MISSISSIPPI LEGISLATURE REGULAR SESSION 2007

By: Senator(s) Burton

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2363

1 AN ACT TO ESTABLISH A LONG-TERM CARE ADVISORY COUNCIL TO
2 STUDY AND DEVELOP RECOMMENDATIONS TO THE GOVERNOR AND THE 2008
3 REGULAR SESSION OF THE LEGISLATURE RELATING TO THE SERVICES
4 PROVIDED TO THE AGED AND DISABLED UNDER RECENT AMENDMENTS TO
5 FEDERAL LAW; TO PROVIDE DEFINITIONS; TO SPECIFICALLY PROVIDE THAT
6 THE ADVISORY COUNCIL SHALL MAKE RECOMMENDATIONS RELATING TO
7 COORDINATION OF HOME- AND COMMUNITY-BASED SERVICES FOR THE AGED
8 AND DISABLED AND THE ESTABLISHMENT OF A COORDINATING UNIT OF
9 GOVERNMENT; TO DIRECT THE DEPARTMENT OF HUMAN SERVICES TO PROVIDE
10 SUPPORT FOR THE WORK OF THE ADVISORY COUNCIL; TO AMEND SECTION
11 43-7-7, MISSISSIPPI CODE OF 1972, TO PRESCRIBE THE
12 RESPONSIBILITIES OF THE DEPARTMENT OF HUMAN SERVICES AS LEAD
13 AGENCY FOR FEDERAL OLD AGE ASSISTANCE PROGRAMS IN FISCAL YEAR
14 2009; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO
15 PROVIDE FOR AN EXPANSION OF HOME- AND COMMUNITY-BASED SERVICES BY
16 THE DIVISION OF MEDICAID, OFFICE OF THE GOVERNOR, IN FISCAL YEAR
17 2009; AND FOR RELATED PURPOSES.

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

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

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

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

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

32 (d) The federal "New Freedom Initiative" was launched
33 in 2001 for the purpose of promoting the goal of independent
34 living for persons with disabilities; and Executive Order No.

35 13217, issued by the President of the United States on June 18,
36 2001, called upon the federal government to assist states and
37 localities to swiftly implement the 1999 United States Supreme
38 Court decision in *Olmstead v. L.C.* and directed federal agencies
39 to evaluate their policies, programs, statutes and regulations to
40 determine whether any should be revised or modified to improve the
41 availability of home- and community-based services for qualified
42 persons with disabilities;

43 (e) The federal "Older Americans Act Amendments of
44 2006" (Public Law 109-365) and the Deficit Reduction Act (DRA)
45 provided states with much flexibility to make significant reforms
46 to pursue innovative ideas in health care, Medicaid services for
47 the aging and disabled, consumer directed health care and
48 rebalancing long-term care. These amendments defined the
49 functions of Aging and Disability Resource Centers to provide
50 comprehensive information on long-term care program options and
51 directed states to create a state system of long-term care to
52 enable older individuals to receive long-term care in home- and
53 community-based settings and to provide counseling services
54 relating to such long-term care; and

55 (f) Older adults and those with physical disabilities
56 or Alzheimer's disease and related disorders that require a
57 nursing facility level of care should not be forced to choose
58 between going into a nursing home or giving up the medical
59 assistance that pays for their needed services, and thereby be
60 denied the right to choose where they receive those services;
61 their eligibility for home- and community-based long-term care
62 services under Medicaid should be based upon the same income and
63 asset standards as those used to determine eligibility for
64 long-term care in an institutional setting.

65 (2) As used in this act:

66 (a) The term "Aging and Disability Resource Center"
67 means a program established by a state as part of the state system
68 of long-term care, to provide a coordinated system for providing:
69 (i) Comprehensive information on the full range of
70 available public and private long-term care programs, options,
71 service providers and resources within a community, including
72 information on the availability of integrated long-term care;
73 (ii) Personal counseling to assist individuals in
74 assessing their existing or anticipated long-term care needs, and
75 developing and implementing a plan for long-term care designed to
76 meet their specific needs and circumstances; and
77 (iii) Consumers' access to the range of publicly
78 supported long-term care programs for which consumers may be
79 eligible, by serving as a convenient point of entry for such
80 programs.
81 (b) The term "at risk for institutional placement"
82 means, with respect to an older individual, that such individual
83 is unable to perform at least two (2) activities of daily living
84 without substantial assistance (including verbal reminding,
85 physical cuing or supervision) and is determined by the state
86 involved to be in need of placement in a long-term care facility.
87 (c) The term "long-term care" means any service, care
88 or item:
89 (i) Intended to assist individuals in coping with,
90 and to the extent practicable compensate for, a functional
91 impairment in carrying out activities of daily living;
92 (ii) Furnished at home, in a community care
93 setting (including a small community care setting as defined in
94 subsection (g)(1), and a large community care setting as defined
95 in subsection (h)(1) of Section 1929 of the Social Security Act
96 (42 USC 1396t), or in a long-term care facility; and
97 (iii) Not furnished to prevent, diagnose, treat or
98 cure a medical disease or condition.

99 (d) The term "state system of long-term care" means the
100 federal, state and local programs and activities administered by a
101 state that provide, support or facilitate access to long-term care
102 to individuals in such state.
103 (e) "Home- and community-based services" means Medicaid
104 home- and community-based long-term care options available in this
105 state, including, but not limited to, the Community Care Program
106 for the Elderly and Disabled, Assisted Living, Adult Family Care,
107 Caregiver Assistance Program, Adult Day Health Services, Traumatic
108 Brain Injury, AIDS Community Care Alternatives Program, Community
109 Resources for People with Disabilities, and Community Resources
110 for People with Disabilities Private Duty Nursing.
111 (3) (a) There is hereby established the Long-Term Care
112 Advisory Council within the Mississippi Department of Human
113 Services. The advisory council shall be entitled to receive such
114 information from the Department of Human Services, the Division of
115 Medicaid, the State Department of Rehabilitation Services and
116 other agencies relating to services for the aged and disabled, as
117 the advisory council deems necessary to carry out its
118 responsibilities under this act.
119 (b) The advisory council shall monitor and assess, and
120 develop a report to the Governor and the 2008 Regular Session of
121 the Legislature on (i) the impact of federal amendments to the
122 "Older Americans Act" and the Deficit Reduction Act on
123 Mississippi's public and private system of programs and care for
124 the aged and disabled; (ii) the need for a new administrative unit
125 of government within the Governor's Office or other appropriate
126 agency to facilitate and coordinate the delivery of services to
127 the aged and disabled under said federal amendments; (iii) the
128 establishment of Aging and Disability Resource Centers on a
129 regional and district basis throughout the state to coordinate and
130 provide services to the aged and disabled as contemplated under
131 federal law and regulations; (iv) the implementation and operation

132 of the Medicaid long-term care expenditure reforms and other
133 provisions of the federal Deficit Reduction Act; and (v)
134 recommendations for a program to recruit and train a stable
135 workforce of home care providers, including recommendations for
136 changes to provider reimbursement under Medicaid home- and
137 community-based care programs.

138 (c) The advisory council shall comprise thirteen (13)
139 members as follows:

140 (i) The Executive Director of the Department of
141 Human Services, the Executive Director of the Division of
142 Medicaid-Office of the Governor, the Executive Director of the
143 State Department of Rehabilitation Services and the State
144 Treasurer, or their designees, as ex officio members;

145 (ii) The Public Health Policy Advisor to the
146 Governor;

147 (iii) Eight (8) public members to be appointed by
148 the Governor as follows: one (1) person appointed upon the
149 recommendation of AARP; one (1) person upon the recommendation of
150 the Mississippi Association of Area Agencies on Aging; one (1)
151 person upon the recommendation of the Mississippi Association for
152 the Rights of Citizens with Disabilities (The ARC); one (1) person
153 upon the recommendation of the Medical Association of Mississippi;
154 one (1) person upon the recommendation of the Mississippi Hospital
155 Association; one (1) person that represents home- and
156 community-based health care workers; and one (1) person who is a
157 representative of the home care industry; and

158 (iv) The Chairman and Vice Chairman of the Senate
159 Public Health and Welfare Committee; the Chairman of the House
160 Public Health and Welfare Committee, the Chairman of the House
161 Medicaid Committee, the Chairman of the Senate Appropriations
162 Committee and the Chairman of the House Appropriations Committee.

163 (d) The advisory council shall organize as soon as
164 possible after the appointment of its members upon call of the

165 Governor and shall select from its membership a chairman and a
166 secretary.
167 (e) The Department of Human Services shall provide such
168 staff and administrative support to the advisory council as it
169 requires to carry out its responsibilities.
170 (f) The advisory council shall identify home- and
171 community-based long-term care service models that are determined
172 by the division to be efficient and cost-effective alternatives to
173 nursing home care, and develop clear and concise performance
174 standards for those services for which standards are not already
175 available in a home- and community-based services waiver.
176 (g) The advisory council shall seek to make information
177 available to the general public on a statewide basis, through
178 print and electronic media, regarding the various forms of
179 long-term care available in this state and the rights accorded to
180 long-term care consumers by statute and regulation, as well as
181 information about public and nonprofit agencies and organizations
182 that provide informational and advocacy services to assist
183 long-term care consumers and their families.
184 (4) Upon presentation of its report to the Governor and the
185 2008 Regular Session of the Legislature, the Long-Term Care
186 Advisory Council shall be dissolved.
187 **SECTION 2.** Section 43-7-7, Mississippi Code of 1972, is
188 amended as follows:
189 43-7-7. (1) The Department of Human Services shall be
190 responsible for the collection of data and statistics and for
191 making a continuing study of conditions affecting the general
192 welfare of the aging population; for providing for an inter-agency
193 and inter-departmental exchange of ideas; for encouraging and
194 assisting in the development of programs for the aging in
195 municipalities and counties of the state; for cooperation with
196 public and private agencies and departments in coordinating
197 programs for the aging; for encouraging and promoting biological,

198 physiological and sociological research; for making
199 recommendations for residential housing and needed nursing and
200 custodial care facilities.
201 (2) Beginning with the 2009 fiscal year, the Department of
202 Human Services shall, consistent with federal law and regulations,
203 promote the development and implementation of a state system of
204 long-term care that is a comprehensive, coordinated system that
205 enables older individuals to receive long-term care in home-and
206 community-based settings, in a manner responsive to the needs and
207 preferences of older individuals and their family caregivers by:
208 (a) Collaborating, coordinating and consulting with
209 other agencies in such state responsible for formulating,
210 implementing and administering programs, benefits and services
211 related to providing long-term care;
212 (b) Participating in any state government activities
213 concerning long-term care, including reviewing and commenting on
214 any state rules, regulations and policies related to long-term
215 care;
216 (c) Conducting analyses and making recommendations with
217 respect to strategies for modifying the state system of long-term
218 care to:
219 (i) Respond to the needs and preference of older
220 individuals and family caregivers;
221 (ii) Facilitate the provision, by service
222 providers, of long-term care in home- and community-based
223 settings; and
224 (iii) Target services to individuals at risk for
225 institutional placement, to permit such individuals to remain in
226 home- and community-based settings;
227 (d) Implementing (through area agencies on aging,
228 service providers and such other entities as the state determines
229 to be appropriate) evidence-based programs to assist older
230 individuals and their family caregivers in learning about and

231 making behavioral changes intended to reduce the risk of injury,
232 disease and disability among older individuals; and
233 (e) Providing for the availability and distribution
234 (through public education campaigns, Aging and Disability Resource
235 Centers, area agencies on aging and other appropriate means) of
236 information relating to:
237 (i) The need to plan in advance for long-term
238 care; and
239 (ii) The full range of available public and
240 private long-term care (including integrated long-term care)
241 programs, options, services providers and resources.
242 **SECTION 3.** Section 43-13-117, Mississippi Code of 1972, is
243 amended as follows:
244 43-13-117. Medicaid as authorized by this article shall
245 include payment of part or all of the costs, at the discretion of
246 the division, with approval of the Governor, of the following
247 types of care and services rendered to eligible applicants who
248 have been determined to be eligible for that care and services,
249 within the limits of state appropriations and federal matching
250 funds:
251 (1) Inpatient hospital services.
252 (a) The division shall allow thirty (30) days of
253 inpatient hospital care annually for all Medicaid recipients.
254 Precertification of inpatient days must be obtained as required by
255 the division. The division may allow unlimited days in
256 disproportionate hospitals as defined by the division for eligible
257 infants and children under the age of six (6) years if certified
258 as medically necessary as required by the division.
259 (b) From and after July 1, 1994, the Executive
260 Director of the Division of Medicaid shall amend the Mississippi
261 Title XIX Inpatient Hospital Reimbursement Plan to remove the
262 occupancy rate penalty from the calculation of the Medicaid

263 Capital Cost Component utilized to determine total hospital costs
264 allocated to the Medicaid program.
265 (c) Hospitals will receive an additional payment
266 for the implantable programmable baclofen drug pump used to treat
267 spasticity that is implanted on an inpatient basis. The payment
268 pursuant to written invoice will be in addition to the facility's
269 per diem reimbursement and will represent a reduction of costs on
270 the facility's annual cost report, and shall not exceed Ten
271 Thousand Dollars ($10,000.00) per year per recipient.
272 (2) Outpatient hospital services.
273 (a) Emergency services. The division shall allow
274 six (6) medically necessary emergency room visits per beneficiary
275 per fiscal year.
276 (b) Other outpatient hospital services. The
277 division shall allow benefits for other medically necessary
278 outpatient hospital services (such as chemotherapy, radiation,
279 surgery and therapy). Where the same services are reimbursed as
280 clinic services, the division may revise the rate or methodology
281 of outpatient reimbursement to maintain consistency, efficiency,
282 economy and quality of care.
283 (3) Laboratory and x-ray services.
284 (4) Nursing facility services.
285 (a) The division shall make full payment to
286 nursing facilities for each day, not exceeding fifty-two (52) days
287 per year, that a patient is absent from the facility on home
288 leave. Payment may be made for the following home leave days in
289 addition to the fifty-two-day limitation: Christmas, the day
290 before Christmas, the day after Christmas, Thanksgiving, the day
291 before Thanksgiving and the day after Thanksgiving.
292 (b) From and after July 1, 1997, the division
293 shall implement the integrated case-mix payment and quality
294 monitoring system, which includes the fair rental system for
295 property costs and in which recapture of depreciation is

296 eliminated. The division may reduce the payment for hospital
297 leave and therapeutic home leave days to the lower of the case-mix
298 category as computed for the resident on leave using the
299 assessment being utilized for payment at that point in time, or a
300 case-mix score of 1.000 for nursing facilities, and shall compute
301 case-mix scores of residents so that only services provided at the
302 nursing facility are considered in calculating a facility's per
303 diem.

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

307 (d) When a facility of a category that does not
308 require a certificate of need for construction and that could not
309 be eligible for Medicaid reimbursement is constructed to nursing
310 facility specifications for licensure and certification, and the
311 facility is subsequently converted to a nursing facility under a
312 certificate of need that authorizes conversion only and the
313 applicant for the certificate of need was assessed an application
314 review fee based on capital expenditures incurred in constructing
315 the facility, the division shall allow reimbursement for capital
316 expenditures necessary for construction of the facility that were
317 incurred within the twenty-four (24) consecutive calendar months
318 immediately preceding the date that the certificate of need
319 authorizing the conversion was issued, to the same extent that
320 reimbursement would be allowed for construction of a new nursing
321 facility under a certificate of need that authorizes that
322 construction. The reimbursement authorized in this subparagraph
323 (d) may be made only to facilities the construction of which was
324 completed after June 30, 1989. Before the division shall be
325 authorized to make the reimbursement authorized in this
326 subparagraph (d), the division first must have received approval
327 from the Centers for Medicare and Medicaid Services (CMS) of the
328 change in the state Medicaid plan providing for the reimbursement.

329 (e) The division shall develop and implement, not
330 later than January 1, 2001, a case-mix payment add-on determined
331 by time studies and other valid statistical data that will
332 reimburse a nursing facility for the additional cost of caring for
333 a resident who has a diagnosis of Alzheimer's or other related
334 dementia and exhibits symptoms that require special care. Any
335 such case-mix add-on payment shall be supported by a determination
336 of additional cost. The division shall also develop and implement
337 as part of the fair rental reimbursement system for nursing
338 facility beds, an Alzheimer's resident bed depreciation enhanced
339 reimbursement system that will provide an incentive to encourage
340 nursing facilities to convert or construct beds for residents with
341 Alzheimer's or other related dementia.
342 (f) The division shall develop and implement an
343 assessment process for long-term care services. The division may
344 provide the assessment and related functions directly or through
345 contract with the area agencies on aging.
346 The division shall apply for necessary federal waivers to
347 assure that additional services providing alternatives to nursing
348 facility care are made available to applicants for nursing
349 facility care.
350 (5) Periodic screening and diagnostic services for
351 individuals under age twenty-one (21) years as are needed to
352 identify physical and mental defects and to provide health care
353 treatment and other measures designed to correct or ameliorate
354 defects and physical and mental illness and conditions discovered
355 by the screening services, regardless of whether these services
356 are included in the state plan. The division may include in its
357 periodic screening and diagnostic program those discretionary
358 services authorized under the federal regulations adopted to
359 implement Title XIX of the federal Social Security Act, as
360 amended. The division, in obtaining physical therapy services,
361 occupational therapy services, and services for individuals with

362 speech, hearing and language disorders, may enter into a
363 cooperative agreement with the State Department of Education for
364 the provision of those services to handicapped students by public
365 school districts using state funds that are provided from the
366 appropriation to the Department of Education to obtain federal
367 matching funds through the division. The division, in obtaining
368 medical and psychological evaluations for children in the custody
369 of the State Department of Human Services may enter into a
370 cooperative agreement with the State Department of Human Services
371 for the provision of those services using state funds that are
372 provided from the appropriation to the Department of Human
373 Services to obtain federal matching funds through the division.
374 (6) Physician's services. The division shall allow
375 twelve (12) physician visits annually. All fees for physicians'
376 services that are covered only by Medicaid shall be reimbursed at
377 ninety percent (90%) of the rate established on January 1, 1999,
378 and as may be adjusted each July thereafter, under Medicare (Title
379 XVIII of the federal Social Security Act, as amended). The
380 division may develop and implement a different reimbursement model
381 or schedule for physician's services provided by physicians based
382 at an academic health care center and by physicians at rural
383 health centers that are associated with an academic health care
384 center.
385 (7) (a) Home health services for eligible persons, not
386 to exceed in cost the prevailing cost of nursing facility
387 services, not to exceed twenty-five (25) visits per year. All
388 home health visits must be precertified as required by the
389 division.
390 (b) Repealed.
391 (8) Emergency medical transportation services. On
392 January 1, 1994, emergency medical transportation services shall
393 be reimbursed at seventy percent (70%) of the rate established
394 under Medicare (Title XVIII of the federal Social Security Act, as

395 amended). "Emergency medical transportation services" shall mean,
396 but shall not be limited to, the following services by a properly
397 permitted ambulance operated by a properly licensed provider in
398 accordance with the Emergency Medical Services Act of 1974
399 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
400 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
401 (vi) disposable supplies, (vii) similar services.

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

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

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

417 The division shall allow for a combination of prescriptions
418 for single source and innovator multiple source drugs and generic
419 drugs to meet the needs of the beneficiaries, not to exceed five
420 (5) prescriptions per month for each noninstitutionalized Medicaid
421 beneficiary, with not more than two (2) of those prescriptions
422 being for single source or innovator multiple source drugs.

423 The executive director may approve specific maintenance drugs
424 for beneficiaries with certain medical conditions, which may be
425 prescribed and dispensed in three-month supply increments. The
426 executive director may allow a state agency or agencies to be the
427 sole source purchaser and distributor of hemophilia factor

428 medications, HIV/AIDS medications and other medications as
429 determined by the executive director as allowed by federal
430 regulations.

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

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

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

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

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

460 Medicare for payment before they may be processed by the
461 division's on-line payment system.
462 The division shall develop a pharmacy policy in which drugs
463 in tamper-resistant packaging that are prescribed for a resident
464 of a nursing facility but are not dispensed to the resident shall
465 be returned to the pharmacy and not billed to Medicaid, in
466 accordance with guidelines of the State Board of Pharmacy.
467 The division shall develop and implement a method or methods
468 by which the division will provide on a regular basis to Medicaid
469 providers who are authorized to prescribe drugs, information about
470 the costs to the Medicaid program of single source drugs and
471 innovator multiple source drugs, and information about other drugs
472 that may be prescribed as alternatives to those single source
473 drugs and innovator multiple source drugs and the costs to the
474 Medicaid program of those alternative drugs.
475 Notwithstanding any law or regulation, information obtained
476 or maintained by the division regarding the prescription drug
477 program, including trade secrets and manufacturer or labeler
478 pricing, is confidential and not subject to disclosure except to
479 other state agencies.
480 (b) Payment by the division for covered
481 multisource drugs shall be limited to the lower of the upper
482 limits established and published by the Centers for Medicare and
483 Medicaid Services (CMS) plus a dispensing fee, or the estimated
484 acquisition cost (EAC) as determined by the division, plus a
485 dispensing fee, or the providers' usual and customary charge to
486 the general public.
487 Payment for other covered drugs, other than multisource drugs
488 with CMS upper limits, shall not exceed the lower of the estimated
489 acquisition cost as determined by the division, plus a dispensing
490 fee or the providers' usual and customary charge to the general
491 public.

492 Payment for nonlegend or over-the-counter drugs covered by
493 the division shall be reimbursed at the lower of the division's
494 estimated shelf price or the providers' usual and customary charge
495 to the general public.
496 The dispensing fee for each new or refill prescription,
497 including nonlegend or over-the-counter drugs covered by the
498 division, shall be not less than Three Dollars and Ninety-one
499 Cents ($3.91), as determined by the division.
500 The division shall not reimburse for single source or
501 innovator multiple source drugs if there are equally effective
502 generic equivalents available and if the generic equivalents are
503 the least expensive.
504 It is the intent of the Legislature that the pharmacists
505 providers be reimbursed for the reasonable costs of filling and
506 dispensing prescriptions for Medicaid beneficiaries.
507 (10) Dental care that is an adjunct to treatment of an
508 acute medical or surgical condition; services of oral surgeons and
509 dentists in connection with surgery related to the jaw or any
510 structure contiguous to the jaw or the reduction of any fracture
511 of the jaw or any facial bone; and emergency dental extractions
512 and treatment related thereto. On July 1, 1999, all fees for
513 dental care and surgery under authority of this paragraph (10)
514 shall be increased to one hundred sixty percent (160%) of the
515 amount of the reimbursement rate that was in effect on June 30,
516 1999. It is the intent of the Legislature to encourage more
517 dentists to participate in the Medicaid program.
518 (11) Eyeglasses for all Medicaid beneficiaries who have
519 (a) had surgery on the eyeball or ocular muscle that results in a
520 vision change for which eyeglasses or a change in eyeglasses is
521 medically indicated within six (6) months of the surgery and is in
522 accordance with policies established by the division, or (b) one
523 (1) pair every five (5) years and in accordance with policies
524 established by the division. In either instance, the eyeglasses

525 must be prescribed by a physician skilled in diseases of the eye
526 or an optometrist, whichever the beneficiary may select.
527 (12) Intermediate care facility services.
528 (a) The division shall make full payment to all
529 intermediate care facilities for the mentally retarded for each
530 day, not exceeding eighty-four (84) days per year, that a patient
531 is absent from the facility on home leave. Payment may be made
532 for the following home leave days in addition to the
533 eighty-four-day limitation: Christmas, the day before Christmas,
534 the day after Christmas, Thanksgiving, the day before Thanksgiving
535 and the day after Thanksgiving.
536 (b) All state-owned intermediate care facilities
537 for the mentally retarded shall be reimbursed on a full reasonable
538 cost basis.
539 (13) Family planning services, including drugs,
540 supplies and devices, when those services are under the
541 supervision of a physician or nurse practitioner.
542 (14) Clinic services. Such diagnostic, preventive,
543 therapeutic, rehabilitative or palliative services furnished to an
544 outpatient by or under the supervision of a physician or dentist
545 in a facility that is not a part of a hospital but that is
546 organized and operated to provide medical care to outpatients.
547 Clinic services shall include any services reimbursed as
548 outpatient hospital services that may be rendered in such a
549 facility, including those that become so after July 1, 1991. On
550 July 1, 1999, all fees for physicians' services reimbursed under
551 authority of this paragraph (14) shall be reimbursed at ninety
552 percent (90%) of the rate established on January 1, 1999, and as
553 may be adjusted each July thereafter, under Medicare (Title XVIII
554 of the federal Social Security Act, as amended). The division may
555 develop and implement a different reimbursement model or schedule
556 for physician's services provided by physicians based at an
557 academic health care center and by physicians at rural health

558 centers that are associated with an academic health care center.
559 On July 1, 1999, all fees for dentists' services reimbursed under
560 authority of this paragraph (14) shall be increased to one hundred
561 sixty percent (160%) of the amount of the reimbursement rate that
562 was in effect on June 30, 1999.

563 (15) Home- and community-based services for the elderly
564 and disabled, as provided under Title XIX of the federal Social
565 Security Act, as amended, under waivers, subject to the
566 availability of funds specifically appropriated for that purpose
567 by the Legislature. Beginning in fiscal year 2009, and in each
568 succeeding fiscal year through fiscal year 2013, the division
569 shall implement a process that rebalances the overall allocation
570 of Medicaid funding for long-term care services through the
571 expansion of home- and community-based services for persons
572 eligible for long-term care as defined by regulation of the
573 division, consistent with federal law and regulation. The
574 expansion of home- and community-based services shall be funded,
575 within the existing level of appropriations, by diverting persons
576 in need of long-term care from nursing home placements to home-
577 and community-based services. The Division of Medicaid shall
578 apply to the federal Centers for Medicare and Medicaid Services
579 for any waiver of federal requirements, or for any state plan
580 amendments or home- and community-based services waiver
581 amendments, which may be necessary to obtain federal financial
582 participation for state Medicaid expenditures in order to
583 effectuate the purposes of this act.

584 (16) Mental health services. Approved therapeutic and
585 case management services (a) provided by an approved regional
586 mental health/retardation center established under Sections
587 41-19-31 through 41-19-39, or by another community mental health
588 service provider meeting the requirements of the Department of
589 Mental Health to be an approved mental health/retardation center
590 if determined necessary by the Department of Mental Health, using

591 state funds that are provided from the appropriation to the State
592 Department of Mental Health and/or funds transferred to the
593 department by a political subdivision or instrumentality of the
594 state and used to match federal funds under a cooperative
595 agreement between the division and the department, or (b) provided
596 by a facility that is certified by the State Department of Mental
597 Health to provide therapeutic and case management services, to be
598 reimbursed on a fee for service basis, or (c) provided in the
599 community by a facility or program operated by the Department of
600 Mental Health. Any such services provided by a facility described
601 in subparagraph (b) must have the prior approval of the division
602 to be reimbursable under this section. After June 30, 1997,
603 mental health services provided by regional mental
604 health/retardation centers established under Sections 41-19-31
605 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
606 and/or their subsidiaries and divisions, or by psychiatric
607 residential treatment facilities as defined in Section 43-11-1, or
608 by another community mental health service provider meeting the
609 requirements of the Department of Mental Health to be an approved
610 mental health/retardation center if determined necessary by the
611 Department of Mental Health, shall not be included in or provided
612 under any capitated managed care pilot program provided for under
613 paragraph (24) of this section.
614 (17) Durable medical equipment services and medical
615 supplies. Precertification of durable medical equipment and
616 medical supplies must be obtained as required by the division.
617 The Division of Medicaid may require durable medical equipment
618 providers to obtain a surety bond in the amount and to the
619 specifications as established by the Balanced Budget Act of 1997.
620 (18) (a) Notwithstanding any other provision of this
621 section to the contrary, the division shall make additional
622 reimbursement to hospitals that serve a disproportionate share of
623 low-income patients and that meet the federal requirements for

624 those payments as provided in Section 1923 of the federal Social
625 Security Act and any applicable regulations. However, from and
626 after January 1, 1999, no public hospital shall participate in the
627 Medicaid disproportionate share program unless the public hospital
628 participates in an intergovernmental transfer program as provided
629 in Section 1903 of the federal Social Security Act and any
630 applicable regulations.

631 (b) The division shall establish a Medicare Upper
632 Payment Limits Program, as defined in Section 1902(a)(30) of the
633 federal Social Security Act and any applicable federal
634 regulations, for hospitals, and may establish a Medicare Upper
635 Payments Limits Program for nursing facilities. The division
636 shall assess each hospital and, if the program is established for
637 nursing facilities, shall assess each nursing facility, based on
638 Medicaid utilization or other appropriate method consistent with
639 federal regulations. The assessment will remain in effect as long
640 as the state participates in the Medicare Upper Payment Limits
641 Program. The division shall make additional reimbursement to
642 hospitals and, if the program is established for nursing
643 facilities, shall make additional reimbursement to nursing
644 facilities, for the Medicare Upper Payment Limits, as defined in
645 Section 1902(a)(30) of the federal Social Security Act and any
646 applicable federal regulations.

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

655 (b) Early intervention system services. The
656 division shall cooperate with the State Department of Health,

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

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

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

690 (22) Ambulatory services delivered in federally
691 qualified health centers, rural health centers and clinics of the
692 local health departments of the State Department of Health for
693 individuals eligible for Medicaid under this article based on
694 reasonable costs as determined by the division.
695 (23) Inpatient psychiatric services. Inpatient
696 psychiatric services to be determined by the division for
697 recipients under age twenty-one (21) that are provided under the
698 direction of a physician in an inpatient program in a licensed
699 acute care psychiatric facility or in a licensed psychiatric
700 residential treatment facility, before the recipient reaches age
701 twenty-one (21) or, if the recipient was receiving the services
702 immediately before he or she reached age twenty-one (21), before
703 the earlier of the date he or she no longer requires the services
704 or the date he or she reaches age twenty-two (22), as provided by
705 federal regulations. Precertification of inpatient days and
706 residential treatment days must be obtained as required by the
707 division.
708 (24) [Deleted]
709 (25) [Deleted]
710 (26) Hospice care. As used in this paragraph, the term
711 "hospice care" means a coordinated program of active professional
712 medical attention within the home and outpatient and inpatient
713 care that treats the terminally ill patient and family as a unit,
714 employing a medically directed interdisciplinary team. The
715 program provides relief of severe pain or other physical symptoms
716 and supportive care to meet the special needs arising out of
717 physical, psychological, spiritual, social and economic stresses
718 that are experienced during the final stages of illness and during
719 dying and bereavement and meets the Medicare requirements for
720 participation as a hospice as provided in federal regulations.

721 (27) Group health plan premiums and cost sharing if it
722 is cost effective as defined by the United States Secretary of
723 Health and Human Services.
724 (28) Other health insurance premiums that are cost
725 effective as defined by the United States Secretary of Health and
726 Human Services. Medicare eligible must have Medicare Part B
727 before other insurance premiums can be paid.
728 (29) The Division of Medicaid may apply for a waiver
729 from the United States Department of Health and Human Services for
730 home- and community-based services for developmentally disabled
731 people using state funds that are provided from the appropriation
732 to the State Department of Mental Health and/or funds transferred
733 to the department by a political subdivision or instrumentality of
734 the state and used to match federal funds under a cooperative
735 agreement between the division and the department, provided that
736 funds for these services are specifically appropriated to the
737 Department of Mental Health and/or transferred to the department
738 by a political subdivision or instrumentality of the state.
739 (30) Pediatric skilled nursing services for eligible
740 persons under twenty-one (21) years of age.
741 (31) Targeted case management services for children
742 with special needs, under waivers from the United States
743 Department of Health and Human Services, using state funds that
744 are provided from the appropriation to the Mississippi Department
745 of Human Services and used to match federal funds under a
746 cooperative agreement between the division and the department.
747 (32) Care and services provided in Christian Science
748 Sanatoria listed and certified by the Commission for Accreditation
749 of Christian Science Nursing Organizations/Facilities, Inc.,
750 rendered in connection with treatment by prayer or spiritual means
751 to the extent that those services are subject to reimbursement
752 under Section 1903 of the federal Social Security Act.
753 (33) Podiatrist services.

754 (34) Assisted living services as provided through home-
755 and community-based services under Title XIX of the federal Social
756 Security Act, as amended, subject to the availability of funds
757 specifically appropriated for that purpose by the Legislature.
758 (35) Services and activities authorized in Sections
759 43-27-101 and 43-27-103, using state funds that are provided from
760 the appropriation to the State Department of Human Services and
761 used to match federal funds under a cooperative agreement between
762 the division and the department.
763 (36) Nonemergency transportation services for
764 Medicaid-eligible persons, to be provided by the Division of
765 Medicaid. The division may contract with additional entities to
766 administer nonemergency transportation services as it deems
767 necessary. All providers shall have a valid driver's license,
768 vehicle inspection sticker, valid vehicle license tags and a
769 standard liability insurance policy covering the vehicle. The
770 division may pay providers a flat fee based on mileage tiers, or
771 in the alternative, may reimburse on actual miles traveled. The
772 division may apply to the Center for Medicare and Medicaid
773 Services (CMS) for a waiver to draw federal matching funds for
774 nonemergency transportation services as a covered service instead
775 of an administrative cost.
776 (37) [Deleted]
777 (38) Chiropractic services. A chiropractor's manual
778 manipulation of the spine to correct a subluxation, if x-ray
779 demonstrates that a subluxation exists and if the subluxation has
780 resulted in a neuromusculoskeletal condition for which
781 manipulation is appropriate treatment, and related spinal x-rays
782 performed to document these conditions. Reimbursement for
783 chiropractic services shall not exceed Seven Hundred Dollars
784 ($700.00) per year per beneficiary.
785 (39) Dually eligible Medicare/Medicaid beneficiaries.
786 The division shall pay the Medicare deductible and coinsurance

787 amounts for services available under Medicare, as determined by
788 the division.
789 (40) [Deleted]
790 (41) Services provided by the State Department of
791 Rehabilitation Services for the care and rehabilitation of persons
792 with spinal cord injuries or traumatic brain injuries, as allowed
793 under waivers from the United States Department of Health and
794 Human Services, using up to seventy-five percent (75%) of the
795 funds that are appropriated to the Department of Rehabilitation
796 Services from the Spinal Cord and Head Injury Trust Fund
797 established under Section 37-33-261 and used to match federal
798 funds under a cooperative agreement between the division and the
799 department.
800 (42) Notwithstanding any other provision in this
801 article to the contrary, the division may develop a population
802 health management program for women and children health services
803 through the age of one (1) year. This program is primarily for
804 obstetrical care associated with low birth weight and pre-term
805 babies. The division may apply to the federal Centers for
806 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
807 any other waivers that may enhance the program. In order to
808 effect cost savings, the division may develop a revised payment
809 methodology that may include at-risk capitated payments, and may
810 require member participation in accordance with the terms and
811 conditions of an approved federal waiver.
812 (43) The division shall provide reimbursement,
813 according to a payment schedule developed by the division, for
814 smoking cessation medications for pregnant women during their
815 pregnancy and other Medicaid-eligible women who are of
816 child-bearing age.
817 (44) Nursing facility services for the severely
818 disabled.

819 (a) Severe disabilities include, but are not
820 limited to, spinal cord injuries, closed head injuries and
821 ventilator dependent patients.
822 (b) Those services must be provided in a long-term
823 care nursing facility dedicated to the care and treatment of
824 persons with severe disabilities, and shall be reimbursed as a
825 separate category of nursing facilities.
826 (45) Physician assistant services. Services furnished
827 by a physician assistant who is licensed by the State Board of
828 Medical Licensure and is practicing with physician supervision
829 under regulations adopted by the board, under regulations adopted
830 by the division. Reimbursement for those services shall not
831 exceed ninety percent (90%) of the reimbursement rate for
832 comparable services rendered by a physician.
833 (46) The division shall make application to the federal
834 Centers for Medicare and Medicaid Services (CMS) for a waiver to
835 develop and provide services for children with serious emotional
836 disturbances as defined in Section 43-14-1(1), which may include
837 home- and community-based services, case management services or
838 managed care services through mental health providers certified by
839 the Department of Mental Health. The division may implement and
840 provide services under this waivered program only if funds for
841 these services are specifically appropriated for this purpose by
842 the Legislature, or if funds are voluntarily provided by affected
843 agencies.
844 (47) (a) Notwithstanding any other provision in this
845 article to the contrary, the division, in conjunction with the
846 State Department of Health, may develop and implement disease
847 management programs for individuals with high-cost chronic
848 diseases and conditions, including the use of grants, waivers,
849 demonstrations or other projects as necessary.
850 (b) Participation in any disease management
851 program implemented under this paragraph (47) is optional with the

852 individual. An individual must affirmatively elect to participate
853 in the disease management program in order to participate.
854 (c) An individual who participates in the disease
855 management program has the option of participating in the
856 prescription drug home delivery component of the program at any
857 time while participating in the program. An individual must
858 affirmatively elect to participate in the prescription drug home
859 delivery component in order to participate.
860 (d) An individual who participates in the disease
861 management program may elect to discontinue participation in the
862 program at any time. An individual who participates in the
863 prescription drug home delivery component may elect to discontinue
864 participation in the prescription drug home delivery component at
865 any time.
866 (e) The division shall send written notice to all
867 individuals who participate in the disease management program
868 informing them that they may continue using their local pharmacy
869 or any other pharmacy of their choice to obtain their prescription
870 drugs while participating in the program.
871 (f) Prescription drugs that are provided to
872 individuals under the prescription drug home delivery component
873 shall be limited only to those drugs that are used for the
874 treatment, management or care of asthma, diabetes or hypertension.
875 (48) Pediatric long-term acute care hospital services.
876 (a) Pediatric long-term acute care hospital
877 services means services provided to eligible persons under
878 twenty-one (21) years of age by a freestanding Medicare-certified
879 hospital that has an average length of inpatient stay greater than
880 twenty-five (25) days and that is primarily engaged in providing
881 chronic or long-term medical care to persons under twenty-one (21)
882 years of age.
883 (b) The services under this paragraph (48) shall
884 be reimbursed as a separate category of hospital services.

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

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

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

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

910 (52) Notwithstanding any provisions of this article,
911 the division may pay enhanced reimbursement fees related to trauma
912 care, as determined by the division in conjunction with the State
913 Department of Health, using funds appropriated to the State
914 Department of Health for trauma care and services and used to
915 match federal funds under a cooperative agreement between the
916 division and the State Department of Health. The division, in
917 conjunction with the State Department of Health, may use grants,

918 waivers, demonstrations, or other projects as necessary in the
919 development and implementation of this reimbursement program.
920 (53) Targeted case management services for high-cost
921 beneficiaries shall be developed by the division for all services
922 under this section.
923 Notwithstanding any other provision of this article to the
924 contrary, the division shall reduce the rate of reimbursement to
925 providers for any service provided under this section by five
926 percent (5%) of the allowed amount for that service. However, the
927 reduction in the reimbursement rates required by this paragraph
928 shall not apply to inpatient hospital services, nursing facility
929 services, intermediate care facility services, psychiatric
930 residential treatment facility services, pharmacy services
931 provided under paragraph (9) of this section, or any service
932 provided by the University of Mississippi Medical Center or a
933 state agency, a state facility or a public agency that either
934 provides its own state match through intergovernmental transfer or
935 certification of funds to the division, or a service for which the
936 federal government sets the reimbursement methodology and rate.
937 In addition, the reduction in the reimbursement rates required by
938 this paragraph shall not apply to case management services and
939 home-delivered meals provided under the home- and community-based
940 services program for the elderly and disabled by a planning and
941 development district (PDD). Planning and development districts
942 participating in the home- and community-based services program
943 for the elderly and disabled as case management providers shall be
944 reimbursed for case management services at the maximum rate
945 approved by the Centers for Medicare and Medicaid Services (CMS).
946 The division may pay to those providers who participate in
947 and accept patient referrals from the division's emergency room
948 redirection program a percentage, as determined by the division,
949 of savings achieved according to the performance measures and
950 reduction of costs required of that program. Federally qualified

951 health centers may participate in the emergency room redirection
952 program, and the division may pay those centers a percentage of
953 any savings to the Medicaid program achieved by the centers'
954 accepting patient referrals through the program, as provided in
955 this paragraph.

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

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

978 The executive director shall keep the Governor advised on a
979 timely basis of the funds available for expenditure and the
980 projected expenditures. If current or projected expenditures of
981 the division are reasonably anticipated to exceed the amount of
982 funds appropriated to the division for any fiscal year, the
983 Governor, after consultation with the executive director, shall

984 discontinue any or all of the payment of the types of care and
985 services as provided in this section that are deemed to be
986 optional services under Title XIX of the federal Social Security
987 Act, as amended, and when necessary, shall institute any other
988 cost containment measures on any program or programs authorized
989 under the article to the extent allowed under the federal law
990 governing that program or programs. However, the Governor shall
991 not be authorized to discontinue or eliminate any service under
992 this section that is mandatory under federal law, or to
993 discontinue or eliminate, or adjust income limits or resource
994 limits for, any eligibility category or group under Section
995 43-13-115. It is the intent of the Legislature that the
996 expenditures of the division during any fiscal year shall not
997 exceed the amounts appropriated to the division for that fiscal
998 year.

999 Notwithstanding any other provision of this article, it shall
1000 be the duty of each nursing facility, intermediate care facility
1001 for the mentally retarded, psychiatric residential treatment
1002 facility, and nursing facility for the severely disabled that is
1003 participating in the Medicaid program to keep and maintain books,
1004 documents and other records as prescribed by the Division of
1005 Medicaid in substantiation of its cost reports for a period of
1006 three (3) years after the date of submission to the Division of
1007 Medicaid of an original cost report, or three (3) years after the
1008 date of submission to the Division of Medicaid of an amended cost
1009 report.

1010 **SECTION 4.** This act shall take effect and be in force from
1011 and after July 1, 2007.

ST: Long-Term Care Advisory Council to develop new programs required by federal law; establish.