

**Adopted  
COMMITTEE AMENDMENT NO 1 PROPOSED TO**

**Senate Bill No. 2416**

**BY: Committee**

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

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

16           43-11-1. When used in this chapter, the following words  
17 shall have the following meaning:

18           (a) "Institutions for the aged or infirm" means a place  
19 either governmental or private which provides group living  
20 arrangements for four (4) or more persons who are unrelated to the  
21 operator and who are being provided food, shelter and personal  
22 care whether any such place be organized or operated for profit or  
23 not. The term "institution for aged or infirm" includes nursing  
24 homes, pediatric skilled nursing facilities, psychiatric  
25 residential treatment facilities, convalescent homes, homes for  
26 the aged and adult foster care facilities, provided that these  
27 institutions fall within the scope of the definitions set forth  
28 above. The term "institution for the aged or infirm" does not  
29 include hospitals, clinics or mental institutions devoted  
30 primarily to providing medical service.

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

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

39           (d) "Psychiatric residential treatment facility" means  
40 any nonhospital establishment with permanent facilities which  
41 provides a twenty-four-hour program of care by qualified  
42 therapists, including, but not limited to, duly licensed mental  
43 health professionals, psychiatrists, psychologists,  
44 psychotherapists and licensed certified social workers, for  
45 emotionally disturbed children and adolescents referred to such  
46 facility by a court, local school district or by the Department of  
47 Human Services, who are not in an acute phase of illness requiring  
48 the services of a psychiatric hospital, and are in need of such  
49 restorative treatment services. For purposes of this paragraph,  
50 the term "emotionally disturbed" means a condition exhibiting one  
51 or more of the following characteristics over a long period of  
52 time and to a marked degree, which adversely affects educational  
53 performance:

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

56                   2. An inability to build or maintain satisfactory  
57 relationships with peers and teachers;

58                   3. Inappropriate types of behavior or feelings  
59 under normal circumstances;

60                   4. A general pervasive mood of unhappiness or  
61 depression; or

62                   5. A tendency to develop physical symptoms or  
63 fears associated with personal or school problems. An  
64 establishment furnishing primarily domiciliary care is not within  
65 this definition.

66                   (e) "Pediatric skilled nursing facility" means an  
67 institution or a distinct part of an institution that is primarily  
68 engaged in providing to inpatients skilled nursing care and  
69 related services for persons under twenty-one (21) years of age  
70 who require medical or nursing care or rehabilitation services for  
71 the rehabilitation of injured, disabled or sick persons.

72                   (f) "Licensing agency" means the State Department of  
73 Health.

74                   (g) "Medical records" mean, without restriction, those  
75 medical histories, records, reports, summaries, diagnoses and  
76 prognoses, records of treatment and medication ordered and given,  
77 notes, entries, x-rays and other written or graphic data prepared,  
78 kept, made or maintained in institutions for the aged or infirm  
79 that pertain to residency in, or services rendered to residents  
80 of, an institution for the aged or infirm.

81                   (h) "Adult foster care facility" means a home setting  
82 for vulnerable adults in the community who are unable to live  
83 independently due to physical, emotional, developmental or mental  
84 impairments, or in need of emergency and continuing protective  
85 social services for purposes of preventing further abuse or  
86 neglect and for safeguarding and enhancing the welfare of the  
87 abused or neglected vulnerable adult. Adult foster care programs  
88 shall be designed to meet the needs of vulnerable adults with  
89 impairments through individual plans of care, which provide a  
90 variety of health, social and related support services in a  
91 protective setting, enabling participants to live in the  
92 community. Adult foster care programs may be (i) traditional,  
93 where the foster care provider lives in the residence and is the

94 primary caregiver to clients in the home; (ii) corporate, where  
95 the foster care home is operated by a corporation with shift staff  
96 delivery services to clients; or (iii) shelter, where the foster  
97 care home accepts clients on an emergency short-term basis for up  
98 to thirty (30) days.

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

101       43-11-13. (1) The licensing agency shall adopt, amend,  
102 promulgate and enforce such rules, regulations and standards,  
103 including classifications, with respect to all institutions for  
104 the aged or infirm to be licensed under this chapter as may be  
105 designed to further the accomplishment of the purpose of this  
106 chapter in promoting adequate care of individuals in those  
107 institutions in the interest of public health, safety and welfare.  
108 Those rules, regulations and standards shall be adopted and  
109 promulgated by the licensing agency and shall be recorded and  
110 indexed in a book to be maintained by the licensing agency in its  
111 main office in the State of Mississippi, entitled "Rules,  
112 Regulations and Minimum Standards for Institutions for the Aged or  
113 Infirm" and the book shall be open and available to all  
114 institutions for the aged or infirm and the public generally at  
115 all reasonable times. Upon the adoption of those rules,  
116 regulations and standards, the licensing agency shall mail copies  
117 thereof to all those institutions in the state that have filed  
118 with the agency their names and addresses for this purpose, but  
119 the failure to mail the same or the failure of the institutions to  
120 receive the same shall in no way affect the validity thereof. The  
121 rules, regulations and standards may be amended by the licensing  
122 agency, from time to time, as necessary to promote the health,  
123 safety and welfare of persons living in those institutions.

124       (2) The licensee shall keep posted in a conspicuous place on  
125 the licensed premises all current rules, regulations and minimum

126 standards applicable to fire protection measures as adopted by the  
127 licensing agency. The licensee shall furnish to the licensing  
128 agency at least once each six (6) months a certificate of approval  
129 and inspection by state or local fire authorities. Failure to  
130 comply with state laws and/or municipal ordinances and current  
131 rules, regulations and minimum standards as adopted by the  
132 licensing agency, relative to fire prevention measures, shall be  
133 prima facie evidence for revocation of license.

134 (3) The State Board of Health shall promulgate rules and  
135 regulations restricting the storage, quantity and classes of drugs  
136 allowed in personal care homes and adult foster care facilities.  
137 Residents requiring administration of Schedule II Narcotics as  
138 defined in the Uniform Controlled Substances Law may be admitted  
139 to a personal care home. Schedule drugs may only be allowed in a  
140 personal care home if they are administered or stored utilizing  
141 proper procedures under the direct supervision of a licensed  
142 physician or nurse.

143 (4) (a) Notwithstanding any determination by the licensing  
144 agency that skilled nursing services would be appropriate for a  
145 resident of a personal care home, that resident, the resident's  
146 guardian or the legally recognized responsible party for the  
147 resident may consent in writing for the resident to continue to  
148 reside in the personal care home, if approved in writing by a  
149 licensed physician. However, no personal care home shall allow  
150 more than two (2) residents, or ten percent (10%) of the total  
151 number of residents in the facility, whichever is greater, to  
152 remain in the personal care home under the provisions of this  
153 subsection (4). This consent shall be deemed to be appropriately  
154 informed consent as described in the regulations promulgated by  
155 the licensing agency. After that written consent has been  
156 obtained, the resident shall have the right to continue to reside  
157 in the personal care home for as long as the resident meets the

158 other conditions for residing in the personal care home. A copy  
159 of the written consent and the physician's approval shall be  
160 forwarded by the personal care home to the licensing agency.

161 (b) The State Board of Health shall promulgate rules  
162 and regulations restricting the handling of a resident's personal  
163 deposits by the director of a personal care home. Any funds given  
164 or provided for the purpose of supplying extra comforts,  
165 conveniences or services to any resident in any personal care  
166 home, and any funds otherwise received and held from, for or on  
167 behalf of any such resident, shall be deposited by the director or  
168 other proper officer of the personal care home to the credit of  
169 that resident in an account that shall be known as the Resident's  
170 Personal Deposit Fund. No more than one (1) month's charge for  
171 the care, support, maintenance and medical attention of the  
172 resident shall be applied from the account at any one time. After  
173 the death, discharge or transfer of any resident for whose benefit  
174 any such fund has been provided, any unexpended balance remaining  
175 in his personal deposit fund shall be applied for the payment of  
176 care, cost of support, maintenance and medical attention that is  
177 accrued. If any unexpended balance remains in that resident's  
178 personal deposit fund after complete reimbursement has been made  
179 for payment of care, support, maintenance and medical attention,  
180 and the director or other proper officer of the personal care home  
181 has been or shall be unable to locate the person or persons  
182 entitled to the unexpended balance, the director or other proper  
183 officer may, after the lapse of one (1) year from the date of that  
184 death, discharge or transfer, deposit the unexpended balance to  
185 the credit of the personal care home's operating fund.

186 (c) The State Board of Health shall promulgate rules  
187 and regulations requiring personal care homes to maintain records  
188 relating to health condition, medicine dispensed and administered,  
189 and any reaction to that medicine. The director of the personal

190 care home shall be responsible for explaining the availability of  
191 those records to the family of the resident at any time upon  
192 reasonable request.

193 (d) The State Board of Health shall evaluate the  
194 effects of this section as it promotes adequate care of  
195 individuals in personal care homes in the interest of public  
196 health, safety and welfare. It shall report its findings to the  
197 Chairmen of the Public Health and Welfare Committees of the House  
198 and Senate by January 1, 2003. This subsection (4) shall stand  
199 repealed on June 30, 2008.

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

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

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

205 (iii) "Employee" means any individual employed by  
206 a covered entity, and also includes any individual who by contract  
207 provides to the patients, residents or clients being served by the  
208 covered entity direct, hands-on, medical patient care in a  
209 patient's, resident's or client's room or in treatment or recovery  
210 rooms. The term "employee" does not include health care  
211 professional/vocational technical students, as defined in Section  
212 37-29-232, performing clinical training in a licensed entity under  
213 contracts between their schools and the licensed entity, and does  
214 not include students at high schools located in Mississippi who  
215 observe the treatment and care of patients in a licensed entity as  
216 part of the requirements of an allied-health course taught in the  
217 high school, if:

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

220 2. The student has signed an affidavit that  
221 is on file at the student's school stating that he or she has not

222 been convicted of or pleaded guilty or nolo contendere to a felony  
223 listed in paragraph (d) of this subsection (5), or that any such  
224 conviction or plea was reversed on appeal or a pardon was granted  
225 for the conviction or plea. Before any student may sign such an  
226 affidavit, the student's school shall provide information to the  
227 student explaining what a felony is and the nature of the felonies  
228 listed in paragraph (d) of this subsection (5).

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

233         (b) Under regulations promulgated by the State Board of  
234 Health, the licensing agency shall require to be performed a  
235 criminal history record check on (i) every new employee of a  
236 covered entity who provides direct patient care or services and  
237 who is employed on or after July 1, 2003, and (ii) every employee  
238 of a covered entity employed before July 1, 2003, who has a  
239 documented disciplinary action by his or her present employer. In  
240 addition, the licensing agency shall require the covered entity to  
241 perform a disciplinary check with the professional licensing  
242 agency of each employee, if any, to determine if any disciplinary  
243 action has been taken against the employee by that agency.

244         Except as otherwise provided in paragraph (c) of this  
245 subsection (5), no such employee hired on or after July 1, 2003,  
246 shall be permitted to provide direct patient care until the  
247 results of the criminal history record check have revealed no  
248 disqualifying record or the employee has been granted a waiver.  
249 In order to determine the employee applicant's suitability for  
250 employment, the applicant shall be fingerprinted. Fingerprints  
251 shall be submitted to the licensing agency from scanning, with the  
252 results processed through the Department of Public Safety's  
253 Criminal Information Center. If no disqualifying record is

254 identified at the state level, the fingerprints shall be forwarded  
255 by the Department of Public Safety to the Federal Bureau of  
256 Investigation for a national criminal history record check. The  
257 licensing agency shall notify the covered entity of the results of  
258 an employee applicant's criminal history record check. If the  
259 criminal history record check discloses a felony conviction,  
260 guilty plea or plea of nolo contendere to a felony of possession  
261 or sale of drugs, murder, manslaughter, armed robbery, rape,  
262 sexual battery, sex offense listed in Section 45-33-23(g), child  
263 abuse, arson, grand larceny, burglary, gratification of lust or  
264 aggravated assault, or felonious abuse and/or battery of a  
265 vulnerable adult that has not been reversed on appeal or for which  
266 a pardon has not been granted, the employee applicant shall not be  
267 eligible to be employed by the covered entity.

268 (c) Any such new employee applicant may, however, be  
269 employed on a temporary basis pending the results of the criminal  
270 history record check, but any employment contract with the new  
271 employee shall be voidable if the new employee receives a  
272 disqualifying criminal history record check and no waiver is  
273 granted as provided in this subsection (5).

274 (d) Under regulations promulgated by the State Board of  
275 Health, the licensing agency shall require every employee of a  
276 covered entity employed before July 1, 2003, to sign an affidavit  
277 stating that he or she has not been convicted of or pleaded guilty  
278 or nolo contendere to a felony of possession or sale of drugs,  
279 murder, manslaughter, armed robbery, rape, sexual battery, any sex  
280 offense listed in Section 45-33-23(g), child abuse, arson, grand  
281 larceny, burglary, gratification of lust, aggravated assault, or  
282 felonious abuse and/or battery of a vulnerable adult, or that any  
283 such conviction or plea was reversed on appeal or a pardon was  
284 granted for the conviction or plea. No such employee of a covered  
285 entity hired before July 1, 2003, shall be permitted to provide

286 direct patient care until the employee has signed the affidavit  
287 required by this paragraph (d). All such existing employees of  
288 covered entities must sign the affidavit required by this  
289 paragraph (d) within six (6) months of the final adoption of the  
290 regulations promulgated by the State Board of Health. If a person  
291 signs the affidavit required by this paragraph (d), and it is  
292 later determined that the person actually had been convicted of or  
293 pleaded guilty or nolo contendere to any of the offenses listed in  
294 this paragraph (d) and the conviction or plea has not been  
295 reversed on appeal or a pardon has not been granted for the  
296 conviction or plea, the person is guilty of perjury. If the  
297 offense that the person was convicted of or pleaded guilty or nolo  
298 contendere to was a violent offense, the person, upon a conviction  
299 of perjury under this paragraph, shall be punished as provided in  
300 Section 97-9-61. If the offense that the person was convicted of  
301 or pleaded guilty or nolo contendere to was a nonviolent offense,  
302 the person, upon a conviction of perjury under this paragraph,  
303 shall be punished by a fine of not more than Five Hundred Dollars  
304 (\$500.00), or by imprisonment in the county jail for not more than  
305 six (6) months, or by both such fine and imprisonment.

306 (e) The covered entity may, in its discretion, allow  
307 any employee who is unable to sign the affidavit required by  
308 paragraph (d) of this subsection (5) or any employee applicant  
309 aggrieved by an employment decision under this subsection (5) to  
310 appear before the covered entity's hiring officer, or his or her  
311 designee, to show mitigating circumstances that may exist and  
312 allow the employee or employee applicant to be employed by the  
313 covered entity. The covered entity, upon report and  
314 recommendation of the hiring officer, may grant waivers for those  
315 mitigating circumstances, which shall include, but not be limited  
316 to: (i) age at which the crime was committed; (ii) circumstances  
317 surrounding the crime; (iii) length of time since the conviction

318 and criminal history since the conviction; (iv) work history; (v)  
319 current employment and character references; and (vi) other  
320 evidence demonstrating the ability of the individual to perform  
321 the employment responsibilities competently and that the  
322 individual does not pose a threat to the health or safety of the  
323 patients of the covered entity.

324 (f) The licensing agency may charge the covered entity  
325 submitting the fingerprints a fee not to exceed Fifty Dollars  
326 (\$50.00), which covered entity may, in its discretion, charge the  
327 same fee, or a portion thereof, to the employee applicant. Any  
328 costs incurred by a covered entity implementing this subsection  
329 (5) shall be reimbursed as an allowable cost under Section  
330 43-13-116.

331 (g) If the results of an employee applicant's criminal  
332 history record check reveals no disqualifying event, then the  
333 covered entity shall, within two (2) weeks of the notification of  
334 no disqualifying event, provide the employee applicant with a  
335 notarized letter signed by the chief executive officer of the  
336 covered entity, or his or her authorized designee, confirming the  
337 employee applicant's suitability for employment based on his or  
338 her criminal history record check. An employee applicant may use  
339 that letter for a period of two (2) years from the date of the  
340 letter to seek employment with any covered entity without the  
341 necessity of an additional criminal history record check. Any  
342 covered entity presented with the letter may rely on the letter  
343 with respect to an employee applicant's criminal background and is  
344 not required for a period of two (2) years from the date of the  
345 letter to conduct or have conducted a criminal history record  
346 check as required in this subsection (5).

347 (h) The licensing agency, the covered entity, and their  
348 agents, officers, employees, attorneys and representatives, shall  
349 be presumed to be acting in good faith for any employment decision

350 or action taken under this subsection (5). The presumption of  
351 good faith may be overcome by a preponderance of the evidence in  
352 any civil action. No licensing agency, covered entity, nor their  
353 agents, officers, employees, attorneys and representatives shall  
354 be held liable in any employment decision or action based in whole  
355 or in part on compliance with or attempts to comply with the  
356 requirements of this subsection (5).

357 (i) The licensing agency shall promulgate regulations  
358 to implement this subsection (5).

359 (j) The provisions of this subsection (5) shall not  
360 apply to:

361 (i) Applicants and employees of the University of  
362 Mississippi Medical Center for whom criminal history record checks  
363 and fingerprinting are obtained in accordance with Section  
364 37-115-41; or

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

368 (6) The State Board of Health shall promulgate rules,  
369 regulations and standards regarding the operation of adult foster  
370 care facilities.

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

373 43-11-8. (1) An application for a license for an adult  
374 foster care facility shall be made to the licensing agency upon  
375 forms provided by it and shall contain such information as the  
376 licensing agency reasonably requires, which may include  
377 affirmative evidence of ability to comply with such reasonable  
378 standards, rules and regulations as are lawfully prescribed  
379 hereunder. Each application for a license for an adult foster  
380 care facility shall be accompanied by a license fee of Ten Dollars  
381 (\$10.00) for each person or bed of licensed capacity, with a

382 minimum fee per home or institution of Fifty Dollars (\$50.00),  
383 which shall be paid to the licensing agency.

384 (2) A license, unless suspended or revoked, shall be  
385 renewable annually upon payment by the licensee of an adult foster  
386 care facility, except for personal care homes, of a renewal fee of  
387 Ten Dollars (\$10.00) for each person or bed of licensed capacity  
388 in the institution, with a minimum renewal fee per institution of  
389 Fifty Dollars (\$50.00), which shall be paid to the licensing  
390 agency, and upon filing by the licensee and approval by the  
391 licensing agency of an annual report upon such uniform dates and  
392 containing such information in such form as the licensing agency  
393 prescribes by regulation. Each license shall be issued only for  
394 the premises and person or persons or other legal entity or  
395 entities named in the application and shall not be transferable or  
396 assignable except with the written approval of the licensing  
397 agency. Licenses shall be posted in a conspicuous place on the  
398 licensed premises.

399 **SECTION 4.** Section 43-13-117, Mississippi Code of 1972, is  
400 amended as follows:

401 43-13-117. Medicaid as authorized by this article shall  
402 include payment of part or all of the costs, at the discretion of  
403 the division, with approval of the Governor, of the following  
404 types of care and services rendered to eligible applicants who  
405 have been determined to be eligible for that care and services,  
406 within the limits of state appropriations and federal matching  
407 funds:

408 (1) Inpatient hospital services.

409 (a) The division shall allow thirty (30) days of  
410 inpatient hospital care annually for all Medicaid recipients.  
411 Precertification of inpatient days must be obtained as required by  
412 the division. The division may allow unlimited days in  
413 disproportionate hospitals as defined by the division for eligible

414 infants and children under the age of six (6) years if certified  
415 as medically necessary as required by the division.

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

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

429 (2) Outpatient hospital services.

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

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

440 (3) Laboratory and x-ray services.

441 (4) Nursing facility services.

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

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

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

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

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

478 facility under a certificate of need that authorizes that  
479 construction. The reimbursement authorized in this subparagraph  
480 (d) may be made only to facilities the construction of which was  
481 completed after June 30, 1989. Before the division shall be  
482 authorized to make the reimbursement authorized in this  
483 subparagraph (d), the division first must have received approval  
484 from the Centers for Medicare and Medicaid Services (CMS) of the  
485 change in the state Medicaid plan providing for the reimbursement.

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

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

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

507 (5) Periodic screening and diagnostic services for  
508 individuals under age twenty-one (21) years as are needed to  
509 identify physical and mental defects and to provide health care

510 treatment and other measures designed to correct or ameliorate  
511 defects and physical and mental illness and conditions discovered  
512 by the screening services, regardless of whether these services  
513 are included in the state plan. The division may include in its  
514 periodic screening and diagnostic program those discretionary  
515 services authorized under the federal regulations adopted to  
516 implement Title XIX of the federal Social Security Act, as  
517 amended. The division, in obtaining physical therapy services,  
518 occupational therapy services, and services for individuals with  
519 speech, hearing and language disorders, may enter into a  
520 cooperative agreement with the State Department of Education for  
521 the provision of those services to handicapped students by public  
522 school districts using state funds that are provided from the  
523 appropriation to the Department of Education to obtain federal  
524 matching funds through the division. The division, in obtaining  
525 medical and psychological evaluations for children in the custody  
526 of the State Department of Human Services may enter into a  
527 cooperative agreement with the State Department of Human Services  
528 for the provision of those services using state funds that are  
529 provided from the appropriation to the Department of Human  
530 Services to obtain federal matching funds through the division.

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

542           (7) (a) Home health services for eligible persons, not  
543 to exceed in cost the prevailing cost of nursing facility  
544 services, not to exceed twenty-five (25) visits per year. All  
545 home health visits must be precertified as required by the  
546 division.

547           (b) Repealed.

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

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

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

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

574           The division shall allow for a combination of prescriptions  
575 for single source and innovator multiple source drugs and generic  
576 drugs to meet the needs of the beneficiaries, not to exceed five  
577 (5) prescriptions per month for each noninstitutionalized Medicaid  
578 beneficiary, with not more than two (2) of those prescriptions  
579 being for single source or innovator multiple source drugs.

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

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

603           The voluntary preferred drug list shall be expanded to  
604 function in the interim in order to have a manageable prior

605 authorization system, thereby minimizing disruption of service to  
606 beneficiaries.

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

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

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

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

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

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

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

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

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

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

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

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

664           (10) Dental care that is an adjunct to treatment of an  
665 acute medical or surgical condition; services of oral surgeons and  
666 dentists in connection with surgery related to the jaw or any  
667 structure contiguous to the jaw or the reduction of any fracture  
668 of the jaw or any facial bone; and emergency dental extractions

669 and treatment related thereto. On July 1, 1999, all fees for  
670 dental care and surgery under authority of this paragraph (10)  
671 shall be increased to one hundred sixty percent (160%) of the  
672 amount of the reimbursement rate that was in effect on June 30,  
673 1999. It is the intent of the Legislature to encourage more  
674 dentists to participate in the Medicaid program.

675 (11) Eyeglasses for all Medicaid beneficiaries who have  
676 (a) had surgery on the eyeball or ocular muscle that results in a  
677 vision change for which eyeglasses or a change in eyeglasses is  
678 medically indicated within six (6) months of the surgery and is in  
679 accordance with policies established by the division, or (b) one  
680 (1) pair every five (5) years and in accordance with policies  
681 established by the division. In either instance, the eyeglasses  
682 must be prescribed by a physician skilled in diseases of the eye  
683 or an optometrist, whichever the beneficiary may select.

684 (12) Intermediate care facility services.

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

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

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

699 (14) Clinic services. Such diagnostic, preventive,  
700 therapeutic, rehabilitative or palliative services furnished to an

701 outpatient by or under the supervision of a physician or dentist  
702 in a facility that is not a part of a hospital but that is  
703 organized and operated to provide medical care to outpatients.  
704 Clinic services shall include any services reimbursed as  
705 outpatient hospital services that may be rendered in such a  
706 facility, including those that become so after July 1, 1991. On  
707 July 1, 1999, all fees for physicians' services reimbursed under  
708 authority of this paragraph (14) shall be reimbursed at ninety  
709 percent (90%) of the rate established on January 1, 1999, and as  
710 may be adjusted each July thereafter, under Medicare (Title XVIII  
711 of the federal Social Security Act, as amended). The division may  
712 develop and implement a different reimbursement model or schedule  
713 for physician's services provided by physicians based at an  
714 academic health care center and by physicians at rural health  
715 centers that are associated with an academic health care center.  
716 On July 1, 1999, all fees for dentists' services reimbursed under  
717 authority of this paragraph (14) shall be increased to one hundred  
718 sixty percent (160%) of the amount of the reimbursement rate that  
719 was in effect on June 30, 1999.

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

725           (16) Mental health services. Approved therapeutic and  
726 case management services (a) provided by an approved regional  
727 mental health/retardation center established under Sections  
728 41-19-31 through 41-19-39, or by another community mental health  
729 service provider meeting the requirements of the Department of  
730 Mental Health to be an approved mental health/retardation center  
731 if determined necessary by the Department of Mental Health, using  
732 state funds that are provided from the appropriation to the State

733 Department of Mental Health and/or funds transferred to the  
734 department by a political subdivision or instrumentality of the  
735 state and used to match federal funds under a cooperative  
736 agreement between the division and the department, or (b) provided  
737 by a facility that is certified by the State Department of Mental  
738 Health to provide therapeutic and case management services, to be  
739 reimbursed on a fee for service basis, or (c) provided in the  
740 community by a facility or program operated by the Department of  
741 Mental Health. Any such services provided by a facility described  
742 in subparagraph (b) must have the prior approval of the division  
743 to be reimbursable under this section. After June 30, 1997,  
744 mental health services provided by regional mental  
745 health/retardation centers established under Sections 41-19-31  
746 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)  
747 and/or their subsidiaries and divisions, or by psychiatric  
748 residential treatment facilities as defined in Section 43-11-1, or  
749 by another community mental health service provider meeting the  
750 requirements of the Department of Mental Health to be an approved  
751 mental health/retardation center if determined necessary by the  
752 Department of Mental Health, shall not be included in or provided  
753 under any capitated managed care pilot program provided for under  
754 paragraph (24) of this section.

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

761           (18) (a) Notwithstanding any other provision of this  
762 section to the contrary, the division shall make additional  
763 reimbursement to hospitals that serve a disproportionate share of  
764 low-income patients and that meet the federal requirements for

765 those payments as provided in Section 1923 of the federal Social  
766 Security Act and any applicable regulations. However, from and  
767 after January 1, 1999, no public hospital shall participate in the  
768 Medicaid disproportionate share program unless the public hospital  
769 participates in an intergovernmental transfer program as provided  
770 in Section 1903 of the federal Social Security Act and any  
771 applicable regulations.

772 (b) The division shall establish a Medicare Upper  
773 Payment Limits Program, as defined in Section 1902(a)(30) of the  
774 federal Social Security Act and any applicable federal  
775 regulations, for hospitals, and may establish a Medicare Upper  
776 Payments Limits Program for nursing facilities. The division  
777 shall assess each hospital and, if the program is established for  
778 nursing facilities, shall assess each nursing facility, based on  
779 Medicaid utilization or other appropriate method consistent with  
780 federal regulations. The assessment will remain in effect as long  
781 as the state participates in the Medicare Upper Payment Limits  
782 Program. The division shall make additional reimbursement to  
783 hospitals and, if the program is established for nursing  
784 facilities, shall make additional reimbursement to nursing  
785 facilities, for the Medicare Upper Payment Limits, as defined in  
786 Section 1902(a)(30) of the federal Social Security Act and any  
787 applicable federal regulations.

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

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

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

821                   (21) Nurse practitioner services. Services furnished  
822 by a registered nurse who is licensed and certified by the  
823 Mississippi Board of Nursing as a nurse practitioner, including,  
824 but not limited to, nurse anesthetists, nurse midwives, family  
825 nurse practitioners, family planning nurse practitioners,  
826 pediatric nurse practitioners, obstetrics-gynecology nurse  
827 practitioners and neonatal nurse practitioners, under regulations

828 adopted by the division. Reimbursement for those services shall  
829 not exceed ninety percent (90%) of the reimbursement rate for  
830 comparable services rendered by a physician.

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

836 (23) Inpatient psychiatric services. Inpatient  
837 psychiatric services to be determined by the division for  
838 recipients under age twenty-one (21) that are provided under the  
839 direction of a physician in an inpatient program in a licensed  
840 acute care psychiatric facility or in a licensed psychiatric  
841 residential treatment facility, before the recipient reaches age  
842 twenty-one (21) or, if the recipient was receiving the services  
843 immediately before he or she reached age twenty-one (21), before  
844 the earlier of the date he or she no longer requires the services  
845 or the date he or she reaches age twenty-two (22), as provided by  
846 federal regulations. Precertification of inpatient days and  
847 residential treatment days must be obtained as required by the  
848 division.

849 (24) [Deleted]

850 (25) [Deleted]

851 (26) Hospice care. As used in this paragraph, the term  
852 "hospice care" means a coordinated program of active professional  
853 medical attention within the home and outpatient and inpatient  
854 care that treats the terminally ill patient and family as a unit,  
855 employing a medically directed interdisciplinary team. The  
856 program provides relief of severe pain or other physical symptoms  
857 and supportive care to meet the special needs arising out of  
858 physical, psychological, spiritual, social and economic stresses  
859 that are experienced during the final stages of illness and during

860 dying and bereavement and meets the Medicare requirements for  
861 participation as a hospice as provided in federal regulations.

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

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

869 (29) The Division of Medicaid may apply for a waiver  
870 from the United States Department of Health and Human Services for  
871 home- and community-based services for developmentally disabled  
872 people using state funds that are provided from the appropriation  
873 to the State Department of Mental Health and/or funds transferred  
874 to the department by a political subdivision or instrumentality of  
875 the state and used to match federal funds under a cooperative  
876 agreement between the division and the department, provided that  
877 funds for these services are specifically appropriated to the  
878 Department of Mental Health and/or transferred to the department  
879 by a political subdivision or instrumentality of the state.

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

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

888 (32) Care and services provided in Christian Science  
889 Sanatoria listed and certified by the Commission for Accreditation  
890 of Christian Science Nursing Organizations/Facilities, Inc.,  
891 rendered in connection with treatment by prayer or spiritual means

892 to the extent that those services are subject to reimbursement  
893 under Section 1903 of the federal Social Security Act.

894 (33) Podiatrist services.

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

899 (35) Services and activities authorized in Sections  
900 43-27-101 and 43-27-103, using state funds that are provided from  
901 the appropriation to the State Department of Human Services and  
902 used to match federal funds under a cooperative agreement between  
903 the division and the department.

904 (36) Nonemergency transportation services for  
905 Medicaid-eligible persons, to be provided by the Division of  
906 Medicaid. The division may contract with additional entities to  
907 administer nonemergency transportation services as it deems  
908 necessary. All providers shall have a valid driver's license,  
909 vehicle inspection sticker, valid vehicle license tags and a  
910 standard liability insurance policy covering the vehicle. The  
911 division may pay providers a flat fee based on mileage tiers, or  
912 in the alternative, may reimburse on actual miles traveled. The  
913 division may apply to the Center for Medicare and Medicaid  
914 Services (CMS) for a waiver to draw federal matching funds for  
915 nonemergency transportation services as a covered service instead  
916 of an administrative cost.

917 (37) [Deleted]

918 (38) Chiropractic services. A chiropractor's manual  
919 manipulation of the spine to correct a subluxation, if x-ray  
920 demonstrates that a subluxation exists and if the subluxation has  
921 resulted in a neuromusculoskeletal condition for which  
922 manipulation is appropriate treatment, and related spinal x-rays  
923 performed to document these conditions. Reimbursement for

924 chiropractic services shall not exceed Seven Hundred Dollars  
925 (\$700.00) per year per beneficiary.

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

930 (40) [Deleted]

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

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

953 (43) The division shall provide reimbursement,  
954 according to a payment schedule developed by the division, for  
955 smoking cessation medications for pregnant women during their

956 pregnancy and other Medicaid-eligible women who are of  
957 child-bearing age.

958 (44) Nursing facility services for the severely  
959 disabled.

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

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

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

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

985 (47) (a) Notwithstanding any other provision in this  
986 article to the contrary, the division, in conjunction with the  
987 State Department of Health, may develop and implement disease

988 management programs for individuals with high-cost chronic  
989 diseases and conditions, including the use of grants, waivers,  
990 demonstrations or other projects as necessary.

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

995 (c) An individual who participates in the disease  
996 management program has the option of participating in the  
997 prescription drug home delivery component of the program at any  
998 time while participating in the program. An individual must  
999 affirmatively elect to participate in the prescription drug home  
1000 delivery component in order to participate.

1001 (d) An individual who participates in the disease  
1002 management program may elect to discontinue participation in the  
1003 program at any time. An individual who participates in the  
1004 prescription drug home delivery component may elect to discontinue  
1005 participation in the prescription drug home delivery component at  
1006 any time.

1007 (e) The division shall send written notice to all  
1008 individuals who participate in the disease management program  
1009 informing them that they may continue using their local pharmacy  
1010 or any other pharmacy of their choice to obtain their prescription  
1011 drugs while participating in the program.

1012 (f) Prescription drugs that are provided to  
1013 individuals under the prescription drug home delivery component  
1014 shall be limited only to those drugs that are used for the  
1015 treatment, management or care of asthma, diabetes or hypertension.

1016 (48) Pediatric long-term acute care hospital services.

1017 (a) Pediatric long-term acute care hospital  
1018 services means services provided to eligible persons under  
1019 twenty-one (21) years of age by a freestanding Medicare-certified

1020 hospital that has an average length of inpatient stay greater than  
1021 twenty-five (25) days and that is primarily engaged in providing  
1022 chronic or long-term medical care to persons under twenty-one (21)  
1023 years of age.

1024 (b) The services under this paragraph (48) shall  
1025 be reimbursed as a separate category of hospital services.

1026 (49) The division shall establish co-payments and/or  
1027 coinsurance for all Medicaid services for which co-payments and/or  
1028 coinsurance are allowable under federal law or regulation, and  
1029 shall set the amount of the co-payment and/or coinsurance for each  
1030 of those services at the maximum amount allowable under federal  
1031 law or regulation.

1032 (50) Services provided by the State Department of  
1033 Rehabilitation Services for the care and rehabilitation of persons  
1034 who are deaf and blind, as allowed under waivers from the United  
1035 States Department of Health and Human Services to provide home-  
1036 and community-based services using state funds that are provided  
1037 from the appropriation to the State Department of Rehabilitation  
1038 Services or if funds are voluntarily provided by another agency.

1039 (51) Upon determination of Medicaid eligibility and in  
1040 association with annual redetermination of Medicaid eligibility,  
1041 beneficiaries shall be encouraged to undertake a physical  
1042 examination that will establish a base-line level of health and  
1043 identification of a usual and customary source of care (a medical  
1044 home) to aid utilization of disease management tools. This  
1045 physical examination and utilization of these disease management  
1046 tools shall be consistent with current United States Preventive  
1047 Services Task Force or other recognized authority recommendations.

1048 For persons who are determined ineligible for Medicaid, the  
1049 division will provide information and direction for accessing  
1050 medical care and services in the area of their residence.

1051           (52) Notwithstanding any provisions of this article,  
1052 the division may pay enhanced reimbursement fees related to trauma  
1053 care, as determined by the division in conjunction with the State  
1054 Department of Health, using funds appropriated to the State  
1055 Department of Health for trauma care and services and used to  
1056 match federal funds under a cooperative agreement between the  
1057 division and the State Department of Health. The division, in  
1058 conjunction with the State Department of Health, may use grants,  
1059 waivers, demonstrations, or other projects as necessary in the  
1060 development and implementation of this reimbursement program.

1061           (53) Targeted case management services for high-cost  
1062 beneficiaries shall be developed by the division for all services  
1063 under this section.

1064           (54) Adult foster care services pilot program. Social  
1065 and protective services on a pilot program basis in an approved  
1066 foster care facility for vulnerable adults who would otherwise  
1067 need care in a long-term care facility, under the Medicaid Waivers  
1068 for the Elderly and Disabled program or an assisted living waiver.  
1069 The division may use grants, waivers, demonstrations or other  
1070 projects as necessary in the development and implementation of  
1071 this adult foster care services pilot program.

1072           Notwithstanding any other provision of this article to the  
1073 contrary, the division shall reduce the rate of reimbursement to  
1074 providers for any service provided under this section by five  
1075 percent (5%) of the allowed amount for that service. However, the  
1076 reduction in the reimbursement rates required by this paragraph  
1077 shall not apply to inpatient hospital services, nursing facility  
1078 services, intermediate care facility services, psychiatric  
1079 residential treatment facility services, pharmacy services  
1080 provided under paragraph (9) of this section, or any service  
1081 provided by the University of Mississippi Medical Center or a  
1082 state agency, a state facility or a public agency that either

1083 provides its own state match through intergovernmental transfer or  
1084 certification of funds to the division, or a service for which the  
1085 federal government sets the reimbursement methodology and rate.  
1086 In addition, the reduction in the reimbursement rates required by  
1087 this paragraph shall not apply to case management services and  
1088 home-delivered meals provided under the home- and community-based  
1089 services program for the elderly and disabled by a planning and  
1090 development district (PDD). Planning and development districts  
1091 participating in the home- and community-based services program  
1092 for the elderly and disabled as case management providers shall be  
1093 reimbursed for case management services at the maximum rate  
1094 approved by the Centers for Medicare and Medicaid Services (CMS).

1095       The division may pay to those providers who participate in  
1096 and accept patient referrals from the division's emergency room  
1097 redirection program a percentage, as determined by the division,  
1098 of savings achieved according to the performance measures and  
1099 reduction of costs required of that program. Federally qualified  
1100 health centers may participate in the emergency room redirection  
1101 program, and the division may pay those centers a percentage of  
1102 any savings to the Medicaid program achieved by the centers'  
1103 accepting patient referrals through the program, as provided in  
1104 this paragraph.

1105       Notwithstanding any provision of this article, except as  
1106 authorized in the following paragraph and in Section 43-13-139,  
1107 neither (a) the limitations on quantity or frequency of use of or  
1108 the fees or charges for any of the care or services available to  
1109 recipients under this section, nor (b) the payments or rates of  
1110 reimbursement to providers rendering care or services authorized  
1111 under this section to recipients, may be increased, decreased or  
1112 otherwise changed from the levels in effect on July 1, 1999,  
1113 unless they are authorized by an amendment to this section by the  
1114 Legislature. However, the restriction in this paragraph shall not

1115 prevent the division from changing the payments or rates of  
1116 reimbursement to providers without an amendment to this section  
1117 whenever those changes are required by federal law or regulation,  
1118 or whenever those changes are necessary to correct administrative  
1119 errors or omissions in calculating those payments or rates of  
1120 reimbursement.

1121 Notwithstanding any provision of this article, no new groups  
1122 or categories of recipients and new types of care and services may  
1123 be added without enabling legislation from the Mississippi  
1124 Legislature, except that the division may authorize those changes  
1125 without enabling legislation when the addition of recipients or  
1126 services is ordered by a court of proper authority.

1127 The executive director shall keep the Governor advised on a  
1128 timely basis of the funds available for expenditure and the  
1129 projected expenditures. If current or projected expenditures of  
1130 the division are reasonably anticipated to exceed the amount of  
1131 funds appropriated to the division for any fiscal year, the  
1132 Governor, after consultation with the executive director, shall  
1133 discontinue any or all of the payment of the types of care and  
1134 services as provided in this section that are deemed to be  
1135 optional services under Title XIX of the federal Social Security  
1136 Act, as amended, and when necessary, shall institute any other  
1137 cost containment measures on any program or programs authorized  
1138 under the article to the extent allowed under the federal law  
1139 governing that program or programs. However, the Governor shall  
1140 not be authorized to discontinue or eliminate any service under  
1141 this section that is mandatory under federal law, or to  
1142 discontinue or eliminate, or adjust income limits or resource  
1143 limits for, any eligibility category or group under Section  
1144 43-13-115. It is the intent of the Legislature that the  
1145 expenditures of the division during any fiscal year shall not

1146 exceed the amounts appropriated to the division for that fiscal  
1147 year.

1148 Notwithstanding any other provision of this article, it shall  
1149 be the duty of each nursing facility, intermediate care facility  
1150 for the mentally retarded, psychiatric residential treatment  
1151 facility, and nursing facility for the severely disabled that is  
1152 participating in the Medicaid program to keep and maintain books,  
1153 documents and other records as prescribed by the Division of  
1154 Medicaid in substantiation of its cost reports for a period of  
1155 three (3) years after the date of submission to the Division of  
1156 Medicaid of an original cost report, or three (3) years after the  
1157 date of submission to the Division of Medicaid of an amended cost  
1158 report.

1159 **SECTION 5.** This act shall take effect and be in force from  
1160 and after July 1, 2007.

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

1 AN ACT TO AMEND SECTION 43-11-1, MISSISSIPPI CODE OF 1972, TO  
2 DEFINE THE TERM "ADULT FOSTER CARE FACILITY" TO PROVIDE PROTECTIVE  
3 SERVICES FOR VULNERABLE ADULTS FOR PURPOSES OF LICENSURE BY THE  
4 STATE DEPARTMENT OF HEALTH; TO AMEND SECTION 43-11-13, MISSISSIPPI  
5 CODE OF 1972, TO DIRECT THE STATE BOARD OF HEALTH TO PROMULGATE  
6 RULES, REGULATIONS AND STANDARDS REGARDING THE OPERATION OF ADULT  
7 FOSTER CARE FACILITIES; TO CODIFY SECTION 43-11-8, MISSISSIPPI  
8 CODE OF 1972, TO PRESCRIBE FEES FOR ADULT FOSTER CARE FACILITY  
9 LICENSURE; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,  
10 TO AUTHORIZE THE DIVISION OF MEDICAID-OFFICE OF THE GOVERNOR TO  
11 APPLY FOR WAIVERS FOR ADULTS TO RECEIVE CARE IN ADULT FOSTER CARE  
12 UNDER THE MEDICAID PROGRAM; AND FOR RELATED PURPOSES.