; TO REQUIRE CERTAIN REPORTS; TO
14 ESTABLISH AND EMPOWER A MEDICAID LONG-TERM CARE FUNDING ADVISORY
15 COUNCIL TO TRACK LONG-TERM CARE EXPENDITURES AND SERVICES; AND FOR
16 RELATED PURPOSES.

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

18 **SECTION 1.** (1) This act shall be known and may be cited as
19 the "Mississippi Independence, Dignity and Choice in Long-Term
20 Care Act of 2007."

21 (2) The Legislature finds and declares that:

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

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

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

34 (d) Mississippi has been striving to redirect long-term
35 care away from an over-reliance on institutional care toward more
36 home- and community-based options; however, it is still often
37 easier for older adults and persons with disabilities to qualify
38 for Medicaid long-term care coverage if they are admitted to a
39 nursing home than if they seek to obtain services through one (1)
40 of the Medicaid home- and community-based long-term care options
41 available in this state, such as the Community Care Program for
42 the Elderly and Disabled, Assisted Living, Adult Family Care,
43 Caregiver Assistance Program, Adult Day Health Services, Traumatic
44 Brain Injury, AIDS Community Care Alternatives Program, Community
45 Resources for People with Disabilities, or Community Resources for
46 People with Disabilities Private Duty Nursing;
47 (e) The federal "New Freedom Initiative" was launched
48 in 2001 for the purpose of promoting the goal of independent
49 living for persons with disabilities; and Executive Order No.
50 13217, issued by the President of the United States on June 18,
51 2001, called upon the federal government to assist states and
52 localities to swiftly implement the 1999 United States Supreme
53 Court decision in *Olmstead v. L.C.* and directed federal agencies
54 to evaluate their policies, programs, statutes and regulations to
55 determine whether any should be revised or modified to improve the
56 availability of home- and community-based services for qualified
57 persons with disabilities;
58 (f) Older adults and those with physical disabilities
59 or Alzheimer's disease and related disorders that require a
60 nursing facility level of care should not be forced to choose
61 between going into a nursing home or giving up the medical
62 assistance that pays for their needed services, and thereby be
63 denied the right to choose where they receive those services;
64 their eligibility for home- and community-based long-term care
65 services under Medicaid should be based upon the same income and

66 asset standards as those used to determine eligibility for
67 long-term care in an institutional setting; and
68 (g) The enactment of this act will ensure that, in the
69 case of Medicaid-funded long-term care services, "the money
70 follows the person" from nursing homes to home- and
71 community-based settings when it does not compromise federal
72 funding or services in the nursing home and, in so doing,
73 significantly expands the choices available to consumers of these
74 services and thereby fulfills the goal of personal independence so
75 highly valued by the growing number of older adults and persons
76 with disabilities in this state.
77 (3) As used in this act:
78 (a) "Home- and community-based services" means Medicaid
79 home- and community-based long-term care options available in this
80 State, including, but not limited to, the Community Care Program
81 for the Elderly and Disabled, Assisted Living, Adult Family Care,
82 Caregiver Assistance Program, Adult Day Health Services, Traumatic
83 Brain Injury, AIDS Community Care Alternatives Program, Community
84 Resources for People with Disabilities, and Community Resources
85 for People with Disabilities Private Duty Nursing.
86 (b) "Funding parity between nursing home care and home-
87 and community-based care" means that the distribution of the
88 amounts expended for these two (2) categories of long-term care
89 under the Medicaid program reflects an appropriate balance between
90 the service delivery costs of those persons whose needs and
91 preferences can most appropriately be met in a nursing home and
92 those persons whose needs and preferences can most appropriately
93 be met in a home- or community-based setting.
94 **SECTION 2.** Section 43-13-117, Mississippi Code of 1972, is
95 amended as follows:
96 43-13-117. Medicaid as authorized by this article shall
97 include payment of part or all of the costs, at the discretion of
98 the division, with approval of the Governor, of the following

99 types of care and services rendered to eligible applicants who
100 have been determined to be eligible for that care and services,
101 within the limits of state appropriations and federal matching
102 funds:
103 (1) Inpatient hospital services.
104 (a) The division shall allow thirty (30) days of
105 inpatient hospital care annually for all Medicaid recipients.
106 Precertification of inpatient days must be obtained as required by
107 the division. The division may allow unlimited days in
108 disproportionate hospitals as defined by the division for eligible
109 infants and children under the age of six (6) years if certified
110 as medically necessary as required by the division.
111 (b) From and after July 1, 1994, the Executive
112 Director of the Division of Medicaid shall amend the Mississippi
113 Title XIX Inpatient Hospital Reimbursement Plan to remove the
114 occupancy rate penalty from the calculation of the Medicaid
115 Capital Cost Component utilized to determine total hospital costs
116 allocated to the Medicaid program.
117 (c) Hospitals will receive an additional payment
118 for the implantable programmable baclofen drug pump used to treat
119 spasticity that is implanted on an inpatient basis. The payment
120 pursuant to written invoice will be in addition to the facility's
121 per diem reimbursement and will represent a reduction of costs on
122 the facility's annual cost report, and shall not exceed Ten
123 Thousand Dollars ($10,000.00) per year per recipient.
124 (2) Outpatient hospital services.
125 (a) Emergency services. The division shall allow
126 six (6) medically necessary emergency room visits per beneficiary
127 per fiscal year.
128 (b) Other outpatient hospital services. The
129 division shall allow benefits for other medically necessary
130 outpatient hospital services (such as chemotherapy, radiation,
131 surgery and therapy). Where the same services are reimbursed as

132 clinic services, the division may revise the rate or methodology
133 of outpatient reimbursement to maintain consistency, efficiency,
134 economy and quality of care.

135 (3) Laboratory and x-ray services.

136 (4) Nursing facility services.

137 (a) The division shall make full payment to
138 nursing facilities for each day, not exceeding fifty-two (52) days
139 per year, that a patient is absent from the facility on home
140 leave. Payment may be made for the following home leave days in
141 addition to the fifty-two-day limitation: Christmas, the day
142 before Christmas, the day after Christmas, Thanksgiving, the day
143 before Thanksgiving and the day after Thanksgiving.

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

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

159 (d) When a facility of a category that does not
160 require a certificate of need for construction and that could not
161 be eligible for Medicaid reimbursement is constructed to nursing
162 facility specifications for licensure and certification, and the
163 facility is subsequently converted to a nursing facility under a
164 certificate of need that authorizes conversion only and the

165 applicant for the certificate of need was assessed an application
166 review fee based on capital expenditures incurred in constructing
167 the facility, the division shall allow reimbursement for capital
168 expenditures necessary for construction of the facility that were
169 incurred within the twenty-four (24) consecutive calendar months
170 immediately preceding the date that the certificate of need
171 authorizing the conversion was issued, to the same extent that
172 reimbursement would be allowed for construction of a new nursing
173 facility under a certificate of need that authorizes that
174 construction. The reimbursement authorized in this subparagraph
175 (d) may be made only to facilities the construction of which was
176 completed after June 30, 1989. Before the division shall be
177 authorized to make the reimbursement authorized in this
178 subparagraph (d), the division first must have received approval
179 from the Centers for Medicare and Medicaid Services (CMS) of the
180 change in the state Medicaid plan providing for the reimbursement.
181 (e) The division shall develop and implement, not
182 later than January 1, 2001, a case-mix payment add-on determined
183 by time studies and other valid statistical data that will
184 reimburse a nursing facility for the additional cost of caring for
185 a resident who has a diagnosis of Alzheimer's or other related
186 dementia and exhibits symptoms that require special care. Any
187 such case-mix add-on payment shall be supported by a determination
188 of additional cost. The division shall also develop and implement
189 as part of the fair rental reimbursement system for nursing
190 facility beds, an Alzheimer's resident bed depreciation enhanced
191 reimbursement system that will provide an incentive to encourage
192 nursing facilities to convert or construct beds for residents with
193 Alzheimer's or other related dementia.
194 (f) The division shall develop and implement an
195 assessment process for long-term care services. The division may
196 provide the assessment and related functions directly or through
197 contract with the area agencies on aging.

198 The division shall apply for necessary federal waivers to
199 assure that additional services providing alternatives to nursing
200 facility care are made available to applicants for nursing
201 facility care.
202 (5) Periodic screening and diagnostic services for
203 individuals under age twenty-one (21) years as are needed to
204 identify physical and mental defects and to provide health care
205 treatment and other measures designed to correct or ameliorate
206 defects and physical and mental illness and conditions discovered
207 by the screening services, regardless of whether these services
208 are included in the state plan. The division may include in its
209 periodic screening and diagnostic program those discretionary
210 services authorized under the federal regulations adopted to
211 implement Title XIX of the federal Social Security Act, as
212 amended. The division, in obtaining physical therapy services,
213 occupational therapy services, and services for individuals with
214 speech, hearing and language disorders, may enter into a
215 cooperative agreement with the State Department of Education for
216 the provision of those services to handicapped students by public
217 school districts using state funds that are provided from the
218 appropriation to the Department of Education to obtain federal
219 matching funds through the division. The division, in obtaining
220 medical and psychological evaluations for children in the custody
221 of the State Department of Human Services may enter into a
222 cooperative agreement with the State Department of Human Services
223 for the provision of those services using state funds that are
224 provided from the appropriation to the Department of Human
225 Services to obtain federal matching funds through the division.
226 (6) Physician's services. The division shall allow
227 twelve (12) physician visits annually. All fees for physicians'
228 services that are covered only by Medicaid shall be reimbursed at
229 ninety percent (90%) of the rate established on January 1, 1999,
230 and as may be adjusted each July thereafter, under Medicare (Title

231 XVIII of the federal Social Security Act, as amended). The
232 division may develop and implement a different reimbursement model
233 or schedule for physician's services provided by physicians based
234 at an academic health care center and by physicians at rural
235 health centers that are associated with an academic health care
236 center.

237 (7) (a) Home health services for eligible persons, not
238 to exceed in cost the prevailing cost of nursing facility
239 services, not to exceed twenty-five (25) visits per year. All
240 home health visits must be precertified as required by the
241 division.

242 (b) Repealed.

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

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

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

260 The division may seek to establish relationships with other
261 states in order to lower acquisition costs of prescription drugs
262 to include single source and innovator multiple source drugs or
263 generic drugs. In addition, if allowed by federal law or

264 regulation, the division may seek to establish relationships with
265 and negotiate with other countries to facilitate the acquisition
266 of prescription drugs to include single source and innovator
267 multiple source drugs or generic drugs, if that will lower the
268 acquisition costs of those prescription drugs.
269 The division shall allow for a combination of prescriptions
270 for single source and innovator multiple source drugs and generic
271 drugs to meet the needs of the beneficiaries, not to exceed five
272 (5) prescriptions per month for each noninstitutionalized Medicaid
273 beneficiary, with not more than two (2) of those prescriptions
274 being for single source or innovator multiple source drugs.
275 The executive director may approve specific maintenance drugs
276 for beneficiaries with certain medical conditions, which may be
277 prescribed and dispensed in three-month supply increments. The
278 executive director may allow a state agency or agencies to be the
279 sole source purchaser and distributor of hemophilia factor
280 medications, HIV/AIDS medications and other medications as
281 determined by the executive director as allowed by federal
282 regulations.
283 Drugs prescribed for a resident of a psychiatric residential
284 treatment facility must be provided in true unit doses when
285 available. The division may require that drugs not covered by
286 Medicare Part D for a resident of a long-term care facility be
287 provided in true unit doses when available. Those drugs that were
288 originally billed to the division but are not used by a resident
289 in any of those facilities shall be returned to the billing
290 pharmacy for credit to the division, in accordance with the
291 guidelines of the State Board of Pharmacy and any requirements of
292 federal law and regulation. Drugs shall be dispensed to a
293 recipient and only one (1) dispensing fee per month may be
294 charged. The division shall develop a methodology for reimbursing
295 for restocked drugs, which shall include a restock fee as

296 determined by the division not exceeding Seven Dollars and
297 Eighty-two Cents ($7.82).

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

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

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

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

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

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

327 Notwithstanding any law or regulation, information obtained
328 or maintained by the division regarding the prescription drug

329 program, including trade secrets and manufacturer or labeler
330 pricing, is confidential and not subject to disclosure except to
331 other state agencies.
332 (b) Payment by the division for covered
333 multisource drugs shall be limited to the lower of the upper
334 limits established and published by the Centers for Medicare and
335 Medicaid Services (CMS) plus a dispensing fee, or the estimated
336 acquisition cost (EAC) as determined by the division, plus a
337 dispensing fee, or the providers' usual and customary charge to
338 the general public.
339 Payment for other covered drugs, other than multisource drugs
340 with CMS upper limits, shall not exceed the lower of the estimated
341 acquisition cost as determined by the division, plus a dispensing
342 fee or the providers' usual and customary charge to the general
343 public.
344 Payment for nonlegend or over-the-counter drugs covered by
345 the division shall be reimbursed at the lower of the division's
346 estimated shelf price or the providers' usual and customary charge
347 to the general public.
348 The dispensing fee for each new or refill prescription,
349 including nonlegend or over-the-counter drugs covered by the
350 division, shall be not less than Three Dollars and Ninety-one
351 Cents ($3.91), as determined by the division.
352 The division shall not reimburse for single source or
353 innovator multiple source drugs if there are equally effective
354 generic equivalents available and if the generic equivalents are
355 the least expensive.
356 It is the intent of the Legislature that the pharmacists
357 providers be reimbursed for the reasonable costs of filling and
358 dispensing prescriptions for Medicaid beneficiaries.
359 (10) Dental care that is an adjunct to treatment of an
360 acute medical or surgical condition; services of oral surgeons and
361 dentists in connection with surgery related to the jaw or any

362 structure contiguous to the jaw or the reduction of any fracture
363 of the jaw or any facial bone; and emergency dental extractions
364 and treatment related thereto. On July 1, 1999, all fees for
365 dental care and surgery under authority of this paragraph (10)
366 shall be increased to one hundred sixty percent (160%) of the
367 amount of the reimbursement rate that was in effect on June 30,
368 1999. It is the intent of the Legislature to encourage more
369 dentists to participate in the Medicaid program.

370 (11) Eyeglasses for all Medicaid beneficiaries who have
371 (a) had surgery on the eyeball or ocular muscle that results in a
372 vision change for which eyeglasses or a change in eyeglasses is
373 medically indicated within six (6) months of the surgery and is in
374 accordance with policies established by the division, or (b) one
375 (1) pair every five (5) years and in accordance with policies
376 established by the division. In either instance, the eyeglasses
377 must be prescribed by a physician skilled in diseases of the eye
378 or an optometrist, whichever the beneficiary may select.

379 (12) Intermediate care facility services.

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

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

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

394 (14) Clinic services. Such diagnostic, preventive,
395 therapeutic, rehabilitative or palliative services furnished to an
396 outpatient by or under the supervision of a physician or dentist
397 in a facility that is not a part of a hospital but that is
398 organized and operated to provide medical care to outpatients.
399 Clinic services shall include any services reimbursed as
400 outpatient hospital services that may be rendered in such a
401 facility, including those that become so after July 1, 1991. On
402 July 1, 1999, all fees for physicians' services reimbursed under
403 authority of this paragraph (14) shall be reimbursed at ninety
404 percent (90%) of the rate established on January 1, 1999, and as
405 may be adjusted each July thereafter, under Medicare (Title XVIII
406 of the federal Social Security Act, as amended). The division may
407 develop and implement a different reimbursement model or schedule
408 for physician's services provided by physicians based at an
409 academic health care center and by physicians at rural health
410 centers that are associated with an academic health care center.
411 On July 1, 1999, all fees for dentists' services reimbursed under
412 authority of this paragraph (14) shall be increased to one hundred
413 sixty percent (160%) of the amount of the reimbursement rate that
414 was in effect on June 30, 1999.
415 (15) Home- and community-based services for the elderly
416 and disabled, as provided under Title XIX of the federal Social
417 Security Act, as amended, under waivers, subject to the
418 availability of funds specifically appropriated for that purpose
419 by the Legislature.
420 (a) "Home- and community-based services" means
421 Medicaid home- and community-based long-term care options
422 available in this state, including, but not limited to, the
423 Community Care Program for the Elderly and Disabled, Assisted
424 Living, Adult Family Care, Caregiver Assistance Program, Adult Day
425 Health Services, Traumatic Brain Injury, AIDS Community Care
426 Alternatives Program, Community Resources for People with

427 Disabilities, and Community Resources for People with Disabilities
428 Private Duty Nursing.
429 (b) Beginning in fiscal year 2008, and in each
430 succeeding fiscal year through fiscal year 2013, the division
431 shall implement a process that rebalances the overall allocation
432 of Medicaid funding for long-term care services through the
433 expansion of home- and community-based services for persons
434 eligible for long-term care as defined by regulation of the
435 division. The expansion of home- and community-based services
436 shall be funded, within the existing level of appropriations, by
437 diverting persons in need of long-term care from nursing home
438 placements to home- and community-based services.
439 (c) Beginning in fiscal year 2008, and in each
440 succeeding fiscal year through fiscal year 2013, funds equal to
441 the amount of the reduction in the projected growth of Medicaid
442 expenditures for nursing home care pursuant to subparagraph (b) of
443 this paragraph (15), for state dollars only plus the percentage
444 anticipated for programs and persons that will receive federal
445 matching dollars, shall be reallocated to home- and
446 community-based care and expended solely for such care, until the
447 executive director of the division determines that total Medicaid
448 expenditures for long-term care have been sufficiently rebalanced
449 to achieve funding parity between nursing home care and home- and
450 community-based care. "Funding parity between nursing home care
451 and home- and community-based care" means that the distribution of
452 the amounts expended for these two (2) categories of long-term
453 care under the Medicaid program reflects an appropriate balance
454 between the service delivery costs of those persons whose needs
455 and preferences can most appropriately be met in a nursing home
456 and those persons whose needs and preferences can most
457 appropriately be met in a home- or community-based setting.
458 (d) Subject to federal approval, the home- and
459 community-based services to which funds are reallocated pursuant

460 to this act shall include services provided under the Medicaid
461 Enhanced Community Options and Assisted Living Waivers.
462 (e) Notwithstanding the provisions of this
463 subparagraph to the contrary, this act shall not be construed to
464 authorize a reduction in funding for Medicaid-approved services
465 based upon the approved state Medicaid nursing home reimbursement
466 methodology, including existing cost screens used to determine
467 daily rates, annual rebasing and inflationary adjustments.
468 (f) The division shall adopt modifications to the
469 Medicaid long-term care intake system that promote increased use
470 of home- and community-based services. These modifications shall
471 include, but not be limited to, the following: Commencing July 1,
472 2007, the provision of home- and community-based services
473 available under Medicaid, in addition to care management services,
474 pending completion of a formal Medicaid financial eligibility
475 determination for the recipient of services, for a period that
476 does not exceed a time limit established by the division; except
477 that the cost of any services provided pursuant to this
478 subparagraph to a person who is subsequently determined to be
479 ineligible for Medicaid may be recovered from that person; and the
480 use of mechanisms for making fast-track Medicaid eligibility
481 determinations, a revised clinical assessment instrument, and a
482 computerized tracking system for Medicaid long-term care
483 expenditures.
484 (g) The division, in consultation with the
485 Medicaid Long-Term Care Funding Advisory Council established
486 pursuant to this act, shall:
487 (i) No later than September 1, 2007, present
488 a report to the Governor and the Legislature that provides a
489 detailed budget and management plan for effectuating the purposes
490 of this act, including a projected schedule and procedures for the
491 implementation and operation of the Medicaid long-term care
492 expenditure reforms required pursuant thereto; and

493 (ii) No later than January 1, 2008, present a
494 report to the Governor and the Legislature that documents the
495 reallocation of funds to home- and community-based care pursuant
496 to subparagraph (b) of this paragraph (15), and present an updated
497 report no later than January 1 of each succeeding year until the
498 division determines that total Medicaid expenditures for long-term
499 care have been sufficiently rebalanced to achieve funding parity
500 between nursing home care and home- and community-based care, at
501 which point the division shall document and certify to the
502 Governor and the Legislature that such funding parity has been
503 achieved.
504 (h) The division, in consultation with the
505 Medicaid Long-Term Care Funding Advisory Council established
506 pursuant to this act, shall:
507 (i) Implement, by such time as the division
508 certifies to the Governor and the Legislature that funding parity
509 has been achieved pursuant to subparagraph (g), a comprehensive
510 data system to track long-term care expenditures and services and
511 consumer profiles and preferences. The data system shall include,
512 but not be limited to: the number of vacant nursing home beds
513 annually and the number of nursing home residents transferred to
514 home- and community-based care pursuant to this act; annual
515 long-term care expenditures for nursing home care and each of the
516 home- and community-based long-term care options available to
517 Medicaid recipients; and annual percentage changes in both
518 long-term care expenditures for, and the number of Medicaid
519 recipients utilizing, nursing home care and each of the home- and
520 community-based long-term care options, respectively;
521 (ii) Complete the following no later than
522 January 1, 2008:
523 1. Implement a system of statewide
524 long-term care service coordination and management designed to
525 minimize administrative costs, improve access to services, and

526 minimize obstacles to the delivery of long-term care services to
527 people in need;
528 2. Identify home- and community-based
529 long-term care service models that are determined by the division
530 to be efficient and cost-effective alternatives to nursing home
531 care, and develop clear and concise performance standards for
532 those services for which standards are not already available in a
533 home- and community-based services waiver;
534 3. Develop and implement a comprehensive
535 consumer assessment instrument that is designed to facilitate an
536 expedited process to authorize the provision of home- and
537 community-based care to a person through presumptive eligibility
538 prior to completion of a formal financial eligibility
539 determination; and
540 4. Develop and implement a comprehensive
541 quality assurance system with appropriate and regular assessments
542 that is designed to ensure that all forms of long-term care
543 available to consumers in this state are financially viable,
544 cost-effective, and promote and sustain consumer independence; and
545 (iii) Seek to make information available to
546 the general public on a statewide basis, through print and
547 electronic media, regarding the various forms of long-term care
548 available in this state and the rights accorded to long-term care
549 consumers by statute and regulation, as well as information about
550 public and nonprofit agencies and organizations that provide
551 informational and advocacy services to assist long-term care
552 consumers and their families.
553 (i) There is established the Medicaid Long-Term
554 Care Funding Advisory Council within the Division of Medicaid.
555 The advisory council shall meet at least quarterly during each
556 fiscal year until such time as the commissioner certifies to the
557 Governor and the Legislature that funding parity has been achieved
558 pursuant to subparagraph (g)(ii), and shall be entitled to receive

559 such information from the Department of Human Services and the
560 Treasury as the advisory council deems necessary to carry out its
561 responsibilities under this act.
562 The advisory council shall monitor and assess, and advise the
563 division on, the implementation and operation of the Medicaid
564 long-term care expenditure reforms and other provisions of this
565 act; and develop recommendations for a program to recruit and
566 train a stable workforce of home care providers, including
567 recommendations for changes to provider reimbursement under
568 Medicaid home- and community-based care programs.
569 The advisory council shall comprise thirteen (13) members as
570 follows:
571 (i) The Executive Director of the Division of
572 Medicaid and the State Treasurer, or their designees, as ex
573 officio members; and
574 (ii) Eight (8) public members to be appointed
575 by the Governor as follows: one (1) person appointed upon the
576 recommendation of AARP; one (1) person upon the recommendation of
577 the Mississippi Association of Area Agencies on Aging; one (1)
578 person upon the recommendation of the Mississippi Coalition for
579 the Disabled; one (1) person upon the recommendation of the
580 Medical Association of Mississippi; one (1) person upon the
581 recommendation of the Mississippi Hospital Association; one (1)
582 person that represents home- and community-based health care
583 workers; and one (1) person who is a representative of the home
584 care industry.
585 The advisory council shall organize as soon as possible after
586 the appointment of its members, and shall annually select from its
587 membership a chairman who shall serve until his successor is
588 elected and qualifies. The members shall also select a secretary
589 who need not be a member of the advisory council.

590 The division shall provide such staff and administrative
591 support to the advisory council as it requires to carry out its
592 responsibilities.
593 (j) The division shall apply to the federal
594 Centers for Medicare and Medicaid Services for any waiver of
595 federal requirements, or for any state plan amendments or home-
596 and community-based services waiver amendments, which may be
597 necessary to obtain federal financial participation for state
598 Medicaid expenditures in order to effectuate the purposes of this
599 act.
600 (16) Mental health services. Approved therapeutic and
601 case management services (a) provided by an approved regional
602 mental health/retardation center established under Sections
603 41-19-31 through 41-19-39, or by another community mental health
604 service provider meeting the requirements of the Department of
605 Mental Health to be an approved mental health/retardation center
606 if determined necessary by the Department of Mental Health, using
607 state funds that are provided from the appropriation to the State
608 Department of Mental Health and/or funds transferred to the
609 department by a political subdivision or instrumentality of the
610 state and used to match federal funds under a cooperative
611 agreement between the division and the department, or (b) provided
612 by a facility that is certified by the State Department of Mental
613 Health to provide therapeutic and case management services, to be
614 reimbursed on a fee for service basis, or (c) provided in the
615 community by a facility or program operated by the Department of
616 Mental Health. Any such services provided by a facility described
617 in subparagraph (b) must have the prior approval of the division
618 to be reimbursable under this section. After June 30, 1997,
619 mental health services provided by regional mental
620 health/retardation centers established under Sections 41-19-31
621 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
622 and/or their subsidiaries and divisions, or by psychiatric

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

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

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

647 (b) The division shall establish a Medicare Upper
648 Payment Limits Program, as defined in Section 1902(a)(30) of the
649 federal Social Security Act and any applicable federal
650 regulations, for hospitals, and may establish a Medicare Upper
651 Payments Limits Program for nursing facilities. The division
652 shall assess each hospital and, if the program is established for
653 nursing facilities, shall assess each nursing facility, based on
654 Medicaid utilization or other appropriate method consistent with
655 federal regulations. The assessment will remain in effect as long

656 as the state participates in the Medicare Upper Payment Limits
657 Program. The division shall make additional reimbursement to
658 hospitals and, if the program is established for nursing
659 facilities, shall make additional reimbursement to nursing
660 facilities, for the Medicare Upper Payment Limits, as defined in
661 Section 1902(a)(30) of the federal Social Security Act and any
662 applicable federal regulations.
663 (19) (a) Perinatal risk management services. The
664 division shall promulgate regulations to be effective from and
665 after October 1, 1988, to establish a comprehensive perinatal
666 system for risk assessment of all pregnant and infant Medicaid
667 recipients and for management, education and follow-up for those
668 who are determined to be at risk. Services to be performed
669 include case management, nutrition assessment/counseling,
670 psychosocial assessment/counseling and health education.
671 (b) Early intervention system services. The
672 division shall cooperate with the State Department of Health,
673 acting as lead agency, in the development and implementation of a
674 statewide system of delivery of early intervention services, under
675 Part C of the Individuals with Disabilities Education Act (IDEA).
676 The State Department of Health shall certify annually in writing
677 to the executive director of the division the dollar amount of
678 state early intervention funds available that will be utilized as
679 a certified match for Medicaid matching funds. Those funds then
680 shall be used to provide expanded targeted case management
681 services for Medicaid eligible children with special needs who are
682 eligible for the state's early intervention system.
683 Qualifications for persons providing service coordination shall be
684 determined by the State Department of Health and the Division of
685 Medicaid.
686 (20) Home- and community-based services for physically
687 disabled approved services as allowed by a waiver from the United
688 States Department of Health and Human Services for home- and

689 community-based services for physically disabled people using
690 state funds that are provided from the appropriation to the State
691 Department of Rehabilitation Services and used to match federal
692 funds under a cooperative agreement between the division and the
693 department, provided that funds for these services are
694 specifically appropriated to the Department of Rehabilitation
695 Services.

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

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

711 (23) Inpatient psychiatric services. Inpatient
712 psychiatric services to be determined by the division for
713 recipients under age twenty-one (21) that are provided under the
714 direction of a physician in an inpatient program in a licensed
715 acute care psychiatric facility or in a licensed psychiatric
716 residential treatment facility, before the recipient reaches age
717 twenty-one (21) or, if the recipient was receiving the services
718 immediately before he or she reached age twenty-one (21), before
719 the earlier of the date he or she no longer requires the services
720 or the date he or she reaches age twenty-two (22), as provided by
721 federal regulations. Precertification of inpatient days and

722 residential treatment days must be obtained as required by the
723 division.

724 (24) [Deleted]

725 (25) [Deleted]

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

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

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

744 (29) The Division of Medicaid may apply for a waiver
745 from the United States Department of Health and Human Services for
746 home- and community-based services for developmentally disabled
747 people using state funds that are provided from the appropriation
748 to the State Department of Mental Health and/or funds transferred
749 to the department by a political subdivision or instrumentality of
750 the state and used to match federal funds under a cooperative
751 agreement between the division and the department, provided that
752 funds for these services are specifically appropriated to the
753 Department of Mental Health and/or transferred to the department
754 by a political subdivision or instrumentality of the state.

755 (30) Pediatric skilled nursing services for eligible
756 persons under twenty-one (21) years of age.
757 (31) Targeted case management services for children
758 with special needs, under waivers from the United States
759 Department of Health and Human Services, using state funds that
760 are provided from the appropriation to the Mississippi Department
761 of Human Services and used to match federal funds under a
762 cooperative agreement between the division and the department.
763 (32) Care and services provided in Christian Science
764 Sanatoria listed and certified by the Commission for Accreditation
765 of Christian Science Nursing Organizations/Facilities, Inc.,
766 rendered in connection with treatment by prayer or spiritual means
767 to the extent that those services are subject to reimbursement
768 under Section 1903 of the federal Social Security Act.
769 (33) Podiatrist services.
770 (34) Assisted living services as provided through home-
771 and community-based services under Title XIX of the federal Social
772 Security Act, as amended, subject to the availability of funds
773 specifically appropriated for that purpose by the Legislature.
774 (35) Services and activities authorized in Sections
775 43-27-101 and 43-27-103, using state funds that are provided from
776 the appropriation to the State Department of Human Services and
777 used to match federal funds under a cooperative agreement between
778 the division and the department.
779 (36) Nonemergency transportation services for
780 Medicaid-eligible persons, to be provided by the Division of
781 Medicaid. The division may contract with additional entities to
782 administer nonemergency transportation services as it deems
783 necessary. All providers shall have a valid driver's license,
784 vehicle inspection sticker, valid vehicle license tags and a
785 standard liability insurance policy covering the vehicle. The
786 division may pay providers a flat fee based on mileage tiers, or
787 in the alternative, may reimburse on actual miles traveled. The

788 division may apply to the Center for Medicare and Medicaid
789 Services (CMS) for a waiver to draw federal matching funds for
790 nonemergency transportation services as a covered service instead
791 of an administrative cost.

792 (37) [Deleted]

793 (38) Chiropractic services. A chiropractor's manual
794 manipulation of the spine to correct a subluxation, if x-ray
795 demonstrates that a subluxation exists and if the subluxation has
796 resulted in a neuromusculoskeletal condition for which
797 manipulation is appropriate treatment, and related spinal x-rays
798 performed to document these conditions. Reimbursement for
799 chiropractic services shall not exceed Seven Hundred Dollars
800 ($700.00) per year per beneficiary.

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

805 (40) [Deleted]

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

816 (42) Notwithstanding any other provision in this
817 article to the contrary, the division may develop a population
818 health management program for women and children health services
819 through the age of one (1) year. This program is primarily for
820 obstetrical care associated with low birth weight and pre-term

821 babies. The division may apply to the federal Centers for
822 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
823 any other waivers that may enhance the program. In order to
824 effect cost savings, the division may develop a revised payment
825 methodology that may include at-risk capitated payments, and may
826 require member participation in accordance with the terms and
827 conditions of an approved federal waiver.
828 (43) The division shall provide reimbursement,
829 according to a payment schedule developed by the division, for
830 smoking cessation medications for pregnant women during their
831 pregnancy and other Medicaid-eligible women who are of
832 child-bearing age.
833 (44) Nursing facility services for the severely
834 disabled.
835 (a) Severe disabilities include, but are not
836 limited to, spinal cord injuries, closed head injuries and
837 ventilator dependent patients.
838 (b) Those services must be provided in a long-term
839 care nursing facility dedicated to the care and treatment of
840 persons with severe disabilities, and shall be reimbursed as a
841 separate category of nursing facilities.
842 (45) Physician assistant services. Services furnished
843 by a physician assistant who is licensed by the State Board of
844 Medical Licensure and is practicing with physician supervision
845 under regulations adopted by the board, under regulations adopted
846 by the division. Reimbursement for those services shall not
847 exceed ninety percent (90%) of the reimbursement rate for
848 comparable services rendered by a physician.
849 (46) The division shall make application to the federal
850 Centers for Medicare and Medicaid Services (CMS) for a waiver to
851 develop and provide services for children with serious emotional
852 disturbances as defined in Section 43-14-1(1), which may include
853 home- and community-based services, case management services or

854 managed care services through mental health providers certified by
855 the Department of Mental Health. The division may implement and
856 provide services under this waivered program only if funds for
857 these services are specifically appropriated for this purpose by
858 the Legislature, or if funds are voluntarily provided by affected
859 agencies.

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

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

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

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

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

887 (f) Prescription drugs that are provided to
888 individuals under the prescription drug home delivery component
889 shall be limited only to those drugs that are used for the
890 treatment, management or care of asthma, diabetes or hypertension.
891 (48) Pediatric long-term acute care hospital services.
892 (a) Pediatric long-term acute care hospital
893 services means services provided to eligible persons under
894 twenty-one (21) years of age by a freestanding Medicare-certified
895 hospital that has an average length of inpatient stay greater than
896 twenty-five (25) days and that is primarily engaged in providing
897 chronic or long-term medical care to persons under twenty-one (21)
898 years of age.
899 (b) The services under this paragraph (48) shall
900 be reimbursed as a separate category of hospital services.
901 (49) The division shall establish co-payments and/or
902 coinsurance for all Medicaid services for which co-payments and/or
903 coinsurance are allowable under federal law or regulation, and
904 shall set the amount of the co-payment and/or coinsurance for each
905 of those services at the maximum amount allowable under federal
906 law or regulation.
907 (50) Services provided by the State Department of
908 Rehabilitation Services for the care and rehabilitation of persons
909 who are deaf and blind, as allowed under waivers from the United
910 States Department of Health and Human Services to provide home-
911 and community-based services using state funds that are provided
912 from the appropriation to the State Department of Rehabilitation
913 Services or if funds are voluntarily provided by another agency.
914 (51) Upon determination of Medicaid eligibility and in
915 association with annual redetermination of Medicaid eligibility,
916 beneficiaries shall be encouraged to undertake a physical
917 examination that will establish a base-line level of health and
918 identification of a usual and customary source of care (a medical
919 home) to aid utilization of disease management tools. This

920 physical examination and utilization of these disease management
921 tools shall be consistent with current United States Preventive
922 Services Task Force or other recognized authority recommendations.
923 For persons who are determined ineligible for Medicaid, the
924 division will provide information and direction for accessing
925 medical care and services in the area of their residence.
926 (52) Notwithstanding any provisions of this article,
927 the division may pay enhanced reimbursement fees related to trauma
928 care, as determined by the division in conjunction with the State
929 Department of Health, using funds appropriated to the State
930 Department of Health for trauma care and services and used to
931 match federal funds under a cooperative agreement between the
932 division and the State Department of Health. The division, in
933 conjunction with the State Department of Health, may use grants,
934 waivers, demonstrations, or other projects as necessary in the
935 development and implementation of this reimbursement program.
936 (53) Targeted case management services for high-cost
937 beneficiaries shall be developed by the division for all services
938 under this section.
939 Notwithstanding any other provision of this article to the
940 contrary, the division shall reduce the rate of reimbursement to
941 providers for any service provided under this section by five
942 percent (5%) of the allowed amount for that service. However, the
943 reduction in the reimbursement rates required by this paragraph
944 shall not apply to inpatient hospital services, nursing facility
945 services, intermediate care facility services, psychiatric
946 residential treatment facility services, pharmacy services
947 provided under paragraph (9) of this section, or any service
948 provided by the University of Mississippi Medical Center or a
949 state agency, a state facility or a public agency that either
950 provides its own state match through intergovernmental transfer or
951 certification of funds to the division, or a service for which the
952 federal government sets the reimbursement methodology and rate.

953 In addition, the reduction in the reimbursement rates required by
954 this paragraph shall not apply to case management services and
955 home-delivered meals provided under the home- and community-based
956 services program for the elderly and disabled by a planning and
957 development district (PDD). Planning and development districts
958 participating in the home- and community-based services program
959 for the elderly and disabled as case management providers shall be
960 reimbursed for case management services at the maximum rate
961 approved by the Centers for Medicare and Medicaid Services (CMS).
962 The division may pay to those providers who participate in
963 and accept patient referrals from the division's emergency room
964 redirection program a percentage, as determined by the division,
965 of savings achieved according to the performance measures and
966 reduction of costs required of that program. Federally qualified
967 health centers may participate in the emergency room redirection
968 program, and the division may pay those centers a percentage of
969 any savings to the Medicaid program achieved by the centers'
970 accepting patient referrals through the program, as provided in
971 this paragraph.
972 Notwithstanding any provision of this article, except as
973 authorized in the following paragraph and in Section 43-13-139,
974 neither (a) the limitations on quantity or frequency of use of or
975 the fees or charges for any of the care or services available to
976 recipients under this section, nor (b) the payments or rates of
977 reimbursement to providers rendering care or services authorized
978 under this section to recipients, may be increased, decreased or
979 otherwise changed from the levels in effect on July 1, 1999,
980 unless they are authorized by an amendment to this section by the
981 Legislature. However, the restriction in this paragraph shall not
982 prevent the division from changing the payments or rates of
983 reimbursement to providers without an amendment to this section
984 whenever those changes are required by federal law or regulation,
985 or whenever those changes are necessary to correct administrative

986 errors or omissions in calculating those payments or rates of
987 reimbursement.
988 Notwithstanding any provision of this article, no new groups
989 or categories of recipients and new types of care and services may
990 be added without enabling legislation from the Mississippi
991 Legislature, except that the division may authorize those changes
992 without enabling legislation when the addition of recipients or
993 services is ordered by a court of proper authority.
994 The executive director shall keep the Governor advised on a
995 timely basis of the funds available for expenditure and the
996 projected expenditures. If current or projected expenditures of
997 the division are reasonably anticipated to exceed the amount of
998 funds appropriated to the division for any fiscal year, the
999 Governor, after consultation with the executive director, shall
1000 discontinue any or all of the payment of the types of care and
1001 services as provided in this section that are deemed to be
1002 optional services under Title XIX of the federal Social Security
1003 Act, as amended, and when necessary, shall institute any other
1004 cost containment measures on any program or programs authorized
1005 under the article to the extent allowed under the federal law
1006 governing that program or programs. However, the Governor shall
1007 not be authorized to discontinue or eliminate any service under
1008 this section that is mandatory under federal law, or to
1009 discontinue or eliminate, or adjust income limits or resource
1010 limits for, any eligibility category or group under Section
1011 43-13-115. It is the intent of the Legislature that the
1012 expenditures of the division during any fiscal year shall not
1013 exceed the amounts appropriated to the division for that fiscal
1014 year.
1015 Notwithstanding any other provision of this article, it shall
1016 be the duty of each nursing facility, intermediate care facility
1017 for the mentally retarded, psychiatric residential treatment
1018 facility, and nursing facility for the severely disabled that is

1019 participating in the Medicaid program to keep and maintain books,
1020 documents and other records as prescribed by the Division of
1021 Medicaid in substantiation of its cost reports for a period of
1022 three (3) years after the date of submission to the Division of
1023 Medicaid of an original cost report, or three (3) years after the
1024 date of submission to the Division of Medicaid of an amended cost
1025 report.

1026 **SECTION 3.** This act shall take effect and be in force from
1027 and after July 1, 2007.