MISSISSIPPI LEGISLATURE REGULAR SESSION 2018

By: Representatives Cockerham, Dixon To: Medicaid

HOUSE BILL NO. 1349

AN ACT TO AMEND SECTION 43-11-1, MISSISSIPPI CODE OF 1972, TO DEFINE THE TERM "ADULT DAY CARE FACILITY" FOR PURPOSES OF LICENSURE BY THE STATE DEPARTMENT OF HEALTH; TO AMEND SECTION 43-11-13, MISSISSIPPI CODE OF 1972, TO DIRECT THE STATE BOARD OF HEALTH TO PROMULGATE RULES, REGULATIONS AND STANDARDS REGARDING THE OPERATION OF ADULT DAY CARE FACILITIES THAT INCORPORATE THE MOST CURRENT RANGES AND LEVELS OF CARE DEVELOPED BY THE NATIONAL ADULT DAY SERVICES ASSOCIATION (NADSA); TO PRESCRIBE THE THREE LEVELS OF SERVICE FOR ADULT DAY CARE FACILITIES; TO AUTHORIZE THE STATE DEPARTMENT OF HEALTH TO IMPLEMENT THE RAP-BACK CRIMINAL HISTORY RECORDS SYSTEM FOR MONITORING EMPLOYEES AT COVERED ENTITIES; TO CODIFY SECTION 43-11-10, MISSISSIPPI CODE OF 1972, TO PROVIDE THE REQUIREMENTS FOR APPLICATION FOR ADULT DAY CARE FACILITY LICENSURE; TO AMEND SECTION 43-13-117.1, MISSISSIPPI CODE OF 1972, TO PROVIDE FOR MEDICAID REIMBURSEMENT FOR ADULT DAY CARE SERVICES BY A MEDICAID PROVIDER; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO REQUIRE THE DIVISION OF MEDICAID TO APPLY FOR A WAIVER AMENDMENT FOR ADULT DAY CARE FACILITIES; TO EXEMPT ADULT DAY CARE FACILITIES FROM A REIMBURSEMENT RATE DEDUCTION; TO EXTEND THE REPEALER ON THE SECTION OF LAW; AND FOR RELATED PURPOSES.

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

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

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

(a) "Institutions for the aged or infirm" means a place either governmental or private that provides group living arrangements for four (4) or more persons who are unrelated to the operator and who are being provided food, shelter and personal care, whether any such place is organized or operated for profit or not. The term "institution for the aged or infirm" includes nursing homes, pediatric skilled nursing facilities, psychiatric residential treatment facilities, convalescent homes, homes for the aged * * *, adult foster care facilities * * * and adult day care facilities provided that these institutions fall within the scope of the definitions set forth * * * in this section. The term "institution for the aged or infirm" does not include hospitals, clinics or mental institutions devoted primarily to providing medical service, and does not include any private residence in which the owner of the residence is providing personal care services to disabled or homeless veterans under an agreement with, and in compliance with the standards prescribed by, the United States Department of Veterans Affairs, if the owner of the residence also provided personal care services to disabled or homeless veterans at any time during calendar year 2008.

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

(c) "Personal care" means assistance rendered by personnel of the home to aged or infirm residents in performing

one or more of the activities of daily living, which includes, but is not limited to, the bathing, walking, excretory functions, feeding, personal grooming and dressing of such residents.

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

*** * ***(i) An inability to learn which cannot be explained by intellectual, sensory or health factors;

*** * ***(ii) An inability to build or maintain satisfactory relationships with peers and teachers;

*** * ***(iii) Inappropriate types of behavior or feelings under normal circumstances;

*** * ***(iv) A general pervasive mood of unhappiness or depression; or

*** * ***(v) A tendency to develop physical symptoms or fears associated with personal or school problems. An establishment furnishing primarily domiciliary care is not within this definition.

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

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

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

(h) "Adult foster care facility" means a home setting for vulnerable adults in the community who are unable to live independently due to physical, emotional, developmental or mental impairments, or in need of emergency and continuing protective

social services for purposes of preventing further abuse or neglect and for safeguarding and enhancing the welfare of the abused or neglected vulnerable adult. Adult foster care programs shall be designed to meet the needs of vulnerable adults with impairments through individual plans of care, which provide a variety of health, social and related support services in a protective setting, enabling participants to live in the community. Adult foster care programs may be (i) traditional, where the foster care provider lives in the residence and is the primary caregiver to clients in the home; (ii) corporate, where the foster care home is operated by a corporation with shift staff delivering services to clients; or (iii) shelter, where the foster care home accepts clients on an emergency short-term basis for up to thirty (30) days.

(i) "Adult day care facility" means a public agency or private organization, or a subdivision of such an agency or organization, that:

(i) Provides the following items and services:

1. Nursing services;

2. Arranged, contracted or provided transportation of the individual, as needed, to and from the adult day care facility in connection with any such item or service, at the discretion of the facility;

3. Meals;

4. A program of supervised activities (that meets such criteria as the licensing agency determines appropriate) designed to promote physical and mental health that are furnished to the individual by such a facility in a group setting for a period of not fewer than four (4) and not greater than twelve (12) hours per day;

5. The administration of medication by a registered nurse, and a medication management program to minimize unnecessary or inappropriate use of prescription drugs and adverse events due to unintended prescription drug-to-drug interactions; and

(ii) Meets such standards established by the licensing agency to assure quality of care and such other requirements as the licensing agency finds necessary in the interest of the health and safety of individuals who are furnished services in the facility.

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

43-11-13. (1) The licensing agency shall adopt, amend, promulgate and enforce such rules, regulations and standards, including classifications, with respect to all institutions for the aged or infirm to be licensed under this chapter as may be designed to further the accomplishment of the purpose of this chapter in promoting adequate care of individuals in those institutions in the interest of public health, safety and welfare.

Those rules, regulations and standards shall be adopted and promulgated by the licensing agency and shall be recorded and indexed in a book to be maintained by the licensing agency in its main office in the State of Mississippi, entitled "Rules, Regulations and Minimum Standards for Institutions for the Aged or Infirm" and the book shall be open and available to all institutions for the aged or infirm and the public generally at all reasonable times. Upon the adoption of those rules, regulations and standards, the licensing agency shall mail copies thereof to all those institutions in the state that have filed with the agency their names and addresses for this purpose, but the failure to mail the same or the failure of the institutions to receive the same shall in no way affect the validity thereof. The rules, regulations and standards may be amended by the licensing agency, from time to time, as necessary to promote the health, safety and welfare of persons living in those institutions.

(2) The licensee shall keep posted in a conspicuous place on the licensed premises all current rules, regulations and minimum standards applicable to fire protection measures as adopted by the licensing agency. The licensee shall furnish to the licensing agency at least once each six (6) months a certificate of approval and inspection by state or local fire authorities. Failure to comply with state laws and/or municipal ordinances and current rules, regulations and minimum standards as adopted by the

licensing agency, relative to fire prevention measures, shall be prima facie evidence for revocation of license.

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

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

in the personal care home for as long as the resident meets the other conditions for residing in the personal care home. A copy of the written consent and the physician's approval shall be forwarded by the personal care home to the licensing agency.

(b) The State Board of Health shall promulgate rules and regulations restricting the handling of a resident's personal deposits by the director of a personal care home. Any funds given or provided for the purpose of supplying extra comforts, conveniences or services to any resident in any personal care home, and any funds otherwise received and held from, for or on behalf of any such resident, shall be deposited by the director or other proper officer of the personal care home to the credit of that resident in an account that shall be known as the Resident's Personal Deposit Fund. No more than one (1) month's charge for the care, support, maintenance and medical attention of the resident shall be applied from the account at any one time. After the death, discharge or transfer of any resident for whose benefit any such fund has been provided, any unexpended balance remaining in his personal deposit fund shall be applied for the payment of care, cost of support, maintenance and medical attention that is accrued. If any unexpended balance remains in that resident's personal deposit fund after complete reimbursement has been made for payment of care, support, maintenance and medical attention, and the director or other proper officer of the personal care home has been or shall be unable to locate the person or persons

entitled to the unexpended balance, the director or other proper officer may, after the lapse of one (1) year from the date of that death, discharge or transfer, deposit the unexpended balance to the credit of the personal care home's operating fund.

(c) The State Board of Health shall promulgate rules and regulations requiring personal care homes to maintain records relating to health condition, medicine dispensed and administered, and any reaction to that medicine. The director of the personal care home shall be responsible for explaining the availability of those records to the family of the resident at any time upon reasonable request.

(5) To operate an adult day care facility in Mississippi, the facility provider must be registered with the licensing agency or possess a current valid license issued under Section 43-11-10. Mississippi Medicaid waiver providers are required to have a state license and must have a Medicaid contract with the Division of Medicaid. The registration and licensure of adult day care facilities shall consist of the following three (3) levels of service:

(a) **Health promotion — Level I.** Facilities serving no more than five (5) clients per day shall not require a license, but the facility must register with the licensing agency. The facility will not provide transportation services or nursing services but shall provide activities for socialization, nutritional services and supervision of the clients attending.

Facilities shall submit, annually at the time of registration renewal, a notarized affidavit attesting to the fact that they are only providing care to five (5) or fewer clients and attesting to their compliance with the provisions of this section. The affidavit shall remain on file within the licensing agency.

(b) **Basic level — Level II.** Facilities shall be licensed to serve clients based on the size and capacity of the facility. The facility shall be required to provide nursing services, nutritional services, socialization and therapeutic activities consistent with national standards. Level II facilities shall maintain, at a minimum, a staff-to-client ratio of one (1) staff member for every seven (7) clients. Standards governing the quality of care and services rendered shall be developed with input from all stakeholders and shall be consistent with national standards. In addition to providing adult day care services, the facility is required to offer transportation services within a reasonable distance from the facility in vehicles designed and equipped to handle the clients attending the facility.

(c) **Enhanced level — Level III.** Enhanced level facilities shall be licensed to serve clients based on the size and capacity of the facility. This type of facility will serve clients with significant impairments and medical needs such as tube feeding, wheelchair bound, trach tubes, Alzheimer's or other severe cognitive deficits, etc. The facility shall be required to

provide nursing services in addition to nutritional services, socialization and therapeutic activities consistent with national standards. Standards governing the quality of care and services rendered shall be developed with input from all stakeholders and shall be consistent with national standards. Enhanced level facilities shall maintain a staff-to-client ratio of not less than one (1) staff member for every five (5) clients. In addition to providing adult day care services, the facility is required to offer transportation services within a reasonable distance from the facility in vehicles designed and equipped to handle the clients attending the facility.

(6) (a) For the purposes of this subsection (* * *6):

(i) "Licensed entity" means a hospital, nursing home, personal care home, home health agency, hospice * * *, adult foster care facility or adult day care facility;

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

(iii) "Employee" means any individual employed by a covered entity, and also includes any individual who by contract provides to the patients, residents or clients being served by the covered entity direct, hands-on, medical patient care in a patient's, resident's or client's room or in treatment or recovery rooms. The term "employee" does not include health care professional/vocational technical students performing clinical training in a licensed entity under contracts between their

schools and the licensed entity, and does not include students at high schools located in Mississippi who observe the treatment and care of patients in a licensed entity as part of the requirements of an allied-health course taught in the high school, if:

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

2. The student has signed an affidavit that is on file at the student's school stating that he or she has not been convicted of or pleaded guilty or nolo contendere to a felony listed in paragraph (d) of this subsection (* * *6), or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea. Before any student may sign such an affidavit, the student's school shall provide information to the student explaining what a felony is and the nature of the felonies listed in paragraph (d) of this subsection (* * *6).

However, the health care professional/vocational technical academic program in which the student is enrolled may require the student to obtain criminal history record checks * * *; and

(iv) "Rap-Back" means the notification to the licensing agency when an individual who has undergone a fingerprint-based, state or federal criminal history information check has a later state or federal criminal history event.

(b) Under regulations promulgated by the State Board of Health, the licensing agency shall require to be performed a criminal history record check on (i) every new employee of a

covered entity who provides direct patient care or services and who is employed on or after July 1, 2003, and (ii) every employee of a covered entity employed before July 1, 2003, who has a documented disciplinary action by his or her present employer. The licensing agency is authorized to put into place methods that reduce duplicate fingerprinting, including the development of Rap-Back capabilities, as required by the Centers for Medicare and Medicaid Services. In addition, the licensing agency shall require the covered entity to perform a disciplinary check with the professional licensing agency of each employee, if any, to determine if any disciplinary action has been taken against the employee by that agency.

Except as otherwise provided in paragraph (c) of this subsection (* * *6), no such employee hired on or after July 1, 2003, shall be permitted to provide direct patient care until the results of the criminal history record check have revealed no disqualifying record or the employee has been granted a waiver. In order to determine the employee applicant's suitability for employment, the applicant shall be fingerprinted. Fingerprints shall be submitted to the licensing agency from scanning, with the results processed through the Department of Public Safety's Criminal Information Center. The fingerprints shall then be forwarded by the Department of Public Safety to the Federal Bureau of Investigation for a national criminal history record check. The licensing agency shall notify the covered entity of the

results of an employee applicant's criminal history record check. If the criminal history record check discloses a felony conviction, guilty plea or plea of nolo contendere to a felony of possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, sex offense listed in Section 45-33-23(h), child abuse, arson, grand larceny, burglary, gratification of lust or aggravated assault, or felonious abuse and/or battery of a vulnerable adult that has not been reversed on appeal or for which a pardon has not been granted, the employee applicant shall not be eligible to be employed by the covered entity.

(c) Any such new employee applicant may, however, be employed on a temporary basis pending the results of the criminal history record check, but any employment contract with the new employee shall be voidable if the new employee receives a disqualifying criminal history record check and no waiver is granted as provided in this subsection (* * *6).

(d) Under regulations promulgated by the State Board of Health, the licensing agency shall require every employee of a covered entity employed before July 1, 2003, to sign an affidavit stating that he or she has not been convicted of or pleaded guilty or nolo contendere to a felony of possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense listed in Section 45-33-23(h), child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or that any

such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea. No such employee of a covered entity hired before July 1, 2003, shall be permitted to provide direct patient care until the employee has signed the affidavit required by this paragraph (d). All such existing employees of covered entities must sign the affidavit required by this paragraph (d) within six (6) months of the final adoption of the regulations promulgated by the State Board of Health. If a person signs the affidavit required by this paragraph (d), and it is later determined that the person actually had been convicted of or pleaded guilty or nolo contendere to any of the offenses listed in this paragraph (d) and the conviction or plea has not been reversed on appeal or a pardon has not been granted for the conviction or plea, the person is guilty of perjury. If the offense that the person was convicted of or pleaded guilty or nolo contendere to was a violent offense, the person, upon a conviction of perjury under this paragraph, shall be punished as provided in Section 97-9-61. If the offense that the person was convicted of or pleaded guilty or nolo contendere to was a nonviolent offense, the person, upon a conviction of perjury under this paragraph, shall be punished by a fine of not more than Five Hundred Dollars ($500.00), or by imprisonment in the county jail for not more than six (6) months, or by both such fine and imprisonment.

(e) The covered entity may, in its discretion, allow any employee who is unable to sign the affidavit required by

paragraph (d) of this subsection (* * *6) or any employee applicant aggrieved by an employment decision under this subsection (* * *6) to appear before the covered entity's hiring officer, or his or her designee, to show mitigating circumstances that may exist and allow the employee or employee applicant to be employed by the covered entity. The covered entity, upon report and recommendation of the hiring officer, may grant waivers for those mitigating circumstances, which shall include, but not be limited to: (i) age at which the crime was committed; (ii) circumstances surrounding the crime; (iii) length of time since the conviction and criminal history since the conviction; (iv) work history; (v) current employment and character references; and (vi) other evidence demonstrating the ability of the individual to perform the employment responsibilities competently and that the individual does not pose a threat to the health or safety of the patients of the covered entity.

(f) The licensing agency may charge the covered entity submitting the fingerprints a fee * * * as established by the State Board of Health, which covered entity may, in its discretion, charge the same fee, or a portion thereof, to the employee applicant. Any increase in the fee charged by the licensing agency under this paragraph shall be in accordance with the provisions of Section 41-3-65. Any costs incurred by a covered entity implementing this subsection (* * *6) shall be reimbursed as an allowable cost under Section 43-13-116.

(g) If the results of an employee applicant's criminal history record check reveals no disqualifying event, then the covered entity shall, within two (2) weeks of the notification of no disqualifying event, provide the employee applicant with a notarized letter signed by the chief executive officer of the covered entity, or his or her authorized designee, confirming the employee applicant's suitability for employment based on his or her criminal history record check. An employee applicant may use that letter for a period of two (2) years from the date of the letter to seek employment with any covered entity without the necessity of an additional criminal history record check. Any covered entity presented with the letter may rely on the letter with respect to an employee applicant's criminal background and is not required for a period of two (2) years from the date of the letter to conduct or have conducted a criminal history record check as required in this subsection (* * *6).

(h) The licensing agency, the covered entity, and their agents, officers, employees, attorneys and representatives, shall be presumed to be acting in good faith for any employment decision or action taken under this subsection (* * *6). The presumption of good faith may be overcome by a preponderance of the evidence in any civil action. No licensing agency, covered entity, nor their agents, officers, employees, attorneys and representatives shall be held liable in any employment decision or action based in

whole or in part on compliance with or attempts to comply with the requirements of this subsection (* * *6).

(i) The licensing agency shall promulgate regulations to implement this subsection (* * *6).

(j) The provisions of this subsection (* * *6) shall not apply to:

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

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

(k) The Mississippi Justice Information Center is authorized to implement the Rap-Back criminal history records system and the licensing agency is authorized to implement and use the state/federal Rap-Back criminal history system as a method of ongoing monitoring of individuals providing care to Mississippi's vulnerable population in covered entities as defined in subsection (6) of this section, and to apply for and provide matching funds in order for Mississippi to receive federal grants to make necessary upgrades to the licensing agency's data system to accommodate Rap-Back capabilities.

(* * *7) The State Board of Health shall promulgate rules, regulations and standards regarding the operation of adult foster

care facilities and regarding the operation of adult day care facilities that incorporate, but are not limited to, the most current ranges and levels of care developed by the National Adult Day Services Association (NADSA).

SECTION 3. The following provision shall be codified as Section 43-11-10, Mississippi Code of 1972:

43-11-10. (1) An application for a license for an adult day care facility shall be made to the licensing agency upon forms provided by it and shall contain such information as the licensing agency reasonably requires, which may include affirmative evidence of ability to comply with such reasonable standards, rules and regulations as are lawfully prescribed under this chapter. Each application for a license for an adult day care facility shall be accompanied by a license fee of Four Hundred Dollars ($400.00) plus Twenty Dollars ($20.00) for each person of licensed capacity, with a maximum fee per facility of Five Hundred Dollars ($500.00), which shall be paid to the licensing agency.

(2) A license, unless suspended or revoked, shall be renewable annually upon payment by the licensee of an adult day care facility of a renewal fee of Four Hundred Dollars ($400.00) plus Twenty Dollars ($20.00) for each person of licensed capacity, with a maximum fee per facility of Five Hundred Dollars ($500.00), which shall be paid to the licensing agency, and upon filing by the licensee and approval by the licensing agency of an annual report upon such uniform dates and containing such information in

such form as the licensing agency prescribes by regulation. Each license shall be issued only for the premises and person or persons or other legal entity or entities named in the application and shall not be transferable or assignable except with the written approval of the licensing agency. Licenses shall be posted in a conspicuous place on the licensed premises.

(3) A fee known as a "user fee" shall be applicable and shall be paid to the licensing agency as set out in subsection (1) of this section. This user fee shall be assessed for the purpose of the required reviewing and inspections of the proposal of any facility in which there are additions, renovations, modernizations, expansion, alterations, conversions, modifications or replacement of the entire facility involved in the proposal. This fee includes the reviewing of architectural plans in all steps required. There shall be a minimum user fee of Two Hundred Dollars ($200.00).

SECTION 4. Section 43-13-117.1, Mississippi Code of 1972, is amended as follows:

43-13-117.1. (1) It is the intent of the Legislature to expand access to Medicaid-funded home- and community-based services for eligible nursing facility residents who choose those services. The Executive Director of the Division of Medicaid is authorized to transfer funds allocated for nursing facility services for eligible residents to cover the cost of services available through the Independent Living Waiver, the Traumatic

Brain Injury/Spinal Cord Injury Waiver, the Elderly and Disabled Waiver, and the Assisted Living Waiver programs when eligible residents choose those community services. The amount of funding transferred by the division shall be sufficient to cover the cost of home- and community-based waiver services for each eligible nursing facility * * * resident who * * * chooses those services. The number of nursing facility residents who return to the community and home- and community-based waiver services shall not count against the total number of waiver slots for which the Legislature appropriates funding each year. Any funds remaining in the program when a former nursing facility resident ceases to participate in a home- and community-based waiver program under this provision shall be returned to nursing facility funding.

(2) To operate an adult day care facility in Mississippi, the facility provider must be registered with the licensing agency or possess a current valid license issued under Section 43-11-10. Mississippi Medicaid waiver providers are required to have the applicable state licenses and must have a Medicaid contract with the Division of Medicaid. Medicaid payments for adult day care facilities shall consist of the following three (3) levels of reimbursement:

(a) For Level I facilities providing the services described in Section 43-11-13 (5)(a), the rate payable by Medicaid shall be Fifty Dollars ($50.00) per day for each client in attendance for each given day.

(b) For Level II facilities providing the services described in Section 43-11-13 (5)(b), the rate payable by Medicaid shall be Seventy-five Dollars ($75.00) per day for each client in attendance for each day.

(c) For Level III facilities providing the services describing in Section 43-11-13 (5)(c), the rate payable by Medicaid shall be One Hundred Twenty-five Dollars ($125.00) per day for each client in attendance for each day.

(3) In addition to the adult day care service reimbursement, facilities providing Level II and Level III services shall be reimbursed a separate reimbursement for those clients who use transportation at the rate of Twelve Dollars and Fifty Cents ($12.50) for a one-way trip and Twenty-five Dollars ($25.00) for a round trip.

SECTION 5. Section 43-13-117, Mississippi Code of 1972, is amended as follows:

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

(1) Inpatient hospital services.

(a) The division shall allow thirty (30) days of inpatient hospital care annually for all Medicaid recipients. Medicaid recipients requiring transplants shall not have those days included in the transplant hospital stay count against the thirty-day limit for inpatient hospital care. Precertification of inpatient days must be obtained as required by the division.

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

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

(d) The division is authorized to implement an All-Patient Refined-Diagnosis Related Groups (APR-DRG) reimbursement methodology for inpatient hospital services.

(e) No service benefits or reimbursement limitations in this section shall apply to payments under an APR-DRG or Ambulatory Payment Classification (APC) model or a

managed care program or similar model described in subsection (H) of this section.

(2) Outpatient hospital services.

(a) Emergency services.

(b) Other outpatient hospital services. The division shall allow benefits for other medically necessary outpatient hospital services (such as chemotherapy, radiation, surgery and therapy), including outpatient services in a clinic or other facility that is not located inside the hospital, but that has been designated as an outpatient facility by the hospital, and that was in operation or under construction on July 1, 2009, provided that the costs and charges associated with the operation of the hospital clinic are included in the hospital's cost report. In addition, the Medicare thirty-five-mile rule will apply to those hospital clinics not located inside the hospital that are constructed after July 1, 2009. Where the same services are reimbursed as clinic services, the division may revise the rate or methodology of outpatient reimbursement to maintain consistency, efficiency, economy and quality of care.

(c) The division is authorized to implement an Ambulatory Payment Classification (APC) methodology for outpatient hospital services.

(d) No service benefits or reimbursement limitations in this section shall apply to payments under an

APR-DRG or APC model or a managed care program or similar model described in subsection (H) of this section.

(3) Laboratory and x-ray services.

(4) Nursing facility services.

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

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

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

(d) On or after January 1, 2015, the division shall update the case-mix payment system resource utilization grouper and classifications and fair rental reimbursement system. The division shall develop and implement a payment add-on to reimburse nursing facilities for ventilator dependent resident services.

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

(f) The division shall develop and implement an assessment process for long-term care services. The division may

provide the assessment and related functions directly or through contract with the area agencies on aging.

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

(5) Periodic screening and diagnostic services for individuals under age twenty-one (21) years as are needed to identify physical and mental defects and to provide health care treatment and other measures designed to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services, regardless of whether these services are included in the state plan. The division may include in its periodic screening and diagnostic program those discretionary services authorized under the federal regulations adopted to implement Title XIX of the federal Social Security Act, as amended. The division, in obtaining physical therapy services, occupational therapy services, and services for individuals with speech, hearing and language disorders, may enter into a cooperative agreement with the State Department of Education for the provision of those services to handicapped students by public school districts using state funds that are provided from the appropriation to the Department of Education to obtain federal matching funds through the division. The division, in obtaining medical and mental health assessments, treatment, care and

services for children who are in, or at risk of being put in, the custody of the Mississippi Department of Human Services may enter into a cooperative agreement with the Mississippi Department of Human Services for the provision of those services using state funds that are provided from the appropriation to the Department of Human Services to obtain federal matching funds through the division.

(6) Physician's services. The division shall allow twelve (12) physician visits annually. The division may develop and implement a different reimbursement model or schedule for physician's services provided by physicians based at an academic health care center and by physicians at rural health centers that are associated with an academic health care center. From and after January 1, 2010, all fees for physician's services that are covered only by Medicaid shall be increased to ninety percent (90%) of the rate established on January 1, 2010, and as may be adjusted each July thereafter, under Medicare. The division may provide for a reimbursement rate for physician's services of up to one hundred percent (100%) of the rate established under Medicare for physician's services that are provided after the normal working hours of the physician, as determined in accordance with regulations of the division. The division may reimburse eligible providers as determined by the Patient Protection and Affordable Care Act for certain primary care services as defined by the act

at one hundred percent (100%) of the rate established under Medicare.

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

(b) [Repealed]

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

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

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

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

The division shall allow for a combination of prescriptions for single source and innovator multiple source drugs and generic drugs to meet the needs of the beneficiaries, not to exceed five (5) prescriptions per month for each noninstitutionalized Medicaid beneficiary, with not more than two (2) of those prescriptions being for single source or innovator multiple source drugs unless the single source or innovator multiple source drug is less expensive than the generic equivalent.

The executive director may approve specific maintenance drugs for beneficiaries with certain medical conditions, which may be prescribed and dispensed in three-month supply increments.

Drugs prescribed for a resident of a psychiatric residential treatment facility must be provided in true unit doses when available. The division may require that drugs not covered by Medicare Part D for a resident of a long-term care facility be provided in true unit doses when available. Those drugs that were

originally billed to the division but are not used by a resident in any of those facilities shall be returned to the billing pharmacy for credit to the division, in accordance with the guidelines of the State Board of Pharmacy and any requirements of federal law and regulation. Drugs shall be dispensed to a recipient and only one (1) dispensing fee per month may be charged. The division shall develop a methodology for reimbursing for restocked drugs, which shall include a restock fee as determined by the division not exceeding Seven Dollars and Eighty-two Cents ($7.82).

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

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

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

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

Medicare for payment before they may be processed by the division's online payment system.

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

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

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

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

dispensing fee, or the providers' usual and customary charge to the general public.

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

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

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

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

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

(10) (a) Dental care that is an adjunct to treatment of an acute medical or surgical condition; services of oral surgeons and dentists in connection with surgery related to the

jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone; and emergency dental extractions and treatment related thereto. On July 1, 2007, fees for dental care and surgery under authority of this paragraph (10) shall be reimbursed as provided in subparagraph (b). It is the intent of the Legislature that this rate revision for dental services will be an incentive designed to increase the number of dentists who actively provide Medicaid services. This dental services rate revision shall be known as the "James Russell Dumas Medicaid Dental Incentive Program."

The division shall annually determine the effect of this incentive by evaluating the number of dentists who are Medicaid providers, the number who and the degree to which they are actively billing Medicaid, the geographic trends of where dentists are offering what types of Medicaid services and other statistics pertinent to the goals of this legislative intent. This data shall be presented to the Chair of the Senate Public Health and Welfare Committee and the Chair of the House Medicaid Committee.

(b) The Division of Medicaid shall establish a fee schedule, to be effective from and after July 1, 2007, for dental services. The schedule shall provide for a fee for each dental service that is equal to a percentile of normal and customary private provider fees, as defined by the Ingenix Customized Fee Analyzer Report, which percentile shall be determined by the division. The schedule shall be reviewed annually by the division

and dental fees shall be adjusted to reflect the percentile determined by the division.

(c) For fiscal year 2008, the amount of state funds appropriated for reimbursement for dental care and surgery shall be increased by ten percent (10%) of the amount of state fund expenditures for that purpose for fiscal year 2007. For each of fiscal years 2009 and 2010, the amount of state funds appropriated for reimbursement for dental care and surgery shall be increased by ten percent (10%) of the amount of state fund expenditures for that purpose for the preceding fiscal year.

(d) The division shall establish an annual benefit limit of Two Thousand Five Hundred Dollars ($2,500.00) in dental expenditures per Medicaid-eligible recipient; however, a recipient may exceed the annual limit on dental expenditures provided in this paragraph with prior approval of the division.

(e) The division shall include dental services as a necessary component of overall health services provided to children who are eligible for services.

(f) This paragraph (10) shall stand repealed on July 1, 2016.

(11) Eyeglasses for all Medicaid beneficiaries who have (a) had surgery on the eyeball or ocular muscle that results in a vision change for which eyeglasses or a change in eyeglasses is medically indicated within six (6) months of the surgery and is in accordance with policies established by the division, or (b) one

(1) pair every five (5) years and in accordance with policies established by the division. In either instance, the eyeglasses must be prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the beneficiary may select.

(12) Intermediate care facility services.

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

(b) All state-owned intermediate care facilities for individuals with intellectual disabilities shall be reimbursed on a full reasonable cost basis.

(c) Effective January 1, 2015, the division shall update the fair rental reimbursement system for intermediate care facilities for individuals with intellectual disabilities.

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

(14) Clinic services. Such diagnostic, preventive, therapeutic, rehabilitative or palliative services furnished to an outpatient by or under the supervision of a physician or dentist

in a facility that is not a part of a hospital but that is organized and operated to provide medical care to outpatients. Clinic services shall include any services reimbursed as outpatient hospital services that may be rendered in such a facility, including those that become so after July 1, 1991. On July 1, 1999, all fees for physicians' services reimbursed under authority of this paragraph (14) shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as may be adjusted each July thereafter, under Medicare (Title XVIII of the federal Social Security Act, as amended). The division may develop and implement a different reimbursement model or schedule for physician's services provided by physicians based at an academic health care center and by physicians at rural health centers that are associated with an academic health care center. The division may provide for a reimbursement rate for physician's clinic services of up to one hundred percent (100%) of the rate established under Medicare for physician's services that are provided after the normal working hours of the physician, as determined in accordance with regulations of the division.

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

Immediately upon passage of House Bill No. 1349, 2018 Regular Session, the Division of Medicaid * * * shall apply for a waiver amendment to increase payments for all licensed adult day care facilities * * * to Seventy-five Dollars ($75.00) per day * * * to go into effect immediately upon approval by Centers for Medicare and Medicaid Services (CMS).

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

(17) Durable medical equipment services and medical supplies. Precertification of durable medical equipment and

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

(18) (a) Notwithstanding any other provision of this section to the contrary, as provided in the Medicaid state plan amendment or amendments as defined in Section 43-13-145(10), the division shall make additional reimbursement to hospitals that serve a disproportionate share of low-income patients and that meet the federal requirements for those payments as provided in Section 1923 of the federal Social Security Act and any applicable regulations. It is the intent of the Legislature that the division shall draw down all available federal funds allotted to the state for disproportionate share hospitals. However, from and after January 1, 1999, public hospitals participating in the Medicaid disproportionate share program may be required to participate in an intergovernmental transfer program as provided in Section 1903 of the federal Social Security Act and any applicable regulations.

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

contracted by public hospitals. Upon successful implementation of a Medicare Upper Payment Limits Program for physicians employed by public hospitals, the division may develop a plan for implementing an Upper Payment Limits Program for physicians employed by other classes of hospitals. The division shall assess each hospital and, if the program is established for nursing facilities, shall assess each nursing facility, for the sole purpose of financing the state portion of the Medicare Upper Payment Limits Program. The hospital assessment shall be as provided in Section 43-13-145(4)(a) and the nursing facility assessment, if established, shall be based on Medicaid utilization or other appropriate method consistent with federal regulations. The assessment will remain in effect as long as the state participates in the Medicare Upper Payment Limits Program. Public hospitals with physicians participating in the Medicare Upper Payment Limits Program shall be required to participate in an intergovernmental transfer program. As provided in the Medicaid state plan amendment or amendments as defined in Section 43-13-145(10), the division shall make additional reimbursement to hospitals and, if the program is established for nursing facilities, shall make additional reimbursement to nursing facilities, for the Medicare Upper Payment Limits, and, if the program is established for physicians, shall make additional reimbursement for physicians, as defined in Section 1902(a)(30) of the federal Social Security Act and any applicable federal regulations. Effective upon

implementation of the Mississippi Hospital Access Program (MHAP) provided in subparagraph (c)(i) below, the hospital portion of the inpatient Upper Payment Limits Program shall transition into and be replaced by the MHAP program.

(c) (i) Not later than December 1, 2015, the division shall, subject to approval by the Centers for Medicare and Medicaid Services (CMS), establish, implement and operate a Mississippi Hospital Access Program (MHAP) for the purpose of protecting patient access to hospital care through hospital inpatient reimbursement programs provided in this section designed to maintain total hospital reimbursement for inpatient services rendered by in-state hospitals and the out-of-state hospital that is authorized by federal law to submit intergovernmental transfers (IGTs) to the State of Mississippi and is classified as Level I trauma center located in a county contiguous to the state line at the maximum levels permissible under applicable federal statutes and regulations, at which time the current inpatient Medicare Upper Payment Limits (UPL) Program for hospital inpatient services shall transition to the MHAP.

(ii) Subject only to approval by the Centers for Medicare and Medicaid Services (CMS) where required, the MHAP shall provide increased inpatient capitation (PMPM) payments to managed care entities contracting with the division pursuant to subsection (H) of this section to support availability of hospital services or such other payments permissible under federal law

necessary to accomplish the intent of this subsection. For inpatient services rendered after July 1, 2015, but prior to the effective date of CMS approval and full implementation of this program, the division may pay lump-sum enhanced, transition payments, prorated inpatient UPL payments based upon fiscal year 2015 June distribution levels, enhanced hospital access (PMPM) payments or such other methodologies as are approved by CMS such that the level of additional reimbursement required by this section is paid for all Medicaid hospital inpatient services delivered in fiscal year 2016.

(iii) The intent of this subparagraph (c) is that effective for all inpatient hospital Medicaid services during state fiscal year 2016, and so long as this provision shall remain in effect hereafter, the division shall to the fullest extent feasible replace the additional reimbursement for hospital inpatient services under the inpatient Medicare Upper Payment Limits (UPL) Program with additional reimbursement under the MHAP.

(iv) The division shall assess each hospital as provided in Section 43-13-145(4)(a) for the purpose of financing the state portion of the MHAP and such other purposes as specified in Section 43-13-145. The assessment will remain in effect as long as the MHAP is in effect.

(v) In the event that the MHAP program under this subparagraph (c) is not approved by CMS, the inpatient UPL program under subparagraph (b) shall immediately become restored

in the manner required to provide the maximum permissible level of UPL payments to hospital providers for all inpatient services rendered from and after July 1, 2015.

(19) (a) Perinatal risk management services. The division shall promulgate regulations to be effective from and after October 1, 1988, to establish a comprehensive perinatal system for risk assessment of all pregnant and infant Medicaid recipients and for management, education and follow-up for those who are determined to be at risk. Services to be performed include case management, nutrition assessment/counseling, psychosocial assessment/counseling and health education. The division shall contract with the State Department of Health to provide the services within this paragraph (Perinatal High Risk Management/Infant Services System (PHRM/ISS)). The State Department of Health as the agency for PHRM/ISS for the Division of Medicaid shall be reimbursed on a full reasonable cost basis.

(b) Early intervention system services. The division shall cooperate with the State Department of Health, acting as lead agency, in the development and implementation of a statewide system of delivery of early intervention services, under Part C of the Individuals with Disabilities Education Act (IDEA). The State Department of Health shall certify annually in writing to the executive director of the division the dollar amount of state early intervention funds available that will be utilized as a certified match for Medicaid matching funds. Those funds then

shall be used to provide expanded targeted case management services for Medicaid eligible children with special needs who are eligible for the state's early intervention system. Qualifications for persons providing service coordination shall be determined by the State Department of Health and the Division of Medicaid.

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

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

comparable services rendered by a physician. The division may provide for a reimbursement rate for nurse practitioner services of up to one hundred percent (100%) of the reimbursement rate for comparable services rendered by a physician for nurse practitioner services that are provided after the normal working hours of the nurse practitioner, as determined in accordance with regulations of the division.

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

(23) Inpatient psychiatric services. Inpatient psychiatric services to be determined by the division for recipients under age twenty-one (21) that are provided under the direction of a physician in an inpatient program in a licensed acute care psychiatric facility or in a licensed psychiatric residential treatment facility, before the recipient reaches age twenty-one (21) or, if the recipient was receiving the services immediately before he or she reached age twenty-one (21), before the earlier of the date he or she no longer requires the services or the date he or she reaches age twenty-two (22), as provided by federal regulations. From and after January 1, 2015, the division shall update the fair rental reimbursement system for psychiatric residential treatment facilities. Precertification of inpatient

days and residential treatment days must be obtained as required by the division. From and after July 1, 2009, all state-owned and state-operated facilities that provide inpatient psychiatric services to persons under age twenty-one (21) who are eligible for Medicaid reimbursement shall be reimbursed for those services on a full reasonable cost basis.

(24) [Deleted]

(25) [Deleted]

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

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

(28) Other health insurance premiums that are cost-effective as defined by the United States Secretary of Health

and Human Services. Medicare eligible must have Medicare Part B before other insurance premiums can be paid.

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

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

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

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

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

(33) Podiatrist services.

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

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

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

of an administrative cost. The PEER Committee shall conduct a performance evaluation of the nonemergency transportation program to evaluate the administration of the program and the providers of transportation services to determine the most cost-effective ways of providing nonemergency transportation services to the patients served under the program. The performance evaluation shall be completed and provided to the members of the Senate Public Health and Welfare Committee and the House Medicaid Committee not later than January 15, 2008.

(37) [Deleted]

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

(39) Dually eligible Medicare/Medicaid beneficiaries. The division shall pay the Medicare deductible and coinsurance amounts for services available under Medicare, as determined by the division. From and after July 1, 2009, the division shall reimburse crossover claims for inpatient hospital services and crossover claims covered under Medicare Part B in the same manner

that was in effect on January 1, 2008, unless specifically authorized by the Legislature to change this method.

(40) [Deleted]

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

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

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

(44) Nursing facility services for the severely disabled.

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

(b) Those services must be provided in a long-term care nursing facility dedicated to the care and treatment of persons with severe disabilities.

(45) Physician assistant services. Services furnished by a physician assistant who is licensed by the State Board of Medical Licensure and is practicing with physician supervision under regulations adopted by the board, under regulations adopted by the division. Reimbursement for those services shall not exceed ninety percent (90%) of the reimbursement rate for comparable services rendered by a physician. The division may provide for a reimbursement rate for physician assistant services of up to one hundred percent (100%) or the reimbursement rate for comparable services rendered by a physician for physician assistant services that are provided after the normal working

hours of the physician assistant, as determined in accordance with regulations of the division.

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

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

(b) Participation in any disease management program implemented under this paragraph (47) is optional with the individual. An individual must affirmatively elect to participate in the disease management program in order to participate, and may elect to discontinue participation in the program at any time.

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

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

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

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

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

(51) Upon determination of Medicaid eligibility and in association with annual redetermination of Medicaid eligibility,

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

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

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

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

(54) Adult foster care services pilot program. Social and protective services on a pilot program basis in an approved

foster care facility for vulnerable adults who would otherwise need care in a long-term care facility, to be implemented in an area of the state with the greatest need for such program, under the Medicaid Waivers for the Elderly and Disabled program or an assisted living waiver. The division may use grants, waivers, demonstrations or other projects as necessary in the development and implementation of this adult foster care services pilot program.

(55) Therapy services. The plan of care for therapy services may be developed to cover a period of treatment for up to six (6) months, but in no event shall the plan of care exceed a six-month period of treatment. The projected period of treatment must be indicated on the initial plan of care and must be updated with each subsequent revised plan of care. Based on medical necessity, the division shall approve certification periods for less than or up to six (6) months, but in no event shall the certification period exceed the period of treatment indicated on the plan of care. The appeal process for any reduction in therapy services shall be consistent with the appeal process in federal regulations.

(56) Prescribed pediatric extended care centers services for medically dependent or technologically dependent children with complex medical conditions that require continual care as prescribed by the child's attending physician, as determined by the division.

(57) No Medicaid benefit shall restrict coverage for medically appropriate treatment prescribed by a physician and agreed to by a fully informed individual, or if the individual lacks legal capacity to consent by a person who has legal authority to consent on his or her behalf, based on an individual's diagnosis with a terminal condition. As used in this paragraph (57), "terminal condition" means any aggressive malignancy, chronic end-stage cardiovascular or cerebral vascular disease, or any other disease, illness or condition which a physician diagnoses as terminal.

(B) Notwithstanding any other provision of this article to the contrary, the division shall reduce the rate of reimbursement to providers for any service provided under this section by five percent (5%) of the allowed amount for that service. However, the reduction in the reimbursement rates required by this subsection (B) shall not apply to inpatient hospital services, nursing facility services, intermediate care facility services, psychiatric residential treatment facility services, pharmacy services provided under subsection (A)(9) of this section, adult day care facilities, or any service provided by the University of Mississippi Medical Center or a state agency, a state facility or a public agency that either provides its own state match through intergovernmental transfer or certification of funds to the division, or a service for which the federal government sets the reimbursement methodology and rate. From and after January 1,

2010, the reduction in the reimbursement rates required by this subsection (B) shall not apply to physicians' services. In addition, the reduction in the reimbursement rates required by this subsection (B) shall not apply to case management services and home-delivered meals provided under the home- and community-based services program for the elderly and disabled by a planning and development district (PDD). Planning and development districts participating in the home- and community-based services program for the elderly and disabled as case management providers shall be reimbursed for case management services at the maximum rate approved by the Centers for Medicare and Medicaid Services (CMS).

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

(D) Notwithstanding any provision of this article, except as authorized in the following subsection and in Section 43-13-139, neither * * * (1) the limitations on quantity or frequency of use

of or the fees or charges for any of the care or services available to recipients under this section, nor * * * (2) the payments, payment methodology as provided below in this subsection (D), or rates of reimbursement to providers rendering care or services authorized under this section to recipients, may be increased, decreased or otherwise changed from the levels in effect on July 1, 1999, unless they are authorized by an amendment to this section by the Legislature. However, the restriction in this subsection shall not prevent the division from changing the payments, payment methodology as provided below in this subsection (D), or rates of reimbursement to providers without an amendment to this section whenever those changes are required by federal law or regulation, or whenever those changes are necessary to correct administrative errors or omissions in calculating those payments or rates of reimbursement. The prohibition on any changes in payment methodology provided in this subsection (D) shall apply only to payment methodologies used for determining the rates of reimbursement for inpatient hospital services, outpatient hospital services, nursing facility services, and/or pharmacy services, except as required by federal law, and the federally mandated rebasing of rates as required by the Centers for Medicare and Medicaid Services (CMS) shall not be considered payment methodology for purposes of this subsection (D). No service benefits or reimbursement limitations in this section shall apply to payments under an APR-DRG or APC model or a managed care

program or similar model described in subsection (H) of this section.

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

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

43-13-115. Beginning in fiscal year 2010 and in fiscal years thereafter, when Medicaid expenditures are projected to exceed funds available for any quarter in the fiscal year, the division shall submit the expected shortfall information to the PEER Committee, which shall review the computations of the division and report its findings to the Legislative Budget Office within thirty (30) days of such notification by the division, and not later than January 7 in any year. If expenditure reductions or cost containments are implemented, the Governor may implement a maximum amount of state share expenditure reductions to providers, of which hospitals will be responsible for twenty-five percent (25%) of provider reductions as follows: in fiscal year 2010, the maximum amount shall be Twenty-four Million Dollars ($24,000,000.00); in fiscal year 2011, the maximum amount shall be Thirty-two Million Dollars ($32,000,000.00); and in fiscal year 2012 and thereafter, the maximum amount shall be Forty Million Dollars ($40,000,000.00). However, instead of implementing cuts, the hospital share shall be in the form of an additional assessment not to exceed Ten Million Dollars ($10,000,000.00) as provided in Section 43-13-145(4)(a)(ii). If Medicaid expenditures are projected to exceed the amount of funds appropriated to the division in any fiscal year in excess of the expenditure reductions to providers, then funds shall be transferred by the State Fiscal Officer from the Health Care Trust Fund into the Health Care Expendable Fund and to the Governor's Office, Division

of Medicaid, from the Health Care Expendable Fund, in the amount and at such time as requested by the Governor to reconcile the deficit. If the cost containment measures described above have been implemented and there are insufficient funds in the Health Care Trust Fund to reconcile any remaining deficit in any fiscal year, the Governor shall institute any other additional cost containment measures on any program or programs authorized under this article to the extent allowed under federal law. Hospitals shall be responsible for twenty-five percent (25%) of any additional imposed provider cuts. However, instead of implementing hospital expenditure reductions, the hospital reductions shall be in the form of an additional assessment not to exceed twenty-five percent (25%) of provider expenditure reductions as provided in Section 43-13-145(4)(a)(ii). It is the intent of the Legislature that the expenditures of the division during any fiscal year shall not exceed the amounts appropriated to the division for that fiscal year.

(G) Notwithstanding any other provision of this article, it shall be the duty of each nursing facility, intermediate care facility for individuals with intellectual disabilities, psychiatric residential treatment facility, and nursing facility for the severely disabled that is participating in the Medicaid program to keep and maintain books, documents and other records as prescribed by the Division of Medicaid in substantiation of its cost reports for a period of three (3) years after the date of

submission to the Division of Medicaid of an original cost report, or three (3) years after the date of submission to the Division of Medicaid of an amended cost report.

(H) (1) Notwithstanding any other provision of this article, the division is authorized to implement (a) a managed care program, (b) a coordinated care program, (c) a coordinated care organization program, (d) a health maintenance organization program, (e) a patient-centered medical home program, (f) an accountable care organization program, (g) provider-sponsored health plan, or (h) any combination of the above programs. Managed care programs, coordinated care programs, coordinated care organization programs, health maintenance organization programs, patient-centered medical home programs, accountable care organization programs, provider-sponsored health plans, or any combination of the above programs or other similar programs implemented by the division under this section shall be limited to the greater of (i) forty-five percent (45%) of the total enrollment of Medicaid beneficiaries, or (ii) the categories of beneficiaries participating in the program as of January 1, 2014, plus the categories of beneficiaries composed primarily of persons younger than nineteen (19) years of age, and the division is authorized to enroll categories of beneficiaries in such program(s) as long as the appropriate limitations are not exceeded in the aggregate. As a condition for the approval of any program

under this subsection (H)(1), the division shall require that no program may:

(a) Pay providers at a rate that is less than the Medicaid All-Patient Refined-Diagnosis Related Groups (APR-DRG) reimbursement rate;

(b) Override the medical decisions of hospital physicians or staff regarding patients admitted to a hospital for an emergency medical condition as defined by 42 US Code Section 1395dd. This restriction (b) does not prohibit the retrospective review of the appropriateness of the determination that an emergency medical condition exists by chart review or coding algorithm, nor does it prohibit prior authorization for nonemergency hospital admissions;

(c) Pay providers at a rate that is less than the normal Medicaid reimbursement rate; however, the division may approve use of innovative payment models that recognize alternative payment models, including quality and value-based payments, provided both parties mutually agree and the Division of Medicaid approves of said models. Participation in the provider network of any managed care, coordinated care, provider-sponsored health plan, or similar contractor shall not be conditioned on the provider's agreement to accept such alternative payment models;

(d) Implement a prior authorization program for prescription drugs that is more stringent than the prior

authorization processes used by the division in its administration of the Medicaid program;

(e) Implement a policy that does not comply with the prescription drugs payment requirements established in subsection (A)(9) of this section;

(f) Implement a preferred drug list that is more stringent than the mandatory preferred drug list established by the division under subsection (A)(9) of this section;

(g) Implement a policy which denies beneficiaries with hemophilia access to the federally funded hemophilia treatment centers as part of the Medicaid Managed Care network of providers. All Medicaid beneficiaries with hemophilia shall receive unrestricted access to anti-hemophilia factor products through noncapitated reimbursement programs.

(2) Any contractors providing direct patient care under a managed care program established in this section shall provide to the Legislature and the division statistical data to be shared with provider groups in order to improve patient access, appropriate utilization, cost savings and health outcomes.

(3) All health maintenance organizations, coordinated care organizations, provider-sponsored health plans, or other organizations paid for services on a capitated basis by the division under any managed care program or coordinated care program implemented by the division under this section shall reimburse all providers in those organizations at rates no lower

than those provided under this section for beneficiaries who are not participating in those programs.

(4) No health maintenance organization, coordinated care organization, provider-sponsored health plan, or other organization paid for services on a capitated basis by the division under any managed care program or coordinated care program implemented by the division under this section shall require its providers or beneficiaries to use any pharmacy that ships, mails or delivers prescription drugs or legend drugs or devices.

(I) [Deleted]

(J) There shall be no cuts in inpatient and outpatient hospital payments, or allowable days or volumes, as long as the hospital assessment provided in Section 43-13-145 is in effect. This subsection (J) shall not apply to decreases in payments that are a result of: reduced hospital admissions, audits or payments under the APR-DRG or APC models, or a managed care program or similar model described in subsection (H) of this section.

(K) This section shall stand repealed on June 30, *** * *** 2021.

SECTION 6. This act shall take effect and be in force from and after July 1, 2018.