

By: Senator(s) Blackwell

To: Medicaid

COMMITTEE SUBSTITUTE  
FOR  
SENATE BILL NO. 2799

1 AN ACT RELATING TO THE MISSISSIPPI MEDICAID PROGRAM; TO AMEND  
2 SECTION 43-13-117, MISSISSIPPI CODE OF 1972, RELATING TO  
3 REIMBURSEMENT FOR CARE AND SERVICES UNDER THE MEDICAID PROGRAM; TO  
4 DELETE CERTAIN OUTDATED PROVISIONS RELATING TO REIMBURSEMENT OF  
5 INPATIENT HOSPITAL SERVICES; TO PROVIDE THAT MEDICAID IS  
6 AUTHORIZED TO MAKE PARTIAL PAYMENTS FOR NURSING SERVICES; TO  
7 PROVIDE FOR NURSING FACILITY REIMBURSEMENT FOR HOME LEAVE DAYS; TO  
8 DELETE CERTAIN OUTDATED PROVISIONS RELATING TO REIMBURSEMENT OF  
9 NURSING FACILITY SERVICES; TO PROVIDE FOR REIMBURSEMENT FOR FEES  
10 FOR PHYSICIAN SERVICES COVERED ONLY BY MEDICAID; TO AUTHORIZE THE  
11 DIVISION TO REIMBURSE OBSTETRICIANS AND GYNECOLOGISTS FOR CERTAIN  
12 PRIMARY CARE SERVICES AT 100% OF THE MEDICARE RATE; TO DELETE THE  
13 PROVISION THAT REQUIRES THE DIVISION TO ALLOW  
14 PHYSICIAN-ADMINISTERED DRUGS TO BE BILLED AND REIMBURSED AS A  
15 MEDICAL CLAIM OR PHARMACY POINT-OF-SALE; TO PROVIDE THAT THE  
16 DIVISION SHALL MAKE PARTIAL PAYMENTS, AS DETERMINED BY THE  
17 DIVISION, TO INTERMEDIATE CARE FACILITY SERVICES AND TO DELETE  
18 CERTAIN PROVISIONS RELATING TO FAIR RENTAL REIMBURSEMENT FOR SUCH  
19 FACILITIES; TO DEFINE CLINIC SERVICES AS IT RELATES TO THE  
20 REIMBURSEMENTS BY MEDICAID FOR THOSE SERVICES; TO AUTHORIZE  
21 MEDICAID REIMBURSEMENT FOR THERAPEUTIC AND CASE MANAGEMENT MENTAL  
22 HEALTH SERVICES PROVIDED BY SERVICE PROVIDERS ACCREDITED BY THE  
23 JOINT COMMISSION OR CERTAIN OTHER ACCREDITING AGENCIES; TO PROVIDE  
24 THAT MEDICAID MAY ESTABLISH AN UPPER PAYMENT LIMITS PROGRAM FOR  
25 AMBULANCE TRANSPORTATION AND ASSESS PROVIDERS OF SUCH SERVICE; TO  
26 REQUIRE THE DIVISION OF MEDICAID TO RECOGNIZE FEDERALLY QUALIFIED  
27 HEALTH CENTERS (FQHC), RURAL HEALTH CLINICS (RHC) AND COMMUNITY  
28 MENTAL HEALTH CENTERS (CMHC) AS BOTH AN ORIGINATING AND DISTANT  
29 SITE PROVIDER FOR THE PURPOSES OF TELEHEALTH REIMBURSEMENT; TO  
30 DELETE THE PROVISIONS RELATING TO MEDICAID'S DEVELOPMENT OF AN  
31 ALTERNATIVE MODEL FOR DISTRIBUTION OF MEDICAL CLAIMS AND  
32 SUPPLEMENTAL PAYMENTS FOR SERVICES; TO AUTHORIZE REIMBURSEMENT FOR  
33 CERTAIN PSYCHIATRIC SERVICES; TO CLARIFY THE REIMBURSEMENT OF  
34 PEDIATRIC SKILLED NURSING SERVICES, INPATIENT PSYCHIATRIST



SERVICES AND NONEMERGENCY TRANSPORTATION SERVICES; TO DELETE THE PROVISION THAT REQUIRES MEDICAID TO REIMBURSE CROSSOVER CLAIMS FOR INPATIENT HOSPITAL SERVICES AND THOSE UNDER MEDICARE PART B; TO DELETE CERTAIN PROVISIONS RELATING TO THE REIMBURSEMENT OF PHYSICIAN ASSISTANT SERVICES; TO PROVIDE THAT THE DIVISION MAY ESTABLISH COPAYMENTS AND COINSURANCE FOR ANY MEDICAID SERVICES; TO ALLOW THE DIVISION TO USE ENHANCED REIMBURSEMENTS AND UPPER PAYMENT LIMIT PROGRAMS FOR ITS REIMBURSEMENT PROGRAM; TO AUTHORIZE REIMBURSEMENT FOR A BARIATRIC SURGERY PROGRAM; TO DELETE THE PROVISION THAT REQUIRES MEDICAID TO REDUCE THE RATE OF REIMBURSEMENT TO CERTAIN PROVIDERS FOR SERVICES BY 5% OF THE ALLOWED AMOUNT FOR THAT SERVICE; TO REQUIRE PROVIDERS TO MAINTAIN RECORDS AS PRESCRIBED BY THE DIVISION AND IN ACCORDANCE WITH FEDERAL LAW; TO DELETE CERTAIN ENROLLMENT LIMITATIONS AND PROVISIONS RELATING TO MANAGED CARE PROGRAMS; TO ALLOW THE DIVISION OF MEDICAID TO APPROVE THE USE OF ALTERNATIVE PAYMENT MODELS FOR REIMBURSEMENT RATES; TO CLARIFY LIMITATIONS ON MEDICAID ELIGIBILITY FOR ENROLLMENT IN MANAGED CARE PROGRAMS; TO DELETE THE PROVISIONS THAT PROVIDE FOR THE COMMISSION ON EXPANDING MEDICAID MANAGED CARE; TO REQUIRE CONTRACTORS RECEIVING PAYMENTS UNDER A MANAGED CARE DELIVERY SYSTEM TO DISCLOSE TO THE CHAIRMEN OF THE SENATE AND HOUSE MEDICAID COMMITTEES THE ADMINISTRATIVE EXPENSES FOR THE PRIOR YEAR, AND THE NUMBER OF EMPLOYEES IN MISSISSIPPI WHO ARE DEDICATED TO MEDICAID AND CHIP LINES OF BUSINESS AS OF JUNE 30 OF EACH YEAR; TO PROVIDE FOR REVIEWS OF THE MANAGED CARE PROGRAMS BY THE STATE AUDITOR; TO REQUIRE THAT ALL MANAGED CARE CONTRACTORS SHALL DEVELOP AND IMPLEMENT A UNIFORM CREDENTIALING PROCESS BY WHICH ALL PROVIDERS ARE CREDENTIALLED BY JULY 1, 2022; TO DELETE THE PROVISION THAT THERE SHALL NOT BE CUTS TO INPATIENT AND OUTPATIENT HOSPITAL PAYMENTS; TO EXTEND THE AUTOMATIC REPEALER ON THIS SECTION; TO DIRECT THE DIVISION TO EVALUATE THE FEASIBILITY OF CONTINUING TO ADMINISTER PHARMACY BENEFITS UNDER FEE-FOR-SERVICE AND DENTAL BENEFITS UNDER MANAGED CARE; TO DIRECT MANAGED CARE CONTRACTORS TO IMPLEMENT INNOVATIVE PROGRAMS FOR MEMBERS WITH PREDIABETES AND DIABETES; TO AUTHORIZE THE DIVISION TO NEGOTIATE A LIMITATION ON LIABILITY TO THE STATE OF CERTAIN PROSPECTIVE CONTRACTORS; TO AMEND SECTION 43-13-145, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT NURSING FACILITIES OPERATED BY THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER ARE NOT EXEMPT FROM THE ANNUAL ASSESSMENT FOR THE SUPPORT OF THE MEDICAID PROGRAM, TO DELETE CERTAIN TECHNICAL PROVISIONS RELATING TO THE ASSESSMENT AND COLLECTION OF THE HOSPITAL ASSESSMENT, TO CLARIFY THE PROCEDURE FOR PAYMENT OF THE HOSPITAL ASSESSMENT FOR THE NONFEDERAL SHARE NECESSARY FOR THE MEDICARE UPPER PAYMENT LIMITS (UPL) PROGRAM AND THE DISPROPORTIONATE SHARE HOSPITAL (DSH) PROGRAM; TO AUTHORIZE AND DIRECT THE DIVISION OF MEDICAID TO PROVIDE UP TO 12 MONTHS OF CONTINUOUS COVERAGE POSTPARTUM FOR ANY INDIVIDUAL WHO QUALIFIES FOR MEDICAID AS A PREGNANT WOMAN TO THE EXTENT ALLOWABLE UNDER FEDERAL LAW; TO EXTEND THE AUTOMATIC REPEALER ON THIS SECTION; TO AMEND SECTION 41-7-191, MISSISSIPPI CODE OF 1972, TO DELETE THE MORATORIUM ON THE AUTHORITY OF THE STATE DEPARTMENT OF HEALTH TO



86 ISSUE A HEALTH CARE CERTIFICATE OF NEED FOR THE CONSTRUCTION OR  
87 CONVERSION OF CHILD/ADOLESCENT PSYCHIATRIC OR CHEMICAL DEPENDENCY  
88 BEDS PARTICIPATING IN THE MEDICAID PROGRAM AND TO DELETE CERTAIN  
89 RESTRICTIONS ON MEDICAID REIMBURSEMENT FOR SUCH BEDS; TO AMEND  
90 SECTION 41-75-5, MISSISSIPPI CODE OF 1972, TO DELETE THE  
91 RESTRICTION ON POST ACUTE RESIDENTIAL BRAIN INJURY REHABILITATION  
92 FACILITIES PARTICIPATION IN THE MEDICAID PROGRAM; TO AMEND SECTION  
93 83-9-353, MISSISSIPPI CODE OF 1972, TO DELETE CERTAIN RESTRICTIONS  
94 ON REMOTE PATIENT TELEMONITORING SERVICES; AND FOR RELATED  
95 PURPOSES.

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

97 **SECTION 1.** Section 43-13-117, Mississippi Code of 1972, is  
98 amended as follows:

99 43-13-117. (A) Medicaid as authorized by this article shall  
100 include payment of part or all of the costs, at the discretion of  
101 the division, with approval of the Governor and the Centers for  
102 Medicare and Medicaid Services, of the following types of care and  
103 services rendered to eligible applicants who have been determined  
104 to be eligible for that care and services, within the limits of  
105 state appropriations and federal matching funds:

106 (1) Inpatient hospital services.

107 \* \* \*

108 ( \* \* \*a) The division is authorized to implement  
109 an All Patient Refined Diagnosis Related Groups (APR-DRG)  
110 reimbursement methodology for inpatient hospital services.

111 ( \* \* \*b) No service benefits or reimbursement  
112 limitations in this subsection (A)(1) shall apply to payments  
113 under an APR-DRG or Ambulatory Payment Classification (APC) model  
114 or a managed care program or similar model described in subsection



(H) of this section unless specifically authorized by the division.

(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. The division may give rural hospitals that have fifty (50) or fewer licensed beds the option to not be reimbursed for outpatient hospital services using the APC methodology, but reimbursement for outpatient hospital services



provided by those hospitals shall be based on one hundred one percent (101%) of the rate established under Medicare for outpatient hospital services. Those hospitals choosing to not be reimbursed under the APC methodology shall remain under cost-based reimbursement for a two-year period.

(d) No service benefits or reimbursement limitations in this subsection (A)(2) 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 unless specifically authorized by the division.

(3) Laboratory and x-ray services.

(4) Nursing facility services.

(a) The division shall make \* \* \* partial payment in an amount not less than fifty percent (50%) of the per diem rate, as determined by the division, to nursing facilities for each day, not exceeding \* \* \* thirty-five (35) 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 \* \* \* thirty-five-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. For the purposes of establishing a facility's per diem rate, the division may \* \* \* adjust the \* \* \* case mix 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) 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



189 encourage nursing facilities to convert or construct beds for  
190 residents with Alzheimer's or other related dementia.

191 ( \* \* \*e) The division shall develop and implement  
192 an assessment process for long-term care services. The division  
193 may provide the assessment and related functions directly or  
194 through contract with the area agencies on aging.

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

199 (5) Periodic screening and diagnostic services for  
200 individuals under age twenty-one (21) years as are needed to  
201 identify physical and mental defects and to provide health care  
202 treatment and other measures designed to correct or ameliorate  
203 defects and physical and mental illness and conditions discovered  
204 by the screening services, regardless of whether these services  
205 are included in the state plan. The division may include in its  
206 periodic screening and diagnostic program those discretionary  
207 services authorized under the federal regulations adopted to  
208 implement Title XIX of the federal Social Security Act, as  
209 amended. The division, in obtaining physical therapy services,  
210 occupational therapy services, and services for individuals with  
211 speech, hearing and language disorders, may enter into a  
212 cooperative agreement with the State Department of Education for  
213 the provision of those services to handicapped students by public



214 school districts using state funds that are provided from the  
215 appropriation to the Department of Education to obtain federal  
216 matching funds through the division. The division, in obtaining  
217 medical and mental health assessments, treatment, care and  
218 services for children who are in, or at risk of being put in, the  
219 custody of the Mississippi Department of Human Services may enter  
220 into a cooperative agreement with the Mississippi Department of  
221 Human Services for the provision of those services using state  
222 funds that are provided from the appropriation to the Department  
223 of Human Services to obtain federal matching funds through the  
224 division.

225           (6) Physician \* \* \* services. \* \* \* Fees for  
226 physician's services that are covered only by Medicaid shall  
227 be \* \* \* reimbursed at ninety percent (90%) of the rate  
228 established on January 1, 2018, and as may be adjusted each July  
229 thereafter, under Medicare. The division may provide for a  
230 reimbursement rate for physician's services of up to one hundred  
231 percent (100%) of the rate established under Medicare for  
232 physician's services that are provided after the normal working  
233 hours of the physician, as determined in accordance with  
234 regulations of the division. The division may reimburse eligible  
235 providers, as determined by the \* \* \* division, for certain  
236 primary care services \* \* \* at one hundred percent (100%) of the  
237 rate established under Medicare. \* \* \* The division shall  
238 reimburse obstetricians and gynecologists for certain primary care



services as defined by the division 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. All home health visits must be precertified as required by the division.

(b) [Repealed]

(8) Emergency medical transportation services as determined by the division.

(9) Prescription drugs and other covered drugs and services as \* \* \* 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.



263           The division may allow for a combination of prescriptions for  
264   single-source and innovator multiple-source drugs and generic  
265   drugs to meet the needs of the beneficiaries.

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

269           Drugs prescribed for a resident of a psychiatric residential  
270   treatment facility must be provided in true unit doses when  
271   available. The division may require that drugs not covered by  
272   Medicare Part D for a resident of a long-term care facility be  
273   provided in true unit doses when available. Those drugs that were  
274   originally billed to the division but are not used by a resident  
275   in any of those facilities shall be returned to the billing  
276   pharmacy for credit to the division, in accordance with the  
277   guidelines of the State Board of Pharmacy and any requirements of  
278   federal law and regulation. Drugs shall be dispensed to a  
279   recipient and only one (1) dispensing fee per month may be  
280   charged. The division shall develop a methodology for reimbursing  
281   for restocked drugs, which shall include a restock fee as  
282   determined by the division not exceeding Seven Dollars and  
283   Eighty-two Cents (\$7.82).

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



288           The division is authorized to develop and implement a program  
289 of payment for additional pharmacist services as \* \* \* determined  
290 by the division.

291           All claims for drugs for dually eligible Medicare/Medicaid  
292 beneficiaries that are paid for by Medicare must be submitted to  
293 Medicare for payment before they may be processed by the  
294 division's online payment system.

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

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

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



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

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

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

324           The division may allow certain drugs, implantable drug system  
325 devices, and medical supplies, with limited distribution or  
326 limited access for beneficiaries and administered in an  
327 appropriate clinical setting, to be reimbursed as either a medical  
328 claim or pharmacy claim, as determined by the division.

329       \* \* \*

330           It is the intent of the Legislature that the division and any  
331 managed care entity described in subsection (H) of this section  
332 encourage the use of Alpha-Hydroxyprogesterone Caproate (17P) to  
333 prevent recurrent preterm birth.

334           (10) Dental and orthodontic services to be determined  
335 by the division.



336           This dental services program under this paragraph shall be  
337 known as the "James Russell Dumas Medicaid Dental Services  
338 Program."

339           The Medical Care Advisory Committee, assisted by the Division  
340 of Medicaid, shall annually determine the effect of this incentive  
341 by evaluating the number of dentists who are Medicaid providers,  
342 the number who and the degree to which they are actively billing  
343 Medicaid, the geographic trends of where dentists are offering  
344 what types of Medicaid services and other statistics pertinent to  
345 the goals of this legislative intent. This data shall annually be  
346 presented to the Chair of the Senate Medicaid Committee and the  
347 Chair of the House Medicaid Committee.

348           The division shall include dental services as a necessary  
349 component of overall health services provided to children who are  
350 eligible for services.

351           (11) Eyeglasses for all Medicaid beneficiaries who have  
352 (a) had surgery on the eyeball or ocular muscle that results in a  
353 vision change for which eyeglasses or a change in eyeglasses is  
354 medically indicated within six (6) months of the surgery and is in  
355 accordance with policies established by the division, or (b) one  
356 (1) pair every five (5) years and in accordance with policies  
357 established by the division. In either instance, the eyeglasses  
358 must be prescribed by a physician skilled in diseases of the eye  
359 or an optometrist, whichever the beneficiary may select.

360           (12) Intermediate care facility services.



(a) The division shall make \* \* \* partial payment in an amount not less than fifty percent (50%) of the per diem rate, as determined by the division, to all intermediate care facilities for individuals with intellectual disabilities for each day, not exceeding \* \* \* seventy (70) 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 \* \* \* seventy-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.

\* \* \*

(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. \* \* \* Preventive, diagnostic, therapeutic, rehabilitative or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Clinic services include, but are not limited to:

(a) Services provided by ambulatory surgical centers (ACSS) as defined in Section 41-75-1(a); and

(b) Dialysis center services.



(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.

\* \* \*

(16) Mental health services. Certain services provided by a psychiatrist shall be reimbursed at up to one hundred percent (100%) of the Medicare rate. 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 \* \* \* 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, or (d) provided by a mental health service provider accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), or the



411 Council on Accreditation (COA) Agencies. Any such services  
412 provided by a facility described in subparagraph (b) must have the  
413 prior approval of the division to be reimbursable under this  
414 section.

415 (17) Durable medical equipment services and medical  
416 supplies. Precertification of durable medical equipment and  
417 medical supplies must be obtained as required by the division.  
418 The Division of Medicaid may require durable medical equipment  
419 providers to obtain a surety bond in the amount and to the  
420 specifications as established by the Balanced Budget Act of 1997.

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



436 (b) (i) The division may establish a Medicare  
437 Upper Payment Limits Program, as defined in Section 1902(a)(30) of  
438 the federal Social Security Act and any applicable federal  
439 regulations, or an allowable delivery system or provider payment  
440 initiative authorized under 42 CFR 438.6(c), for hospitals, \* \* \*  
441 nursing facilities, \* \* \* physicians employed or contracted  
442 by \* \* \* hospitals, and emergency ambulance transportation  
443 providers. \* \* \*

444 (ii) The division shall assess each  
445 hospital \* \* \*, \* \* \* nursing facility, and emergency ambulance  
446 transportation provider for the sole purpose of financing the  
447 state portion of the Medicare Upper Payment Limits Program or  
448 other program(s) authorized under this subsection (A)(18)(b). The  
449 hospital assessment shall be as provided in Section  
450 43-13-145(4)(a), and the nursing facility \* \* \* and the emergency  
451 ambulance transportation assessments, if established, shall be  
452 based on Medicaid utilization or other appropriate method, as  
453 determined by the division, consistent with federal regulations.  
454 The assessments will remain in effect as long as the state  
455 participates in the Medicare Upper Payment Limits Program or other  
456 program(s) authorized under this subsection (A)(18)(b). \* \* \* In  
457 addition to the hospital assessment provided in Section  
458 43-13-145(4)(a), hospitals with physicians participating in the  
459 Medicare Upper Payment Limits Program or other program(s)  
460 authorized under this subsection (A)(18)(b) shall be required to



participate in an intergovernmental transfer \* \* \* or assessment,  
as determined by the division, for the purpose of financing the  
state portion of the physician UPL payments or other payment(s)  
authorized under this subsection (A)(18)(b).

\* \* \* (iii) Subject to approval by the  
Centers for Medicare and Medicaid Services (CMS) and the  
provisions of this subsection (A)(18)(b), the division shall make  
additional reimbursement to hospitals \* \* \*, \* \* \* nursing  
facilities, and emergency ambulance transportation providers for  
the Medicare Upper Payment Limits Program or other program(s)  
authorized under this subsection (A)(18)(b), 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,  
provided the assessment in this subsection (A)(18)(b) is in  
effect.

(iv) Notwithstanding any other provision of  
this article to the contrary, 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. However, the division is authorized to  
develop and implement an alternative fee-for-service Upper Payment  
Limits model in accordance with federal laws and regulations if  
necessary to preserve supplemental funding. Further, the



486 division, in consultation with the Mississippi Hospital  
487 Association and a governmental hospital located in a county  
488 bordering the Gulf of Mexico and the State of Alabama shall  
489 develop alternative models for distribution of medical claims and  
490 supplemental payments for inpatient and outpatient hospital  
491 services, and such models may include, but shall not be limited to  
492 the following: increasing rates for inpatient and outpatient  
493 services; creating a low-income utilization pool of funds to  
494 reimburse hospitals for the costs of uncompensated care, charity  
495 care and bad debts as permitted and approved pursuant to federal  
496 regulations and the Centers for Medicare and Medicaid Services;  
497 supplemental payments based upon Medicaid utilization, quality,  
498 service lines and/or costs of providing such services to Medicaid  
499 beneficiaries and to uninsured patients. The goals of such  
500 payment models shall be to ensure access to inpatient and  
501 outpatient care and to maximize any federal funds that are  
502 available to reimburse hospitals for services provided. Any such  
503 documents required to achieve the goals described in this  
504 paragraph shall be submitted to the Centers for Medicare and  
505 Medicaid Services, with a proposed effective date of July 1, 2019,  
506 to the extent possible, but in no event shall the effective date  
507 of such payment models be later than July 1, 2020. The Chairmen  
508 of the Senate and House Medicaid Committees shall be provided a  
509 copy of the proposed payment model(s) prior to submission.  
510 Effective July 1, 2018, and until such time as any payment



511 model(s) as described above become effective, the division, in  
512 consultation with the Mississippi Hospital Association and a  
513 governmental hospital located in a county bordering the Gulf of  
514 Mexico and the State of Alabama is authorized to implement a  
515 transitional program for inpatient and outpatient payments and/or  
516 supplemental payments (including, but not limited to, MHAP and  
517 directed payments), to redistribute available supplemental funds  
518 among hospital providers, provided that when compared to a  
519 hospital's prior year supplemental payments, supplemental payments  
520 made pursuant to any such transitional program shall not result in  
521 a decrease of more than five percent (5%) and shall not increase  
522 by more than the amount needed to maximize the distribution of the  
523 available funds.

524                   (c) (i) Not later than December 1, 2015, the  
525 division shall, subject to approval by the Centers for Medicare  
526 and Medicaid Services (CMS), establish, implement and operate a  
527 Mississippi Hospital Access Program (MHAP) for the purpose of  
528 protecting patient access to hospital care through hospital  
529 inpatient reimbursement programs provided in this section designed  
530 to maintain total hospital reimbursement for inpatient services  
531 rendered by in-state hospitals and the out-of-state hospital that  
532 is authorized by federal law to submit intergovernmental transfers  
533 (IGTs) to the State of Mississippi and is classified as Level I  
534 trauma center located in a county contiguous to the state line at  
535 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 \* \* \* to approval by the Centers for Medicare and Medicaid Services (CMS) \* \* \*, 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.

(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 and other payment programs for inpatient and/or outpatient payments which may be developed under the authority of this paragraph.

(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, supplemental payments and such other purposes as specified in Section 43-13-145. The



assessment will remain in effect as long as the MHAP and supplemental payments are in effect.

(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 \* \* \* 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 for services provided under this subparagraph (a).

(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. Federally qualified health centers shall be reimbursed by the Medicaid prospective payment system as approved by the Centers for Medicare and Medicaid Services. The division shall recognize federally qualified health centers (FQHCs), rural health clinics (RHCs) and community mental health centers (CMHCs) as both an originating and distant site provider for the purposes of telehealth reimbursement. The division is further authorized and directed to reimburse FQHCs, RHCs and CMHCs for both distant site and originating site services when such services are appropriately provided by the same organization.

(23) Inpatient psychiatric services.

(a) 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.

(b) The division may reimburse for services provided by a licensed freestanding psychiatric hospital to Medicaid recipients over the age of twenty-one (21) in a method and manner consistent with the provisions of Section 43-13-117.5.

(24) [Deleted]

(25) [Deleted]

(26) Hospice care. As used in this paragraph, the term "hospice care" means a coordinated program of active professional



660 medical attention within the home and outpatient and inpatient  
661 care that treats the terminally ill patient and family as a unit,  
662 employing a medically directed interdisciplinary team. The  
663 program provides relief of severe pain or other physical symptoms  
664 and supportive care to meet the special needs arising out of  
665 physical, psychological, spiritual, social and economic stresses  
666 that are experienced during the final stages of illness and during  
667 dying and bereavement and meets the Medicare requirements for  
668 participation as a hospice as provided in federal regulations.

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

672           (28) Other health insurance premiums that are  
673 cost-effective as defined by the United States Secretary of Health  
674 and Human Services. Medicare eligible must have Medicare Part B  
675 before other insurance premiums can be paid.

676           (29) The Division of Medicaid may apply for a waiver  
677 from the United States Department of Health and Human Services for  
678 home- and community-based services for developmentally disabled  
679 people using state funds that are provided from the appropriation  
680 to the State Department of Mental Health and/or funds transferred  
681 to the department by a political subdivision or instrumentality of  
682 the state and used to match federal funds under a cooperative  
683 agreement between the division and the department, provided that  
684 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 \* \* \* as  
determined by the division.

(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 \* \* \* as determined by the division.

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 Medicaid Committee and the House Medicaid Committee not later than January 1, 2019, and every two (2) years thereafter.

(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



734 amounts for services available under Medicare, as determined by  
735 the division. \* \* \*

736 (40) [Deleted]

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

747 (42) [Deleted]

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

753 (44) Nursing facility services for the severely  
754 disabled.

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



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

761 (45) Physician assistant services. Services furnished  
762 by a physician assistant who is licensed by the State Board of  
763 Medical Licensure and is practicing with physician supervision  
764 under regulations adopted by the board, under regulations adopted  
765 by the division. Reimbursement for those services shall not  
766 exceed ninety percent (90%) of the reimbursement rate for  
767 comparable services rendered by a physician. The division may  
768 provide for a reimbursement rate for physician assistant services  
769 of up to one hundred percent (100%) or the reimbursement rate for  
770 comparable services rendered by a physician for physician  
771 assistant services that are provided after the normal working  
772 hours of the physician assistant, as determined in accordance with  
773 regulations of the division.

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



the Legislature, or if funds are voluntarily provided by affected agencies.

(47) (a) 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 \* \* \* may establish copayments and/or coinsurance for \* \* \* any Medicaid services for which copayments and/or coinsurance are allowable under federal law or regulation.



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

814                   (51)   Upon determination of Medicaid eligibility and in  
815   association with annual redetermination of Medicaid eligibility,  
816   beneficiaries shall be encouraged to undertake a physical  
817   examination that will establish a base-line level of health and  
818   identification of a usual and customary source of care (a medical  
819   home) to aid utilization of disease management tools. This  
820   physical examination and utilization of these disease management  
821   tools shall be consistent with current United States Preventive  
822   Services Task Force or other recognized authority recommendations.

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

826                   (52)   Notwithstanding any provisions of this article,  
827   the division may pay enhanced reimbursement fees related to trauma  
828   care, as determined by the division in conjunction with the State  
829   Department of Health, using funds appropriated to the State  
830   Department of Health for trauma care and services and used to  
831   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, enhanced reimbursements, Upper Payment Limits Programs, supplemental payments, or other projects as necessary in the development and implementation of this reimbursement program.

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

(54) [Deleted]

(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.

(58) Treatment services for persons with opioid dependency or other highly addictive substance use disorders. The division is authorized to reimburse eligible providers for treatment of opioid dependency and other highly addictive substance use disorders, as determined by the division. Treatment related to these conditions shall not count against any physician visit limit imposed under this section.

(59) The division shall allow beneficiaries between the ages of ten (10) and eighteen (18) years to receive vaccines through a pharmacy venue. The division and the State Department of Health shall coordinate and notify OB-GYN providers that the Vaccines for Children program is available to providers free of charge.



882           (60) Bariatric surgery as determined by the division  
883 and as allowed by federal law and regulation.

884           (61) The division is authorized and directed to provide  
885 up to twelve (12) months of continuous coverage postpartum for any  
886 individual who qualifies for Medicaid coverage under this section  
887 as a pregnant woman, to the extent allowable under federal law and  
888 as determined by the division. It is the intent of the  
889 Legislature that the division shall reduce the application time  
890 and simplify application procedures for pregnant women applying  
891 for Medicaid coverage postpartum. Not later than July 1, 2022,  
892 the division or its designee shall develop a report to the  
893 Legislature evaluating the effectiveness of extending Medicaid  
894 coverage for pregnant women from sixty (60) days postpartum to  
895 three hundred sixty-five (365) days postpartum.

896           (B) \* \* \* [Deleted]

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



907 (D) [Deleted]

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

914 (F) The executive director shall keep the Governor advised  
915 on a timely basis of the funds available for expenditure and the  
916 projected expenditures. Notwithstanding any other provisions of  
917 this article, if current or projected expenditures of the division  
918 are reasonably anticipated to exceed the amount of funds  
919 appropriated to the division for any fiscal year, the Governor,  
920 after consultation with the executive director, shall take all  
921 appropriate measures to reduce costs, which may include, but are  
922 not limited to:

923 (1) Reducing or discontinuing any or all services that  
924 are deemed to be optional under Title XIX of the Social Security  
925 Act;

926 (2) Reducing reimbursement rates for any or all service  
927 types to the extent allowed under federal law to first include the  
928 administrative fee portion of capitated payments to organizations  
929 described in subsection (H)(1) of this section before enacting  
930 reimbursement rate reductions for health care providers;



(3) Imposing additional assessments on health care providers; or

(4) Any additional cost-containment measures deemed appropriate by the Governor.

Beginning in fiscal year 2010 and in fiscal years thereafter, when Medicaid expenditures are projected to exceed funds available for the fiscal year, the division shall submit the expected shortfall information to the PEER Committee not later than December 1 of the year in which the shortfall is projected to occur. PEER shall review the computations of the division and report its findings to the Legislative Budget Office not later than January 7 in any year.

(G) Notwithstanding any other provision of this article, it shall be the duty of each provider participating in the Medicaid program to keep and maintain books, documents and other records as prescribed by the Division of Medicaid in \* \* \* accordance with federal laws and regulations.

(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. \* \* \*

As a condition for the approval of any program under this



subsection (H) (1), the division shall require that no managed care 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 alternative payment models, including quality and value-based payment arrangements, provided both parties, the health care provider and the organization described in this subsection (H) (1), mutually agree and the Division of Medicaid approves of said models. It is the intent of the Legislature that all managed care entities described in this subsection (H), in collaboration with the division, develop and implement innovative payment models that incentivize improvements in health care quality, outcomes, or value, as determined by the division. 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 medical services, transportation services and prescription drugs that is more stringent than the prior authorization processes used by the division in its administration of the Medicaid program;

(e) [Deleted]

(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 health maintenance organizations, coordinated care organizations, provider-sponsored health plans, 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 implement a Level of Care Guidelines in the determination of medical necessity and in all utilization management practices, including the prior authorization process, concurrent reviews, retrospective reviews and payments.



1005           (2) Notwithstanding any provision of this section, the  
1006 recipients eligible for enrollment into a Medicaid managed care  
1007 program authorized under this subsection (H) shall include only  
1008 those categories of recipients eligible for participation in the  
1009 Medicaid managed care program as of January 1, 2019, and the  
1010 Children's Health Insurance Program (CHIP), CMS approved Section  
1011 1115 demonstration waivers in operation as of January 1, 2021, and  
1012 a demonstration waiver to extend postpartum coverage for pregnant  
1013 women up to twelve (12) months or a period of time as may  
1014 otherwise be authorized under this article. No expansion of  
1015 Medicaid managed care program contracts may be implemented by the  
1016 division without enabling legislation from the Mississippi  
1017 Legislature. \* \* \*

1018       \* \* \*

1019           (3) (a) Any contractors \* \* \* receiving capitated  
1020 payments under a managed care \* \* \* delivery system established in  
1021 this section shall provide to the Legislature and the division  
1022 statistical data to be shared with provider groups in order to  
1023 improve patient access, appropriate utilization, cost savings and  
1024 health outcomes not later than October 1 of each year.  
1025 Additionally, each contractor shall disclose to the Chairmen of  
1026 the Senate and House Medicaid Committees the administrative  
1027 expenses costs for the prior calendar year, and the number of  
1028 full-equivalent employees located in the State of Mississippi



1029 dedicated to the Medicaid and CHIP lines of business as of June 30  
1030 of the current year.

1031 (b) The division and the contractors participating  
1032 in the managed care program, a coordinated care program or a  
1033 provider-sponsored health plan shall be subject to annual program  
1034 reviews or audits performed by the Office of the State Auditor,  
1035 the PEER Committee and/or \* \* \* independent third \* \* \* parties.

1036 (c) Those \* \* \* reviews shall \* \* \* include, but  
1037 not be limited to, at least two (2) of the following items \* \* \*:

1038 (i) The financial benefit to the State of  
1039 Mississippi of the managed care program,

1040 (ii) The difference between the premiums paid  
1041 to the managed care contractors and the payments made by those  
1042 contractors to health care providers, \* \* \*

1043 (iii) Compliance with performance measures  
1044 required under the contracts,

1045 (iv) Administrative expense allocation  
1046 methodologies,

1047 (v) Whether nonprovider payments assigned as  
1048 medical expenses are appropriate,

1049 (vi) Capitated arrangements with related  
1050 party subcontractors,

1051 (vii) Reasonableness of corporate  
1052 allocations,



1053                    (viii) Value-added benefits and the extent to  
1054 which they are used,

1055                    (ix) The effectiveness of subcontractor  
1056 oversight, including subcontractor review,

1057                    (x) Whether \* \* \* health care outcomes \* \* \*  
1058 have been improved, and

1059                    (xi) The most common claim denial codes to  
1060 determine the reasons for the denials.

1061                \* \* \* The audit reports shall be considered \* \* \* public  
1062 documents and shall be posted in \* \* \* their entirety on the  
1063 division's website.

1064                (4) \* \* \* [Deleted]

1065                (5) No health maintenance organization, coordinated  
1066 care organization, provider-sponsored health plan, or other  
1067 organization paid for services on a capitated basis by the  
1068 division under any managed care program or coordinated care  
1069 program implemented by the division under this section shall  
1070 require its providers or beneficiaries to use any pharmacy that  
1071 ships, mails or delivers prescription drugs or legend drugs or  
1072 devices.

1073                (6) Not later than July 1, 2022, any contractors  
1074 receiving capitated payments under a managed care delivery system  
1075 established in this section shall develop and implement a uniform  
1076 credentialing process by which all providers will be credentialed.  
1077 If the provisions of this subsection are not met by July 1, 2022,



1078 the division shall establish a uniform credentialing or screening  
1079 process, and no health maintenance organization, coordinated care  
1080 organization, provider-sponsored health plan, or other  
1081 organization paid for services on a capitated basis by the  
1082 division under any managed care program or coordinated care  
1083 program implemented by the division under this section shall  
1084 require its providers to be credentialed by the organization in  
1085 order to receive reimbursement from the organization, but those  
1086 organizations shall recognize the credentialing or screening of  
1087 the providers by the division.

1088 (7) It is the intent of the Legislature that the  
1089 division evaluate the feasibility of continuing to administer  
1090 pharmacy benefits under the fee-for-service delivery system.

1091 (8) It is the intent of the Legislature that the  
1092 division evaluate the feasibility of utilizing a single vendor to  
1093 administer dental benefits provided under a managed care delivery  
1094 system established in this section.

1095 (9) It is the intent of the Legislature that any  
1096 contractor receiving capitated payments under a managed care  
1097 delivery system established in this section shall implement  
1098 innovative programs to improve the health and well-being of  
1099 members diagnosed with prediabetes and diabetes.

1100 (I) [Deleted]

1101 (J) \* \* \* [Deleted]



1102           (K) In the negotiation and execution of such contracts  
1103 involving services performed by actuarial firms, the Executive  
1104 Director of the Division of Medicaid may negotiate a limitation on  
1105 liability to the state of prospective contractors.

1106           ( \* \* \*L) This section shall stand repealed on July 1, \* \* \*  
1107 2022.

1108           **SECTION 2.** Section 43-13-145, Mississippi Code of 1972, is  
1109 amended as follows:

1110           43-13-145. (1) (a) Upon each nursing facility licensed by  
1111 the State of Mississippi, there is levied an assessment in an  
1112 amount set by the division, equal to the maximum rate allowed by  
1113 federal law or regulation, for each licensed and occupied bed of  
1114 the facility.

1115           (b) A nursing facility is exempt from the assessment  
1116 levied under this subsection if the facility is operated under the  
1117 direction and control of:

1118                       (i) The United States Veterans Administration or  
1119 other agency or department of the United States government; or

1120                       (ii) The State Veterans Affairs Board \* \* \*.

1121           \* \* \*

1122           (2) (a) Upon each intermediate care facility for  
1123 individuals with intellectual disabilities licensed by the State  
1124 of Mississippi, there is levied an assessment in an amount set by  
1125 the division, equal to the maximum rate allowed by federal law or  
1126 regulation, for each licensed and occupied bed of the facility.



1127           (b) An intermediate care facility for individuals with  
1128 intellectual disabilities is exempt from the assessment levied  
1129 under this subsection if the facility is operated under the  
1130 direction and control of:

1131                   (i) The United States Veterans Administration or  
1132 other agency or department of the United States government;

1133                   (ii) The State Veterans Affairs Board; or

1134                   (iii) The University of Mississippi Medical  
1135 Center.

1136       (3) (a) Upon each psychiatric residential treatment  
1137 facility licensed by the State of Mississippi, there is levied an  
1138 assessment in an amount set by the division, equal to the maximum  
1139 rate allowed by federal law or regulation, for each licensed and  
1140 occupied bed of the facility.

1141           (b) A psychiatric residential treatment facility is  
1142 exempt from the assessment levied under this subsection if the  
1143 facility is operated under the direction and control of:

1144                   (i) The United States Veterans Administration or  
1145 other agency or department of the United States government;

1146                   (ii) The University of Mississippi Medical Center;  
1147 or

1148                   (iii) A state agency or a state facility that  
1149 either provides its own state match through intergovernmental  
1150 transfer or certification of funds to the division.

1151       (4) Hospital assessment.



1152           (a)   (i)   Subject to and upon fulfillment of the  
1153 requirements and conditions of paragraph (f) below, and  
1154 notwithstanding any other provisions of this section, \* \* \* an  
1155 annual assessment on each hospital licensed in the state is  
1156 imposed on each non-Medicare hospital inpatient day as defined  
1157 below at a rate that is determined by dividing the sum prescribed  
1158 in this subparagraph (i), plus the nonfederal share necessary to  
1159 maximize the Disproportionate Share Hospital (DSH) and Medicare  
1160 Upper Payment Limits (UPL) Program payments and hospital access  
1161 payments and such other supplemental payments as may be developed  
1162 pursuant to Section 43-13-117(A)(18), by the total number of  
1163 non-Medicare hospital inpatient days as defined below for all  
1164 licensed Mississippi hospitals, except as provided in paragraph  
1165 (d) below. If the state-matching funds percentage for the  
1166 Mississippi Medicaid program is sixteen percent (16%) or less, the  
1167 sum used in the formula under this subparagraph (i) shall be  
1168 Seventy-four Million Dollars (\$74,000,000.00). If the  
1169 state-matching funds percentage for the Mississippi Medicaid  
1170 program is twenty-four percent (24%) or higher, the sum used in  
1171 the formula under this subparagraph (i) shall be One Hundred Four  
1172 Million Dollars (\$104,000,000.00). If the state-matching funds  
1173 percentage for the Mississippi Medicaid program is between sixteen  
1174 percent (16%) and twenty-four percent (24%), the sum used in the  
1175 formula under this subparagraph (i) shall be a pro rata amount  
1176 determined as follows: the current state-matching funds



1177 percentage rate minus sixteen percent (16%) divided by eight  
1178 percent (8%) multiplied by Thirty Million Dollars (\$30,000,000.00)  
1179 and add that amount to Seventy-four Million Dollars  
1180 (\$74,000,000.00). However, no assessment in a quarter under this  
1181 subparagraph (i) may exceed the assessment in the previous quarter  
1182 by more than Three Million Seven Hundred Fifty Thousand Dollars  
1183 (\$3,750,000.00) (which would be Fifteen Million Dollars  
1184 (\$15,000,000.00) on an annualized basis). The division shall  
1185 publish the state-matching funds percentage rate applicable to the  
1186 Mississippi Medicaid program on the tenth day of the first month  
1187 of each quarter and the assessment determined under the formula  
1188 prescribed above shall be applicable in the quarter following any  
1189 adjustment in that state-matching funds percentage rate. The  
1190 division shall notify each hospital licensed in the state as to  
1191 any projected increases or decreases in the assessment determined  
1192 under this subparagraph (i). However, if the Centers for Medicare  
1193 and Medicaid Services (CMS) does not approve the provision in  
1194 Section 43-13-117(39) requiring the division to reimburse  
1195 crossover claims for inpatient hospital services and crossover  
1196 claims covered under Medicare Part B for dually eligible  
1197 beneficiaries in the same manner that was in effect on January 1,  
1198 2008, the sum that otherwise would have been used in the formula  
1199 under this subparagraph (i) shall be reduced by Seven Million  
1200 Dollars (\$7,000,000.00).



1201                   (ii) In addition to the assessment provided under  
1202 subparagraph (i), \* \* \* an additional annual assessment on each  
1203 hospital licensed in the state is imposed on each non-Medicare  
1204 hospital inpatient day as defined below at a rate that is  
1205 determined by dividing twenty-five percent (25%) of any provider  
1206 reductions in the Medicaid program as authorized in Section  
1207 43-13-117(F) for that fiscal year up to the following maximum  
1208 amount, plus the nonfederal share necessary to maximize the  
1209 Disproportionate Share Hospital (DSH) and inpatient Medicare Upper  
1210 Payment Limits (UPL) Program payments and inpatient hospital  
1211 access payments, by the total number of non-Medicare hospital  
1212 inpatient days as defined below for all licensed Mississippi  
1213 hospitals: in fiscal year 2010, the maximum amount shall be  
1214 Twenty-four Million Dollars (\$24,000,000.00); in fiscal year 2011,  
1215 the maximum amount shall be Thirty-two Million Dollars  
1216 (\$32,000,000.00); and in fiscal year 2012 and thereafter, the  
1217 maximum amount shall be Forty Million Dollars (\$40,000,000.00).  
1218 Any such deficit in the Medicaid program shall be reviewed by the  
1219 PEER Committee as provided in Section 43-13-117(F).

1220                   (iii) In addition to the assessments provided in  
1221 subparagraphs (i) and (ii), \* \* \* an additional annual assessment  
1222 on each hospital licensed in the state is imposed pursuant to the  
1223 provisions of Section 43-13-117(F) if the cost containment  
1224 measures described therein have been implemented and there are  
1225 insufficient funds in the Health Care Trust Fund to reconcile any



1226 remaining deficit in any fiscal year. If the Governor institutes  
1227 any other additional cost-containment measures on any program or  
1228 programs authorized under the Medicaid program pursuant to Section  
1229 43-13-117(F), hospitals shall be responsible for twenty-five  
1230 percent (25%) of any such additional imposed provider cuts, which  
1231 shall be in the form of an additional assessment not to exceed the  
1232 twenty-five percent (25%) of provider expenditure reductions.  
1233 Such additional assessment shall be imposed on each non-Medicare  
1234 hospital inpatient day in the same manner as assessments are  
1235 imposed under subparagraphs (i) and (ii).

1236 (b) \* \* \* Definitions.

1237 (i) \* \* \* [Deleted]

1238 (ii) \* \* \* For purposes of this subsection (4):

1239 1. "Non-Medicare hospital inpatient day"

1240 means total hospital inpatient days including subcomponent days  
1241 less Medicare inpatient days including subcomponent days from the  
1242 hospital's most recent Medicare cost report for the second  
1243 calendar year preceding the beginning of the state fiscal year, on  
1244 file with CMS per the CMS HCRIS database, or cost report submitted  
1245 to the Division if the HCRIS database is not available to the  
1246 division, as of June 1 of each year.

1247 a. Total hospital inpatient days shall  
1248 be the sum of Worksheet S-3, Part 1, column 8 row 14, column 8 row  
1249 16, and column 8 row 17, excluding column 8 rows 5 and 6.



1250                               b. Hospital Medicare inpatient days  
1251 shall be the sum of Worksheet S-3, Part 1, column 6 row 14, column  
1252 6 row 16.00, and column 6 row 17, excluding column 6 rows 5 and 6.

1253                               c. Inpatient days shall not include  
1254 residential treatment or long-term care days.

1255                               2. "Subcomponent inpatient day" means the  
1256 number of days of care charged to a beneficiary for inpatient  
1257 hospital rehabilitation and psychiatric care services in units of  
1258 full days. A day begins at midnight and ends twenty-four (24)  
1259 hours later. A part of a day, including the day of admission and  
1260 day on which a patient returns from leave of absence, counts as a  
1261 full day. However, the day of discharge, death, or a day on which  
1262 a patient begins a leave of absence is not counted as a day unless  
1263 discharge or death occur on the day of admission. If admission  
1264 and discharge or death occur on the same day, the day is  
1265 considered a day of admission and counts as one (1) subcomponent  
1266 inpatient day.

1267                               (c) The assessment provided in this subsection is  
1268 intended to satisfy and not be in addition to the assessment and  
1269 intergovernmental transfers provided in Section 43-13-117(A) (18).  
1270 Nothing in this section shall be construed to authorize any state  
1271 agency, division or department, or county, municipality or other  
1272 local governmental unit to license for revenue, levy or impose any  
1273 other tax, fee or assessment upon hospitals in this state not  
1274 authorized by a specific statute.



1275                   (d) Hospitals operated by the United States Department  
1276 of Veterans Affairs and state-operated facilities that provide  
1277 only inpatient and outpatient psychiatric services shall not be  
1278 subject to the hospital assessment provided in this subsection.

1279                   (e) Multihospital systems, closure, merger, change of  
1280 ownership and new hospitals.

1281                   (i) If a hospital conducts, operates or maintains  
1282 more than one (1) hospital licensed by the State Department of  
1283 Health, the provider shall pay the hospital assessment for each  
1284 hospital separately.

1285                   (ii) Notwithstanding any other provision in this  
1286 section, if a hospital subject to this assessment operates or  
1287 conducts business only for a portion of a fiscal year, the  
1288 assessment for the state fiscal year shall be adjusted by  
1289 multiplying the assessment by a fraction, the numerator of which  
1290 is the number of days in the year during which the hospital  
1291 operates, and the denominator of which is three hundred sixty-five  
1292 (365). Immediately upon ceasing to operate, the hospital shall  
1293 pay the assessment for the year as so adjusted (to the extent not  
1294 previously paid).

1295                   (iii) The division shall determine the tax for new  
1296 hospitals and hospitals that undergo a change of ownership in  
1297 accordance with this section, using the best available  
1298 information, as determined by the division.

1299                   (f) Applicability.



The hospital assessment imposed by this subsection shall not take effect and/or shall cease to be imposed if:

(i) The assessment is determined to be an impermissible tax under Title XIX of the Social Security Act; or

(ii) CMS revokes its approval of the division's 2009 Medicaid State Plan Amendment for the methodology for DSH payments to hospitals under Section 43-13-117(A)(18).

\* \* \*

(5) Each health care facility that is subject to the provisions of this section shall keep and preserve such suitable books and records as may be necessary to determine the amount of assessment for which it is liable under this section. The books and records shall be kept and preserved for a period of not less than five (5) years, during which time those books and records shall be open for examination during business hours by the division, the Department of Revenue, the Office of the Attorney General and the State Department of Health.

(6) \* \* \* [Deleted]

(7) All assessments collected under this section shall be deposited in the Medical Care Fund created by Section 43-13-143.

(8) The assessment levied under this section shall be in addition to any other assessments, taxes or fees levied by law, and the assessment shall constitute a debt due the State of Mississippi from the time the assessment is due until it is paid.



1324           (9)   (a)   If a health care facility that is liable for  
1325 payment of an assessment levied by the division does not pay the  
1326 assessment when it is due, the division shall give written notice  
1327 to the health care facility \* \* \* demanding payment of the  
1328 assessment within ten (10) days from the date of delivery of the  
1329 notice. If the health care facility fails or refuses to pay the  
1330 assessment after receiving the notice and demand from the  
1331 division, the division shall withhold from any Medicaid  
1332 reimbursement payments that are due to the health care facility  
1333 the amount of the unpaid assessment and a penalty of ten percent  
1334 (10%) of the amount of the assessment, plus the legal rate of  
1335 interest until the assessment is paid in full. If the health care  
1336 facility does not participate in the Medicaid program, the  
1337 division shall turn over to the Office of the Attorney General the  
1338 collection of the unpaid assessment by civil action. In any such  
1339 civil action, the Office of the Attorney General shall collect the  
1340 amount of the unpaid assessment and a penalty of ten percent (10%)  
1341 of the amount of the assessment, plus the legal rate of interest  
1342 until the assessment is paid in full.

1343           (b)   As an additional or alternative method for  
1344 collecting unpaid assessments levied by the division, if a health  
1345 care facility fails or refuses to pay the assessment after  
1346 receiving notice and demand from the division, the division may  
1347 file a notice of a tax lien with the chancery clerk of the county  
1348 in which the health care facility is located, for the amount of



1349 the unpaid assessment and a penalty of ten percent (10%) of the  
1350 amount of the assessment, plus the legal rate of interest until  
1351 the assessment is paid in full. Immediately upon receipt of  
1352 notice of the tax lien for the assessment, the chancery clerk  
1353 shall forward the notice to the circuit clerk who shall enter the  
1354 notice of the tax lien as a judgment upon the judgment roll and  
1355 show in the appropriate columns the name of the health care  
1356 facility as judgment debtor, the name of the division as judgment  
1357 creditor, the amount of the unpaid assessment, and the date and  
1358 time of enrollment. The judgment shall be valid as against  
1359 mortgagees, pledgees, entrusters, purchasers, judgment creditors  
1360 and other persons from the time of filing with the clerk. The  
1361 amount of the judgment shall be a debt due the State of  
1362 Mississippi and remain a lien upon the tangible property of the  
1363 health care facility until the judgment is satisfied. The  
1364 judgment shall be the equivalent of any enrolled judgment of a  
1365 court of record and shall serve as authority for the issuance of  
1366 writs of execution, writs of attachment or other remedial writs.

1367 (10) (a) To further the provisions of Section  
1368 43-13-117(A)(18), the Division of Medicaid shall submit to the  
1369 Centers for Medicare and Medicaid Services (CMS) any documents  
1370 regarding the hospital assessment established under subsection (4)  
1371 of this section. In addition to defining the assessment  
1372 established in subsection (4) of this section if necessary, the  
1373 documents shall describe any supplement payment programs and/or



1374 payment methodologies as authorized in Section 43-13-117(A) (18) if  
1375 necessary.

1376 (b) All hospitals satisfying the minimum federal DSH  
1377 eligibility requirements (Section 1923(d) of the Social Security  
1378 Act) may, subject to OBRA 1993 payment limitations, receive a DSH  
1379 payment. This DSH payment shall expend the balance of the federal  
1380 DSH allotment and associated state share not utilized in DSH  
1381 payments to state-owned institutions for treatment of mental  
1382 diseases. The payment to each hospital shall be calculated by  
1383 applying a uniform percentage to the uninsured costs of each  
1384 eligible hospital, excluding state-owned institutions for  
1385 treatment of mental diseases; however, that percentage for a  
1386 state-owned teaching hospital located in Hinds County shall be  
1387 multiplied by a factor of two (2).

1388 (11) The division shall implement DSH and supplemental  
1389 payment calculation methodologies that result in the maximization  
1390 of available federal funds.

1391 (12) The DSH payments shall be paid on or before December  
1392 31, March 31, and June 30 of each fiscal year, in increments of  
1393 one-third (1/3) of the total calculated DSH amounts. Supplemental  
1394 payments developed pursuant to Section 43-13-117(A) (18) shall be  
1395 paid monthly.

1396 (13) \* \* \* Payment.

1397 (a) The hospital assessment as described in subsection  
1398 (4) for the nonfederal share necessary to maximize the Medicare



1399 Upper Payments Limits (UPL) Program payments and hospital access  
1400 payments and such other supplemental payments as may be developed  
1401 pursuant to Section 43-3-117(A) (18) shall be assessed and  
1402 collected monthly no later than the fifteenth calendar day of each  
1403 month.

1404 (b) The hospital assessment as described in subsection  
1405 (4) for the nonfederal share necessary to maximize the  
1406 Disproportionate Share Hospital (DSH) payments shall be assessed  
1407 and collected on December 15, March 15 and June 15.

1408 (c) The annual hospital assessment and any additional  
1409 hospital assessment as described in subsection (4) shall be  
1410 assessed and collected on September 15 and on the 15th of each  
1411 month from December through June.

1412 (14) If for any reason any part of the plan for annual DSH  
1413 and supplemental payment programs to hospitals provided under  
1414 subsection (10) of this section and/or developed pursuant to  
1415 Section 43-13-117(A) (18) is not approved by CMS, the remainder of  
1416 the plan shall remain in full force and effect.

1417 (15) Nothing in this section shall prevent the Division of  
1418 Medicaid from facilitating participation in Medicaid supplemental  
1419 hospital payment programs by a hospital located in a county  
1420 contiguous to the State of Mississippi that is also authorized by  
1421 federal law to submit intergovernmental transfers (IGTs) to the  
1422 State of Mississippi to fund the state share of the hospital's  
1423 supplemental and/or MHAP payments.



(16) Subsections (10) through (15) of this section shall stand repealed on July 1, \* \* \* 2022.

**SECTION 3.** Section 41-7-191, Mississippi Code of 1972, is amended as follows:

41-7-191. (1) No person shall engage in any of the following activities without obtaining the required certificate of need:

(a) The construction, development or other establishment of a new health care facility, which establishment shall include the reopening of a health care facility that has ceased to operate for a period of sixty (60) months or more;

(b) The relocation of a health care facility or portion thereof, or major medical equipment, unless such relocation of a health care facility or portion thereof, or major medical equipment, which does not involve a capital expenditure by or on behalf of a health care facility, is within five thousand two hundred eighty (5,280) feet from the main entrance of the health care facility;

(c) Any change in the existing bed complement of any health care facility through the addition or conversion of any beds or the alteration, modernizing or refurbishing of any unit or department in which the beds may be located; however, if a health care facility has voluntarily delicensed some of its existing bed complement, it may later relicense some or all of its delicensed beds without the necessity of having to acquire a certificate of



1449 need. The State Department of Health shall maintain a record of  
1450 the delicensing health care facility and its voluntarily  
1451 delicensed beds and continue counting those beds as part of the  
1452 state's total bed count for health care planning purposes. If a  
1453 health care facility that has voluntarily delicensed some of its  
1454 beds later desires to relicense some or all of its voluntarily  
1455 delicensed beds, it shall notify the State Department of Health of  
1456 its intent to increase the number of its licensed beds. The State  
1457 Department of Health shall survey the health care facility within  
1458 thirty (30) days of that notice and, if appropriate, issue the  
1459 health care facility a new license reflecting the new contingent  
1460 of beds. However, in no event may a health care facility that has  
1461 voluntarily delicensed some of its beds be reissued a license to  
1462 operate beds in excess of its bed count before the voluntary  
1463 delicensure of some of its beds without seeking certificate of  
1464 need approval;

1465 (d) Offering of the following health services if those  
1466 services have not been provided on a regular basis by the proposed  
1467 provider of such services within the period of twelve (12) months  
1468 prior to the time such services would be offered:

- 1469 (i) Open-heart surgery services;  
1470 (ii) Cardiac catheterization services;  
1471 (iii) Comprehensive inpatient rehabilitation  
1472 services;  
1473 (iv) Licensed psychiatric services;



1474 (v) Licensed chemical dependency services;  
1475 (vi) Radiation therapy services;  
1476 (vii) Diagnostic imaging services of an invasive  
1477 nature, i.e. invasive digital angiography;  
1478 (viii) Nursing home care as defined in  
1479 subparagraphs (iv), (vi) and (viii) of Section 41-7-173(h);  
1480 (ix) Home health services;  
1481 (x) Swing-bed services;  
1482 (xi) Ambulatory surgical services;  
1483 (xii) Magnetic resonance imaging services;  
1484 (xiii) [Deleted]  
1485 (xiv) Long-term care hospital services;  
1486 (xv) Positron emission tomography (PET) services;  
1487 (e) The relocation of one or more health services from  
1488 one physical facility or site to another physical facility or  
1489 site, unless such relocation, which does not involve a capital  
1490 expenditure by or on behalf of a health care facility, (i) is to a  
1491 physical facility or site within five thousand two hundred eighty  
1492 (5,280) feet from the main entrance of the health care facility  
1493 where the health care service is located, or (ii) is the result of  
1494 an order of a court of appropriate jurisdiction or a result of  
1495 pending litigation in such court, or by order of the State  
1496 Department of Health, or by order of any other agency or legal  
1497 entity of the state, the federal government, or any political



1498 subdivision of either, whose order is also approved by the State  
1499 Department of Health;

1500 (f) The acquisition or otherwise control of any major  
1501 medical equipment for the provision of medical services; however,  
1502 (i) the acquisition of any major medical equipment used only for  
1503 research purposes, and (ii) the acquisition of major medical  
1504 equipment to replace medical equipment for which a facility is  
1505 already providing medical services and for which the State  
1506 Department of Health has been notified before the date of such  
1507 acquisition shall be exempt from this paragraph; an acquisition  
1508 for less than fair market value must be reviewed, if the  
1509 acquisition at fair market value would be subject to review;

1510 (g) Changes of ownership of existing health care  
1511 facilities in which a notice of intent is not filed with the State  
1512 Department of Health at least thirty (30) days prior to the date  
1513 such change of ownership occurs, or a change in services or bed  
1514 capacity as prescribed in paragraph (c) or (d) of this subsection  
1515 as a result of the change of ownership; an acquisition for less  
1516 than fair market value must be reviewed, if the acquisition at  
1517 fair market value would be subject to review;

1518 (h) The change of ownership of any health care facility  
1519 defined in subparagraphs (iv), (vi) and (viii) of Section  
1520 41-7-173(h), in which a notice of intent as described in paragraph  
1521 (g) has not been filed and if the Executive Director, Division of  
1522 Medicaid, Office of the Governor, has not certified in writing



1523 that there will be no increase in allowable costs to Medicaid from  
1524 revaluation of the assets or from increased interest and  
1525 depreciation as a result of the proposed change of ownership;

1526 (i) Any activity described in paragraphs (a) through  
1527 (h) if undertaken by any person if that same activity would  
1528 require certificate of need approval if undertaken by a health  
1529 care facility;

1530 (j) Any capital expenditure or deferred capital  
1531 expenditure by or on behalf of a health care facility not covered  
1532 by paragraphs (a) through (h);

1533 (k) The contracting of a health care facility as  
1534 defined in subparagraphs (i) through (viii) of Section 41-7-173(h)  
1535 to establish a home office, subunit, or branch office in the space  
1536 operated as a health care facility through a formal arrangement  
1537 with an existing health care facility as defined in subparagraph  
1538 (ix) of Section 41-7-173(h);

1539 (l) The replacement or relocation of a health care  
1540 facility designated as a critical access hospital shall be exempt  
1541 from subsection (1) of this section so long as the critical access  
1542 hospital complies with all applicable federal law and regulations  
1543 regarding such replacement or relocation;

1544 (m) Reopening a health care facility that has ceased to  
1545 operate for a period of sixty (60) months or more, which reopening  
1546 requires a certificate of need for the establishment of a new  
1547 health care facility.



1548           (2) The State Department of Health shall not grant approval  
1549 for or issue a certificate of need to any person proposing the new  
1550 construction of, addition to, or expansion of any health care  
1551 facility defined in subparagraphs (iv) (skilled nursing facility)  
1552 and (vi) (intermediate care facility) of Section 41-7-173(h) or  
1553 the conversion of vacant hospital beds to provide skilled or  
1554 intermediate nursing home care, except as hereinafter authorized:

1555           (a) The department may issue a certificate of need to  
1556 any person proposing the new construction of any health care  
1557 facility defined in subparagraphs (iv) and (vi) of Section  
1558 41-7-173(h) as part of a life care retirement facility, in any  
1559 county bordering on the Gulf of Mexico in which is located a  
1560 National Aeronautics and Space Administration facility, not to  
1561 exceed forty (40) beds. From and after July 1, 1999, there shall  
1562 be no prohibition or restrictions on participation in the Medicaid  
1563 program (Section 43-13-101 et seq.) for the beds in the health  
1564 care facility that were authorized under this paragraph (a).

1565           (b) The department may issue certificates of need in  
1566 Harrison County to provide skilled nursing home care for  
1567 Alzheimer's disease patients and other patients, not to exceed one  
1568 hundred fifty (150) beds. From and after July 1, 1999, there  
1569 shall be no prohibition or restrictions on participation in the  
1570 Medicaid program (Section 43-13-101 et seq.) for the beds in the  
1571 nursing facilities that were authorized under this paragraph (b).



1572           (c) The department may issue a certificate of need for  
1573 the addition to or expansion of any skilled nursing facility that  
1574 is part of an existing continuing care retirement community  
1575 located in Madison County, provided that the recipient of the  
1576 certificate of need agrees in writing that the skilled nursing  
1577 facility will not at any time participate in the Medicaid program  
1578 (Section 43-13-101 et seq.) or admit or keep any patients in the  
1579 skilled nursing facility who are participating in the Medicaid  
1580 program. This written agreement by the recipient of the  
1581 certificate of need shall be fully binding on any subsequent owner  
1582 of the skilled nursing facility, if the ownership of the facility  
1583 is transferred at any time after the issuance of the certificate  
1584 of need. Agreement that the skilled nursing facility will not  
1585 participate in the Medicaid program shall be a condition of the  
1586 issuance of a certificate of need to any person under this  
1587 paragraph (c), and if such skilled nursing facility at any time  
1588 after the issuance of the certificate of need, regardless of the  
1589 ownership of the facility, participates in the Medicaid program or  
1590 admits or keeps any patients in the facility who are participating  
1591 in the Medicaid program, the State Department of Health shall  
1592 revoke the certificate of need, if it is still outstanding, and  
1593 shall deny or revoke the license of the skilled nursing facility,  
1594 at the time that the department determines, after a hearing  
1595 complying with due process, that the facility has failed to comply  
1596 with any of the conditions upon which the certificate of need was



1597 issued, as provided in this paragraph and in the written agreement  
1598 by the recipient of the certificate of need. The total number of  
1599 beds that may be authorized under the authority of this paragraph  
1600 (c) shall not exceed sixty (60) beds.

1601 (d) The State Department of Health may issue a  
1602 certificate of need to any hospital located in DeSoto County for  
1603 the new construction of a skilled nursing facility, not to exceed  
1604 one hundred twenty (120) beds, in DeSoto County. From and after  
1605 July 1, 1999, there shall be no prohibition or restrictions on  
1606 participation in the Medicaid program (Section 43-13-101 et seq.)  
1607 for the beds in the nursing facility that were authorized under  
1608 this paragraph (d).

1609 (e) The State Department of Health may issue a  
1610 certificate of need for the construction of a nursing facility or  
1611 the conversion of beds to nursing facility beds at a personal care  
1612 facility for the elderly in Lowndes County that is owned and  
1613 operated by a Mississippi nonprofit corporation, not to exceed  
1614 sixty (60) beds. From and after July 1, 1999, there shall be no  
1615 prohibition or restrictions on participation in the Medicaid  
1616 program (Section 43-13-101 et seq.) for the beds in the nursing  
1617 facility that were authorized under this paragraph (e).

1618 (f) The State Department of Health may issue a  
1619 certificate of need for conversion of a county hospital facility  
1620 in Itawamba County to a nursing facility, not to exceed sixty (60)  
1621 beds, including any necessary construction, renovation or



1622 expansion. From and after July 1, 1999, there shall be no  
1623 prohibition or restrictions on participation in the Medicaid  
1624 program (Section 43-13-101 et seq.) for the beds in the nursing  
1625 facility that were authorized under this paragraph (f).

1626 (g) The State Department of Health may issue a  
1627 certificate of need for the construction or expansion of nursing  
1628 facility beds or the conversion of other beds to nursing facility  
1629 beds in either Hinds, Madison or Rankin County, not to exceed  
1630 sixty (60) beds. From and after July 1, 1999, there shall be no  
1631 prohibition or restrictions on participation in the Medicaid  
1632 program (Section 43-13-101 et seq.) for the beds in the nursing  
1633 facility that were authorized under this paragraph (g).

1634 (h) The State Department of Health may issue a  
1635 certificate of need for the construction or expansion of nursing  
1636 facility beds or the conversion of other beds to nursing facility  
1637 beds in either Hancock, Harrison or Jackson County, not to exceed  
1638 sixty (60) beds. From and after July 1, 1999, there shall be no  
1639 prohibition or restrictions on participation in the Medicaid  
1640 program (Section 43-13-101 et seq.) for the beds in the facility  
1641 that were authorized under this paragraph (h).

1642 (i) The department may issue a certificate of need for  
1643 the new construction of a skilled nursing facility in Leake  
1644 County, provided that the recipient of the certificate of need  
1645 agrees in writing that the skilled nursing facility will not at  
1646 any time participate in the Medicaid program (Section 43-13-101 et



1647 seq.) or admit or keep any patients in the skilled nursing  
1648 facility who are participating in the Medicaid program. This  
1649 written agreement by the recipient of the certificate of need  
1650 shall be fully binding on any subsequent owner of the skilled  
1651 nursing facility, if the ownership of the facility is transferred  
1652 at any time after the issuance of the certificate of need.  
1653 Agreement that the skilled nursing facility will not participate  
1654 in the Medicaid program shall be a condition of the issuance of a  
1655 certificate of need to any person under this paragraph (i), and if  
1656 such skilled nursing facility at any time after the issuance of  
1657 the certificate of need, regardless of the ownership of the  
1658 facility, participates in the Medicaid program or admits or keeps  
1659 any patients in the facility who are participating in the Medicaid  
1660 program, the State Department of Health shall revoke the  
1661 certificate of need, if it is still outstanding, and shall deny or  
1662 revoke the license of the skilled nursing facility, at the time  
1663 that the department determines, after a hearing complying with due  
1664 process, that the facility has failed to comply with any of the  
1665 conditions upon which the certificate of need was issued, as  
1666 provided in this paragraph and in the written agreement by the  
1667 recipient of the certificate of need. The provision of Section  
1668 41-7-193(1) regarding substantial compliance of the projection of  
1669 need as reported in the current State Health Plan is waived for  
1670 the purposes of this paragraph. The total number of nursing  
1671 facility beds that may be authorized by any certificate of need



1672 issued under this paragraph (i) shall not exceed sixty (60) beds.  
1673 If the skilled nursing facility authorized by the certificate of  
1674 need issued under this paragraph is not constructed and fully  
1675 operational within eighteen (18) months after July 1, 1994, the  
1676 State Department of Health, after a hearing complying with due  
1677 process, shall revoke the certificate of need, if it is still  
1678 outstanding, and shall not issue a license for the skilled nursing  
1679 facility at any time after the expiration of the eighteen-month  
1680 period.

1681 (j) The department may issue certificates of need to  
1682 allow any existing freestanding long-term care facility in  
1683 Tishomingo County and Hancock County that on July 1, 1995, is  
1684 licensed with fewer than sixty (60) beds. For the purposes of  
1685 this paragraph (j), the provisions of Section 41-7-193(1)  
1686 requiring substantial compliance with the projection of need as  
1687 reported in the current State Health Plan are waived. From and  
1688 after July 1, 1999, there shall be no prohibition or restrictions  
1689 on participation in the Medicaid program (Section 43-13-101 et  
1690 seq.) for the beds in the long-term care facilities that were  
1691 authorized under this paragraph (j).

1692 (k) The department may issue a certificate of need for  
1693 the construction of a nursing facility at a continuing care  
1694 retirement community in Lowndes County. The total number of beds  
1695 that may be authorized under the authority of this paragraph (k)  
1696 shall not exceed sixty (60) beds. From and after July 1, 2001,



1697 the prohibition on the facility participating in the Medicaid  
1698 program (Section 43-13-101 et seq.) that was a condition of  
1699 issuance of the certificate of need under this paragraph (k) shall  
1700 be revised as follows: The nursing facility may participate in  
1701 the Medicaid program from and after July 1, 2001, if the owner of  
1702 the facility on July 1, 2001, agrees in writing that no more than  
1703 thirty (30) of the beds at the facility will be certified for  
1704 participation in the Medicaid program, and that no claim will be  
1705 submitted for Medicaid reimbursement for more than thirty (30)  
1706 patients in the facility in any month or for any patient in the  
1707 facility who is in a bed that is not Medicaid-certified. This  
1708 written agreement by the owner of the facility shall be a  
1709 condition of licensure of the facility, and the agreement shall be  
1710 fully binding on any subsequent owner of the facility if the  
1711 ownership of the facility is transferred at any time after July 1,  
1712 2001. After this written agreement is executed, the Division of  
1713 Medicaid and the State Department of Health shall not certify more  
1714 than thirty (30) of the beds in the facility for participation in  
1715 the Medicaid program. If the facility violates the terms of the  
1716 written agreement by admitting or keeping in the facility on a  
1717 regular or continuing basis more than thirty (30) patients who are  
1718 participating in the Medicaid program, the State Department of  
1719 Health shall revoke the license of the facility, at the time that  
1720 the department determines, after a hearing complying with due  
1721 process, that the facility has violated the written agreement.



1722           (1) Provided that funds are specifically appropriated  
1723 therefor by the Legislature, the department may issue a  
1724 certificate of need to a rehabilitation hospital in Hinds County  
1725 for the construction of a sixty-bed long-term care nursing  
1726 facility dedicated to the care and treatment of persons with  
1727 severe disabilities including persons with spinal cord and  
1728 closed-head injuries and ventilator dependent patients. The  
1729 provisions of Section 41-7-193(1) regarding substantial compliance  
1730 with projection of need as reported in the current State Health  
1731 Plan are waived for the purpose of this paragraph.

1732           (m) The State Department of Health may issue a  
1733 certificate of need to a county-owned hospital in the Second  
1734 Judicial District of Panola County for the conversion of not more  
1735 than seventy-two (72) hospital beds to nursing facility beds,  
1736 provided that the recipient of the certificate of need agrees in  
1737 writing that none of the beds at the nursing facility will be  
1738 certified for participation in the Medicaid program (Section  
1739 43-13-101 et seq.), and that no claim will be submitted for  
1740 Medicaid reimbursement in the nursing facility in any day or for  
1741 any patient in the nursing facility. This written agreement by  
1742 the recipient of the certificate of need shall be a condition of  
1743 the issuance of the certificate of need under this paragraph, and  
1744 the agreement shall be fully binding on any subsequent owner of  
1745 the nursing facility if the ownership of the nursing facility is  
1746 transferred at any time after the issuance of the certificate of



1747 need. After this written agreement is executed, the Division of  
1748 Medicaid and the State Department of Health shall not certify any  
1749 of the beds in the nursing facility for participation in the  
1750 Medicaid program. If the nursing facility violates the terms of  
1751 the written agreement by admitting or keeping in the nursing  
1752 facility on a regular or continuing basis any patients who are  
1753 participating in the Medicaid program, the State Department of  
1754 Health shall revoke the license of the nursing facility, at the  
1755 time that the department determines, after a hearing complying  
1756 with due process, that the nursing facility has violated the  
1757 condition upon which the certificate of need was issued, as  
1758 provided in this paragraph and in the written agreement. If the  
1759 certificate of need authorized under this paragraph is not issued  
1760 within twelve (12) months after July 1, 2001, the department shall  
1761 deny the application for the certificate of need and shall not  
1762 issue the certificate of need at any time after the twelve-month  
1763 period, unless the issuance is contested. If the certificate of  
1764 need is issued and substantial construction of the nursing  
1765 facility beds has not commenced within eighteen (18) months after  
1766 July 1, 2001, the State Department of Health, after a hearing  
1767 complying with due process, shall revoke the certificate of need  
1768 if it is still outstanding, and the department shall not issue a  
1769 license for the nursing facility at any time after the  
1770 eighteen-month period. However, if the issuance of the  
1771 certificate of need is contested, the department shall require



1772 substantial construction of the nursing facility beds within six  
1773 (6) months after final adjudication on the issuance of the  
1774 certificate of need.

1775           (n) The department may issue a certificate of need for  
1776 the new construction, addition or conversion of skilled nursing  
1777 facility beds in Madison County, provided that the recipient of  
1778 the certificate of need agrees in writing that the skilled nursing  
1779 facility will not at any time participate in the Medicaid program  
1780 (Section 43-13-101 et seq.) or admit or keep any patients in the  
1781 skilled nursing facility who are participating in the Medicaid  
1782 program. This written agreement by the recipient of the  
1783 certificate of need shall be fully binding on any subsequent owner  
1784 of the skilled nursing facility, if the ownership of the facility  
1785 is transferred at any time after the issuance of the certificate  
1786 of need. Agreement that the skilled nursing facility will not  
1787 participate in the Medicaid program shall be a condition of the  
1788 issuance of a certificate of need to any person under this  
1789 paragraph (n), and if such skilled nursing facility at any time  
1790 after the issuance of the certificate of need, regardless of the  
1791 ownership of the facility, participates in the Medicaid program or  
1792 admits or keeps any patients in the facility who are participating  
1793 in the Medicaid program, the State Department of Health shall  
1794 revoke the certificate of need, if it is still outstanding, and  
1795 shall deny or revoke the license of the skilled nursing facility,  
1796 at the time that the department determines, after a hearing



1797 complying with due process, that the facility has failed to comply  
1798 with any of the conditions upon which the certificate of need was  
1799 issued, as provided in this paragraph and in the written agreement  
1800 by the recipient of the certificate of need. The total number of  
1801 nursing facility beds that may be authorized by any certificate of  
1802 need issued under this paragraph (n) shall not exceed sixty (60)  
1803 beds. If the certificate of need authorized under this paragraph  
1804 is not issued within twelve (12) months after July 1, 1998, the  
1805 department shall deny the application for the certificate of need  
1806 and shall not issue the certificate of need at any time after the  
1807 twelve-month period, unless the issuance is contested. If the  
1808 certificate of need is issued and substantial construction of the  
1809 nursing facility beds has not commenced within eighteen (18)  
1810 months after July 1, 1998, the State Department of Health, after a  
1811 hearing complying with due process, shall revoke the certificate  
1812 of need if it is still outstanding, and the department shall not  
1813 issue a license for the nursing facility at any time after the  
1814 eighteen-month period. However, if the issuance of the  
1815 certificate of need is contested, the department shall require  
1816 substantial construction of the nursing facility beds within six  
1817 (6) months after final adjudication on the issuance of the  
1818 certificate of need.

1819           (o) The department may issue a certificate of need for  
1820 the new construction, addition or conversion of skilled nursing  
1821 facility beds in Leake County, provided that the recipient of the



1822 certificate of need agrees in writing that the skilled nursing  
1823 facility will not at any time participate in the Medicaid program  
1824 (Section 43-13-101 et seq.) or admit or keep any patients in the  
1825 skilled nursing facility who are participating in the Medicaid  
1826 program. This written agreement by the recipient of the  
1827 certificate of need shall be fully binding on any subsequent owner  
1828 of the skilled nursing facility, if the ownership of the facility  
1829 is transferred at any time after the issuance of the certificate  
1830 of need. Agreement that the skilled nursing facility will not  
1831 participate in the Medicaid program shall be a condition of the  
1832 issuance of a certificate of need to any person under this  
1833 paragraph (o), and if such skilled nursing facility at any time  
1834 after the issuance of the certificate of need, regardless of the  
1835 ownership of the facility, participates in the Medicaid program or  
1836 admits or keeps any patients in the facility who are participating  
1837 in the Medicaid program, the State Department of Health shall  
1838 revoke the certificate of need, if it is still outstanding, and  
1839 shall deny or revoke the license of the skilled nursing facility,  
1840 at the time that the department determines, after a hearing  
1841 complying with due process, that the facility has failed to comply  
1842 with any of the conditions upon which the certificate of need was  
1843 issued, as provided in this paragraph and in the written agreement  
1844 by the recipient of the certificate of need. The total number of  
1845 nursing facility beds that may be authorized by any certificate of  
1846 need issued under this paragraph (o) shall not exceed sixty (60)



beds. If the certificate of need authorized under this paragraph is not issued within twelve (12) months after July 1, 2001, the department shall deny the application for the certificate of need and shall not issue the certificate of need at any time after the twelve-month period, unless the issuance is contested. If the certificate of need is issued and substantial construction of the nursing facility beds has not commenced within eighteen (18) months after July 1, 2001, the State Department of Health, after a hearing complying with due process, shall revoke the certificate of need if it is still outstanding, and the department shall not issue a license for the nursing facility at any time after the eighteen-month period. However, if the issuance of the certificate of need is contested, the department shall require substantial construction of the nursing facility beds within six (6) months after final adjudication on the issuance of the certificate of need.

(p) The department may issue a certificate of need for the construction of a municipally owned nursing facility within the Town of Belmont in Tishomingo County, not to exceed sixty (60) beds, provided that the recipient of the certificate of need agrees in writing that the skilled nursing facility will not at any time participate in the Medicaid program (Section 43-13-101 et seq.) or admit or keep any patients in the skilled nursing facility who are participating in the Medicaid program. This written agreement by the recipient of the certificate of need



1872 shall be fully binding on any subsequent owner of the skilled  
1873 nursing facility, if the ownership of the facility is transferred  
1874 at any time after the issuance of the certificate of need.  
1875 Agreement that the skilled nursing facility will not participate  
1876 in the Medicaid program shall be a condition of the issuance of a  
1877 certificate of need to any person under this paragraph (p), and if  
1878 such skilled nursing facility at any time after the issuance of  
1879 the certificate of need, regardless of the ownership of the  
1880 facility, participates in the Medicaid program or admits or keeps  
1881 any patients in the facility who are participating in the Medicaid  
1882 program, the State Department of Health shall revoke the  
1883 certificate of need, if it is still outstanding, and shall deny or  
1884 revoke the license of the skilled nursing facility, at the time  
1885 that the department determines, after a hearing complying with due  
1886 process, that the facility has failed to comply with any of the  
1887 conditions upon which the certificate of need was issued, as  
1888 provided in this paragraph and in the written agreement by the  
1889 recipient of the certificate of need. The provision of Section  
1890 41-7-193(1) regarding substantial compliance of the projection of  
1891 need as reported in the current State Health Plan is waived for  
1892 the purposes of this paragraph. If the certificate of need  
1893 authorized under this paragraph is not issued within twelve (12)  
1894 months after July 1, 1998, the department shall deny the  
1895 application for the certificate of need and shall not issue the  
1896 certificate of need at any time after the twelve-month period,



1897 unless the issuance is contested. If the certificate of need is  
1898 issued and substantial construction of the nursing facility beds  
1899 has not commenced within eighteen (18) months after July 1, 1998,  
1900 the State Department of Health, after a hearing complying with due  
1901 process, shall revoke the certificate of need if it is still  
1902 outstanding, and the department shall not issue a license for the  
1903 nursing facility at any time after the eighteen-month period.  
1904 However, if the issuance of the certificate of need is contested,  
1905 the department shall require substantial construction of the  
1906 nursing facility beds within six (6) months after final  
1907 adjudication on the issuance of the certificate of need.

1908 (q) (i) Beginning on July 1, 1999, the State  
1909 Department of Health shall issue certificates of need during each  
1910 of the next four (4) fiscal years for the construction or  
1911 expansion of nursing facility beds or the conversion of other beds  
1912 to nursing facility beds in each county in the state having a need  
1913 for fifty (50) or more additional nursing facility beds, as shown  
1914 in the fiscal year 1999 State Health Plan, in the manner provided  
1915 in this paragraph (q). The total number of nursing facility beds  
1916 that may be authorized by any certificate of need authorized under  
1917 this paragraph (q) shall not exceed sixty (60) beds.

1918 (ii) Subject to the provisions of subparagraph  
1919 (v), during each of the next four (4) fiscal years, the department  
1920 shall issue six (6) certificates of need for new nursing facility  
1921 beds, as follows: During fiscal years 2000, 2001 and 2002, one



(1) certificate of need shall be issued for new nursing facility beds in the county in each of the four (4) Long-Term Care Planning Districts designated in the fiscal year 1999 State Health Plan that has the highest need in the district for those beds; and two (2) certificates of need shall be issued for new nursing facility beds in the two (2) counties from the state at large that have the highest need in the state for those beds, when considering the need on a statewide basis and without regard to the Long-Term Care Planning Districts in which the counties are located. During fiscal year 2003, one (1) certificate of need shall be issued for new nursing facility beds in any county having a need for fifty (50) or more additional nursing facility beds, as shown in the fiscal year 1999 State Health Plan, that has not received a certificate of need under this paragraph (q) during the three (3) previous fiscal years. During fiscal year 2000, in addition to the six (6) certificates of need authorized in this subparagraph, the department also shall issue a certificate of need for new nursing facility beds in Amite County and a certificate of need for new nursing facility beds in Carroll County.

(iii) Subject to the provisions of subparagraph (v), the certificate of need issued under subparagraph (ii) for nursing facility beds in each Long-Term Care Planning District during each fiscal year shall first be available for nursing facility beds in the county in the district having the highest need for those beds, as shown in the fiscal year 1999 State Health



1947 Plan. If there are no applications for a certificate of need for  
1948 nursing facility beds in the county having the highest need for  
1949 those beds by the date specified by the department, then the  
1950 certificate of need shall be available for nursing facility beds  
1951 in other counties in the district in descending order of the need  
1952 for those beds, from the county with the second highest need to  
1953 the county with the lowest need, until an application is received  
1954 for nursing facility beds in an eligible county in the district.

1955 (iv) Subject to the provisions of subparagraph  
1956 (v), the certificate of need issued under subparagraph (ii) for  
1957 nursing facility beds in the two (2) counties from the state at  
1958 large during each fiscal year shall first be available for nursing  
1959 facility beds in the two (2) counties that have the highest need  
1960 in the state for those beds, as shown in the fiscal year 1999  
1961 State Health Plan, when considering the need on a statewide basis  
1962 and without regard to the Long-Term Care Planning Districts in  
1963 which the counties are located. If there are no applications for  
1964 a certificate of need for nursing facility beds in either of the  
1965 two (2) counties having the highest need for those beds on a  
1966 statewide basis by the date specified by the department, then the  
1967 certificate of need shall be available for nursing facility beds  
1968 in other counties from the state at large in descending order of  
1969 the need for those beds on a statewide basis, from the county with  
1970 the second highest need to the county with the lowest need, until



an application is received for nursing facility beds in an eligible county from the state at large.

(v) If a certificate of need is authorized to be issued under this paragraph (q) for nursing facility beds in a county on the basis of the need in the Long-Term Care Planning District during any fiscal year of the four-year period, a certificate of need shall not also be available under this paragraph (q) for additional nursing facility beds in that county on the basis of the need in the state at large, and that county shall be excluded in determining which counties have the highest need for nursing facility beds in the state at large for that fiscal year. After a certificate of need has been issued under this paragraph (q) for nursing facility beds in a county during any fiscal year of the four-year period, a certificate of need shall not be available again under this paragraph (q) for additional nursing facility beds in that county during the four-year period, and that county shall be excluded in determining which counties have the highest need for nursing facility beds in succeeding fiscal years.

(vi) If more than one (1) application is made for a certificate of need for nursing home facility beds available under this paragraph (q), in Yalobusha, Newton or Tallahatchie County, and one (1) of the applicants is a county-owned hospital located in the county where the nursing facility beds are available, the department shall give priority to the county-owned



1996 hospital in granting the certificate of need if the following  
1997 conditions are met:

1998                   1. The county-owned hospital fully meets all  
1999 applicable criteria and standards required to obtain a certificate  
2000 of need for the nursing facility beds; and

2001                   2. The county-owned hospital's qualifications  
2002 for the certificate of need, as shown in its application and as  
2003 determined by the department, are at least equal to the  
2004 qualifications of the other applicants for the certificate of  
2005 need.

2006                   (r) (i) Beginning on July 1, 1999, the State  
2007 Department of Health shall issue certificates of need during each  
2008 of the next two (2) fiscal years for the construction or expansion  
2009 of nursing facility beds or the conversion of other beds to  
2010 nursing facility beds in each of the four (4) Long-Term Care  
2011 Planning Districts designated in the fiscal year 1999 State Health  
2012 Plan, to provide care exclusively to patients with Alzheimer's  
2013 disease.

2014                   (ii) Not more than twenty (20) beds may be  
2015 authorized by any certificate of need issued under this paragraph  
2016 (r), and not more than a total of sixty (60) beds may be  
2017 authorized in any Long-Term Care Planning District by all  
2018 certificates of need issued under this paragraph (r). However,  
2019 the total number of beds that may be authorized by all  
2020 certificates of need issued under this paragraph (r) during any



fiscal year shall not exceed one hundred twenty (120) beds, and the total number of beds that may be authorized in any Long-Term Care Planning District during any fiscal year shall not exceed forty (40) beds. Of the certificates of need that are issued for each Long-Term Care Planning District during the next two (2) fiscal years, at least one (1) shall be issued for beds in the northern part of the district, at least one (1) shall be issued for beds in the central part of the district, and at least one (1) shall be issued for beds in the southern part of the district.

(iii) The State Department of Health, in consultation with the Department of Mental Health and the Division of Medicaid, shall develop and prescribe the staffing levels, space requirements and other standards and requirements that must be met with regard to the nursing facility beds authorized under this paragraph (r) to provide care exclusively to patients with Alzheimer's disease.

(s) The State Department of Health may issue a certificate of need to a nonprofit skilled nursing facility using the Green House model of skilled nursing care and located in Yazoo City, Yazoo County, Mississippi, for the construction, expansion or conversion of not more than nineteen (19) nursing facility beds. For purposes of this paragraph (s), the provisions of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in the current State Health Plan and the provisions of Section 41-7-197 requiring a formal



certificate of need hearing process are waived. There shall be no prohibition or restrictions on participation in the Medicaid program for the person receiving the certificate of need authorized under this paragraph (s).

(t) The State Department of Health shall issue certificates of need to the owner of a nursing facility in operation at the time of Hurricane Katrina in Hancock County that was not operational on December 31, 2005, because of damage sustained from Hurricane Katrina to authorize the following: (i) the construction of a new nursing facility in Harrison County; (ii) the relocation of forty-nine (49) nursing facility beds from the Hancock County facility to the new Harrison County facility; (iii) the establishment of not more than twenty (20) non-Medicaid nursing facility beds at the Hancock County facility; and (iv) the establishment of not more than twenty (20) non-Medicaid beds at the new Harrison County facility. The certificates of need that authorize the non-Medicaid nursing facility beds under subparagraphs (iii) and (iv) of this paragraph (t) shall be subject to the following conditions: The owner of the Hancock County facility and the new Harrison County facility must agree in writing that no more than fifty (50) of the beds at the Hancock County facility and no more than forty-nine (49) of the beds at the Harrison County facility will be certified for participation in the Medicaid program, and that no claim will be submitted for Medicaid reimbursement for more than fifty (50) patients in the



2071 Hancock County facility in any month, or for more than forty-nine  
2072 (49) patients in the Harrison County facility in any month, or for  
2073 any patient in either facility who is in a bed that is not  
2074 Medicaid-certified. This written agreement by the owner of the  
2075 nursing facilities shall be a condition of the issuance of the  
2076 certificates of need under this paragraph (t), and the agreement  
2077 shall be fully binding on any later owner or owners of either  
2078 facility if the ownership of either facility is transferred at any  
2079 time after the certificates of need are issued. After this  
2080 written agreement is executed, the Division of Medicaid and the  
2081 State Department of Health shall not certify more than fifty (50)  
2082 of the beds at the Hancock County facility or more than forty-nine  
2083 (49) of the beds at the Harrison County facility for participation  
2084 in the Medicaid program. If the Hancock County facility violates  
2085 the terms of the written agreement by admitting or keeping in the  
2086 facility on a regular or continuing basis more than fifty (50)  
2087 patients who are participating in the Medicaid program, or if the  
2088 Harrison County facility violates the terms of the written  
2089 agreement by admitting or keeping in the facility on a regular or  
2090 continuing basis more than forty-nine (49) patients who are  
2091 participating in the Medicaid program, the State Department of  
2092 Health shall revoke the license of the facility that is in  
2093 violation of the agreement, at the time that the department  
2094 determines, after a hearing complying with due process, that the  
2095 facility has violated the agreement.



2096                   (u) The State Department of Health shall issue a  
2097 certificate of need to a nonprofit venture for the establishment,  
2098 construction and operation of a skilled nursing facility of not  
2099 more than sixty (60) beds to provide skilled nursing care for  
2100 ventilator dependent or otherwise medically dependent pediatric  
2101 patients who require medical and nursing care or rehabilitation  
2102 services to be located in a county in which an academic medical  
2103 center and a children's hospital are located, and for any  
2104 construction and for the acquisition of equipment related to those  
2105 beds. The facility shall be authorized to keep such ventilator  
2106 dependent or otherwise medically dependent pediatric patients  
2107 beyond age twenty-one (21) in accordance with regulations of the  
2108 State Board of Health. For purposes of this paragraph (u), the  
2109 provisions of Section 41-7-193(1) requiring substantial compliance  
2110 with the projection of need as reported in the current State  
2111 Health Plan are waived, and the provisions of Section 41-7-197  
2112 requiring a formal certificate of need hearing process are waived.  
2113 The beds authorized by this paragraph shall be counted as  
2114 pediatric skilled nursing facility beds for health planning  
2115 purposes under Section 41-7-171 et seq. There shall be no  
2116 prohibition of or restrictions on participation in the Medicaid  
2117 program for the person receiving the certificate of need  
2118 authorized by this paragraph.

2119                   (3) The State Department of Health may grant approval for  
2120 and issue certificates of need to any person proposing the new



2121 construction of, addition to, conversion of beds of or expansion  
2122 of any health care facility defined in subparagraph (x)  
2123 (psychiatric residential treatment facility) of Section  
2124 41-7-173(h). The total number of beds which may be authorized by  
2125 such certificates of need shall not exceed three hundred  
2126 thirty-four (334) beds for the entire state.

2127 (a) Of the total number of beds authorized under this  
2128 subsection, the department shall issue a certificate of need to a  
2129 privately owned psychiatric residential treatment facility in  
2130 Simpson County for the conversion of sixteen (16) intermediate  
2131 care facility for the mentally retarded (ICF-MR) beds to  
2132 psychiatric residential treatment facility beds, provided that  
2133 facility agrees in writing that the facility shall give priority  
2134 for the use of those sixteen (16) beds to Mississippi residents  
2135 who are presently being treated in out-of-state facilities.

2136 (b) Of the total number of beds authorized under this  
2137 subsection, the department may issue a certificate or certificates  
2138 of need for the construction or expansion of psychiatric  
2139 residential treatment facility beds or the conversion of other  
2140 beds to psychiatric residential treatment facility beds in Warren  
2141 County, not to exceed sixty (60) psychiatric residential treatment  
2142 facility beds, provided that the facility agrees in writing that  
2143 no more than thirty (30) of the beds at the psychiatric  
2144 residential treatment facility will be certified for participation  
2145 in the Medicaid program (Section 43-13-101 et seq.) for the use of



2146 any patients other than those who are participating only in the  
2147 Medicaid program of another state, and that no claim will be  
2148 submitted to the Division of Medicaid for Medicaid reimbursement  
2149 for more than thirty (30) patients in the psychiatric residential  
2150 treatment facility in any day or for any patient in the  
2151 psychiatric residential treatment facility who is in a bed that is  
2152 not Medicaid-certified. This written agreement by the recipient  
2153 of the certificate of need shall be a condition of the issuance of  
2154 the certificate of need under this paragraph, and the agreement  
2155 shall be fully binding on any subsequent owner of the psychiatric  
2156 residential treatment facility if the ownership of the facility is  
2157 transferred at any time after the issuance of the certificate of  
2158 need. After this written agreement is executed, the Division of  
2159 Medicaid and the State Department of Health shall not certify more  
2160 than thirty (30) of the beds in the psychiatric residential  
2161 treatment facility for participation in the Medicaid program for  
2162 the use of any patients other than those who are participating  
2163 only in the Medicaid program of another state. If the psychiatric  
2164 residential treatment facility violates the terms of the written  
2165 agreement by admitting or keeping in the facility on a regular or  
2166 continuing basis more than thirty (30) patients who are  
2167 participating in the Mississippi Medicaid program, the State  
2168 Department of Health shall revoke the license of the facility, at  
2169 the time that the department determines, after a hearing complying  
2170 with due process, that the facility has violated the condition



upon which the certificate of need was issued, as provided in this paragraph and in the written agreement.

The State Department of Health, on or before July 1, 2002, shall transfer the certificate of need authorized under the authority of this paragraph (b), or reissue the certificate of need if it has expired, to River Region Health System.

(c) Of the total number of beds authorized under this subsection, the department shall issue a certificate of need to a hospital currently operating Medicaid-certified acute psychiatric beds for adolescents in DeSoto County, for the establishment of a forty-bed psychiatric residential treatment facility in DeSoto County, provided that the hospital agrees in writing (i) that the hospital shall give priority for the use of those forty (40) beds to Mississippi residents who are presently being treated in out-of-state facilities, and (ii) that no more than fifteen (15) of the beds at the psychiatric residential treatment facility will be certified for participation in the Medicaid program (Section 43-13-101 et seq.), and that no claim will be submitted for Medicaid reimbursement for more than fifteen (15) patients in the psychiatric residential treatment facility in any day or for any patient in the psychiatric residential treatment facility who is in a bed that is not Medicaid-certified. This written agreement by the recipient of the certificate of need shall be a condition of the issuance of the certificate of need under this paragraph, and the agreement shall be fully binding on any subsequent owner



2196 of the psychiatric residential treatment facility if the ownership  
2197 of the facility is transferred at any time after the issuance of  
2198 the certificate of need. After this written agreement is  
2199 executed, the Division of Medicaid and the State Department of  
2200 Health shall not certify more than fifteen (15) of the beds in the  
2201 psychiatric residential treatment facility for participation in  
2202 the Medicaid program. If the psychiatric residential treatment  
2203 facility violates the terms of the written agreement by admitting  
2204 or keeping in the facility on a regular or continuing basis more  
2205 than fifteen (15) patients who are participating in the Medicaid  
2206 program, the State Department of Health shall revoke the license  
2207 of the facility, at the time that the department determines, after  
2208 a hearing complying with due process, that the facility has  
2209 violated the condition upon which the certificate of need was  
2210 issued, as provided in this paragraph and in the written  
2211 agreement.

2212 (d) Of the total number of beds authorized under this  
2213 subsection, the department may issue a certificate or certificates  
2214 of need for the construction or expansion of psychiatric  
2215 residential treatment facility beds or the conversion of other  
2216 beds to psychiatric treatment facility beds, not to exceed thirty  
2217 (30) psychiatric residential treatment facility beds, in either  
2218 Alcorn, Tishomingo, Prentiss, Lee, Itawamba, Monroe, Chickasaw,  
2219 Pontotoc, Calhoun, Lafayette, Union, Benton or Tippah County.



2220                   (e) Of the total number of beds authorized under this  
2221 subsection (3) the department shall issue a certificate of need to  
2222 a privately owned, nonprofit psychiatric residential treatment  
2223 facility in Hinds County for an eight-bed expansion of the  
2224 facility, provided that the facility agrees in writing that the  
2225 facility shall give priority for the use of those eight (8) beds  
2226 to Mississippi residents who are presently being treated in  
2227 out-of-state facilities.

2228                   (f) The department shall issue a certificate of need to  
2229 a one-hundred-thirty-four-bed specialty hospital located on  
2230 twenty-nine and forty-four one-hundredths (29.44) commercial acres  
2231 at 5900 Highway 39 North in Meridian (Lauderdale County),  
2232 Mississippi, for the addition, construction or expansion of  
2233 child/adolescent psychiatric residential treatment facility beds  
2234 in Lauderdale County. As a condition of issuance of the  
2235 certificate of need under this paragraph, the facility shall give  
2236 priority in admissions to the child/adolescent psychiatric  
2237 residential treatment facility beds authorized under this  
2238 paragraph to patients who otherwise would require out-of-state  
2239 placement. The Division of Medicaid, in conjunction with the  
2240 Department of Human Services, shall furnish the facility a list of  
2241 all out-of-state patients on a quarterly basis. Furthermore,  
2242 notice shall also be provided to the parent, custodial parent or  
2243 guardian of each out-of-state patient notifying them of the  
2244 priority status granted by this paragraph. For purposes of this



2245 paragraph, the provisions of Section 41-7-193(1) requiring  
2246 substantial compliance with the projection of need as reported in  
2247 the current State Health Plan are waived. The total number of  
2248 child/adolescent psychiatric residential treatment facility beds  
2249 that may be authorized under the authority of this paragraph shall  
2250 be sixty (60) beds. There shall be no prohibition or restrictions  
2251 on participation in the Medicaid program (Section 43-13-101 et  
2252 seq.) for the person receiving the certificate of need authorized  
2253 under this paragraph or for the beds converted pursuant to the  
2254 authority of that certificate of need.

2255 (4) (a) From and after \* \* \* passage of this act, the  
2256 department \* \* \* may issue a certificate of need to any person for  
2257 the new construction of any hospital, psychiatric hospital or  
2258 chemical dependency hospital that will contain any  
2259 child/adolescent psychiatric or child/adolescent chemical  
2260 dependency beds, or for the conversion of any other health care  
2261 facility to a hospital, psychiatric hospital or chemical  
2262 dependency hospital that will contain any child/adolescent  
2263 psychiatric or child/adolescent chemical dependency beds, or for  
2264 the addition of any child/adolescent psychiatric or  
2265 child/adolescent chemical dependency beds in any hospital,  
2266 psychiatric hospital or chemical dependency hospital, or for the  
2267 conversion of any beds of another category in any hospital,  
2268 psychiatric hospital or chemical dependency hospital to  
2269 child/adolescent psychiatric or child/adolescent chemical



2270 dependency beds. There shall be no prohibition or restrictions on  
2271 participation in the Medicaid program (Section 43-13-101 et seq.)  
2272 for the person(s) receiving the certificate(s) of need authorized  
2273 under this paragraph (a) or for the beds converted pursuant to the  
2274 authority of that certificate of need.

2275 (i) \* \* \* (Deleted)

2276 (ii) The department may issue a certificate of  
2277 need for the conversion of existing beds in a county hospital in  
2278 Choctaw County from acute care beds to child/adolescent chemical  
2279 dependency beds. For purposes of this subparagraph (ii), the  
2280 provisions of Section 41-7-193(1) requiring substantial compliance  
2281 with the projection of need as reported in the current State  
2282 Health Plan are waived. The total number of beds that may be  
2283 authorized under authority of this subparagraph shall not exceed  
2284 twenty (20) beds. There shall be no prohibition or restrictions  
2285 on participation in the Medicaid program (Section 43-13-101 et  
2286 seq.) for the hospital receiving the certificate of need  
2287 authorized under this subparagraph or for the beds converted  
2288 pursuant to the authority of that certificate of need.

2289 (iii) The department may issue a certificate or  
2290 certificates of need for the construction or expansion of  
2291 child/adolescent psychiatric beds or the conversion of other beds  
2292 to child/adolescent psychiatric beds in Warren County. For  
2293 purposes of this subparagraph (iii), the provisions of Section  
2294 41-7-193(1) requiring substantial compliance with the projection



2295 of need as reported in the current State Health Plan are waived.  
2296 The total number of beds that may be authorized under the  
2297 authority of this subparagraph shall not exceed twenty (20) beds.  
2298 There shall be no prohibition or restrictions on participation in  
2299 the Medicaid program (Section 43-13-101 et seq.) for the person  
2300 receiving the certificate of need authorized under this  
2301 subparagraph or for the beds converted pursuant to the authority  
2302 of that certificate of need.

2303       If by January 1, 2002, there has been no significant  
2304 commencement of construction of the beds authorized under this  
2305 subparagraph (iii), or no significant action taken to convert  
2306 existing beds to the beds authorized under this subparagraph, then  
2307 the certificate of need that was previously issued under this  
2308 subparagraph shall expire. If the previously issued certificate  
2309 of need expires, the department may accept applications for  
2310 issuance of another certificate of need for the beds authorized  
2311 under this subparagraph, and may issue a certificate of need to  
2312 authorize the construction, expansion or conversion of the beds  
2313 authorized under this subparagraph.

2314               (iv) The department shall issue a certificate of  
2315 need to the Region 7 Mental Health/Retardation Commission for the  
2316 construction or expansion of child/adolescent psychiatric beds or  
2317 the conversion of other beds to child/adolescent psychiatric beds  
2318 in any of the counties served by the commission. For purposes of  
2319 this subparagraph (iv), the provisions of Section 41-7-193(1)



2320 requiring substantial compliance with the projection of need as  
2321 reported in the current State Health Plan are waived. The total  
2322 number of beds that may be authorized under the authority of this  
2323 subparagraph shall not exceed twenty (20) beds. There shall be no  
2324 prohibition or restrictions on participation in the Medicaid  
2325 program (Section 43-13-101 et seq.) for the person receiving the  
2326 certificate of need authorized under this subparagraph or for the  
2327 beds converted pursuant to the authority of that certificate of  
2328 need.

2329                   (v) The department may issue a certificate of need  
2330 to any county hospital located in Leflore County for the  
2331 construction or expansion of adult psychiatric beds or the  
2332 conversion of other beds to adult psychiatric beds, not to exceed  
2333 twenty (20) beds, provided that the recipient of the certificate  
2334 of need agrees in writing that the adult psychiatric beds will not  
2335 at any time be certified for participation in the Medicaid program  
2336 and that the hospital will not admit or keep any patients who are  
2337 participating in the Medicaid program in any of such adult  
2338 psychiatric beds. This written agreement by the recipient of the  
2339 certificate of need shall be fully binding on any subsequent owner  
2340 of the hospital if the ownership of the hospital is transferred at  
2341 any time after the issuance of the certificate of need. Agreement  
2342 that the adult psychiatric beds will not be certified for  
2343 participation in the Medicaid program shall be a condition of the  
2344 issuance of a certificate of need to any person under this



2345 subparagraph (v), and if such hospital at any time after the  
2346 issuance of the certificate of need, regardless of the ownership  
2347 of the hospital, has any of such adult psychiatric beds certified  
2348 for participation in the Medicaid program or admits or keeps any  
2349 Medicaid patients in such adult psychiatric beds, the State  
2350 Department of Health shall revoke the certificate of need, if it  
2351 is still outstanding, and shall deny or revoke the license of the  
2352 hospital at the time that the department determines, after a  
2353 hearing complying with due process, that the hospital has failed  
2354 to comply with any of the conditions upon which the certificate of  
2355 need was issued, as provided in this subparagraph and in the  
2356 written agreement by the recipient of the certificate of need.

2357                   (vi) The department may issue a certificate or  
2358 certificates of need for the expansion of child psychiatric beds  
2359 or the conversion of other beds to child psychiatric beds at the  
2360 University of Mississippi Medical Center. For purposes of this  
2361 subparagraph (vi), the provisions of Section 41-7-193(1) requiring  
2362 substantial compliance with the projection of need as reported in  
2363 the current State Health Plan are waived. The total number of  
2364 beds that may be authorized under the authority of this  
2365 subparagraph shall not exceed fifteen (15) beds. There shall be  
2366 no prohibition or restrictions on participation in the Medicaid  
2367 program (Section 43-13-101 et seq.) for the hospital receiving the  
2368 certificate of need authorized under this subparagraph or for the



2369 beds converted pursuant to the authority of that certificate of  
2370 need.

2371 (b) From and after July 1, 1990, no hospital,  
2372 psychiatric hospital or chemical dependency hospital shall be  
2373 authorized to add any child/adolescent psychiatric or  
2374 child/adolescent chemical dependency beds or convert any beds of  
2375 another category to child/adolescent psychiatric or  
2376 child/adolescent chemical dependency beds without a certificate of  
2377 need under the authority of subsection (1)(c) and subsection  
2378 (4)(a) of this section.

2379 (5) The department may issue a certificate of need to a  
2380 county hospital in Winston County for the conversion of fifteen  
2381 (15) acute care beds to geriatric psychiatric care beds.

2382 (6) The State Department of Health shall issue a certificate  
2383 of need to a Mississippi corporation qualified to manage a  
2384 long-term care hospital as defined in Section 41-7-173(h)(xii) in  
2385 Harrison County, not to exceed eighty (80) beds, including any  
2386 necessary renovation or construction required for licensure and  
2387 certification, provided that the recipient of the certificate of  
2388 need agrees in writing that the long-term care hospital will not  
2389 at any time participate in the Medicaid program (Section 43-13-101  
2390 et seq.) or admit or keep any patients in the long-term care  
2391 hospital who are participating in the Medicaid program. This  
2392 written agreement by the recipient of the certificate of need  
2393 shall be fully binding on any subsequent owner of the long-term



2394 care hospital, if the ownership of the facility is transferred at  
2395 any time after the issuance of the certificate of need. Agreement  
2396 that the long-term care hospital will not participate in the  
2397 Medicaid program shall be a condition of the issuance of a  
2398 certificate of need to any person under this subsection (6), and  
2399 if such long-term care hospital at any time after the issuance of  
2400 the certificate of need, regardless of the ownership of the  
2401 facility, participates in the Medicaid program or admits or keeps  
2402 any patients in the facility who are participating in the Medicaid  
2403 program, the State Department of Health shall revoke the  
2404 certificate of need, if it is still outstanding, and shall deny or  
2405 revoke the license of the long-term care hospital, at the time  
2406 that the department determines, after a hearing complying with due  
2407 process, that the facility has failed to comply with any of the  
2408 conditions upon which the certificate of need was issued, as  
2409 provided in this subsection and in the written agreement by the  
2410 recipient of the certificate of need. For purposes of this  
2411 subsection, the provisions of Section 41-7-193(1) requiring  
2412 substantial compliance with the projection of need as reported in  
2413 the current State Health Plan are waived.

2414 (7) The State Department of Health may issue a certificate  
2415 of need to any hospital in the state to utilize a portion of its  
2416 beds for the "swing-bed" concept. Any such hospital must be in  
2417 conformance with the federal regulations regarding such swing-bed  
2418 concept at the time it submits its application for a certificate



2419 of need to the State Department of Health, except that such  
2420 hospital may have more licensed beds or a higher average daily  
2421 census (ADC) than the maximum number specified in federal  
2422 regulations for participation in the swing-bed program. Any  
2423 hospital meeting all federal requirements for participation in the  
2424 swing-bed program which receives such certificate of need shall  
2425 render services provided under the swing-bed concept to any  
2426 patient eligible for Medicare (Title XVIII of the Social Security  
2427 Act) who is certified by a physician to be in need of such  
2428 services, and no such hospital shall permit any patient who is  
2429 eligible for both Medicaid and Medicare or eligible only for  
2430 Medicaid to stay in the swing beds of the hospital for more than  
2431 thirty (30) days per admission unless the hospital receives prior  
2432 approval for such patient from the Division of Medicaid, Office of  
2433 the Governor. Any hospital having more licensed beds or a higher  
2434 average daily census (ADC) than the maximum number specified in  
2435 federal regulations for participation in the swing-bed program  
2436 which receives such certificate of need shall develop a procedure  
2437 to insure that before a patient is allowed to stay in the swing  
2438 beds of the hospital, there are no vacant nursing home beds  
2439 available for that patient located within a fifty-mile radius of  
2440 the hospital. When any such hospital has a patient staying in the  
2441 swing beds of the hospital and the hospital receives notice from a  
2442 nursing home located within such radius that there is a vacant bed  
2443 available for that patient, the hospital shall transfer the



2444 patient to the nursing home within a reasonable time after receipt  
2445 of the notice. Any hospital which is subject to the requirements  
2446 of the two (2) preceding sentences of this subsection may be  
2447 suspended from participation in the swing-bed program for a  
2448 reasonable period of time by the State Department of Health if the  
2449 department, after a hearing complying with due process, determines  
2450 that the hospital has failed to comply with any of those  
2451 requirements.

2452       (8) The Department of Health shall not grant approval for or  
2453 issue a certificate of need to any person proposing the new  
2454 construction of, addition to or expansion of a health care  
2455 facility as defined in subparagraph (viii) of Section 41-7-173(h),  
2456 except as hereinafter provided: The department may issue a  
2457 certificate of need to a nonprofit corporation located in Madison  
2458 County, Mississippi, for the construction, expansion or conversion  
2459 of not more than twenty (20) beds in a community living program  
2460 for developmentally disabled adults in a facility as defined in  
2461 subparagraph (viii) of Section 41-7-173(h). For purposes of this  
2462 subsection (8), the provisions of Section 41-7-193(1) requiring  
2463 substantial compliance with the projection of need as reported in  
2464 the current State Health Plan and the provisions of Section  
2465 41-7-197 requiring a formal certificate of need hearing process  
2466 are waived. There shall be no prohibition or restrictions on  
2467 participation in the Medicaid program for the person receiving the  
2468 certificate of need authorized under this subsection (8).



2469           (9) The Department of Health shall not grant approval for or  
2470 issue a certificate of need to any person proposing the  
2471 establishment of, or expansion of the currently approved territory  
2472 of, or the contracting to establish a home office, subunit or  
2473 branch office within the space operated as a health care facility  
2474 as defined in Section 41-7-173(h)(i) through (viii) by a health  
2475 care facility as defined in subparagraph (ix) of Section  
2476 41-7-173(h).

2477           (10) Health care facilities owned and/or operated by the  
2478 state or its agencies are exempt from the restraints in this  
2479 section against issuance of a certificate of need if such addition  
2480 or expansion consists of repairing or renovation necessary to  
2481 comply with the state licensure law. This exception shall not  
2482 apply to the new construction of any building by such state  
2483 facility. This exception shall not apply to any health care  
2484 facilities owned and/or operated by counties, municipalities,  
2485 districts, unincorporated areas, other defined persons, or any  
2486 combination thereof.

2487           (11) The new construction, renovation or expansion of or  
2488 addition to any health care facility defined in subparagraph (ii)  
2489 (psychiatric hospital), subparagraph (iv) (skilled nursing  
2490 facility), subparagraph (vi) (intermediate care facility),  
2491 subparagraph (viii) (intermediate care facility for the mentally  
2492 retarded) and subparagraph (x) (psychiatric residential treatment  
2493 facility) of Section 41-7-173(h) which is owned by the State of



2494 Mississippi and under the direction and control of the State  
2495 Department of Mental Health, and the addition of new beds or the  
2496 conversion of beds from one category to another in any such  
2497 defined health care facility which is owned by the State of  
2498 Mississippi and under the direction and control of the State  
2499 Department of Mental Health, shall not require the issuance of a  
2500 certificate of need under Section 41-7-171 et seq.,  
2501 notwithstanding any provision in Section 41-7-171 et seq. to the  
2502 contrary.

2503       (12) The new construction, renovation or expansion of or  
2504 addition to any veterans homes or domiciliaries for eligible  
2505 veterans of the State of Mississippi as authorized under Section  
2506 35-1-19 shall not require the issuance of a certificate of need,  
2507 notwithstanding any provision in Section 41-7-171 et seq. to the  
2508 contrary.

2509       (13) The repair or the rebuilding of an existing, operating  
2510 health care facility that sustained significant damage from a  
2511 natural disaster that occurred after April 15, 2014, in an area  
2512 that is proclaimed a disaster area or subject to a state of  
2513 emergency by the Governor or by the President of the United States  
2514 shall be exempt from all of the requirements of the Mississippi  
2515 Certificate of Need Law (Section 41-7-171 et seq.) and any and all  
2516 rules and regulations promulgated under that law, subject to the  
2517 following conditions:



2518           (a) The repair or the rebuilding of any such damaged  
2519 health care facility must be within one (1) mile of the  
2520 pre-disaster location of the campus of the damaged health care  
2521 facility, except that any temporary post-disaster health care  
2522 facility operating location may be within five (5) miles of the  
2523 pre-disaster location of the damaged health care facility;

2524           (b) The repair or the rebuilding of the damaged health  
2525 care facility (i) does not increase or change the complement of  
2526 its bed capacity that it had before the Governor's or the  
2527 President's proclamation, (ii) does not increase or change its  
2528 levels and types of health care services that it provided before  
2529 the Governor's or the President's proclamation, and (iii) does not  
2530 rebuild in a different county; however, this paragraph does not  
2531 restrict or prevent a health care facility from decreasing its bed  
2532 capacity that it had before the Governor's or the President's  
2533 proclamation, or from decreasing the levels of or decreasing or  
2534 eliminating the types of health care services that it provided  
2535 before the Governor's or the President's proclamation, when the  
2536 damaged health care facility is repaired or rebuilt;

2537           (c) The exemption from Certificate of Need Law provided  
2538 under this subsection (13) is valid for only five (5) years from  
2539 the date of the Governor's or the President's proclamation. If  
2540 actual construction has not begun within that five-year period,  
2541 the exemption provided under this subsection is inapplicable; and



2542           (d) The Division of Health Facilities Licensure and  
2543 Certification of the State Department of Health shall provide the  
2544 same oversight for the repair or the rebuilding of the damaged  
2545 health care facility that it provides to all health care facility  
2546 construction projects in the state.

2547           For the purposes of this subsection (13), "significant  
2548 damage" to a health care facility means damage to the health care  
2549 facility requiring an expenditure of at least One Million Dollars  
2550 (\$1,000,000.00).

2551           (14) The State Department of Health shall issue a  
2552 certificate of need to any hospital which is currently licensed  
2553 for two hundred fifty (250) or more acute care beds and is located  
2554 in any general hospital service area not having a comprehensive  
2555 cancer center, for the establishment and equipping of such a  
2556 center which provides facilities and services for outpatient  
2557 radiation oncology therapy, outpatient medical oncology therapy,  
2558 and appropriate support services including the provision of  
2559 radiation therapy services. The provisions of Section 41-7-193(1)  
2560 regarding substantial compliance with the projection of need as  
2561 reported in the current State Health Plan are waived for the  
2562 purpose of this subsection.

2563           (15) The State Department of Health may authorize the  
2564 transfer of hospital beds, not to exceed sixty (60) beds, from the  
2565 North Panola Community Hospital to the South Panola Community



Hospital. The authorization for the transfer of those beds shall be exempt from the certificate of need review process.

(16) The State Department of Health shall issue any certificates of need necessary for Mississippi State University and a public or private health care provider to jointly acquire and operate a linear accelerator and a magnetic resonance imaging unit. Those certificates of need shall cover all capital expenditures related to the project between Mississippi State University and the health care provider, including, but not limited to, the acquisition of the linear accelerator, the magnetic resonance imaging unit and other radiological modalities; the offering of linear accelerator and magnetic resonance imaging services; and the cost of construction of facilities in which to locate these services. The linear accelerator and the magnetic resonance imaging unit shall be (a) located in the City of Starkville, Oktibbeha County, Mississippi; (b) operated jointly by Mississippi State University and the public or private health care provider selected by Mississippi State University through a request for proposals (RFP) process in which Mississippi State University selects, and the Board of Trustees of State Institutions of Higher Learning approves, the health care provider that makes the best overall proposal; (c) available to Mississippi State University for research purposes two-thirds (2/3) of the time that the linear accelerator and magnetic resonance imaging unit are operational; and (d) available to the public or private



2591 health care provider selected by Mississippi State University and  
2592 approved by the Board of Trustees of State Institutions of Higher  
2593 Learning one-third (1/3) of the time for clinical, diagnostic and  
2594 treatment purposes. For purposes of this subsection, the  
2595 provisions of Section 41-7-193(1) requiring substantial compliance  
2596 with the projection of need as reported in the current State  
2597 Health Plan are waived.

2598       (17) The State Department of Health shall issue a  
2599 certificate of need for the construction of an acute care hospital  
2600 in Kemper County, not to exceed twenty-five (25) beds, which shall  
2601 be named the "John C. Stennis Memorial Hospital." In issuing the  
2602 certificate of need under this subsection, the department shall  
2603 give priority to a hospital located in Lauderdale County that has  
2604 two hundred fifteen (215) beds. For purposes of this subsection,  
2605 the provisions of Section 41-7-193(1) requiring substantial  
2606 compliance with the projection of need as reported in the current  
2607 State Health Plan and the provisions of Section 41-7-197 requiring  
2608 a formal certificate of need hearing process are waived. There  
2609 shall be no prohibition or restrictions on participation in the  
2610 Medicaid program (Section 43-13-101 et seq.) for the person or  
2611 entity receiving the certificate of need authorized under this  
2612 subsection or for the beds constructed under the authority of that  
2613 certificate of need.

2614       (18) The planning, design, construction, renovation,  
2615 addition, furnishing and equipping of a clinical research unit at



2616 any health care facility defined in Section 41-7-173(h) that is  
2617 under the direction and control of the University of Mississippi  
2618 Medical Center and located in Jackson, Mississippi, and the  
2619 addition of new beds or the conversion of beds from one (1)  
2620 category to another in any such clinical research unit, shall not  
2621 require the issuance of a certificate of need under Section  
2622 41-7-171 et seq., notwithstanding any provision in Section  
2623 41-7-171 et seq. to the contrary.

2624 (19) [Repealed]

2625 (20) Nothing in this section or in any other provision of  
2626 Section 41-7-171 et seq. shall prevent any nursing facility from  
2627 designating an appropriate number of existing beds in the facility  
2628 as beds for providing care exclusively to patients with  
2629 Alzheimer's disease.

2630 (21) Nothing in this section or any other provision of  
2631 Section 41-7-171 et seq. shall prevent any health care facility  
2632 from the new construction, renovation, conversion or expansion of  
2633 new beds in the facility designated as intensive care units,  
2634 negative pressure rooms, or isolation rooms pursuant to the  
2635 provisions of Sections 41-14-1 through 41-14-11. For purposes of  
2636 this subsection, the provisions of Section 41-7-193(1) requiring  
2637 substantial compliance with the projection of need as reported in  
2638 the current State Health Plan and the provisions of Section  
2639 41-7-197 requiring a formal certificate of need hearing process  
2640 are waived.



**SECTION 4.** Section 41-75-5, Mississippi Code of 1972, is amended as follows:

41-75-5. No person as defined in Section 41-7-173, acting severally or jointly with any other person, shall establish, conduct, operate or maintain an ambulatory surgical facility or an abortion facility or a freestanding emergency room or a post-acute residential brain injury rehabilitation facility in this state without a license under this chapter.

\* \* \*

**SECTION 5.** Section 83-9-353, Mississippi Code of 1972, is amended as follows:

83-9-353. (1) As used in this section:

(a) "Employee benefit plan" means any plan, fund or program established or maintained by an employer or by an employee organization, or both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, hospital care or other benefits.

(b) "Health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, and includes the State and School Employees Health Insurance Plan and any other public health care assistance program offered or administered by the state or any political subdivision or instrumentality of the state. The term does not include policies



2666 or plans providing coverage for specified disease or other limited  
2667 benefit coverage.

2668 (c) "Health insurer" means any health insurance  
2669 company, nonprofit hospital and medical service corporation,  
2670 health maintenance organization, preferred provider organization,  
2671 managed care organization, pharmacy benefit manager, and, to the  
2672 extent permitted under federal law, any administrator of an  
2673 insured, self-insured or publicly funded health care benefit plan  
2674 offered by public and private entities, and other parties that are  
2675 by statute, contract, or agreement, legally responsible for  
2676 payment of a claim for a health care item or service.

2677 (d) "Store-and-forward telemedicine services" means the  
2678 use of asynchronous computer-based communication between a patient  
2679 and a consulting provider or a referring health care provider and  
2680 a medical specialist at a distant site for the purpose of  
2681 diagnostic and therapeutic assistance in the care of patients who  
2682 otherwise have no access to specialty care. Store-and-forward  
2683 telemedicine services involve the transferring of medical data  
2684 from one (1) site to another through the use of a camera or  
2685 similar device that records (stores) an image that is sent  
2686 (forwarded) via telecommunication to another site for  
2687 consultation.

2688 (e) "Remote patient monitoring services" means the  
2689 delivery of home health services using telecommunications  
2690 technology to enhance the delivery of home health care, including:



2691 (i) Monitoring of clinical patient data such as  
2692 weight, blood pressure, pulse, pulse oximetry and other  
2693 condition-specific data, such as blood glucose;  
2694 (ii) Medication adherence monitoring; and  
2695 (iii) Interactive video conferencing with or  
2696 without digital image upload as needed.

2697 (f) "Medication adherence management services" means the  
2698 monitoring of a patient's conformance with the clinician's  
2699 medication plan with respect to timing, dosing and frequency of  
2700 medication-taking through electronic transmission of data in a  
2701 home telemonitoring program.

2702 (2) Store-and-forward telemedicine services allow a health  
2703 care provider trained and licensed in his or her given specialty  
2704 to review forwarded images and patient history in order to provide  
2705 diagnostic and therapeutic assistance in the care of the patient  
2706 without the patient being present in real time. Treatment  
2707 recommendations made via electronic means shall be held to the  
2708 same standards of appropriate practice as those in traditional  
2709 provider-patient setting.

2710 (3) Any patient receiving medical care by store-and-forward  
2711 telemedicine services shall be notified of the right to receive  
2712 interactive communication with the distant specialist health care  
2713 provider and shall receive an interactive communication with the  
2714 distant specialist upon request. If requested, communication with  
2715 the distant specialist may occur at the time of the consultation



2716 or within thirty (30) days of the patient's notification of the  
2717 request of the consultation. Telemedicine networks unable to  
2718 offer the interactive consultation shall not be reimbursed for  
2719 store-and-forward telemedicine services.

2720 (4) Remote patient monitoring services aim to allow more  
2721 people to remain at home or in other residential settings and to  
2722 improve the quality and cost of their care, including prevention  
2723 of more costly care. Remote patient monitoring services via  
2724 telehealth aim to coordinate primary, acute, behavioral and  
2725 long-term social service needs for high-need, high-cost patients.  
2726 Specific patient criteria must be met in order for reimbursement  
2727 to occur.

2728 (5) Qualifying patients for remote patient monitoring  
2729 services must meet all the following criteria:

2730 (a) Be diagnosed, in the last eighteen (18) months,  
2731 with one or more chronic conditions, as defined by the Centers for  
2732 Medicare and Medicaid Services (CMS), which include, but are not  
2733 limited to, sickle cell, mental health, asthma, diabetes, and  
2734 heart disease; and

2735 \* \* \*

2736 ( \* \* \* b) The patient's health care provider recommends  
2737 disease management services via remote patient monitoring.

2738 (6) A remote patient monitoring prior authorization request  
2739 form \* \* \* may be required for approval of telemonitoring  
2740 services. \* \* \* Any such request \* \* \* may include the following:



2741           (a) An order for home telemonitoring services, signed  
2742 and dated by the prescribing physician;

2743           (b) A plan of care, signed and dated by the prescribing  
2744 physician, that includes telemonitoring transmission frequency and  
2745 duration of monitoring requested;

2746           (c) The client's diagnosis and risk factors that  
2747 qualify the client for home telemonitoring services;

2748           (d) Attestation that the client is sufficiently  
2749 cognitively intact and able to operate the equipment or has a  
2750 willing and able person to assist in completing electronic  
2751 transmission of data; and

2752           (e) Attestation that the client is not receiving  
2753 duplicative services via disease management services.

2754       (7) The entity that will provide the remote monitoring must  
2755 be a Mississippi-based entity and have protocols in place to  
2756 address all of the following:

2757           (a) Authentication and authorization of users;

2758           (b) A mechanism for monitoring, tracking and responding  
2759 to changes in a client's clinical condition;

2760           (c) A standard of acceptable and unacceptable  
2761 parameters for client's clinical parameters, which can be adjusted  
2762 based on the client's condition;

2763           (d) How monitoring staff will respond to abnormal  
2764 parameters for client's vital signs, symptoms and/or lab results;



2765                   (e) The monitoring, tracking and responding to changes  
2766 in client's clinical condition;

2767                   (f) The process for notifying the prescribing physician  
2768 for significant changes in the client's clinical signs and  
2769 symptoms;

2770                   (g) The prevention of unauthorized access to the system  
2771 or information;

2772                   (h) System security, including the integrity of  
2773 information that is collected, program integrity and system  
2774 integrity;

2775                   (i) Information storage, maintenance and transmission;

2776                   (j) Synchronization and verification of patient profile  
2777 data; and

2778                   (k) Notification of the client's discharge from remote  
2779 patient monitoring services or the de-installation of the remote  
2780 patient monitoring unit.

2781           (8) The telemonitoring equipment must:

2782                   (a) Be capable of monitoring any data parameters in the  
2783 plan of care; and

2784                   (b) Be a FDA Class II hospital-grade medical device.

2785           (9) Monitoring of the client's data shall not be duplicated  
2786 by another provider.

2787           (10) To receive payment for the delivery of remote patient  
2788 monitoring services via telehealth, the service must involve:



2789           (a) An assessment, problem identification, and  
2790 evaluation that includes:

2791           (i) Assessment and monitoring of clinical data  
2792 including, but not limited to, appropriate vital signs, pain  
2793 levels and other biometric measures specified in the plan of care,  
2794 and also includes assessment of response to previous changes in  
2795 the plan of care; and

2796           (ii) Detection of condition changes based on the  
2797 telemedicine encounter that may indicate the need for a change in  
2798 the plan of care.

2799           (b) Implementation of a management plan through one or  
2800 more of the following:

2801           (i) Teaching regarding medication management as  
2802 appropriate based on the telemedicine findings for that encounter;

2803           (ii) Teaching regarding other interventions as  
2804 appropriate to both the patient and the caregiver;

2805           (iii) Management and evaluation of the plan of  
2806 care including changes in visit frequency or addition of other  
2807 skilled services;

2808           (iv) Coordination of care with the ordering health  
2809 care provider regarding telemedicine findings;

2810           (v) Coordination and referral to other medical  
2811 providers as needed; and

2812           (vi) Referral for an in-person visit or the  
2813 emergency room as needed.



2814           (11) The telemedicine equipment and network used for remote  
2815 patient monitoring services should meet the following  
2816 requirements:

2817                   (a) Comply with applicable standards of the United  
2818 States Food and Drug Administration;

2819                   (b) Telehealth equipment be maintained in good repair  
2820 and free from safety hazards;

2821                   (c) Telehealth equipment be new or sanitized before  
2822 installation in the patient's home setting;

2823                   (d) Accommodate non-English language options; and

2824                   (e) Have 24/7 technical and clinical support services  
2825 available for the patient user.

2826           (12) All health insurance and employee benefit plans in this  
2827 state must provide coverage and reimbursement for the asynchronous  
2828 telemedicine services of store-and-forward telemedicine services  
2829 and remote patient monitoring services based on the criteria set  
2830 out in this section. Store-and-forward telemedicine services  
2831 shall be reimbursed to the same extent that the services would be  
2832 covered if they were provided through in-person consultation.

2833           (13) Remote patient monitoring services shall include  
2834 reimbursement for a daily monitoring rate at a minimum of Ten  
2835 Dollars (\$10.00) per day each month and Sixteen Dollars (\$16.00)  
2836 per day when medication adherence management services are  
2837 included, not to exceed thirty-one (31) days per month. These  
2838 reimbursement rates are only eligible to Mississippi-based



2839 telehealth programs affiliated with a Mississippi health care  
2840 facility.

2841       (14) A one-time telehealth installation/training fee for  
2842 remote patient monitoring services will also be reimbursed at a  
2843 minimum rate of Fifty Dollars (\$50.00) per patient, with a maximum  
2844 of two (2) installation/training fees/calendar year. These  
2845 reimbursement rates are only eligible to Mississippi-based  
2846 telehealth programs affiliated with a Mississippi health care  
2847 facility.

2848       (15) No geographic restrictions shall be placed on the  
2849 delivery of telemedicine services in the home setting other than  
2850 requiring the patient reside within the State of Mississippi.

2851       (16) Health care providers seeking reimbursement for  
2852 store-and-forward telemedicine services must be licensed  
2853 Mississippi providers that are affiliated with an established  
2854 Mississippi health care facility in order to qualify for  
2855 reimbursement of telemedicine services in the state. If a service  
2856 is not available in Mississippi, then a health insurance or  
2857 employee benefit plan may decide to allow a non-Mississippi-based  
2858 provider who is licensed to practice in Mississippi reimbursement  
2859 for those services.

2860       (17) A health insurance or employee benefit plan may charge  
2861 a deductible, co-payment, or coinsurance for a health care service  
2862 provided through store-and-forward telemedicine services or remote  
2863 patient monitoring services so long as it does not exceed the



2864 deductible, co-payment, or coinsurance applicable to an in-person  
2865 consultation.

2866 (18) A health insurance or employee benefit plan may limit  
2867 coverage to health care providers in a telemedicine network  
2868 approved by the plan.

2869 (19) Nothing in this section shall be construed to prohibit  
2870 a health insurance or employee benefit plan from providing  
2871 coverage for only those services that are medically necessary,  
2872 subject to the terms and conditions of the covered person's  
2873 policy.

2874 (20) In a claim for the services provided, the appropriate  
2875 procedure code for the covered service shall be included with the  
2876 appropriate modifier indicating telemedicine services were used.  
2877 A "GQ" modifier is required for asynchronous telemedicine services  
2878 such as store-and-forward and remote patient monitoring.

2879 (21) The originating site is eligible to receive a facility  
2880 fee, but facility fees are not payable to the distant site.

2881 **SECTION 6.** This act shall take effect and be in force from  
2882 and after its passage.

