

By: Senator(s) Blackwell

To: Medicaid

## SENATE BILL NO. 2799

1 AN ACT RELATING TO THE MISSISSIPPI MEDICAID PROGRAM; TO AMEND  
2 SECTION 43-13-115, MISSISSIPPI CODE OF 1972, TO AUTHORIZE AND  
3 DIRECT THE DIVISION OF MEDICAID TO PROVIDE UP TO 12 MONTHS OF  
4 CONTINUOUS COVERAGE POSTPARTUM FOR ANY INDIVIDUAL WHO QUALIFIES  
5 FOR MEDICAID AS A PREGNANT WOMAN TO THE EXTENT ALLOWABLE UNDER  
6 FEDERAL LAW; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,  
7 RELATING TO REIMBURSEMENT FOR CARE AND SERVICES UNDER THE MEDICAID  
8 PROGRAM; TO DELETE CERTAIN OUTDATED PROVISIONS RELATING TO  
9 REIMBURSEMENT OF INPATIENT HOSPITAL SERVICES; TO PROVIDE THAT  
10 MEDICAID IS AUTHORIZED TO MAKE PARTIAL PAYMENTS FOR NURSING  
11 SERVICES; TO PROVIDE FOR NURSING FACILITY REIMBURSEMENT FOR HOME  
12 LEAVE DAYS; TO DELETE CERTAIN OUTDATED PROVISIONS RELATING TO  
13 REIMBURSEMENT OF NURSING FACILITY SERVICES; TO PROVIDE FOR  
14 REIMBURSEMENT FOR FEES FOR PHYSICIAN SERVICES COVERED ONLY BY  
15 MEDICAID; TO AUTHORIZE THE DIVISION TO REIMBURSE OBSTETRICIANS AND  
16 GYNECOLOGISTS FOR CERTAIN PRIMARY CARE SERVICES AT 100% OF THE  
17 MEDICARE RATE; TO DELETE THE PROVISION THAT REQUIRES THE DIVISION  
18 TO ALLOW PHYSICIAN-ADMINISTERED DRUGS TO BE BILLED AND REIMBURSED  
19 AS A MEDICAL CLAIM OR PHARMACY POINT-OF-SALE; TO PROVIDE THAT THE  
20 DIVISION SHALL MAKE PARTIAL PAYMENTS, AS DETERMINED BY THE  
21 DIVISION, TO INTERMEDIATE CARE FACILITY SERVICES AND TO DELETE  
22 CERTAIN PROVISIONS RELATING TO FAIR RENTAL REIMBURSEMENT FOR SUCH  
23 FACILITIES; TO DEFINE CLINIC SERVICES AS IT RELATES TO THE  
24 REIMBURSEMENTS BY MEDICAID FOR THOSE SERVICES; TO AUTHORIZE  
25 MEDICAID REIMBURSEMENT FOR THERAPEUTIC AND CASE MANAGEMENT MENTAL  
26 HEALTH SERVICES PROVIDED BY SERVICE PROVIDERS ACCREDITED BY THE  
27 JOINT COMMISSION OR CERTAIN OTHER ACCREDITING AGENCIES; TO PROVIDE  
28 THAT MEDICAID MAY ESTABLISH AN UPPER PAYMENT LIMITS PROGRAM FOR  
29 AMBULANCE TRANSPORTATION AND ASSESS PROVIDERS OF SUCH SERVICE; TO  
30 REQUIRE THE DIVISION OF MEDICAID TO RECOGNIZE FEDERALLY QUALIFIED  
31 HEALTH CENTERS (FQHC), RURAL HEALTH CLINICS (RHC) AND COMMUNITY  
32 MENTAL HEALTH CENTERS (CMHC) AS BOTH AN ORIGINATING AND DISTANT  
33 SITE PROVIDER FOR THE PURPOSES OF TELEHEALTH REIMBURSEMENT; TO  
34 DELETE THE PROVISIONS RELATING TO MEDICAID'S DEVELOPMENT OF AN



35 ALTERNATIVE MODEL FOR DISTRIBUTION OF MEDICAL CLAIMS AND  
36 SUPPLEMENTAL PAYMENTS FOR SERVICES; TO AUTHORIZE REIMBURSEMENT FOR  
37 CERTAIN PSYCHIATRIC SERVICES; TO CLARIFY THE REIMBURSEMENT OF  
38 PEDIATRIC SKILLED NURSING SERVICES, INPATIENT PSYCHIATRIST  
39 SERVICES AND NONEMERGENCY TRANSPORTATION SERVICES; TO DELETE THE  
40 PROVISION THAT REQUIRES MEDICAID TO REIMBURSE CROSSOVER CLAIMS FOR  
41 INPATIENT HOSPITAL SERVICES AND THOSE UNDER MEDICARE PART B; TO  
42 DELETE CERTAIN PROVISIONS RELATING TO THE REIMBURSEMENT OF  
43 PHYSICIAN ASSISTANT SERVICES; TO PROVIDE THAT THE DIVISION MAY  
44 ESTABLISH COPAYMENTS AND COINSURANCE FOR ANY MEDICAID SERVICES; TO  
45 ALLOW THE DIVISION TO USE ENHANCED REIMBURSEMENTS AND UPPER  
46 PAYMENT LIMIT PROGRAMS FOR ITS REIMBURSEMENT PROGRAM; TO AUTHORIZE  
47 REIMBURSEMENT FOR A BARIATRIC SURGERY PROGRAM; TO DELETE THE  
48 PROVISION THAT REQUIRES MEDICAID TO REDUCE THE RATE OF  
49 REIMBURSEMENT TO CERTAIN PROVIDERS FOR SERVICES BY 5% OF THE  
50 ALLOWED AMOUNT FOR THAT SERVICE; TO REQUIRE PROVIDERS TO MAINTAIN  
51 RECORDS AS PRESCRIBED BY THE DIVISION AND IN ACCORDANCE WITH  
52 FEDERAL LAW; TO DELETE CERTAIN ENROLLMENT LIMITATIONS AND  
53 PROVISIONS RELATING TO MANAGED CARE PROGRAMS; TO ALLOW THE  
54 DIVISION OF MEDICAID TO APPROVE THE USE OF ALTERNATIVE PAYMENT  
55 MODELS FOR REIMBURSEMENT RATES; TO CLARIFY LIMITATIONS ON MEDICAID  
56 ELIGIBILITY FOR ENROLLMENT IN MANAGED CARE PROGRAMS; TO DELETE THE  
57 PROVISIONS THAT PROVIDE FOR THE COMMISSION ON EXPANDING MEDICAID  
58 MANAGED CARE; TO REQUIRE CONTRACTORS RECEIVING PAYMENTS UNDER A  
59 MANAGED CARE DELIVERY SYSTEM TO DISCLOSE TO THE CHAIRMEN OF THE  
60 SENATE AND HOUSE MEDICAID COMMITTEES THE ADMINISTRATIVE EXPENSES  
61 FOR THE PRIOR YEAR, AND THE NUMBER OF EMPLOYEES IN MISSISSIPPI WHO  
62 ARE DEDICATED TO MEDICAID AND CHIP LINES OF BUSINESS AS OF JUNE 30  
63 OF EACH YEAR; TO PROVIDE FOR REVIEWS OF THE MANAGED CARE PROGRAMS  
64 BY THE STATE AUDITOR; TO REQUIRE THAT ALL MANAGED CARE CONTRACTORS  
65 SHALL DEVELOP AND IMPLEMENT A UNIFORM CREDENTIALING PROCESS BY  
66 WHICH ALL PROVIDERS ARE CREDENTIALLED BY JULY 1, 2022; TO DELETE  
67 THE PROVISION THAT THERE SHALL NOT BE CUTS TO INPATIENT AND  
68 OUTPATIENT HOSPITAL PAYMENTS; TO EXTEND THE AUTOMATIC REPEALER ON  
69 THIS SECTION; TO DIRECT THE DIVISION TO EVALUATE THE FEASIBILITY  
70 OF UTILIZING A SINGLE VENDOR TO ADMINISTER PHARMACY BENEFITS  
71 AND/OR DENTAL BENEFITS PROVIDED UNDER MANAGED CARE; TO DIRECT  
72 MANAGED CARE CONTRACTORS TO IMPLEMENT INNOVATIVE PROGRAMS FOR  
73 MEMBERS WITH DIABETES; TO AUTHORIZE THE DIVISION TO NEGOTIATE A  
74 LIMITATION ON LIABILITY TO THE STATE OF CERTAIN PROSPECTIVE  
75 CONTRACTORS; TO AMEND SECTION 43-13-145, MISSISSIPPI CODE OF 1972,  
76 TO PROVIDE THAT NURSING FACILITIES OPERATED BY THE UNIVERSITY OF  
77 MISSISSIPPI MEDICAL CENTER ARE NOT EXEMPT FROM THE ANNUAL  
78 ASSESSMENT FOR THE SUPPORT OF THE MEDICAID PROGRAM, TO DELETE  
79 CERTAIN TECHNICAL PROVISIONS RELATING TO THE ASSESSMENT AND  
80 COLLECTION OF THE HOSPITAL ASSESSMENT, TO CLARIFY THE PROCEDURE  
81 FOR PAYMENT OF THE HOSPITAL ASSESSMENT FOR THE NONFEDERAL SHARE  
82 NECESSARY FOR THE MEDICARE UPPER PAYMENT LIMITS (UPL) PROGRAM AND  
83 THE DISPROPORTIONATE SHARE HOSPITAL (DSH) PROGRAM; TO EXTEND THE  
84 AUTOMATIC REPEALER ON THIS SECTION; TO AMEND SECTION 41-7-191,  
85 MISSISSIPPI CODE OF 1972, TO DELETE THE MORATORIUM ON THE



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

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

98 **SECTION 1.** Section 43-13-115, Mississippi Code of 1972, is  
99 amended as follows:

100 43-13-115. Recipients of Medicaid shall be the following  
101 persons only:

102 (1) Those who are qualified for public assistance  
103 grants under provisions of Title IV-A and E of the federal Social  
104 Security Act, as amended, including those statutorily deemed to be  
105 IV-A and low-income families and children under Section 1931 of  
106 the federal Social Security Act. For the purposes of this  
107 paragraph (1) and paragraphs (8), (17) and (18) of this section,  
108 any reference to Title IV-A or to Part A of Title IV of the  
109 federal Social Security Act, as amended, or the state plan under  
110 Title IV-A or Part A of Title IV, shall be considered as a  
111 reference to Title IV-A of the federal Social Security Act, as  
112 amended, and the state plan under Title IV-A, including the income  
113 and resource standards and methodologies under Title IV-A and the  
114 state plan, as they existed on July 16, 1996. The Department of  
115 Human Services shall determine Medicaid eligibility for children  
116 receiving public assistance grants under Title IV-E. The division



shall determine eligibility for low-income families under Section 1931 of the federal Social Security Act and shall redetermine eligibility for those continuing under Title IV-A grants.

(2) Those qualified for Supplemental Security Income (SSI) benefits under Title XVI of the federal Social Security Act, as amended, and those who are deemed SSI eligible as contained in federal statute. The eligibility of individuals covered in this paragraph shall be determined by the Social Security Administration and certified to the Division of Medicaid.

(3) Qualified pregnant women who would be eligible for Medicaid as a low-income family member under Section 1931 of the federal Social Security Act if her child were born. The eligibility of the individuals covered under this paragraph shall be determined by the division.

(4) [Deleted]

(5) A child born on or after October 1, 1984, to a woman eligible for and receiving Medicaid under the state plan on the date of the child's birth shall be deemed to have applied for Medicaid and to have been found eligible for Medicaid under the plan on the date of that birth, and will remain eligible for Medicaid for a period of one (1) year so long as the child is a member of the woman's household and the woman remains eligible for Medicaid or would be eligible for Medicaid if pregnant. The eligibility of individuals covered in this paragraph shall be determined by the Division of Medicaid.



142           (6) Children certified by the State Department of Human  
143 Services to the Division of Medicaid of whom the state and county  
144 departments of human services have custody and financial  
145 responsibility, and children who are in adoptions subsidized in  
146 full or part by the Department of Human Services, including  
147 special needs children in non-Title IV-E adoption assistance, who  
148 are approvable under Title XIX of the Medicaid program. The  
149 eligibility of the children covered under this paragraph shall be  
150 determined by the State Department of Human Services.

151           (7) Persons certified by the Division of Medicaid who  
152 are patients in a medical facility (nursing home, hospital,  
153 tuberculosis sanatorium or institution for treatment of mental  
154 diseases), and who, except for the fact that they are patients in  
155 that medical facility, would qualify for grants under Title IV,  
156 Supplementary Security Income (SSI) benefits under Title XVI or  
157 state supplements, and those aged, blind and disabled persons who  
158 would not be eligible for Supplemental Security Income (SSI)  
159 benefits under Title XVI or state supplements if they were not  
160 institutionalized in a medical facility but whose income is below  
161 the maximum standard set by the Division of Medicaid, which  
162 standard shall not exceed that prescribed by federal regulation.

163           (8) Children under eighteen (18) years of age and  
164 pregnant women (including those in intact families) who meet the  
165 financial standards of the state plan approved under Title IV-A of  
166 the federal Social Security Act, as amended. The eligibility of



children covered under this paragraph shall be determined by the Division of Medicaid.

(9) Individuals who are:

(a) Children born after September 30, 1983, who have not attained the age of nineteen (19), with family income that does not exceed one hundred percent (100%) of the nonfarm official poverty level;

(b) Pregnant women, infants and children who have not attained the age of six (6), with family income that does not exceed one hundred thirty-three percent (133%) of the federal poverty level; and

(c) Pregnant women and infants who have not attained the age of one (1), with family income that does not exceed one hundred eighty-five percent (185%) of the federal poverty level.

The eligibility of individuals covered in (a), (b) and (c) of this paragraph shall be determined by the division.

(10) Certain disabled children age eighteen (18) or under who are living at home, who would be eligible, if in a medical institution, for SSI or a state supplemental payment under Title XVI of the federal Social Security Act, as amended, and therefore for Medicaid under the plan, and for whom the state has made a determination as required under Section 1902(e)(3)(b) of the federal Social Security Act, as amended. The eligibility of



191 individuals under this paragraph shall be determined by the  
192 Division of Medicaid.

193           (11) Until the end of the day on December 31, 2005,  
194 individuals who are sixty-five (65) years of age or older or are  
195 disabled as determined under Section 1614(a)(3) of the federal  
196 Social Security Act, as amended, and whose income does not exceed  
197 one hundred thirty-five percent (135%) of the nonfarm official  
198 poverty level as defined by the Office of Management and Budget  
199 and revised annually, and whose resources do not exceed those  
200 established by the Division of Medicaid. The eligibility of  
201 individuals covered under this paragraph shall be determined by  
202 the Division of Medicaid. After December 31, 2005, only those  
203 individuals covered under the 1115(c) Healthier Mississippi waiver  
204 will be covered under this category.

205           Any individual who applied for Medicaid during the period  
206 from July 1, 2004, through March 31, 2005, who otherwise would  
207 have been eligible for coverage under this paragraph (11) if it  
208 had been in effect at the time the individual submitted his or her  
209 application and is still eligible for coverage under this  
210 paragraph (11) on March 31, 2005, shall be eligible for Medicaid  
211 coverage under this paragraph (11) from March 31, 2005, through  
212 December 31, 2005. The division shall give priority in processing  
213 the applications for those individuals to determine their  
214 eligibility under this paragraph (11).



215           (12)   Individuals who are qualified Medicare  
216 beneficiaries (QMB) entitled to Part A Medicare as defined under  
217 Section 301, Public Law 100-360, known as the Medicare  
218 Catastrophic Coverage Act of 1988, and whose income does not  
219 exceed one hundred percent (100%) of the nonfarm official poverty  
220 level as defined by the Office of Management and Budget and  
221 revised annually.

222           The eligibility of individuals covered under this paragraph  
223 shall be determined by the Division of Medicaid, and those  
224 individuals determined eligible shall receive Medicare  
225 cost-sharing expenses only as more fully defined by the Medicare  
226 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of  
227 1997.

228           (13)   (a)   Individuals who are entitled to Medicare Part  
229 A as defined in Section 4501 of the Omnibus Budget Reconciliation  
230 Act of 1990, and whose income does not exceed one hundred twenty  
231 percent (120%) of the nonfarm official poverty level as defined by  
232 the Office of Management and Budget and revised annually.  
233 Eligibility for Medicaid benefits is limited to full payment of  
234 Medicare Part B premiums.

235           (b)   Individuals entitled to Part A of Medicare,  
236 with income above one hundred twenty percent (120%), but less than  
237 one hundred thirty-five percent (135%) of the federal poverty  
238 level, and not otherwise eligible for Medicaid. Eligibility for  
239 Medicaid benefits is limited to full payment of Medicare Part B





premiums. The number of eligible individuals is limited by the availability of the federal capped allocation at one hundred percent (100%) of federal matching funds, as more fully defined in the Balanced Budget Act of 1997.

The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid.

(14) [Deleted]

(15) Disabled workers who are eligible to enroll in Part A Medicare as required by Public Law 101-239, known as the Omnibus Budget Reconciliation Act of 1989, and whose income does not exceed two hundred percent (200%) of the federal poverty level as determined in accordance with the Supplemental Security Income (SSI) program. The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid and those individuals shall be entitled to buy-in coverage of Medicare Part A premiums only under the provisions of this paragraph (15).

(16) In accordance with the terms and conditions of approved Title XIX waiver from the United States Department of Health and Human Services, persons provided home- and community-based services who are physically disabled and certified by the Division of Medicaid as eligible due to applying the income and deeming requirements as if they were institutionalized.

(17) In accordance with the terms of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193), persons who become ineligible for



265 assistance under Title IV-A of the federal Social Security Act, as  
266 amended, because of increased income from or hours of employment  
267 of the caretaker relative or because of the expiration of the  
268 applicable earned income disregards, who were eligible for  
269 Medicaid for at least three (3) of the six (6) months preceding  
270 the month in which the ineligibility begins, shall be eligible for  
271 Medicaid for up to twelve (12) months. The eligibility of the  
272 individuals covered under this paragraph shall be determined by  
273 the division.

274 (18) Persons who become ineligible for assistance under  
275 Title IV-A of the federal Social Security Act, as amended, as a  
276 result, in whole or in part, of the collection or increased  
277 collection of child or spousal support under Title IV-D of the  
278 federal Social Security Act, as amended, who were eligible for  
279 Medicaid for at least three (3) of the six (6) months immediately  
280 preceding the month in which the ineligibility begins, shall be  
281 eligible for Medicaid for an additional four (4) months beginning  
282 with the month in which the ineligibility begins. The eligibility  
283 of the individuals covered under this paragraph shall be  
284 determined by the division.

285 (19) Disabled workers, whose incomes are above the  
286 Medicaid eligibility limits, but below two hundred fifty percent  
287 (250%) of the federal poverty level, shall be allowed to purchase  
288 Medicaid coverage on a sliding fee scale developed by the Division  
289 of Medicaid.



290           (20)   Medicaid eligible children under age eighteen (18)  
291   shall remain eligible for Medicaid benefits until the end of a  
292   period of twelve (12) months following an eligibility  
293   determination, or until such time that the individual exceeds age  
294   eighteen (18).

295           (21)   Women of childbearing age whose family income does  
296   not exceed one hundred eighty-five percent (185%) of the federal  
297   poverty level. The eligibility of individuals covered under this  
298   paragraph (21) shall be determined by the Division of Medicaid,  
299   and those individuals determined eligible shall only receive  
300   family planning services covered under Section 43-13-117(13) and  
301   not any other services covered under Medicaid. However, any  
302   individual eligible under this paragraph (21) who is also eligible  
303   under any other provision of this section shall receive the  
304   benefits to which he or she is entitled under that other  
305   provision, in addition to family planning services covered under  
306   Section 43-13-117(13).

307           The Division of Medicaid shall apply to the United States  
308   Secretary of Health and Human Services for a federal waiver of the  
309   applicable provisions of Title XIX of the federal Social Security  
310   Act, as amended, and any other applicable provisions of federal  
311   law as necessary to allow for the implementation of this paragraph  
312   (21). The provisions of this paragraph (21) shall be implemented  
313   from and after the date that the Division of Medicaid receives the  
314   federal waiver.



315           (22) Persons who are workers with a potentially severe  
316 disability, as determined by the division, shall be allowed to  
317 purchase Medicaid coverage. The term "worker with a potentially  
318 severe disability" means a person who is at least sixteen (16)  
319 years of age but under sixty-five (65) years of age, who has a  
320 physical or mental impairment that is reasonably expected to cause  
321 the person to become blind or disabled as defined under Section  
322 1614(a) of the federal Social Security Act, as amended, if the  
323 person does not receive items and services provided under  
324 Medicaid.

325           The eligibility of persons under this paragraph (22) shall be  
326 conducted as a demonstration project that is consistent with  
327 Section 204 of the Ticket to Work and Work Incentives Improvement  
328 Act of 1999, Public Law 106-170, for a certain number of persons  
329 as specified by the division. The eligibility of individuals  
330 covered under this paragraph (22) shall be determined by the  
331 Division of Medicaid.

332           (23) Children certified by the Mississippi Department  
333 of Human Services for whom the state and county departments of  
334 human services have custody and financial responsibility who are  
335 in foster care on their eighteenth birthday as reported by the  
336 Mississippi Department of Human Services shall be certified  
337 Medicaid eligible by the Division of Medicaid until their  
338 twenty-first birthday.



(24) Individuals who have not attained age sixty-five (65), are not otherwise covered by creditable coverage as defined in the Public Health Services Act, and have been screened for breast and cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act in accordance with the requirements of that act and who need treatment for breast or cervical cancer. Eligibility of individuals under this paragraph (24) shall be determined by the Division of Medicaid.

(25) The division shall apply to the Centers for Medicare and Medicaid Services (CMS) for any necessary waivers to provide services to individuals who are sixty-five (65) years of age or older or are disabled as determined under Section 1614(a)(3) of the federal Social Security Act, as amended, and whose income does not exceed one hundred thirty-five percent (135%) of the nonfarm official poverty level as defined by the Office of Management and Budget and revised annually, and whose resources do not exceed those established by the Division of Medicaid, and who are not otherwise covered by Medicare. Nothing contained in this paragraph (25) shall entitle an individual to benefits. The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid.

(26) The division shall apply to the Centers for Medicare and Medicaid Services (CMS) for any necessary waivers to



provide services to individuals who are sixty-five (65) years of age or older or are disabled as determined under Section 1614(a)(3) of the federal Social Security Act, as amended, who are end stage renal disease patients on dialysis, cancer patients on chemotherapy or organ transplant recipients on antirejection drugs, whose income does not exceed one hundred thirty-five percent (135%) of the nonfarm official poverty level as defined by the Office of Management and Budget and revised annually, and whose resources do not exceed those established by the division. Nothing contained in this paragraph (26) shall entitle an individual to benefits. The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid.

(27) Individuals who are entitled to Medicare Part D and whose income does not exceed one hundred fifty percent (150%) of the nonfarm official poverty level as defined by the Office of Management and Budget and revised annually. Eligibility for payment of the Medicare Part D subsidy under this paragraph shall be determined by the division.

(28) The division is authorized and directed to provide up to twelve (12) months of continuous coverage postpartum for any individual who qualifies for Medicaid coverage under this section as a pregnant woman, to the extent allowable under federal law and as determined by the division. It is the intent of the Legislature that the division shall reduce the application time



and simplify application procedures for pregnant women applying for Medicaid coverage postpartum. Not later than July 1, 2022, the division or its designee shall develop a report to the Legislature evaluating the effectiveness of extending Medicaid coverage for pregnant women from sixty (60) days postpartum to three hundred sixty-five (365) days postpartum.

The division shall redetermine eligibility for all categories of recipients described in each paragraph of this section not less frequently than required by federal law.

**SECTION 2.** Section 43-13-117, Mississippi Code of 1972, is amended as follows:

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

(1) Inpatient hospital services.

\* \* \*

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

( \* \* \*b) No service benefits or reimbursement limitations in this subsection (A)(1) shall apply to payments



414 under an APR-DRG or Ambulatory Payment Classification (APC) model  
415 or a managed care program or similar model described in subsection  
416 (H) of this section unless specifically authorized by the  
417 division.

418 (2) Outpatient hospital services.

419 (a) Emergency services.

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

435 (c) The division is authorized to implement an  
436 Ambulatory Payment Classification (APC) methodology for outpatient  
437 hospital services. The division may give rural hospitals that  
438 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-two (32) 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-two-day limitation: Christmas, the day before Christmas, the day after Christmas, Thanksgiving, the day before Thanksgiving and the day after Thanksgiving.

(b) From and after July 1, 1997, the division shall implement the integrated case-mix payment and quality



monitoring system, which includes the fair rental system for property costs and in which recapture of depreciation is eliminated. 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 encourage nursing facilities to convert or construct beds for residents with Alzheimer's or other related dementia.

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

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

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



the provision of those services to handicapped students by public school districts using state funds that are provided from the appropriation to the Department of Education to obtain federal matching funds through the division. The division, in obtaining medical and mental health assessments, treatment, care and services for children who are in, or at risk of being put in, the custody of the Mississippi Department of Human Services may enter into a cooperative agreement with the Mississippi Department of Human Services for the provision of those services using state funds that are provided from the appropriation to the Department of Human Services to obtain federal matching funds through the division.

(6) Physician \* \* \* services. \* \* \* From and after January 1, 2010, all fees for physician's services that are covered only by Medicaid shall be increased to ninety percent (90%) of the rate established on January 1, 2018, and as may be adjusted each July thereafter, under Medicare. The division may provide for a reimbursement rate for physician's services of up to one hundred percent (100%) of the rate established under Medicare for physician's services that are provided after the normal working hours of the physician, as determined in accordance with regulations of the division. The division may reimburse eligible providers, as determined by the \* \* \* division, for certain primary care services \* \* \* at one hundred percent (100%) of the rate established under Medicare. \* \* \* The division shall



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.



564       The division may allow for a combination of prescriptions for  
565   single-source and innovator multiple-source drugs and generic  
566   drugs to meet the needs of the beneficiaries.

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

570       Drugs prescribed for a resident of a psychiatric residential  
571   treatment facility must be provided in true unit doses when  
572   available. The division may require that drugs not covered by  
573   Medicare Part D for a resident of a long-term care facility be  
574   provided in true unit doses when available. Those drugs that were  
575   originally billed to the division but are not used by a resident  
576   in any of those facilities shall be returned to the billing  
577   pharmacy for credit to the division, in accordance with the  
578   guidelines of the State Board of Pharmacy and any requirements of  
579   federal law and regulation. Drugs shall be dispensed to a  
580   recipient and only one (1) dispensing fee per month may be  
581   charged. The division shall develop a methodology for reimbursing  
582   for restocked drugs, which shall include a restock fee as  
583   determined by the division not exceeding Seven Dollars and  
584   Eighty-two Cents (\$7.82).

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



589           The division is authorized to develop and implement a program  
590 of payment for additional pharmacist services as \* \* \* determined  
591 by the division.

592           All claims for drugs for dually eligible Medicare/Medicaid  
593 beneficiaries that are paid for by Medicare must be submitted to  
594 Medicare for payment before they may be processed by the  
595 division's online payment system.

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

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

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



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

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

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

625           The division may allow certain drugs, implantable drug system  
626 devices, and medical supplies, with limited distribution or  
627 limited access for beneficiaries and administered in an  
628 appropriate clinical setting, to be reimbursed as either a medical  
629 claim or pharmacy claim, as determined by the division.

630       \* \* \*

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

635           (10) Dental and orthodontic services to be determined  
636 by the division.





637           This dental services program under this paragraph shall be  
638 known as the "James Russell Dumas Medicaid Dental Services  
639 Program."

640           The Medical Care Advisory Committee, assisted by the Division  
641 of Medicaid, shall annually determine the effect of this incentive  
642 by evaluating the number of dentists who are Medicaid providers,  
643 the number who and the degree to which they are actively billing  
644 Medicaid, the geographic trends of where dentists are offering  
645 what types of Medicaid services and other statistics pertinent to  
646 the goals of this legislative intent. This data shall annually be  
647 presented to the Chair of the Senate Medicaid Committee and the  
648 Chair of the House Medicaid Committee.

649           The division shall include dental services as a necessary  
650 component of overall health services provided to children who are  
651 eligible for services.

652           (11) Eyeglasses for all Medicaid beneficiaries who have  
653 (a) had surgery on the eyeball or ocular muscle that results in a  
654 vision change for which eyeglasses or a change in eyeglasses is  
655 medically indicated within six (6) months of the surgery and is in  
656 accordance with policies established by the division, or (b) one  
657 (1) pair every five (5) years and in accordance with policies  
658 established by the division. In either instance, the eyeglasses  
659 must be prescribed by a physician skilled in diseases of the eye  
660 or an optometrist, whichever the beneficiary may select.

661           (12) Intermediate care facility services.



662 (a) The division shall make \* \* \* partial payment  
663 in an amount not less than fifty percent (50%) of the per diem  
664 rate, as determined by the division, to all intermediate care  
665 facilities for individuals with intellectual disabilities for each  
666 day, not exceeding \* \* \* seventy (70) days per year, that a  
667 patient is absent from the facility on home leave. Payment may be  
668 made for the following home leave days in addition to the \* \* \*  
669 seventy-day limitation: Christmas, the day before Christmas, the  
670 day after Christmas, Thanksgiving, the day before Thanksgiving and  
671 the day after Thanksgiving.

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

675 \* \* \*

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

679 (14) Clinic services \* \* \*, which means preventive,  
680 diagnostic, therapeutic, rehabilitative or palliative services  
681 that are furnished by a facility that is not part of a hospital  
682 but is organized and operated to provide medical care to  
683 outpatients. Clinic services include, but are not limited to:

684 (a) Services provided by ambulatory surgical  
685 centers (ACSS); and

686 (b) Dialysis center services.



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

692       \* \* \*

693           (16) Mental health services. Certain services provided  
694 by a psychiatrist shall be reimbursed at up to one hundred percent  
695 (100%) of the Medicare rate. Approved therapeutic and case  
696 management services (a) provided by an approved regional mental  
697 health/intellectual disability center established under Sections  
698 41-19-31 through 41-19-39, or by another \* \* \* mental health  
699 service provider meeting the requirements of the Department of  
700 Mental Health to be an approved mental health/intellectual  
701 disability center if determined necessary by the Department of  
702 Mental Health, using state funds that are provided in the  
703 appropriation to the division to match federal funds, or (b)  
704 provided by a facility that is certified by the State Department  
705 of Mental Health to provide therapeutic and case management  
706 services, to be reimbursed on a fee for service basis, or (c)  
707 provided in the community by a facility or program operated by the  
708 Department of Mental Health, or (d) provided by a mental health  
709 service provider accredited by the Joint Commission on  
710 Accreditation of Healthcare Organizations (JCAHO), the Commission  
711 on Accreditation of Rehabilitation Facilities (CARF), or the



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

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

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



737 (b) (i) The division may establish a Medicare  
738 Upper Payment Limits Program, as defined in Section 1902(a)(30) of  
739 the federal Social Security Act and any applicable federal  
740 regulations, or an allowable delivery system or provider payment  
741 initiative authorized under 42 CFR 438.6(c), for hospitals, \* \* \*  
742 nursing facilities, \* \* \* physicians employed or contracted  
743 by \* \* \* hospitals, and emergency ambulance transportation. \* \* \*  
744 (ii) The division shall assess each  
745 hospital \* \* \*, \* \* \* nursing facility, and emergency ambulance  
746 transportation provider for the sole purpose of financing the  
747 state portion of the Medicare Upper Payment Limits Program or  
748 other program(s) authorized under this subsection (A)(18)(b). The  
749 hospital assessment shall be as provided in Section  
750 43-13-145(4)(a), and the nursing facility \* \* \* and the emergency  
751 ambulance transportation assessments, if established, shall be  
752 based on Medicaid utilization or other appropriate method, as  
753 determined by the division, consistent with federal regulations.  
754 The assessments will remain in effect as long as the state  
755 participates in the Medicare Upper Payment Limits Program or other  
756 program(s) authorized under this subsection (A)(18)(b). \* \* \*  
757 \* \* \* (iii) Subject to approval by the  
758 Centers for Medicare and Medicaid Services (CMS) and the  
759 provisions of this subsection (A)(18)(b), the division shall make  
760 additional reimbursement to hospitals \* \* \*, \* \* \* nursing  
761 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.

(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. \* \* \*

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



787 the maximum levels permissible under applicable federal statutes  
788 and regulations, at which time the current inpatient Medicare  
789 Upper Payment Limits (UPL) Program for hospital inpatient services  
790 shall transition to the MHAP.

791 (ii) Subject \* \* \* to approval by the Centers  
792 for Medicare and Medicaid Services (CMS) \* \* \*, the MHAP shall  
793 provide increased inpatient capitation (PMPM) payments to managed  
794 care entities contracting with the division pursuant to subsection  
795 (H) of this section to support availability of hospital services  
796 or such other payments permissible under federal law necessary to  
797 accomplish the intent of this subsection.

798 (iii) The intent of this subparagraph (c) is  
799 that effective for all inpatient hospital Medicaid services during  
800 state fiscal year 2016, and so long as this provision shall remain  
801 in effect hereafter, the division shall to the fullest extent  
802 feasible replace the additional reimbursement for hospital  
803 inpatient services under the inpatient Medicare Upper Payment  
804 Limits (UPL) Program with additional reimbursement under the MHAP  
805 and other payment programs for inpatient and/or outpatient  
806 payments which may be developed under the authority of this  
807 paragraph.

808 (iv) The division shall assess each hospital  
809 as provided in Section 43-13-145(4) (a) for the purpose of  
810 financing the state portion of the MHAP, supplemental payments and  
811 such other purposes as specified in Section 43-13-145. The



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

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

827           (b) Early intervention system services. The  
828 division shall cooperate with the State Department of Health,  
829 acting as lead agency, in the development and implementation of a  
830 statewide system of delivery of early intervention services, under  
831 Part C of the Individuals with Disabilities Education Act (IDEA).  
832 The State Department of Health shall certify annually in writing  
833 to the executive director of the division the dollar amount of  
834 state early intervention funds available that will be utilized as  
835 a certified match for Medicaid matching funds. Those funds then  
836 shall be used to provide expanded targeted case management





837 services for Medicaid eligible children with special needs who are  
838 eligible for the state's early intervention system.

839 Qualifications for persons providing service coordination shall be  
840 determined by the State Department of Health and the Division of  
841 Medicaid.

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

852           (21) Nurse practitioner services. Services furnished  
853 by a registered nurse who is licensed and certified by the  
854 Mississippi Board of Nursing as a nurse practitioner, including,  
855 but not limited to, nurse anesthetists, nurse midwives, family  
856 nurse practitioners, family planning nurse practitioners,  
857 pediatric nurse practitioners, obstetrics-gynecology nurse  
858 practitioners and neonatal nurse practitioners, under regulations  
859 adopted by the division. Reimbursement for those services shall  
860 not exceed ninety percent (90%) of the reimbursement rate for  
861 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 medical attention within the home and outpatient and inpatient



912 care that treats the terminally ill patient and family as a unit,  
913 employing a medically directed interdisciplinary team. The  
914 program provides relief of severe pain or other physical symptoms  
915 and supportive care to meet the special needs arising out of  
916 physical, psychological, spiritual, social and economic stresses  
917 that are experienced during the final stages of illness and during  
918 dying and bereavement and meets the Medicare requirements for  
919 participation as a hospice as provided in federal regulations.

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

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

927 (29) The Division of Medicaid may apply for a waiver  
928 from the United States Department of Health and Human Services for  
929 home- and community-based services for developmentally disabled  
930 people using state funds that are provided from the appropriation  
931 to the State Department of Mental Health and/or funds transferred  
932 to the department by a political subdivision or instrumentality of  
933 the state and used to match federal funds under a cooperative  
934 agreement between the division and the department, provided that  
935 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



961 and used to match federal funds under a cooperative agreement  
962 between the division and the department.

963 (36) Nonemergency transportation services for  
964 Medicaid-eligible persons \* \* \* as determined by the division.

965 The PEER Committee shall conduct a performance evaluation of the  
966 nonemergency transportation program to evaluate the administration  
967 of the program and the providers of transportation services to  
968 determine the most cost-effective ways of providing nonemergency  
969 transportation services to the patients served under the program.  
970 The performance evaluation shall be completed and provided to the  
971 members of the Senate Medicaid Committee and the House Medicaid  
972 Committee not later than January 1, 2019, and every two (2) years  
973 thereafter.

974 (37) [Deleted]

975 (38) Chiropractic services. A chiropractor's manual  
976 manipulation of the spine to correct a subluxation, if x-ray  
977 demonstrates that a subluxation exists and if the subluxation has  
978 resulted in a neuromusculoskeletal condition for which  
979 manipulation is appropriate treatment, and related spinal x-rays  
980 performed to document these conditions. Reimbursement for  
981 chiropractic services shall not exceed Seven Hundred Dollars  
982 (\$700.00) per year per beneficiary.

983 (39) Dually eligible Medicare/Medicaid beneficiaries.  
984 The division shall pay the Medicare deductible and coinsurance



985 amounts for services available under Medicare, as determined by  
986 the division. \* \* \*

987 (40) [Deleted]

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

998 (42) [Deleted]

999 (43) The division shall provide reimbursement,  
1000 according to a payment schedule developed by the division, for  
1001 smoking cessation medications for pregnant women during their  
1002 pregnancy and other Medicaid-eligible women who are of  
1003 child-bearing age.

1004 (44) Nursing facility services for the severely  
1005 disabled.

1006 (a) Severe disabilities include, but are not  
1007 limited to, spinal cord injuries, closed-head injuries and  
1008 ventilator-dependent patients.



1009 (b) Those services must be provided in a long-term  
1010 care nursing facility dedicated to the care and treatment of  
1011 persons with severe disabilities.

1012 (45) Physician assistant services. Services furnished  
1013 by a physician assistant who is licensed by the State Board of  
1014 Medical Licensure and is practicing with physician supervision  
1015 under regulations adopted by the board, under regulations adopted  
1016 by the division. Reimbursement for those services shall not  
1017 exceed ninety percent (90%) of the reimbursement rate for  
1018 comparable services rendered by a physician. The division may  
1019 provide for a reimbursement rate for physician assistant services  
1020 of up to one hundred percent (100%) or the reimbursement rate for  
1021 comparable services rendered by a physician for physician  
1022 assistant services that are provided after the normal working  
1023 hours of the physician assistant, as determined in accordance with  
1024 regulations of the division.

1025 (46) The division shall make application to the federal  
1026 Centers for Medicare and Medicaid Services (CMS) for a waiver to  
1027 develop and provide services for children with serious emotional  
1028 disturbances as defined in Section 43-14-1(1), which may include  
1029 home- and community-based services, case management services or  
1030 managed care services through mental health providers certified by  
1031 the Department of Mental Health. The division may implement and  
1032 provide services under this waived program only if funds for  
1033 these services are specifically appropriated for this purpose by





1034 the Legislature, or if funds are voluntarily provided by affected  
1035 agencies.

1036 (47) (a) The division may develop and implement  
1037 disease management programs for individuals with high-cost chronic  
1038 diseases and conditions, including the use of grants, waivers,  
1039 demonstrations or other projects as necessary.

1040 (b) Participation in any disease management  
1041 program implemented under this paragraph (47) is optional with the  
1042 individual. An individual must affirmatively elect to participate  
1043 in the disease management program in order to participate, and may  
1044 elect to discontinue participation in the program at any time.

1045 (48) Pediatric long-term acute care hospital services.

1046 (a) Pediatric long-term acute care hospital  
1047 services means services provided to eligible persons under  
1048 twenty-one (21) years of age by a freestanding Medicare-certified  
1049 hospital that has an average length of inpatient stay greater than  
1050 twenty-five (25) days and that is primarily engaged in providing  
1051 chronic or long-term medical care to persons under twenty-one (21)  
1052 years of age.

1053 (b) The services under this paragraph (48) shall  
1054 be reimbursed as a separate category of hospital services.

1055 (49) The division \* \* \* may establish copayments and/or  
1056 coinsurance for \* \* \* any Medicaid services for which copayments  
1057 and/or coinsurance are allowable under federal law or regulation.



1058                   (50)   Services provided by the State Department of  
1059   Rehabilitation Services for the care and rehabilitation of persons  
1060   who are deaf and blind, as allowed under waivers from the United  
1061   States Department of Health and Human Services to provide home-  
1062   and community-based services using state funds that are provided  
1063   from the appropriation to the State Department of Rehabilitation  
1064   Services or if funds are voluntarily provided by another agency.

1065                   (51)   Upon determination of Medicaid eligibility and in  
1066   association with annual redetermination of Medicaid eligibility,  
1067   beneficiaries shall be encouraged to undertake a physical  
1068   examination that will establish a base-line level of health and  
1069   identification of a usual and customary source of care (a medical  
1070   home) to aid utilization of disease management tools. This  
1071   physical examination and utilization of these disease management  
1072   tools shall be consistent with current United States Preventive  
1073   Services Task Force or other recognized authority recommendations.

1074               For persons who are determined ineligible for Medicaid, the  
1075   division will provide information and direction for accessing  
1076   medical care and services in the area of their residence.

1077                   (52)   Notwithstanding any provisions of this article,  
1078   the division may pay enhanced reimbursement fees related to trauma  
1079   care, as determined by the division in conjunction with the State  
1080   Department of Health, using funds appropriated to the State  
1081   Department of Health for trauma care and services and used to  
1082   match federal funds under a cooperative agreement between the



1083 division and the State Department of Health. The division, in  
1084 conjunction with the State Department of Health, may use grants,  
1085 waivers, demonstrations, enhanced reimbursements, Upper Payment  
1086 Limits Programs, supplemental payments, or other projects as  
1087 necessary in the development and implementation of this  
1088 reimbursement program.

1089 (53) Targeted case management services for high-cost  
1090 beneficiaries may be developed by the division for all services  
1091 under this section.

1092 (54) [Deleted]

1093 (55) Therapy services. The plan of care for therapy  
1094 services may be developed to cover a period of treatment for up to  
1095 six (6) months, but in no event shall the plan of care exceed a  
1096 six-month period of treatment. The projected period of treatment  
1097 must be indicated on the initial plan of care and must be updated  
1098 with each subsequent revised plan of care. Based on medical  
1099 necessity, the division shall approve certification periods for  
1100 less than or up to six (6) months, but in no event shall the  
1101 certification period exceed the period of treatment indicated on  
1102 the plan of care. The appeal process for any reduction in therapy  
1103 services shall be consistent with the appeal process in federal  
1104 regulations.

1105 (56) Prescribed pediatric extended care centers  
1106 services for medically dependent or technologically dependent  
1107 children with complex medical conditions that require continual



1108 care as prescribed by the child's attending physician, as  
1109 determined by the division.

1110 (57) No Medicaid benefit shall restrict coverage for  
1111 medically appropriate treatment prescribed by a physician and  
1112 agreed to by a fully informed individual, or if the individual  
1113 lacks legal capacity to consent by a person who has legal  
1114 authority to consent on his or her behalf, based on an  
1115 individual's diagnosis with a terminal condition. As used in this  
1116 paragraph (57), "terminal condition" means any aggressive  
1117 malignancy, chronic end-stage cardiovascular or cerebral vascular  
1118 disease, or any other disease, illness or condition which a  
1119 physician diagnoses as terminal.

1120 (58) Treatment services for persons with opioid  
1121 dependency or other highly addictive substance use disorders. The  
1122 division is authorized to reimburse eligible providers for  
1123 treatment of opioid dependency and other highly addictive  
1124 substance use disorders, as determined by the division. Treatment  
1125 related to these conditions shall not count against any physician  
1126 visit limit imposed under this section.

1127 (59) The division shall allow beneficiaries between the  
1128 ages of ten (10) and eighteen (18) years to receive vaccines  
1129 through a pharmacy venue, obstetrician (OB-GYN), or other primary  
1130 health care providers.

1131 (60) Bariatric surgery as determined by the division  
1132 and as allowed by federal law and regulation.



1133 (B) \* \* \* [Deleted]

1134 (C) The division may pay to those providers who participate  
1135 in and accept patient referrals from the division's emergency room  
1136 redirection program a percentage, as determined by the division,  
1137 of savings achieved according to the performance measures and  
1138 reduction of costs required of that program. Federally qualified  
1139 health centers may participate in the emergency room redirection  
1140 program, and the division may pay those centers a percentage of  
1141 any savings to the Medicaid program achieved by the centers'  
1142 accepting patient referrals through the program, as provided in  
1143 this subsection (C).

1144 (D) [Deleted]

1145 (E) Notwithstanding any provision of this article, no new  
1146 groups or categories of recipients and new types of care and  
1147 services may be added without enabling legislation from the  
1148 Mississippi Legislature, except that the division may authorize  
1149 those changes without enabling legislation when the addition of  
1150 recipients or services is ordered by a court of proper authority.

1151 (F) The executive director shall keep the Governor advised  
1152 on a timely basis of the funds available for expenditure and the  
1153 projected expenditures. Notwithstanding any other provisions of  
1154 this article, if current or projected expenditures of the division  
1155 are reasonably anticipated to exceed the amount of funds  
1156 appropriated to the division for any fiscal year, the Governor,  
1157 after consultation with the executive director, shall take all



1158 appropriate measures to reduce costs, which may include, but are  
1159 not limited to:

1160 (1) Reducing or discontinuing any or all services that  
1161 are deemed to be optional under Title XIX of the Social Security  
1162 Act;

1163 (2) Reducing reimbursement rates for any or all service  
1164 types to the extent allowed under federal law to first include the  
1165 administrative fee portion of capitated payments to organizations  
1166 described in subsection (H) (1) of this section before enacting  
1167 reimbursement rate reductions for health care providers;

1168 (3) Imposing additional assessments on health care  
1169 providers; or

1170 (4) Any additional cost-containment measures deemed  
1171 appropriate by the Governor.

1172 Beginning in fiscal year 2010 and in fiscal years thereafter,  
1173 when Medicaid expenditures are projected to exceed funds available  
1174 for the fiscal year, the division shall submit the expected  
1175 shortfall information to the PEER Committee not later than  
1176 December 1 of the year in which the shortfall is projected to  
1177 occur. PEER shall review the computations of the division and  
1178 report its findings to the Legislative Budget Office not later  
1179 than January 7 in any year.

1180 (G) Notwithstanding any other provision of this article, it  
1181 shall be the duty of each provider participating in the Medicaid  
1182 program to keep and maintain books, documents and other records as



1183 prescribed by the Division of Medicaid in \* \* \* accordance with  
1184 federal laws and regulations.

1185 (H) (1) Notwithstanding any other provision of this  
1186 article, the division is authorized to implement (a) a managed  
1187 care program, (b) a coordinated care program, (c) a coordinated  
1188 care organization program, (d) a health maintenance organization  
1189 program, (e) a patient-centered medical home program, (f) an  
1190 accountable care organization program, (g) provider-sponsored  
1191 health plan, or (h) any combination of the above programs. \* \* \*  
1192 As a condition for the approval of any program under this  
1193 subsection (H) (1), the division shall require that no managed care  
1194 program may:

1195 (a) \* \* \* [Deleted]

1196 (b) Override the medical decisions of hospital  
1197 physicians or staff regarding patients admitted to a hospital for  
1198 an emergency medical condition as defined by 42 US Code Section  
1199 1395dd. This restriction (b) does not prohibit the retrospective  
1200 review of the appropriateness of the determination that an  
1201 emergency medical condition exists by chart review or coding  
1202 algorithm, nor does it prohibit prior authorization for  
1203 nonemergency hospital admissions;

1204 (c) Pay providers at a rate that is less than the  
1205 normal Medicaid reimbursement rate. However, the division may  
1206 approve use of alternative payment models, including quality and  
1207 value-based payment arrangements, provided both parties mutually



1208 agree and the Division of Medicaid approves of said models. It is  
1209 the intent of the Legislature that all managed care entities  
1210 described in this subsection (H), in collaboration with the  
1211 division, develop and implement innovative payment models that  
1212 incentivize improvements in health care quality, outcomes, or  
1213 value, as determined by the division. Participation in the  
1214 provider network of any managed care, coordinated care,  
1215 provider-sponsored health plan, or similar contractor shall not be  
1216 conditioned on the provider's agreement to accept such alternative  
1217 payment models;

1218 (d) Implement a prior authorization and  
1219 utilization review program for medical services, transportation  
1220 services and prescription drugs that is more stringent than the  
1221 prior authorization processes used by the division in its  
1222 administration of the Medicaid program;

1223 (e) [Deleted]

1224 (f) Implement a preferred drug list that is more  
1225 stringent than the mandatory preferred drug list established by  
1226 the division under subsection (A)(9) of this section;

1227 (g) Implement a policy which denies beneficiaries  
1228 with hemophilia access to the federally funded hemophilia  
1229 treatment centers as part of the Medicaid Managed Care network of  
1230 providers. \* \* \*

1231 (2) Notwithstanding any provision of this section, the  
1232 recipients eligible for enrollment into a Medicaid managed care





1233 program authorized under this subsection (H) shall include only  
1234 those categories of recipients eligible for participation in the  
1235 Medicaid managed care program as of January 1, 2019, and the  
1236 Children's Health Insurance Program (CHIP), CMS approved Section  
1237 1115 demonstration waivers in operation as of January 1, 2021, and  
1238 a demonstration waiver to extend postpartum coverage for pregnant  
1239 women up to twelve (12) months or a period of time as may  
1240 otherwise be authorized under this section. No expansion of  
1241 Medicaid managed care program contracts may be implemented by the  
1242 division without enabling legislation from the Mississippi  
1243 Legislature. \* \* \*

1244 \* \* \*

1245 (3) (a) Any contractors \* \* \* receiving capitated  
1246 payments under a managed care \* \* \* delivery system established in  
1247 this section shall provide to the Legislature and the division  
1248 statistical data to be shared with provider groups in order to  
1249 improve patient access, appropriate utilization, cost savings and  
1250 health outcomes not later than October 1 of each year.  
1251 Additionally, each contractor shall disclose to the Chairmen of  
1252 the Senate and House Medicaid Committees the administrative  
1253 expenses costs for the prior calendar year, and the number of  
1254 full-equivalent employees located in the State of Mississippi  
1255 dedicated to the Medicaid and CHIP lines of business as of June 30  
1256 of the current year.



1257                   **(b)** The division and the contractors participating  
1258 in the managed care program, a coordinated care program or a  
1259 provider-sponsored health plan shall be subject to \* \* \* program  
1260 reviews or audits performed by the Office of the State Auditor,  
1261 the PEER Committee and/or \* \* \* independent third \* \* \* parties.

1262                   **(c)** Those \* \* \* reviews shall \* \* \* include the  
1263 following items \* \* \*:

1264                   **(i)** The financial benefit to the State of  
1265 Mississippi of the managed care program,

1266                   **(ii)** The difference between the premiums paid  
1267 to the managed care contractors and the payments made by those  
1268 contractors to health care providers, \* \* \*

1269                   **(iii)** Compliance with performance measures  
1270 required under the contracts,

1271                   **(iv)** Administrative expense allocation  
1272 methodologies,

1273                   **(v)** Whether nonprovider payments assigned as  
1274 medical expenses are appropriate,

1275                   **(vi)** Capitated arrangements with related  
1276 party subcontractors,

1277                   **(vii)** Reasonableness of corporate  
1278 allocations,

1279                   **(viii)** Value-added benefits and the extent to  
1280 which they are used,



1281                    (ix) The effectiveness of subcontractor  
1282 oversight, including subcontractor review,

1283                    (x) Whether \* \* \* health care outcomes \* \* \*  
1284 have been improved, and

1285                    (xi) The most common claim denial codes to  
1286 determine the reasons for the denials.

1287                    \* \* \* The audit reports shall be considered \* \* \* public  
1288 documents and shall be posted in \* \* \* their entirety on the  
1289 division's website.

1290                    (4) \* \* \* [Deleted]

1291                    (5) No health maintenance organization, coordinated  
1292 care organization, provider-sponsored health plan, or other  
1293 organization paid for services on a capitated basis by the  
1294 division under any managed care program or coordinated care  
1295 program implemented by the division under this section shall  
1296 require its providers or beneficiaries to use any pharmacy that  
1297 ships, mails or delivers prescription drugs or legend drugs or  
1298 devices.

1299                    (6) Not later than July 1, 2022, any contractors  
1300 receiving capitated payments under a managed care delivery system  
1301 established in this section shall develop and implement a uniform  
1302 credentialing process by which all providers will be credentialed.  
1303 If the provisions of this subsection are not met by July 1, 2022,  
1304 the division shall establish a uniform credentialing or screening  
1305 process, and no health maintenance organization, coordinated care



1306 organization, provider-sponsored health plan, or other  
1307 organization paid for services on a capitated basis by the  
1308 division under any managed care program or coordinated care  
1309 program implemented by the division under this section shall  
1310 require its providers to be credentialed by the organization in  
1311 order to receive reimbursement from the organization, but those  
1312 organizations shall recognize the credentialing or screening of  
1313 the providers by the division.

1314 (7) It is the intent of the Legislature that the  
1315 division evaluate the feasibility of utilizing a single vendor to  
1316 administer pharmacy benefits provided under a managed care  
1317 delivery system established in this section.

1318 (8) It is the intent of the Legislature that the  
1319 division evaluate the feasibility of utilizing a single vendor to  
1320 administer dental benefits provided under a managed care delivery  
1321 system established in this section.

1322 (9) It is the intent of the Legislature that any  
1323 contractor receiving capitated payments under a managed care  
1324 delivery system established in this section shall implement  
1325 innovative programs to improve the health and well-being of  
1326 members diagnosed with diabetes.

1327 (I) [Deleted]

1328 (J) \* \* \* [Deleted]

1329 (K) In the negotiation and execution of such contracts  
1330 involving services performed by actuarial firms, the Executive



1331 Director of the Division of Medicaid may negotiate a limitation on  
1332 liability to the state of prospective contractors.

1333 ( \* \* \*L) This section shall stand repealed on July 1, \* \* \*  
1334 2022.

1335 **SECTION 3.** Section 43-13-145, Mississippi Code of 1972, is  
1336 amended as follows:

1337 43-13-145. (1) (a) Upon each nursing facility licensed by  
1338 the State of Mississippi, there is levied an assessment in an  
1339 amount set by the division, equal to the maximum rate allowed by  
1340 federal law or regulation, for each licensed and occupied bed of  
1341 the facility.

1342 (b) A nursing facility is exempt from the assessment  
1343 levied under this subsection if the facility is operated under the  
1344 direction and control of:

1345 (i) The United States Veterans Administration or  
1346 other agency or department of the United States government; or

1347 (ii) The State Veterans Affairs Board \* \* \*.

1348 \* \* \*

1349 (2) (a) Upon each intermediate care facility for  
1350 individuals with intellectual disabilities licensed by the State  
1351 of Mississippi, there is levied an assessment in an amount set by  
1352 the division, equal to the maximum rate allowed by federal law or  
1353 regulation, for each licensed and occupied bed of the facility.

1354 (b) An intermediate care facility for individuals with  
1355 intellectual disabilities is exempt from the assessment levied



1356 under this subsection if the facility is operated under the  
1357 direction and control of:

1358 (i) The United States Veterans Administration or  
1359 other agency or department of the United States government;

1360 (ii) The State Veterans Affairs Board; or

1361 (iii) The University of Mississippi Medical  
1362 Center.

1363 (3) (a) Upon each psychiatric residential treatment  
1364 facility licensed by the State of Mississippi, there is levied an  
1365 assessment in an amount set by the division, equal to the maximum  
1366 rate allowed by federal law or regulation, for each licensed and  
1367 occupied bed of the facility.

1368 (b) A psychiatric residential treatment facility is  
1369 exempt from the assessment levied under this subsection if the  
1370 facility is operated under the direction and control of:

1371 (i) The United States Veterans Administration or  
1372 other agency or department of the United States government;

1373 (ii) The University of Mississippi Medical Center;  
1374 or

1375 (iii) A state agency or a state facility that  
1376 either provides its own state match through intergovernmental  
1377 transfer or certification of funds to the division.

1378 (4) Hospital assessment.

1379 (a) (i) Subject to and upon fulfillment of the  
1380 requirements and conditions of paragraph (f) below, and



1381 notwithstanding any other provisions of this section, \* \* \* an  
1382 annual assessment on each hospital licensed in the state is  
1383 imposed on each non-Medicare hospital inpatient day as defined  
1384 below at a rate that is determined by dividing the sum prescribed  
1385 in this subparagraph (i), plus the nonfederal share necessary to  
1386 maximize the Disproportionate Share Hospital (DSH) and Medicare  
1387 Upper Payment Limits (UPL) Program payments and hospital access  
1388 payments and such other supplemental payments as may be developed  
1389 pursuant to Section 43-13-117(A)(18), by the total number of  
1390 non-Medicare hospital inpatient days as defined below for all  
1391 licensed Mississippi hospitals, except as provided in paragraph  
1392 (d) below. If the state-matching funds percentage for the  
1393 Mississippi Medicaid program is sixteen percent (16%) or less, the  
1394 sum used in the formula under this subparagraph (i) shall be  
1395 Seventy-four Million Dollars (\$74,000,000.00). If the  
1396 state-matching funds percentage for the Mississippi Medicaid  
1397 program is twenty-four percent (24%) or higher, the sum used in  
1398 the formula under this subparagraph (i) shall be One Hundred Four  
1399 Million Dollars (\$104,000,000.00). If the state-matching funds  
1400 percentage for the Mississippi Medicaid program is between sixteen  
1401 percent (16%) and twenty-four percent (24%), the sum used in the  
1402 formula under this subparagraph (i) shall be a pro rata amount  
1403 determined as follows: the current state-matching funds  
1404 percentage rate minus sixteen percent (16%) divided by eight  
1405 percent (8%) multiplied by Thirty Million Dollars (\$30,000,000.00)



1406 and add that amount to Seventy-four Million Dollars  
1407 (\$74,000,000.00). However, no assessment in a quarter under this  
1408 subparagraph (i) may exceed the assessment in the previous quarter  
1409 by more than Three Million Seven Hundred Fifty Thousand Dollars  
1410 (\$3,750,000.00) (which would be Fifteen Million Dollars  
1411 (\$15,000,000.00) on an annualized basis). The division shall  
1412 publish the state-matching funds percentage rate applicable to the  
1413 Mississippi Medicaid program on the tenth day of the first month  
1414 of each quarter and the assessment determined under the formula  
1415 prescribed above shall be applicable in the quarter following any  
1416 adjustment in that state-matching funds percentage rate. The  
1417 division shall notify each hospital licensed in the state as to  
1418 any projected increases or decreases in the assessment determined  
1419 under this subparagraph (i). However, if the Centers for Medicare  
1420 and Medicaid Services (CMS) does not approve the provision in  
1421 Section 43-13-117(39) requiring the division to reimburse  
1422 crossover claims for inpatient hospital services and crossover  
1423 claims covered under Medicare Part B for dually eligible  
1424 beneficiaries in the same manner that was in effect on January 1,  
1425 2008, the sum that otherwise would have been used in the formula  
1426 under this subparagraph (i) shall be reduced by Seven Million  
1427 Dollars (\$7,000,000.00).

1428 (ii) In addition to the assessment provided under  
1429 subparagraph (i), \* \* \* an additional annual assessment on each  
1430 hospital licensed in the state is imposed on each non-Medicare





1431 hospital inpatient day as defined below at a rate that is  
1432 determined by dividing twenty-five percent (25%) of any provider  
1433 reductions in the Medicaid program as authorized in Section  
1434 43-13-117(F) for that fiscal year up to the following maximum  
1435 amount, plus the nonfederal share necessary to maximize the  
1436 Disproportionate Share Hospital (DSH) and inpatient Medicare Upper  
1437 Payment Limits (UPL) Program payments and inpatient hospital  
1438 access payments, by the total number of non-Medicare hospital  
1439 inpatient days as defined below for all licensed Mississippi  
1440 hospitals: in fiscal year 2010, the maximum amount shall be  
1441 Twenty-four Million Dollars (\$24,000,000.00); in fiscal year 2011,  
1442 the maximum amount shall be Thirty-two Million Dollars  
1443 (\$32,000,000.00); and in fiscal year 2012 and thereafter, the  
1444 maximum amount shall be Forty Million Dollars (\$40,000,000.00).  
1445 Any such deficit in the Medicaid program shall be reviewed by the  
1446 PEER Committee as provided in Section 43-13-117(F).

1447 (iii) In addition to the assessments provided in  
1448 subparagraphs (i) and (ii), \* \* \* an additional annual assessment  
1449 on each hospital licensed in the state is imposed pursuant to the  
1450 provisions of Section 43-13-117(F) if the costcontainment  
1451 measures described therein have been implemented and there are  
1452 insufficient funds in the Health Care Trust Fund to reconcile any  
1453 remaining deficit in any fiscal year. If the Governor institutes  
1454 any other additional costcontainment measures on any program or  
1455 programs authorized under the Medicaid program pursuant to Section



1456 43-13-117(F), hospitals shall be responsible for twenty-five  
1457 percent (25%) of any such additional imposed provider cuts, which  
1458 shall be in the form of an additional assessment not to exceed the  
1459 twenty-five percent (25%) of provider expenditure reductions.  
1460 Such additional assessment shall be imposed on each non-Medicare  
1461 hospital inpatient day in the same manner as assessments are  
1462 imposed under subparagraphs (i) and (ii).

1463 (b) \* \* \* Definitions.

1464 (i) \* \* \* [Deleted]

1465 (ii) \* \* \* For purposes of this subsection (4):

1466 1. "Non-Medicare hospital inpatient day"

1467 means total hospital inpatient days including subcomponent days  
1468 less Medicare inpatient days including subcomponent days from the  
1469 hospital's most recent Medicare cost report for the second  
1470 calendar year preceding the beginning of the state fiscal year, on  
1471 file with CMS per the CMS HCRIS database, or cost report submitted  
1472 to the Division if the HCRIS database is not available to the  
1473 division, as of June 1 of each year.

1474 a. Total hospital inpatient days shall  
1475 be the sum of Worksheet S-3, Part 1, column 8 row 14, column 8 row  
1476 16, and column 8 row 17, excluding column 8 rows 5 and 6.

1477 b. Hospital Medicare inpatient days  
1478 shall be the sum of Worksheet S-3, Part 1, column 6 row 14, column  
1479 6 row 16.00, and column 6 row 17, excluding column 6 rows 5 and 6.



1480 c. Inpatient days shall not include  
1481 residential treatment or long-term care days.

1482 2. "Subcomponent inpatient day" means the  
1483 number of days of care charged to a beneficiary for inpatient  
1484 hospital rehabilitation and psychiatric care services in units of  
1485 full days. A day begins at midnight and ends twenty-four (24)  
1486 hours later. A part of a day, including the day of admission and  
1487 day on which a patient returns from leave of absence, counts as a  
1488 full day. However, the day of discharge, death, or a day on which  
1489 a patient begins a leave of absence is not counted as a day unless  
1490 discharge or death occur on the day of admission. If admission  
1491 and discharge or death occur on the same day, the day is  
1492 considered a day of admission and counts as one (1) subcomponent  
1493 inpatient day.

1494 (c) The assessment provided in this subsection is  
1495 intended to satisfy and not be in addition to the assessment and  
1496 intergovernmental transfers provided in Section 43-13-117(A)(18).  
1497 Nothing in this section shall be construed to authorize any state  
1498 agency, division or department, or county, municipality or other  
1499 local governmental unit to license for revenue, levy or impose any  
1500 other tax, fee or assessment upon hospitals in this state not  
1501 authorized by a specific statute.

1502 (d) Hospitals operated by the United States Department  
1503 of Veterans Affairs and state-operated facilities that provide



1504 only inpatient and outpatient psychiatric services shall not be  
1505 subject to the hospital assessment provided in this subsection.

1506 (e) Multihospital systems, closure, merger, change of  
1507 ownership and new hospitals.

1508 (i) If a hospital conducts, operates or maintains  
1509 more than one (1) hospital licensed by the State Department of  
1510 Health, the provider shall pay the hospital assessment for each  
1511 hospital separately.

1512 (ii) Notwithstanding any other provision in this  
1513 section, if a hospital subject to this assessment operates or  
1514 conducts business only for a portion of a fiscal year, the  
1515 assessment for the state fiscal year shall be adjusted by  
1516 multiplying the assessment by a fraction, the numerator of which  
1517 is the number of days in the year during which the hospital  
1518 operates, and the denominator of which is three hundred sixty-five  
1519 (365). Immediately upon ceasing to operate, the hospital shall  
1520 pay the assessment for the year as so adjusted (to the extent not  
1521 previously paid).

1522 (iii) The division shall determine the tax for new  
1523 hospitals and hospitals that undergo a change of ownership in  
1524 accordance with this section, using the best available  
1525 information, as determined by the division.

1526 (f) Applicability.

1527 The hospital assessment imposed by this subsection shall not  
1528 take effect and/or shall cease to be imposed if:



1529 (i) The assessment is determined to be an  
1530 impermissible tax under Title XIX of the Social Security Act; or  
1531 (ii) CMS revokes its approval of the division's  
1532 2009 Medicaid State Plan Amendment for the methodology for DSH  
1533 payments to hospitals under Section 43-13-117(A)(18).

1534 \* \* \*

1535 (5) Each health care facility that is subject to the  
1536 provisions of this section shall keep and preserve such suitable  
1537 books and records as may be necessary to determine the amount of  
1538 assessment for which it is liable under this section. The books  
1539 and records shall be kept and preserved for a period of not less  
1540 than five (5) years, during which time those books and records  
1541 shall be open for examination during business hours by the  
1542 division, the Department of Revenue, the Office of the Attorney  
1543 General and the State Department of Health.

1544 (6) \* \* \* [Deleted]

1545 (7) All assessments collected under this section shall be  
1546 deposited in the Medical Care Fund created by Section 43-13-143.

1547 (8) The assessment levied under this section shall be in  
1548 addition to any other assessments, taxes or fees levied by law,  
1549 and the assessment shall constitute a debt due the State of  
1550 Mississippi from the time the assessment is due until it is paid.

1551 (9) (a) If a health care facility that is liable for  
1552 payment of an assessment levied by the division does not pay the  
1553 assessment when it is due, the division shall give written notice



1554 to the health care facility \* \* \* demanding payment of the  
1555 assessment within ten (10) days from the date of delivery of the  
1556 notice. If the health care facility fails or refuses to pay the  
1557 assessment after receiving the notice and demand from the  
1558 division, the division shall withhold from any Medicaid  
1559 reimbursement payments that are due to the health care facility  
1560 the amount of the unpaid assessment and a penalty of ten percent  
1561 (10%) of the amount of the assessment, plus the legal rate of  
1562 interest until the assessment is paid in full. If the health care  
1563 facility does not participate in the Medicaid program, the  
1564 division shall turn over to the Office of the Attorney General the  
1565 collection of the unpaid assessment by civil action. In any such  
1566 civil action, the Office of the Attorney General shall collect the  
1567 amount of the unpaid assessment and a penalty of ten percent (10%)  
1568 of the amount of the assessment, plus the legal rate of interest  
1569 until the assessment is paid in full.

1570 (b) As an additional or alternative method for  
1571 collecting unpaid assessments levied by the division, if a health  
1572 care facility fails or refuses to pay the assessment after  
1573 receiving notice and demand from the division, the division may  
1574 file a notice of a tax lien with the chancery clerk of the county  
1575 in which the health care facility is located, for the amount of  
1576 the unpaid assessment and a penalty of ten percent (10%) of the  
1577 amount of the assessment, plus the legal rate of interest until  
1578 the assessment is paid in full. Immediately upon receipt of



1579 notice of the tax lien for the assessment, the chancery clerk  
1580 shall forward the notice to the circuit clerk who shall enter the  
1581 notice of the tax lien as a judgment upon the judgment roll and  
1582 show in the appropriate columns the name of the health care  
1583 facility as judgment debtor, the name of the division as judgment  
1584 creditor, the amount of the unpaid assessment, and the date and  
1585 time of enrollment. The judgment shall be valid as against  
1586 mortgagees, pledgees, entrusters, purchasers, judgment creditors  
1587 and other persons from the time of filing with the clerk. The  
1588 amount of the judgment shall be a debt due the State of  
1589 Mississippi and remain a lien upon the tangible property of the  
1590 health care facility until the judgment is satisfied. The  
1591 judgment shall be the equivalent of any enrolled judgment of a  
1592 court of record and shall serve as authority for the issuance of  
1593 writs of execution, writs of attachment or other remedial writs.

1594       (10) (a) To further the provisions of Section  
1595 43-13-117(A)(18), the Division of Medicaid shall submit to the  
1596 Centers for Medicare and Medicaid Services (CMS) any documents  
1597 regarding the hospital assessment established under subsection (4)  
1598 of this section. In addition to defining the assessment  
1599 established in subsection (4) of this section if necessary, the  
1600 documents shall describe any supplement payment programs and/or  
1601 payment methodologies as authorized in Section 43-13-117(A)(18) if  
1602 necessary.



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

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

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

(13) \* \* \* Payment.

(a) The hospital assessment as described in subsection (4) for the nonfederal share necessary to maximize the Medicare Upper Payments Limits (UPL) Program payments and hospital access payments and such other supplemental payments as may be developed





1628 pursuant to Section 43-3-117(A) (18) shall be assessed and  
1629 collected monthly no later than the fifteenth calendar day of each  
1630 month.

1631 (b) The hospital assessment as described in subsection  
1632 (4) for the nonfederal share necessary to maximize the  
1633 Disproportionate Share Hospital (DSH) payments shall be assessed  
1634 and collected on December 15, March 15 and June 15.

1635 (c) The annual hospital assessment and any additional  
1636 hospital assessment as described in subsection (4) shall be  
1637 assessed and collected on September 15 and on the 15th of each  
1638 month from December through June.

1639 (14) If for any reason any part of the plan for annual DSH  
1640 and supplemental payment programs to hospitals provided under  
1641 subsection (10) of this section and/or developed pursuant to  
1642 Section 43-13-117(A) (18) is not approved by CMS, the remainder of  
1643 the plan shall remain in full force and effect.

1644 (15) Nothing in this section shall prevent the Division of  
1645 Medicaid from facilitating participation in Medicaid supplemental  
1646 hospital payment programs by a hospital located in a county  
1647 contiguous to the State of Mississippi that is also authorized by  
1648 federal law to submit intergovernmental transfers (IGTs) to the  
1649 State of Mississippi to fund the state share of the hospital's  
1650 supplemental and/or MHAP payments.

1651 (16) Subsections (10) through (15) of this section shall  
1652 stand repealed on July 1, \* \* \* 2022.



1653           **SECTION 4.** Section 41-7-191, Mississippi Code of 1972, is  
1654 amended as follows:

1655           41-7-191. (1) No person shall engage in any of the  
1656 following activities without obtaining the required certificate of  
1657 need:

1658                   (a) The construction, development or other  
1659 establishment of a new health care facility, which establishment  
1660 shall include the reopening of a health care facility that has  
1661 ceased to operate for a period of sixty (60) months or more;

1662                   (b) The relocation of a health care facility or portion  
1663 thereof, or major medical equipment, unless such relocation of a  
1664 health care facility or portion thereof, or major medical  
1665 equipment, which does not involve a capital expenditure by or on  
1666 behalf of a health care facility, is within five thousand two  
1667 hundred eighty (5,280) feet from the main entrance of the health  
1668 care facility;

1669                   (c) Any change in the existing bed complement of any  
1670 health care facility through the addition or conversion of any  
1671 beds or the alteration, modernizing or refurbishing of any unit or  
1672 department in which the beds may be located; however, if a health  
1673 care facility has voluntarily delicensed some of its existing bed  
1674 complement, it may later relicense some or all of its delicensed  
1675 beds without the necessity of having to acquire a certificate of  
1676 need. The State Department of Health shall maintain a record of  
1677 the delicensing health care facility and its voluntarily



1678 delicensed beds and continue counting those beds as part of the  
1679 state's total bed count for health care planning purposes. If a  
1680 health care facility that has voluntarily delicensed some of its  
1681 beds later desires to relicense some or all of its voluntarily  
1682 delicensed beds, it shall notify the State Department of Health of  
1683 its intent to increase the number of its licensed beds. The State  
1684 Department of Health shall survey the health care facility within  
1685 thirty (30) days of that notice and, if appropriate, issue the  
1686 health care facility a new license reflecting the new contingent  
1687 of beds. However, in no event may a health care facility that has  
1688 voluntarily delicensed some of its beds be reissued a license to  
1689 operate beds in excess of its bed count before the voluntary  
1690 delicensure of some of its beds without seeking certificate of  
1691 need approval;

1692 (d) Offering of the following health services if those  
1693 services have not been provided on a regular basis by the proposed  
1694 provider of such services within the period of twelve (12) months  
1695 prior to the time such services would be offered:

- 1696 (i) Open-heart surgery services;  
1697 (ii) Cardiac catheterization services;  
1698 (iii) Comprehensive inpatient rehabilitation  
1699 services;  
1700 (iv) Licensed psychiatric services;  
1701 (v) Licensed chemical dependency services;  
1702 (vi) Radiation therapy services;



1703 (vii) Diagnostic imaging services of an invasive  
1704 nature, i.e. invasive digital angiography;  
1705 (viii) Nursing home care as defined in  
1706 subparagraphs (iv), (vi) and (viii) of Section 41-7-173(h);  
1707 (ix) Home health services;  
1708 (x) Swing-bed services;  
1709 (xi) Ambulatory surgical services;  
1710 (xii) Magnetic resonance imaging services;  
1711 (xiii) [Deleted]  
1712 (xiv) Long-term care hospital services;  
1713 (xv) Positron emission tomography (PET) services;  
1714 (e) The relocation of one or more health services from  
1715 one physical facility or site to another physical facility or  
1716 site, unless such relocation, which does not involve a capital  
1717 expenditure by or on behalf of a health care facility, (i) is to a  
1718 physical facility or site within five thousand two hundred eighty  
1719 (5,280) feet from the main entrance of the health care facility  
1720 where the health care service is located, or (ii) is the result of  
1721 an order of a court of appropriate jurisdiction or a result of  
1722 pending litigation in such court, or by order of the State  
1723 Department of Health, or by order of any other agency or legal  
1724 entity of the state, the federal government, or any political  
1725 subdivision of either, whose order is also approved by the State  
1726 Department of Health;



1727           (f) The acquisition or otherwise control of any major  
1728 medical equipment for the provision of medical services; however,  
1729 (i) the acquisition of any major medical equipment used only for  
1730 research purposes, and (ii) the acquisition of major medical  
1731 equipment to replace medical equipment for which a facility is  
1732 already providing medical services and for which the State  
1733 Department of Health has been notified before the date of such  
1734 acquisition shall be exempt from this paragraph; an acquisition  
1735 for less than fair market value must be reviewed, if the  
1736 acquisition at fair market value would be subject to review;

1737           (g) Changes of ownership of existing health care  
1738 facilities in which a notice of intent is not filed with the State  
1739 Department of Health at least thirty (30) days prior to the date  
1740 such change of ownership occurs, or a change in services or bed  
1741 capacity as prescribed in paragraph (c) or (d) of this subsection  
1742 as a result of the change of ownership; an acquisition for less  
1743 than fair market value must be reviewed, if the acquisition at  
1744 fair market value would be subject to review;

1745           (h) The change of ownership of any health care facility  
1746 defined in subparagraphs (iv), (vi) and (viii) of Section  
1747 41-7-173(h), in which a notice of intent as described in paragraph  
1748 (g) has not been filed and if the Executive Director, Division of  
1749 Medicaid, Office of the Governor, has not certified in writing  
1750 that there will be no increase in allowable costs to Medicaid from



1751 revaluation of the assets or from increased interest and  
1752 depreciation as a result of the proposed change of ownership;  
1753 (i) Any activity described in paragraphs (a) through  
1754 (h) if undertaken by any person if that same activity would  
1755 require certificate of need approval if undertaken by a health  
1756 care facility;  
1757 (j) Any capital expenditure or deferred capital  
1758 expenditure by or on behalf of a health care facility not covered  
1759 by paragraphs (a) through (h);  
1760 (k) The contracting of a health care facility as  
1761 defined in subparagraphs (i) through (viii) of Section 41-7-173(h)  
1762 to establish a home office, subunit, or branch office in the space  
1763 operated as a health care facility through a formal arrangement  
1764 with an existing health care facility as defined in subparagraph  
1765 (ix) of Section 41-7-173(h);  
1766 (l) The replacement or relocation of a health care  
1767 facility designated as a critical access hospital shall be exempt  
1768 from subsection (1) of this section so long as the critical access  
1769 hospital complies with all applicable federal law and regulations  
1770 regarding such replacement or relocation;  
1771 (m) Reopening a health care facility that has ceased to  
1772 operate for a period of sixty (60) months or more, which reopening  
1773 requires a certificate of need for the establishment of a new  
1774 health care facility.



1775           (2) The State Department of Health shall not grant approval  
1776 for or issue a certificate of need to any person proposing the new  
1777 construction of, addition to, or expansion of any health care  
1778 facility defined in subparagraphs (iv) (skilled nursing facility)  
1779 and (vi) (intermediate care facility) of Section 41-7-173(h) or  
1780 the conversion of vacant hospital beds to provide skilled or  
1781 intermediate nursing home care, except as hereinafter authorized:

1782           (a) The department may issue a certificate of need to  
1783 any person proposing the new construction of any health care  
1784 facility defined in subparagraphs (iv) and (vi) of Section  
1785 41-7-173(h) as part of a life care retirement facility, in any  
1786 county bordering on the Gulf of Mexico in which is located a  
1787 National Aeronautics and Space Administration facility, not to  
1788 exceed forty (40) beds. From and after July 1, 1999, there shall  
1789 be no prohibition or restrictions on participation in the Medicaid  
1790 program (Section 43-13-101 et seq.) for the beds in the health  
1791 care facility that were authorized under this paragraph (a).

1792           (b) The department may issue certificates of need in  
1793 Harrison County to provide skilled nursing home care for  
1794 Alzheimer's disease patients and other patients, not to exceed one  
1795 hundred fifty (150) beds. From and after July 1, 1999, there  
1796 shall be no prohibition or restrictions on participation in the  
1797 Medicaid program (Section 43-13-101 et seq.) for the beds in the  
1798 nursing facilities that were authorized under this paragraph (b).



1799 (c) The department may issue a certificate of need for  
1800 the addition to or expansion of any skilled nursing facility that  
1801 is part of an existing continuing care retirement community  
1802 located in Madison County, provided that the recipient of the  
1803 certificate of need agrees in writing that the skilled nursing  
1804 facility will not at any time participate in the Medicaid program  
1805 (Section 43-13-101 et seq.) or admit or keep any patients in the  
1806 skilled nursing facility who are participating in the Medicaid  
1807 program. This written agreement by the recipient of the  
1808 certificate of need shall be fully binding on any subsequent owner  
1809 of the skilled nursing facility, if the ownership of the facility  
1810 is transferred at any time after the issuance of the certificate  
1811 of need. Agreement that the skilled nursing facility will not  
1812 participate in the Medicaid program shall be a condition of the  
1813 issuance of a certificate of need to any person under this  
1814 paragraph (c), and if such skilled nursing facility at any time  
1815 after the issuance of the certificate of need, regardless of the  
1816 ownership of the facility, participates in the Medicaid program or  
1817 admits or keeps any patients in the facility who are participating  
1818 in the Medicaid program, the State Department of Health shall  
1819 revoke the certificate of need, if it is still outstanding, and  
1820 shall deny or revoke the license of the skilled nursing facility,  
1821 at the time that the department determines, after a hearing  
1822 complying with due process, that the facility has failed to comply  
1823 with any of the conditions upon which the certificate of need was





1824 issued, as provided in this paragraph and in the written agreement  
1825 by the recipient of the certificate of need. The total number of  
1826 beds that may be authorized under the authority of this paragraph  
1827 (c) shall not exceed sixty (60) beds.

1828 (d) The State Department of Health may issue a  
1829 certificate of need to any hospital located in DeSoto County for  
1830 the new construction of a skilled nursing facility, not to exceed  
1831 one hundred twenty (120) beds, in DeSoto County. From and after  
1832 July 1, 1999, there shall be no prohibition or restrictions on  
1833 participation in the Medicaid program (Section 43-13-101 et seq.)  
1834 for the beds in the nursing facility that were authorized under  
1835 this paragraph (d).

1836 (e) The State Department of Health may issue a  
1837 certificate of need for the construction of a nursing facility or  
1838 the conversion of beds to nursing facility beds at a personal care  
1839 facility for the elderly in Lowndes County that is owned and  
1840 operated by a Mississippi nonprofit corporation, not to exceed  
1841 sixty (60) beds. From and after July 1, 1999, there shall be no  
1842 prohibition or restrictions on participation in the Medicaid  
1843 program (Section 43-13-101 et seq.) for the beds in the nursing  
1844 facility that were authorized under this paragraph (e).

1845 (f) The State Department of Health may issue a  
1846 certificate of need for conversion of a county hospital facility  
1847 in Itawamba County to a nursing facility, not to exceed sixty (60)  
1848 beds, including any necessary construction, renovation or



1849 expansion. From and after July 1, 1999, there shall be no  
1850 prohibition or restrictions on participation in the Medicaid  
1851 program (Section 43-13-101 et seq.) for the beds in the nursing  
1852 facility that were authorized under this paragraph (f).

1853 (g) The State Department of Health may issue a  
1854 certificate of need for the construction or expansion of nursing  
1855 facility beds or the conversion of other beds to nursing facility  
1856 beds in either Hinds, Madison or Rankin County, not to exceed  
1857 sixty (60) beds. From and after July 1, 1999, there shall be no  
1858 prohibition or restrictions on participation in the Medicaid  
1859 program (Section 43-13-101 et seq.) for the beds in the nursing  
1860 facility that were authorized under this paragraph (g).

1861 (h) The State Department of Health may issue a  
1862 certificate of need for the construction or expansion of nursing  
1863 facility beds or the conversion of other beds to nursing facility  
1864 beds in either Hancock, Harrison or Jackson County, not to exceed  
1865 sixty (60) beds. From and after July 1, 1999, there shall be no  
1866 prohibition or restrictions on participation in the Medicaid  
1867 program (Section 43-13-101 et seq.) for the beds in the facility  
1868 that were authorized under this paragraph (h).

1869 (i) The department may issue a certificate of need for  
1870 the new construction of a skilled nursing facility in Leake  
1871 County, provided that the recipient of the certificate of need  
1872 agrees in writing that the skilled nursing facility will not at  
1873 any time participate in the Medicaid program (Section 43-13-101 et



1874 seq.) or admit or keep any patients in the skilled nursing  
1875 facility who are participating in the Medicaid program. This  
1876 written agreement by the recipient of the certificate of need  
1877 shall be fully binding on any subsequent owner of the skilled  
1878 nursing facility, if the ownership of the facility is transferred  
1879 at any time after the issuance of the certificate of need.  
1880 Agreement that the skilled nursing facility will not participate  
1881 in the Medicaid program shall be a condition of the issuance of a  
1882 certificate of need to any person under this paragraph (i), and if  
1883 such skilled nursing facility at any time after the issuance of  
1884 the certificate of need, regardless of the ownership of the  
1885 facility, participates in the Medicaid program or admits or keeps  
1886 any patients in the facility who are participating in the Medicaid  
1887 program, the State Department of Health shall revoke the  
1888 certificate of need, if it is still outstanding, and shall deny or  
1889 revoke the license of the skilled nursing facility, at the time  
1890 that the department determines, after a hearing complying with due  
1891 process, that the facility has failed to comply with any of the  
1892 conditions upon which the certificate of need was issued, as  
1893 provided in this paragraph and in the written agreement by the  
1894 recipient of the certificate of need. The provision of Section  
1895 41-7-193(1) regarding substantial compliance of the projection of  
1896 need as reported in the current State Health Plan is waived for  
1897 the purposes of this paragraph. The total number of nursing  
1898 facility beds that may be authorized by any certificate of need



1899 issued under this paragraph (i) shall not exceed sixty (60) beds.  
1900 If the skilled nursing facility authorized by the certificate of  
1901 need issued under this paragraph is not constructed and fully  
1902 operational within eighteen (18) months after July 1, 1994, the  
1903 State Department of Health, after a hearing complying with due  
1904 process, shall revoke the certificate of need, if it is still  
1905 outstanding, and shall not issue a license for the skilled nursing  
1906 facility at any time after the expiration of the eighteen-month  
1907 period.

1908           (j) The department may issue certificates of need to  
1909 allow any existing freestanding long-term care facility in  
1910 Tishomingo County and Hancock County that on July 1, 1995, is  
1911 licensed with fewer than sixty (60) beds. For the purposes of  
1912 this paragraph (j), the provisions of Section 41-7-193(1)  
1913 requiring substantial compliance with the projection of need as  
1914 reported in the current State Health Plan are waived. From and  
1915 after July 1, 1999, there shall be no prohibition or restrictions  
1916 on participation in the Medicaid program (Section 43-13-101 et  
1917 seq.) for the beds in the long-term care facilities that were  
1918 authorized under this paragraph (j).

1919           (k) The department may issue a certificate of need for  
1920 the construction of a nursing facility at a continuing care  
1921 retirement community in Lowndes County. The total number of beds  
1922 that may be authorized under the authority of this paragraph (k)  
1923 shall not exceed sixty (60) beds. From and after July 1, 2001,



1924 the prohibition on the facility participating in the Medicaid  
1925 program (Section 43-13-101 et seq.) that was a condition of  
1926 issuance of the certificate of need under this paragraph (k) shall  
1927 be revised as follows: The nursing facility may participate in  
1928 the Medicaid program from and after July 1, 2001, if the owner of  
1929 the facility on July 1, 2001, agrees in writing that no more than  
1930 thirty (30) of the beds at the facility will be certified for  
1931 participation in the Medicaid program, and that no claim will be  
1932 submitted for Medicaid reimbursement for more than thirty (30)  
1933 patients in the facility in any month or for any patient in the  
1934 facility who is in a bed that is not Medicaid-certified. This  
1935 written agreement by the owner of the facility shall be a  
1936 condition of licensure of the facility, and the agreement shall be  
1937 fully binding on any subsequent owner of the facility if the  
1938 ownership of the facility is transferred at any time after July 1,  
1939 2001. After this written agreement is executed, the Division of  
1940 Medicaid and the State Department of Health shall not certify more  
1941 than thirty (30) of the beds in the facility for participation in  
1942 the Medicaid program. If the facility violates the terms of the  
1943 written agreement by admitting or keeping in the facility on a  
1944 regular or continuing basis more than thirty (30) patients who are  
1945 participating in the Medicaid program, the State Department of  
1946 Health shall revoke the license of the facility, at the time that  
1947 the department determines, after a hearing complying with due  
1948 process, that the facility has violated the written agreement.



1949                   (1) Provided that funds are specifically appropriated  
1950 therefor by the Legislature, the department may issue a  
1951 certificate of need to a rehabilitation hospital in Hinds County  
1952 for the construction of a sixty-bed long-term care nursing  
1953 facility dedicated to the care and treatment of persons with  
1954 severe disabilities including persons with spinal cord and  
1955 closed-head injuries and ventilator dependent patients. The  
1956 provisions of Section 41-7-193(1) regarding substantial compliance  
1957 with projection of need as reported in the current State Health  
1958 Plan are waived for the purpose of this paragraph.

1959                   (m) The State Department of Health may issue a  
1960 certificate of need to a county-owned hospital in the Second  
1961 Judicial District of Panola County for the conversion of not more  
1962 than seventy-two (72) hospital beds to nursing facility beds,  
1963 provided that the recipient of the certificate of need agrees in  
1964 writing that none of the beds at the nursing facility will be  
1965 certified for participation in the Medicaid program (Section  
1966 43-13-101 et seq.), and that no claim will be submitted for  
1967 Medicaid reimbursement in the nursing facility in any day or for  
1968 any patient in the nursing facility. This written agreement by  
1969 the recipient of the certificate of need shall be a condition of  
1970 the issuance of the certificate of need under this paragraph, and  
1971 the agreement shall be fully binding on any subsequent owner of  
1972 the nursing facility if the ownership of the nursing facility is  
1973 transferred at any time after the issuance of the certificate of



1974 need. After this written agreement is executed, the Division of  
1975 Medicaid and the State Department of Health shall not certify any  
1976 of the beds in the nursing facility for participation in the  
1977 Medicaid program. If the nursing facility violates the terms of  
1978 the written agreement by admitting or keeping in the nursing  
1979 facility on a regular or continuing basis any patients who are  
1980 participating in the Medicaid program, the State Department of  
1981 Health shall revoke the license of the nursing facility, at the  
1982 time that the department determines, after a hearing complying  
1983 with due process, that the nursing facility has violated the  
1984 condition upon which the certificate of need was issued, as  
1985 provided in this paragraph and in the written agreement. If the  
1986 certificate of need authorized under this paragraph is not issued  
1987 within twelve (12) months after July 1, 2001, the department shall  
1988 deny the application for the certificate of need and shall not  
1989 issue the certificate of need at any time after the twelve-month  
1990 period, unless the issuance is contested. If the certificate of  
1991 need is issued and substantial construction of the nursing  
1992 facility beds has not commenced within eighteen (18) months after  
1993 July 1, 2001, the State Department of Health, after a hearing  
1994 complying with due process, shall revoke the certificate of need  
1995 if it is still outstanding, and the department shall not issue a  
1996 license for the nursing facility at any time after the  
1997 eighteen-month period. However, if the issuance of the  
1998 certificate of need is contested, the department shall require



1999 substantial construction of the nursing facility beds within six  
2000 (6) months after final adjudication on the issuance of the  
2001 certificate of need.

2002 (n) The department may issue a certificate of need for  
2003 the new construction, addition or conversion of skilled nursing  
2004 facility beds in Madison County, provided that the recipient of  
2005 the certificate of need agrees in writing that the skilled nursing  
2006 facility will not at any time participate in the Medicaid program  
2007 (Section 43-13-101 et seq.) or admit or keep any patients in the  
2008 skilled nursing facility who are participating in the Medicaid  
2009 program. This written agreement by the recipient of the  
2010 certificate of need shall be fully binding on any subsequent owner  
2011 of the skilled nursing facility, if the ownership of the facility  
2012 is transferred at any time after the issuance of the certificate  
2013 of need. Agreement that the skilled nursing facility will not  
2014 participate in the Medicaid program shall be a condition of the  
2015 issuance of a certificate of need to any person under this  
2016 paragraph (n), and if such skilled nursing facility at any time  
2017 after the issuance of the certificate of need, regardless of the  
2018 ownership of the facility, participates in the Medicaid program or  
2019 admits or keeps any patients in the facility who are participating  
2020 in the Medicaid program, the State Department of Health shall  
2021 revoke the certificate of need, if it is still outstanding, and  
2022 shall deny or revoke the license of the skilled nursing facility,  
2023 at the time that the department determines, after a hearing





2024 complying with due process, that the facility has failed to comply  
2025 with any of the conditions upon which the certificate of need was  
2026 issued, as provided in this paragraph and in the written agreement  
2027 by the recipient of the certificate of need. The total number of  
2028 nursing facility beds that may be authorized by any certificate of  
2029 need issued under this paragraph (n) shall not exceed sixty (60)  
2030 beds. If the certificate of need authorized under this paragraph  
2031 is not issued within twelve (12) months after July 1, 1998, the  
2032 department shall deny the application for the certificate of need  
2033 and shall not issue the certificate of need at any time after the  
2034 twelve-month period, unless the issuance is contested. If the  
2035 certificate of need is issued and substantial construction of the  
2036 nursing facility beds has not commenced within eighteen (18)  
2037 months after July 1, 1998, the State Department of Health, after a  
2038 hearing complying with due process, shall revoke the certificate  
2039 of need if it is still outstanding, and the department shall not  
2040 issue a license for the nursing facility at any time after the  
2041 eighteen-month period. However, if the issuance of the  
2042 certificate of need is contested, the department shall require  
2043 substantial construction of the nursing facility beds within six  
2044 (6) months after final adjudication on the issuance of the  
2045 certificate of need.

2046           (o) The department may issue a certificate of need for  
2047 the new construction, addition or conversion of skilled nursing  
2048 facility beds in Leake County, provided that the recipient of the



2049 certificate of need agrees in writing that the skilled nursing  
2050 facility will not at any time participate in the Medicaid program  
2051 (Section 43-13-101 et seq.) or admit or keep any patients in the  
2052 skilled nursing facility who are participating in the Medicaid  
2053 program. This written agreement by the recipient of the  
2054 certificate of need shall be fully binding on any subsequent owner  
2055 of the skilled nursing facility, if the ownership of the facility  
2056 is transferred at any time after the issuance of the certificate  
2057 of need. Agreement that the skilled nursing facility will not  
2058 participate in the Medicaid program shall be a condition of the  
2059 issuance of a certificate of need to any person under this  
2060 paragraph (o), and if such skilled nursing facility at any time  
2061 after the issuance of the certificate of need, regardless of the  
2062 ownership of the facility, participates in the Medicaid program or  
2063 admits or keeps any patients in the facility who are participating  
2064 in the Medicaid program, the State Department of Health shall  
2065 revoke the certificate of need, if it is still outstanding, and  
2066 shall deny or revoke the license of the skilled nursing facility,  
2067 at the time that the department determines, after a hearing  
2068 complying with due process, that the facility has failed to comply  
2069 with any of the conditions upon which the certificate of need was  
2070 issued, as provided in this paragraph and in the written agreement  
2071 by the recipient of the certificate of need. The total number of  
2072 nursing facility beds that may be authorized by any certificate of  
2073 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



2099 shall be fully binding on any subsequent owner of the skilled  
2100 nursing facility, if the ownership of the facility is transferred  
2101 at any time after the issuance of the certificate of need.  
2102 Agreement that the skilled nursing facility will not participate  
2103 in the Medicaid program shall be a condition of the issuance of a  
2104 certificate of need to any person under this paragraph (p), and if  
2105 such skilled nursing facility at any time after the issuance of  
2106 the certificate of need, regardless of the ownership of the  
2107 facility, participates in the Medicaid program or admits or keeps  
2108 any patients in the facility who are participating in the Medicaid  
2109 program, the State Department of Health shall revoke the  
2110 certificate of need, if it is still outstanding, and shall deny or  
2111 revoke the license of the skilled nursing facility, at the time  
2112 that the department determines, after a hearing complying with due  
2113 process, that the facility has failed to comply with any of the  
2114 conditions upon which the certificate of need was issued, as  
2115 provided in this paragraph and in the written agreement by the  
2116 recipient of the certificate of need. The provision of Section  
2117 41-7-193(1) regarding substantial compliance of the projection of  
2118 need as reported in the current State Health Plan is waived for  
2119 the purposes of this paragraph. If the certificate of need  
2120 authorized under this paragraph is not issued within twelve (12)  
2121 months after July 1, 1998, the department shall deny the  
2122 application for the certificate of need and shall not issue the  
2123 certificate of need at any time after the twelve-month period,



2124 unless the issuance is contested. If the certificate of need is  
2125 issued and substantial construction of the nursing facility beds  
2126 has not commenced within eighteen (18) months after July 1, 1998,  
2127 the State Department of Health, after a hearing complying with due  
2128 process, shall revoke the certificate of need if it is still  
2129 outstanding, and the department shall not issue a license for the  
2130 nursing facility at any time after the eighteen-month period.  
2131 However, if the issuance of the certificate of need is contested,  
2132 the department shall require substantial construction of the  
2133 nursing facility beds within six (6) months after final  
2134 adjudication on the issuance of the certificate of need.

2135 (q) (i) Beginning on July 1, 1999, the State  
2136 Department of Health shall issue certificates of need during each  
2137 of the next four (4) fiscal years for the construction or  
2138 expansion of nursing facility beds or the conversion of other beds  
2139 to nursing facility beds in each county in the state having a need  
2140 for fifty (50) or more additional nursing facility beds, as shown  
2141 in the fiscal year 1999 State Health Plan, in the manner provided  
2142 in this paragraph (q). The total number of nursing facility beds  
2143 that may be authorized by any certificate of need authorized under  
2144 this paragraph (q) shall not exceed sixty (60) beds.

2145 (ii) Subject to the provisions of subparagraph  
2146 (v), during each of the next four (4) fiscal years, the department  
2147 shall issue six (6) certificates of need for new nursing facility  
2148 beds, as follows: During fiscal years 2000, 2001 and 2002, one



2149 (1) certificate of need shall be issued for new nursing facility  
2150 beds in the county in each of the four (4) Long-Term Care Planning  
2151 Districts designated in the fiscal year 1999 State Health Plan  
2152 that has the highest need in the district for those beds; and two  
2153 (2) certificates of need shall be issued for new nursing facility  
2154 beds in the two (2) counties from the state at large that have the  
2155 highest need in the state for those beds, when considering the  
2156 need on a statewide basis and without regard to the Long-Term Care  
2157 Planning Districts in which the counties are located. During  
2158 fiscal year 2003, one (1) certificate of need shall be issued for  
2159 new nursing facility beds in any county having a need for fifty  
2160 (50) or more additional nursing facility beds, as shown in the  
2161 fiscal year 1999 State Health Plan, that has not received a  
2162 certificate of need under this paragraph (q) during the three (3)  
2163 previous fiscal years. During fiscal year 2000, in addition to  
2164 the six (6) certificates of need authorized in this subparagraph,  
2165 the department also shall issue a certificate of need for new  
2166 nursing facility beds in Amite County and a certificate of need  
2167 for new nursing facility beds in Carroll County.

2168 (iii) Subject to the provisions of subparagraph  
2169 (v), the certificate of need issued under subparagraph (ii) for  
2170 nursing facility beds in each Long-Term Care Planning District  
2171 during each fiscal year shall first be available for nursing  
2172 facility beds in the county in the district having the highest  
2173 need for those beds, as shown in the fiscal year 1999 State Health



2174 Plan. If there are no applications for a certificate of need for  
2175 nursing facility beds in the county having the highest need for  
2176 those beds by the date specified by the department, then the  
2177 certificate of need shall be available for nursing facility beds  
2178 in other counties in the district in descending order of the need  
2179 for those beds, from the county with the second highest need to  
2180 the county with the lowest need, until an application is received  
2181 for nursing facility beds in an eligible county in the district.

2182 (iv) Subject to the provisions of subparagraph  
2183 (v), the certificate of need issued under subparagraph (ii) for  
2184 nursing facility beds in the two (2) counties from the state at  
2185 large during each fiscal year shall first be available for nursing  
2186 facility beds in the two (2) counties that have the highest need  
2187 in the state for those beds, as shown in the fiscal year 1999  
2188 State Health Plan, when considering the need on a statewide basis  
2189 and without regard to the Long-Term Care Planning Districts in  
2190 which the counties are located. If there are no applications for  
2191 a certificate of need for nursing facility beds in either of the  
2192 two (2) counties having the highest need for those beds on a  
2193 statewide basis by the date specified by the department, then the  
2194 certificate of need shall be available for nursing facility beds  
2195 in other counties from the state at large in descending order of  
2196 the need for those beds on a statewide basis, from the county with  
2197 the second highest need to the county with the lowest need, until



2198 an application is received for nursing facility beds in an  
2199 eligible county from the state at large.

2200 (v) If a certificate of need is authorized to be  
2201 issued under this paragraph (q) for nursing facility beds in a  
2202 county on the basis of the need in the Long-Term Care Planning  
2203 District during any fiscal year of the four-year period, a  
2204 certificate of need shall not also be available under this  
2205 paragraph (q) for additional nursing facility beds in that county  
2206 on the basis of the need in the state at large, and that county  
2207 shall be excluded in determining which counties have the highest  
2208 need for nursing facility beds in the state at large for that  
2209 fiscal year. After a certificate of need has been issued under  
2210 this paragraph (q) for nursing facility beds in a county during  
2211 any fiscal year of the four-year period, a certificate of need  
2212 shall not be available again under this paragraph (q) for  
2213 additional nursing facility beds in that county during the  
2214 four-year period, and that county shall be excluded in determining  
2215 which counties have the highest need for nursing facility beds in  
2216 succeeding fiscal years.

2217 (vi) If more than one (1) application is made for  
2218 a certificate of need for nursing home facility beds available  
2219 under this paragraph (q), in Yalobusha, Newton or Tallahatchie  
2220 County, and one (1) of the applicants is a county-owned hospital  
2221 located in the county where the nursing facility beds are  
2222 available, the department shall give priority to the county-owned





2223 hospital in granting the certificate of need if the following  
2224 conditions are met:

2225                   1. The county-owned hospital fully meets all  
2226 applicable criteria and standards required to obtain a certificate  
2227 of need for the nursing facility beds; and

2228                   2. The county-owned hospital's qualifications  
2229 for the certificate of need, as shown in its application and as  
2230 determined by the department, are at least equal to the  
2231 qualifications of the other applicants for the certificate of  
2232 need.

2233                   (r) (i) Beginning on July 1, 1999, the State  
2234 Department of Health shall issue certificates of need during each  
2235 of the next two (2) fiscal years for the construction or expansion  
2236 of nursing facility beds or the conversion of other beds to  
2237 nursing facility beds in each of the four (4) Long-Term Care  
2238 Planning Districts designated in the fiscal year 1999 State Health  
2239 Plan, to provide care exclusively to patients with Alzheimer's  
2240 disease.

2241                   (ii) Not more than twenty (20) beds may be  
2242 authorized by any certificate of need issued under this paragraph  
2243 (r), and not more than a total of sixty (60) beds may be  
2244 authorized in any Long-Term Care Planning District by all  
2245 certificates of need issued under this paragraph (r). However,  
2246 the total number of beds that may be authorized by all  
2247 certificates of need issued under this paragraph (r) during any



2248 fiscal year shall not exceed one hundred twenty (120) beds, and  
2249 the total number of beds that may be authorized in any Long-Term  
2250 Care Planning District during any fiscal year shall not exceed  
2251 forty (40) beds. Of the certificates of need that are issued for  
2252 each Long-Term Care Planning District during the next two (2)  
2253 fiscal years, at least one (1) shall be issued for beds in the  
2254 northern part of the district, at least one (1) shall be issued  
2255 for beds in the central part of the district, and at least one (1)  
2256 shall be issued for beds in the southern part of the district.

2257 (iii) The State Department of Health, in  
2258 consultation with the Department of Mental Health and the Division  
2259 of Medicaid, shall develop and prescribe the staffing levels,  
2260 space requirements and other standards and requirements that must  
2261 be met with regard to the nursing facility beds authorized under  
2262 this paragraph (r) to provide care exclusively to patients with  
2263 Alzheimer's disease.

2264 (s) The State Department of Health may issue a  
2265 certificate of need to a nonprofit skilled nursing facility using  
2266 the Green House model of skilled nursing care and located in Yazoo  
2267 City, Yazoo County, Mississippi, for the construction, expansion  
2268 or conversion of not more than nineteen (19) nursing facility  
2269 beds. For purposes of this paragraph (s), the provisions of  
2270 Section 41-7-193(1) requiring substantial compliance with the  
2271 projection of need as reported in the current State Health Plan  
2272 and the provisions of Section 41-7-197 requiring a formal



2273 certificate of need hearing process are waived. There shall be no  
2274 prohibition or restrictions on participation in the Medicaid  
2275 program for the person receiving the certificate of need  
2276 authorized under this paragraph (s).

2277 (t) The State Department of Health shall issue  
2278 certificates of need to the owner of a nursing facility in  
2279 operation at the time of Hurricane Katrina in Hancock County that  
2280 was not operational on December 31, 2005, because of damage  
2281 sustained from Hurricane Katrina to authorize the following: (i)  
2282 the construction of a new nursing facility in Harrison County;  
2283 (ii) the relocation of forty-nine (49) nursing facility beds from  
2284 the Hancock County facility to the new Harrison County facility;  
2285 (iii) the establishment of not more than twenty (20) non-Medicaid  
2286 nursing facility beds at the Hancock County facility; and (iv) the  
2287 establishment of not more than twenty (20) non-Medicaid beds at  
2288 the new Harrison County facility. The certificates of need that  
2289 authorize the non-Medicaid nursing facility beds under  
2290 subparagraphs (iii) and (iv) of this paragraph (t) shall be  
2291 subject to the following conditions: The owner of the Hancock  
2292 County facility and the new Harrison County facility must agree in  
2293 writing that no more than fifty (50) of the beds at the Hancock  
2294 County facility and no more than forty-nine (49) of the beds at  
2295 the Harrison County facility will be certified for participation  
2296 in the Medicaid program, and that no claim will be submitted for  
2297 Medicaid reimbursement for more than fifty (50) patients in the



2298 Hancock County facility in any month, or for more than forty-nine  
2299 (49) patients in the Harrison County facility in any month, or for  
2300 any patient in either facility who is in a bed that is not  
2301 Medicaid-certified. This written agreement by the owner of the  
2302 nursing facilities shall be a condition of the issuance of the  
2303 certificates of need under this paragraph (t), and the agreement  
2304 shall be fully binding on any later owner or owners of either  
2305 facility if the ownership of either facility is transferred at any  
2306 time after the certificates of need are issued. After this  
2307 written agreement is executed, the Division of Medicaid and the  
2308 State Department of Health shall not certify more than fifty (50)  
2309 of the beds at the Hancock County facility or more than forty-nine  
2310 (49) of the beds at the Harrison County facility for participation  
2311 in the Medicaid program. If the Hancock County facility violates  
2312 the terms of the written agreement by admitting or keeping in the  
2313 facility on a regular or continuing basis more than fifty (50)  
2314 patients who are participating in the Medicaid program, or if the  
2315 Harrison County facility violates the terms of the written  
2316 agreement by admitting or keeping in the facility on a regular or  
2317 continuing basis more than forty-nine (49) patients who are  
2318 participating in the Medicaid program, the State Department of  
2319 Health shall revoke the license of the facility that is in  
2320 violation of the agreement, at the time that the department  
2321 determines, after a hearing complying with due process, that the  
2322 facility has violated the agreement.



2323           (u) The State Department of Health shall issue a  
2324 certificate of need to a nonprofit venture for the establishment,  
2325 construction and operation of a skilled nursing facility of not  
2326 more than sixty (60) beds to provide skilled nursing care for  
2327 ventilator dependent or otherwise medically dependent pediatric  
2328 patients who require medical and nursing care or rehabilitation  
2329 services to be located in a county in which an academic medical  
2330 center and a children's hospital are located, and for any  
2331 construction and for the acquisition of equipment related to those  
2332 beds. The facility shall be authorized to keep such ventilator  
2333 dependent or otherwise medically dependent pediatric patients  
2334 beyond age twenty-one (21) in accordance with regulations of the  
2335 State Board of Health. For purposes of this paragraph (u), the  
2336 provisions of Section 41-7-193(1) requiring substantial compliance  
2337 with the projection of need as reported in the current State  
2338 Health Plan are waived, and the provisions of Section 41-7-197  
2339 requiring a formal certificate of need hearing process are waived.  
2340 The beds authorized by this paragraph shall be counted as  
2341 pediatric skilled nursing facility beds for health planning  
2342 purposes under Section 41-7-171 et seq. There shall be no  
2343 prohibition of or restrictions on participation in the Medicaid  
2344 program for the person receiving the certificate of need  
2345 authorized by this paragraph.

2346           (3) The State Department of Health may grant approval for  
2347 and issue certificates of need to any person proposing the new



2348 construction of, addition to, conversion of beds of or expansion  
2349 of any health care facility defined in subparagraph (x)  
2350 (psychiatric residential treatment facility) of Section  
2351 41-7-173(h). The total number of beds which may be authorized by  
2352 such certificates of need shall not exceed three hundred  
2353 thirty-four (334) beds for the entire state.

2354 (a) Of the total number of beds authorized under this  
2355 subsection, the department shall issue a certificate of need to a  
2356 privately owned psychiatric residential treatment facility in  
2357 Simpson County for the conversion of sixteen (16) intermediate  
2358 care facility for the mentally retarded (ICF-MR) beds to  
2359 psychiatric residential treatment facility beds, provided that  
2360 facility agrees in writing that the facility shall give priority  
2361 for the use of those sixteen (16) beds to Mississippi residents  
2362 who are presently being treated in out-of-state facilities.

2363 (b) Of the total number of beds authorized under this  
2364 subsection, the department may issue a certificate or certificates  
2365 of need for the construction or expansion of psychiatric  
2366 residential treatment facility beds or the conversion of other  
2367 beds to psychiatric residential treatment facility beds in Warren  
2368 County, not to exceed sixty (60) psychiatric residential treatment  
2369 facility beds, provided that the facility agrees in writing that  
2370 no more than thirty (30) of the beds at the psychiatric  
2371 residential treatment facility will be certified for participation  
2372 in the Medicaid program (Section 43-13-101 et seq.) for the use of



2373 any patients other than those who are participating only in the  
2374 Medicaid program of another state, and that no claim will be  
2375 submitted to the Division of Medicaid for Medicaid reimbursement  
2376 for more than thirty (30) patients in the psychiatric residential  
2377 treatment facility in any day or for any patient in the  
2378 psychiatric residential treatment facility who is in a bed that is  
2379 not Medicaid-certified. This written agreement by the recipient  
2380 of the certificate of need shall be a condition of the issuance of  
2381 the certificate of need under this paragraph, and the agreement  
2382 shall be fully binding on any subsequent owner of the psychiatric  
2383 residential treatment facility if the ownership of the facility is  
2384 transferred at any time after the issuance of the certificate of  
2385 need. After this written agreement is executed, the Division of  
2386 Medicaid and the State Department of Health shall not certify more  
2387 than thirty (30) of the beds in the psychiatric residential  
2388 treatment facility for participation in the Medicaid program for  
2389 the use of any patients other than those who are participating  
2390 only in the Medicaid program of another state. If the psychiatric  
2391 residential treatment facility violates the terms of the written  
2392 agreement by admitting or keeping in the facility on a regular or  
2393 continuing basis more than thirty (30) patients who are  
2394 participating in the Mississippi Medicaid program, the State  
2395 Department of Health shall revoke the license of the facility, at  
2396 the time that the department determines, after a hearing complying  
2397 with due process, that the facility has violated the condition



2398 upon which the certificate of need was issued, as provided in this  
2399 paragraph and in the written agreement.

2400 The State Department of Health, on or before July 1, 2002,  
2401 shall transfer the certificate of need authorized under the  
2402 authority of this paragraph (b), or reissue the certificate of  
2403 need if it has expired, to River Region Health System.

2404 (c) Of the total number of beds authorized under this  
2405 subsection, the department shall issue a certificate of need to a  
2406 hospital currently operating Medicaid-certified acute psychiatric  
2407 beds for adolescents in DeSoto County, for the establishment of a  
2408 forty-bed psychiatric residential treatment facility in DeSoto  
2409 County, provided that the hospital agrees in writing (i) that the  
2410 hospital shall give priority for the use of those forty (40) beds  
2411 to Mississippi residents who are presently being treated in  
2412 out-of-state facilities, and (ii) that no more than fifteen (15)  
2413 of the beds at the psychiatric residential treatment facility will  
2414 be certified for participation in the Medicaid program (Section  
2415 43-13-101 et seq.), and that no claim will be submitted for  
2416 Medicaid reimbursement for more than fifteen (15) patients in the  
2417 psychiatric residential treatment facility in any day or for any  
2418 patient in the psychiatric residential treatment facility who is  
2419 in a bed that is not Medicaid-certified. This written agreement  
2420 by the recipient of the certificate of need shall be a condition  
2421 of the issuance of the certificate of need under this paragraph,  
2422 and the agreement shall be fully binding on any subsequent owner





2423 of the psychiatric residential treatment facility if the ownership  
2424 of the facility is transferred at any time after the issuance of  
2425 the certificate of need. After this written agreement is  
2426 executed, the Division of Medicaid and the State Department of  
2427 Health shall not certify more than fifteen (15) of the beds in the  
2428 psychiatric residential treatment facility for participation in  
2429 the Medicaid program. If the psychiatric residential treatment  
2430 facility violates the terms of the written agreement by admitting  
2431 or keeping in the facility on a regular or continuing basis more  
2432 than fifteen (15) patients who are participating in the Medicaid  
2433 program, the State Department of Health shall revoke the license  
2434 of the facility, at the time that the department determines, after  
2435 a hearing complying with due process, that the facility has  
2436 violated the condition upon which the certificate of need was  
2437 issued, as provided in this paragraph and in the written  
2438 agreement.

2439 (d) Of the total number of beds authorized under this  
2440 subsection, the department may issue a certificate or certificates  
2441 of need for the construction or expansion of psychiatric  
2442 residential treatment facility beds or the conversion of other  
2443 beds to psychiatric treatment facility beds, not to exceed thirty  
2444 (30) psychiatric residential treatment facility beds, in either  
2445 Alcorn, Tishomingo, Prentiss, Lee, Itawamba, Monroe, Chickasaw,  
2446 Pontotoc, Calhoun, Lafayette, Union, Benton or Tippah County.



2447           (e) Of the total number of beds authorized under this  
2448 subsection (3) the department shall issue a certificate of need to  
2449 a privately owned, nonprofit psychiatric residential treatment  
2450 facility in Hinds County for an eight-bed expansion of the  
2451 facility, provided that the facility agrees in writing that the  
2452 facility shall give priority for the use of those eight (8) beds  
2453 to Mississippi residents who are presently being treated in  
2454 out-of-state facilities.

2455           (f) The department shall issue a certificate of need to  
2456 a one-hundred-thirty-four-bed specialty hospital located on  
2457 twenty-nine and forty-four one-hundredths (29.44) commercial acres  
2458 at 5900 Highway 39 North in Meridian (Lauderdale County),  
2459 Mississippi, for the addition, construction or expansion of  
2460 child/adolescent psychiatric residential treatment facility beds  
2461 in Lauderdale County. As a condition of issuance of the  
2462 certificate of need under this paragraph, the facility shall give  
2463 priority in admissions to the child/adolescent psychiatric  
2464 residential treatment facility beds authorized under this  
2465 paragraph to patients who otherwise would require out-of-state  
2466 placement. The Division of Medicaid, in conjunction with the  
2467 Department of Human Services, shall furnish the facility a list of  
2468 all out-of-state patients on a quarterly basis. Furthermore,  
2469 notice shall also be provided to the parent, custodial parent or  
2470 guardian of each out-of-state patient notifying them of the  
2471 priority status granted by this paragraph. For purposes of this



2472 paragraph, the provisions of Section 41-7-193(1) requiring  
2473 substantial compliance with the projection of need as reported in  
2474 the current State Health Plan are waived. The total number of  
2475 child/adolescent psychiatric residential treatment facility beds  
2476 that may be authorized under the authority of this paragraph shall  
2477 be sixty (60) beds. There shall be no prohibition or restrictions  
2478 on participation in the Medicaid program (Section 43-13-101 et  
2479 seq.) for the person receiving the certificate of need authorized  
2480 under this paragraph or for the beds converted pursuant to the  
2481 authority of that certificate of need.

2482 (4) (a) From and after \* \* \* passage of this act, the  
2483 department \* \* \* may issue a certificate of need to any person for  
2484 the new construction of any hospital, psychiatric hospital or  
2485 chemical dependency hospital that will contain any  
2486 child/adolescent psychiatric or child/adolescent chemical  
2487 dependency beds, or for the conversion of any other health care  
2488 facility to a hospital, psychiatric hospital or chemical  
2489 dependency hospital that will contain any child/adolescent  
2490 psychiatric or child/adolescent chemical dependency beds, or for  
2491 the addition of any child/adolescent psychiatric or  
2492 child/adolescent chemical dependency beds in any hospital,  
2493 psychiatric hospital or chemical dependency hospital, or for the  
2494 conversion of any beds of another category in any hospital,  
2495 psychiatric hospital or chemical dependency hospital to  
2496 child/adolescent psychiatric or child/adolescent chemical



2497 dependency beds. There shall be no prohibition or restrictions on  
2498 participation in the Medicaid program (Section 43-13-101 et seq.)  
2499 for the person(s) receiving the certificate(s) of need authorized  
2500 under this paragraph (a) or for the beds converted pursuant to the  
2501 authority of that certificate of need.

2502 (i) \* \* \* (Deleted)

2503 (ii) The department may issue a certificate of  
2504 need for the conversion of existing beds in a county hospital in  
2505 Choctaw County from acute care beds to child/adolescent chemical  
2506 dependency beds. For purposes of this subparagraph (ii), the  
2507 provisions of Section 41-7-193(1) requiring substantial compliance  
2508 with the projection of need as reported in the current State  
2509 Health Plan are waived. The total number of beds that may be  
2510 authorized under authority of this subparagraph shall not exceed  
2511 twenty (20) beds. There shall be no prohibition or restrictions  
2512 on participation in the Medicaid program (Section 43-13-101 et  
2513 seq.) for the hospital receiving the certificate of need  
2514 authorized under this subparagraph or for the beds converted  
2515 pursuant to the authority of that certificate of need.

2516 (iii) The department may issue a certificate or  
2517 certificates of need for the construction or expansion of  
2518 child/adolescent psychiatric beds or the conversion of other beds  
2519 to child/adolescent psychiatric beds in Warren County. For  
2520 purposes of this subparagraph (iii), the provisions of Section  
2521 41-7-193(1) requiring substantial compliance with the projection



2522 of need as reported in the current State Health Plan are waived.  
2523 The total number of beds that may be authorized under the  
2524 authority of this subparagraph shall not exceed twenty (20) beds.  
2525 There shall be no prohibition or restrictions on participation in  
2526 the Medicaid program (Section 43-13-101 et seq.) for the person  
2527 receiving the certificate of need authorized under this  
2528 subparagraph or for the beds converted pursuant to the authority  
2529 of that certificate of need.

2530       If by January 1, 2002, there has been no significant  
2531 commencement of construction of the beds authorized under this  
2532 subparagraph (iii), or no significant action taken to convert  
2533 existing beds to the beds authorized under this subparagraph, then  
2534 the certificate of need that was previously issued under this  
2535 subparagraph shall expire. If the previously issued certificate  
2536 of need expires, the department may accept applications for  
2537 issuance of another certificate of need for the beds authorized  
2538 under this subparagraph, and may issue a certificate of need to  
2539 authorize the construction, expansion or conversion of the beds  
2540 authorized under this subparagraph.

2541               (iv) The department shall issue a certificate of  
2542 need to the Region 7 Mental Health/Retardation Commission for the  
2543 construction or expansion of child/adolescent psychiatric beds or  
2544 the conversion of other beds to child/adolescent psychiatric beds  
2545 in any of the counties served by the commission. For purposes of  
2546 this subparagraph (iv), the provisions of Section 41-7-193(1)



2547 requiring substantial compliance with the projection of need as  
2548 reported in the current State Health Plan are waived. The total  
2549 number of beds that may be authorized under the authority of this  
2550 subparagraph shall not exceed twenty (20) beds. There shall be no  
2551 prohibition or restrictions on participation in the Medicaid  
2552 program (Section 43-13-101 et seq.) for the person receiving the  
2553 certificate of need authorized under this subparagraph or for the  
2554 beds converted pursuant to the authority of that certificate of  
2555 need.

2556 (v) The department may issue a certificate of need  
2557 to any county hospital located in Leflore County for the  
2558 construction or expansion of adult psychiatric beds or the  
2559 conversion of other beds to adult psychiatric beds, not to exceed  
2560 twenty (20) beds, provided that the recipient of the certificate  
2561 of need agrees in writing that the adult psychiatric beds will not  
2562 at any time be certified for participation in the Medicaid program  
2563 and that the hospital will not admit or keep any patients who are  
2564 participating in the Medicaid program in any of such adult  
2565 psychiatric beds. This written agreement by the recipient of the  
2566 certificate of need shall be fully binding on any subsequent owner  
2567 of the hospital if the ownership of the hospital is transferred at  
2568 any time after the issuance of the certificate of need. Agreement  
2569 that the adult psychiatric beds will not be certified for  
2570 participation in the Medicaid program shall be a condition of the  
2571 issuance of a certificate of need to any person under this



2572 subparagraph (v), and if such hospital at any time after the  
2573 issuance of the certificate of need, regardless of the ownership  
2574 of the hospital, has any of such adult psychiatric beds certified  
2575 for participation in the Medicaid program or admits or keeps any  
2576 Medicaid patients in such adult psychiatric beds, the State  
2577 Department of Health shall revoke the certificate of need, if it  
2578 is still outstanding, and shall deny or revoke the license of the  
2579 hospital at the time that the department determines, after a  
2580 hearing complying with due process, that the hospital has failed  
2581 to comply with any of the conditions upon which the certificate of  
2582 need was issued, as provided in this subparagraph and in the  
2583 written agreement by the recipient of the certificate of need.

2584                   (vi) The department may issue a certificate or  
2585 certificates of need for the expansion of child psychiatric beds  
2586 or the conversion of other beds to child psychiatric beds at the  
2587 University of Mississippi Medical Center. For purposes of this  
2588 subparagraph (vi), the provisions of Section 41-7-193(1) requiring  
2589 substantial compliance with the projection of need as reported in  
2590 the current State Health Plan are waived. The total number of  
2591 beds that may be authorized under the authority of this  
2592 subparagraph shall not exceed fifteen (15) beds. There shall be  
2593 no prohibition or restrictions on participation in the Medicaid  
2594 program (Section 43-13-101 et seq.) for the hospital receiving the  
2595 certificate of need authorized under this subparagraph or for the



2596 beds converted pursuant to the authority of that certificate of  
2597 need.

2598 (b) From and after July 1, 1990, no hospital,  
2599 psychiatric hospital or chemical dependency hospital shall be  
2600 authorized to add any child/adolescent psychiatric or  
2601 child/adolescent chemical dependency beds or convert any beds of  
2602 another category to child/adolescent psychiatric or  
2603 child/adolescent chemical dependency beds without a certificate of  
2604 need under the authority of subsection (1)(c) and subsection  
2605 (4)(a) of this section.

2606 (5) The department may issue a certificate of need to a  
2607 county hospital in Winston County for the conversion of fifteen  
2608 (15) acute care beds to geriatric psychiatric care beds.

2609 (6) The State Department of Health shall issue a certificate  
2610 of need to a Mississippi corporation qualified to manage a  
2611 long-term care hospital as defined in Section 41-7-173(h)(xii) in  
2612 Harrison County, not to exceed eighty (80) beds, including any  
2613 necessary renovation or construction required for licensure and  
2614 certification, provided that the recipient of the certificate of  
2615 need agrees in writing that the long-term care hospital will not  
2616 at any time participate in the Medicaid program (Section 43-13-101  
2617 et seq.) or admit or keep any patients in the long-term care  
2618 hospital who are participating in the Medicaid program. This  
2619 written agreement by the recipient of the certificate of need  
2620 shall be fully binding on any subsequent owner of the long-term





2621 care hospital, if the ownership of the facility is transferred at  
2622 any time after the issuance of the certificate of need. Agreement  
2623 that the long-term care hospital will not participate in the  
2624 Medicaid program shall be a condition of the issuance of a  
2625 certificate of need to any person under this subsection (6), and  
2626 if such long-term care hospital at any time after the issuance of  
2627 the certificate of need, regardless of the ownership of the  
2628 facility, participates in the Medicaid program or admits or keeps  
2629 any patients in the facility who are participating in the Medicaid  
2630 program, the State Department of Health shall revoke the  
2631 certificate of need, if it is still outstanding, and shall deny or  
2632 revoke the license of the long-term care hospital, at the time  
2633 that the department determines, after a hearing complying with due  
2634 process, that the facility has failed to comply with any of the  
2635 conditions upon which the certificate of need was issued, as  
2636 provided in this subsection and in the written agreement by the  
2637 recipient of the certificate of need. For purposes of this  
2638 subsection, the provisions of Section 41-7-193(1) requiring  
2639 substantial compliance with the projection of need as reported in  
2640 the current State Health Plan are waived.

2641 (7) The State Department of Health may issue a certificate  
2642 of need to any hospital in the state to utilize a portion of its  
2643 beds for the "swing-bed" concept. Any such hospital must be in  
2644 conformance with the federal regulations regarding such swing-bed  
2645 concept at the time it submits its application for a certificate



2646 of need to the State Department of Health, except that such  
2647 hospital may have more licensed beds or a higher average daily  
2648 census (ADC) than the maximum number specified in federal  
2649 regulations for participation in the swing-bed program. Any  
2650 hospital meeting all federal requirements for participation in the  
2651 swing-bed program which receives such certificate of need shall  
2652 render services provided under the swing-bed concept to any  
2653 patient eligible for Medicare (Title XVIII of the Social Security  
2654 Act) who is certified by a physician to be in need of such  
2655 services, and no such hospital shall permit any patient who is  
2656 eligible for both Medicaid and Medicare or eligible only for  
2657 Medicaid to stay in the swing beds of the hospital for more than  
2658 thirty (30) days per admission unless the hospital receives prior  
2659 approval for such patient from the Division of Medicaid, Office of  
2660 the Governor. Any hospital having more licensed beds or a higher  
2661 average daily census (ADC) than the maximum number specified in  
2662 federal regulations for participation in the swing-bed program  
2663 which receives such certificate of need shall develop a procedure  
2664 to insure that before a patient is allowed to stay in the swing  
2665 beds of the hospital, there are no vacant nursing home beds  
2666 available for that patient located within a fifty-mile radius of  
2667 the hospital. When any such hospital has a patient staying in the  
2668 swing beds of the hospital and the hospital receives notice from a  
2669 nursing home located within such radius that there is a vacant bed  
2670 available for that patient, the hospital shall transfer the



2671 patient to the nursing home within a reasonable time after receipt  
2672 of the notice. Any hospital which is subject to the requirements  
2673 of the two (2) preceding sentences of this subsection may be  
2674 suspended from participation in the swing-bed program for a  
2675 reasonable period of time by the State Department of Health if the  
2676 department, after a hearing complying with due process, determines  
2677 that the hospital has failed to comply with any of those  
2678 requirements.

2679       (8) The Department of Health shall not grant approval for or  
2680 issue a certificate of need to any person proposing the new  
2681 construction of, addition to or expansion of a health care  
2682 facility as defined in subparagraph (viii) of Section 41-7-173(h),  
2683 except as hereinafter provided: The department may issue a  
2684 certificate of need to a nonprofit corporation located in Madison  
2685 County, Mississippi, for the construction, expansion or conversion  
2686 of not more than twenty (20) beds in a community living program  
2687 for developmentally disabled adults in a facility as defined in  
2688 subparagraph (viii) of Section 41-7-173(h). For purposes of this  
2689 subsection (8), the provisions of Section 41-7-193(1) requiring  
2690 substantial compliance with the projection of need as reported in  
2691 the current State Health Plan and the provisions of Section  
2692 41-7-197 requiring a formal certificate of need hearing process  
2693 are waived. There shall be no prohibition or restrictions on  
2694 participation in the Medicaid program for the person receiving the  
2695 certificate of need authorized under this subsection (8).



2696           (9) The Department of Health shall not grant approval for or  
2697 issue a certificate of need to any person proposing the  
2698 establishment of, or expansion of the currently approved territory  
2699 of, or the contracting to establish a home office, subunit or  
2700 branch office within the space operated as a health care facility  
2701 as defined in Section 41-7-173(h)(i) through (viii) by a health  
2702 care facility as defined in subparagraph (ix) of Section  
2703 41-7-173(h).

2704           (10) Health care facilities owned and/or operated by the  
2705 state or its agencies are exempt from the restraints in this  
2706 section against issuance of a certificate of need if such addition  
2707 or expansion consists of repairing or renovation necessary to  
2708 comply with the state licensure law. This exception shall not  
2709 apply to the new construction of any building by such state  
2710 facility. This exception shall not apply to any health care  
2711 facilities owned and/or operated by counties, municipalities,  
2712 districts, unincorporated areas, other defined persons, or any  
2713 combination thereof.

2714           (11) The new construction, renovation or expansion of or  
2715 addition to any health care facility defined in subparagraph (ii)  
2716 (psychiatric hospital), subparagraph (iv) (skilled nursing  
2717 facility), subparagraph (vi) (intermediate care facility),  
2718 subparagraph (viii) (intermediate care facility for the mentally  
2719 retarded) and subparagraph (x) (psychiatric residential treatment  
2720 facility) of Section 41-7-173(h) which is owned by the State of



2721 Mississippi and under the direction and control of the State  
2722 Department of Mental Health, and the addition of new beds or the  
2723 conversion of beds from one category to another in any such  
2724 defined health care facility which is owned by the State of  
2725 Mississippi and under the direction and control of the State  
2726 Department of Mental Health, shall not require the issuance of a  
2727 certificate of need under Section 41-7-171 et seq.,  
2728 notwithstanding any provision in Section 41-7-171 et seq. to the  
2729 contrary.

2730       (12) The new construction, renovation or expansion of or  
2731 addition to any veterans homes or domiciliaries for eligible  
2732 veterans of the State of Mississippi as authorized under Section  
2733 35-1-19 shall not require the issuance of a certificate of need,  
2734 notwithstanding any provision in Section 41-7-171 et seq. to the  
2735 contrary.

2736       (13) The repair or the rebuilding of an existing, operating  
2737 health care facility that sustained significant damage from a  
2738 natural disaster that occurred after April 15, 2014, in an area  
2739 that is proclaimed a disaster area or subject to a state of  
2740 emergency by the Governor or by the President of the United States  
2741 shall be exempt from all of the requirements of the Mississippi  
2742 Certificate of Need Law (Section 41-7-171 et seq.) and any and all  
2743 rules and regulations promulgated under that law, subject to the  
2744 following conditions:



2745           (a) The repair or the rebuilding of any such damaged  
2746 health care facility must be within one (1) mile of the  
2747 pre-disaster location of the campus of the damaged health care  
2748 facility, except that any temporary post-disaster health care  
2749 facility operating location may be within five (5) miles of the  
2750 pre-disaster location of the damaged health care facility;

2751           (b) The repair or the rebuilding of the damaged health  
2752 care facility (i) does not increase or change the complement of  
2753 its bed capacity that it had before the Governor's or the  
2754 President's proclamation, (ii) does not increase or change its  
2755 levels and types of health care services that it provided before  
2756 the Governor's or the President's proclamation, and (iii) does not  
2757 rebuild in a different county; however, this paragraph does not  
2758 restrict or prevent a health care facility from decreasing its bed  
2759 capacity that it had before the Governor's or the President's  
2760 proclamation, or from decreasing the levels of or decreasing or  
2761 eliminating the types of health care services that it provided  
2762 before the Governor's or the President's proclamation, when the  
2763 damaged health care facility is repaired or rebuilt;

2764           (c) The exemption from Certificate of Need Law provided  
2765 under this subsection (13) is valid for only five (5) years from  
2766 the date of the Governor's or the President's proclamation. If  
2767 actual construction has not begun within that five-year period,  
2768 the exemption provided under this subsection is inapplicable; and



2769           (d) The Division of Health Facilities Licensure and  
2770 Certification of the State Department of Health shall provide the  
2771 same oversight for the repair or the rebuilding of the damaged  
2772 health care facility that it provides to all health care facility  
2773 construction projects in the state.

2774           For the purposes of this subsection (13), "significant  
2775 damage" to a health care facility means damage to the health care  
2776 facility requiring an expenditure of at least One Million Dollars  
2777 (\$1,000,000.00).

2778           (14) The State Department of Health shall issue a  
2779 certificate of need to any hospital which is currently licensed  
2780 for two hundred fifty (250) or more acute care beds and is located  
2781 in any general hospital service area not having a comprehensive  
2782 cancer center, for the establishment and equipping of such a  
2783 center which provides facilities and services for outpatient  
2784 radiation oncology therapy, outpatient medical oncology therapy,  
2785 and appropriate support services including the provision of  
2786 radiation therapy services. The provisions of Section 41-7-193(1)  
2787 regarding substantial compliance with the projection of need as  
2788 reported in the current State Health Plan are waived for the  
2789 purpose of this subsection.

2790           (15) The State Department of Health may authorize the  
2791 transfer of hospital beds, not to exceed sixty (60) beds, from the  
2792 North Panola Community Hospital to the South Panola Community



2793 Hospital. The authorization for the transfer of those beds shall  
2794 be exempt from the certificate of need review process.

2795 (16) The State Department of Health shall issue any  
2796 certificates of need necessary for Mississippi State University  
2797 and a public or private health care provider to jointly acquire  
2798 and operate a linear accelerator and a magnetic resonance imaging  
2799 unit. Those certificates of need shall cover all capital  
2800 expenditures related to the project between Mississippi State  
2801 University and the health care provider, including, but not  
2802 limited to, the acquisition of the linear accelerator, the  
2803 magnetic resonance imaging unit and other radiological modalities;  
2804 the offering of linear accelerator and magnetic resonance imaging  
2805 services; and the cost of construction of facilities in which to  
2806 locate these services. The linear accelerator and the magnetic  
2807 resonance imaging unit shall be (a) located in the City of  
2808 Starkville, Oktibbeha County, Mississippi; (b) operated jointly by  
2809 Mississippi State University and the public or private health care  
2810 provider selected by Mississippi State University through a  
2811 request for proposals (RFP) process in which Mississippi State  
2812 University selects, and the Board of Trustees of State  
2813 Institutions of Higher Learning approves, the health care provider  
2814 that makes the best overall proposal; (c) available to Mississippi  
2815 State University for research purposes two-thirds (2/3) of the  
2816 time that the linear accelerator and magnetic resonance imaging  
2817 unit are operational; and (d) available to the public or private





2818 health care provider selected by Mississippi State University and  
2819 approved by the Board of Trustees of State Institutions of Higher  
2820 Learning one-third (1/3) of the time for clinical, diagnostic and  
2821 treatment purposes. For purposes of this subsection, the  
2822 provisions of Section 41-7-193(1) requiring substantial compliance  
2823 with the projection of need as reported in the current State  
2824 Health Plan are waived.

2825       (17) The State Department of Health shall issue a  
2826 certificate of need for the construction of an acute care hospital  
2827 in Kemper County, not to exceed twenty-five (25) beds, which shall  
2828 be named the "John C. Stennis Memorial Hospital." In issuing the  
2829 certificate of need under this subsection, the department shall  
2830 give priority to a hospital located in Lauderdale County that has  
2831 two hundred fifteen (215) beds. For purposes of this subsection,  
2832 the provisions of Section 41-7-193(1) requiring substantial  
2833 compliance with the projection of need as reported in the current  
2834 State Health Plan and the provisions of Section 41-7-197 requiring  
2835 a formal certificate of need hearing process are waived. There  
2836 shall be no prohibition or restrictions on participation in the  
2837 Medicaid program (Section 43-13-101 et seq.) for the person or  
2838 entity receiving the certificate of need authorized under this  
2839 subsection or for the beds constructed under the authority of that  
2840 certificate of need.

2841       (18) The planning, design, construction, renovation,  
2842 addition, furnishing and equipping of a clinical research unit at



2843 any health care facility defined in Section 41-7-173(h) that is  
2844 under the direction and control of the University of Mississippi  
2845 Medical Center and located in Jackson, Mississippi, and the  
2846 addition of new beds or the conversion of beds from one (1)  
2847 category to another in any such clinical research unit, shall not  
2848 require the issuance of a certificate of need under Section  
2849 41-7-171 et seq., notwithstanding any provision in Section  
2850 41-7-171 et seq. to the contrary.

2851 (19) [Repealed]

2852 (20) Nothing in this section or in any other provision of  
2853 Section 41-7-171 et seq. shall prevent any nursing facility from  
2854 designating an appropriate number of existing beds in the facility  
2855 as beds for providing care exclusively to patients with  
2856 Alzheimer's disease.

2857 (21) Nothing in this section or any other provision of  
2858 Section 41-7-171 et seq. shall prevent any health care facility  
2859 from the new construction, renovation, conversion or expansion of  
2860 new beds in the facility designated as intensive care units,  
2861 negative pressure rooms, or isolation rooms pursuant to the  
2862 provisions of Sections 41-14-1 through 41-14-11. For purposes of  
2863 this subsection, the provisions of Section 41-7-193(1) requiring  
2864 substantial compliance with the projection of need as reported in  
2865 the current State Health Plan and the provisions of Section  
2866 41-7-197 requiring a formal certificate of need hearing process  
2867 are waived.



2868           **SECTION 5.** Section 41-75-5, Mississippi Code of 1972, is  
2869 amended as follows:

2870           41-75-5. No person as defined in Section 41-7-173, acting  
2871 severally or jointly with any other person, shall establish,  
2872 conduct, operate or maintain an ambulatory surgical facility or an  
2873 abortion facility or a freestanding emergency room or a post-acute  
2874 residential brain injury rehabilitation facility in this state  
2875 without a license under this chapter.

2876       \* \* \*

2877           **SECTION 6.** Section 83-9-353, Mississippi Code of 1972, is  
2878 amended as follows:

2879           83-9-353. (1) As used in this section:

2880               (a) "Employee benefit plan" means any plan, fund or  
2881 program established or maintained by an employer or by an employee  
2882 organization, or both, to the extent that such plan, fund or  
2883 program was established or is maintained for the purpose of  
2884 providing for its participants or their beneficiaries, through the  
2885 purchase of insurance or otherwise, medical, surgical, hospital  
2886 care or other benefits.

2887               (b) "Health insurance plan" means any health insurance  
2888 policy or health benefit plan offered by a health insurer, and  
2889 includes the State and School Employees Health Insurance Plan and  
2890 any other public health care assistance program offered or  
2891 administered by the state or any political subdivision or  
2892 instrumentality of the state. The term does not include policies



2893 or plans providing coverage for specified disease or other limited  
2894 benefit coverage.

2895 (c) "Health insurer" means any health insurance  
2896 company, nonprofit hospital and medical service corporation,  
2897 health maintenance organization, preferred provider organization,  
2898 managed care organization, pharmacy benefit manager, and, to the  
2899 extent permitted under federal law, any administrator of an  
2900 insured, self-insured or publicly funded health care benefit plan  
2901 offered by public and private entities, and other parties that are  
2902 by statute, contract, or agreement, legally responsible for  
2903 payment of a claim for a health care item or service.

2904 (d) "Store-and-forward telemedicine services" means the  
2905 use of asynchronous computer-based communication between a patient  
2906 and a consulting provider or a referring health care provider and  
2907 a medical specialist at a distant site for the purpose of  
2908 diagnostic and therapeutic assistance in the care of patients who  
2909 otherwise have no access to specialty care. Store-and-forward  
2910 telemedicine services involve the transferring of medical data  
2911 from one (1) site to another through the use of a camera or  
2912 similar device that records (stores) an image that is sent  
2913 (forwarded) via telecommunication to another site for  
2914 consultation.

2915 (e) "Remote patient monitoring services" means the  
2916 delivery of home health services using telecommunications  
2917 technology to enhance the delivery of home health care, including:



2918 (i) Monitoring of clinical patient data such as  
2919 weight, blood pressure, pulse, pulse oximetry and other  
2920 condition-specific data, such as blood glucose;  
2921 (ii) Medication adherence monitoring; and  
2922 (iii) Interactive video conferencing with or  
2923 without digital image upload as needed.

2924 (f) "Medication adherence management services" means the  
2925 monitoring of a patient's conformance with the clinician's  
2926 medication plan with respect to timing, dosing and frequency of  
2927 medication-taking through electronic transmission of data in a  
2928 home telemonitoring program.

2929 (2) Store-and-forward telemedicine services allow a health  
2930 care provider trained and licensed in his or her given specialty  
2931 to review forwarded images and patient history in order to provide  
2932 diagnostic and therapeutic assistance in the care of the patient  
2933 without the patient being present in real time. Treatment  
2934 recommendations made via electronic means shall be held to the  
2935 same standards of appropriate practice as those in traditional  
2936 provider-patient setting.

2937 (3) Any patient receiving medical care by store-and-forward  
2938 telemedicine services shall be notified of the right to receive  
2939 interactive communication with the distant specialist health care  
2940 provider and shall receive an interactive communication with the  
2941 distant specialist upon request. If requested, communication with  
2942 the distant specialist may occur at the time of the consultation



2943 or within thirty (30) days of the patient's notification of the  
2944 request of the consultation. Telemedicine networks unable to  
2945 offer the interactive consultation shall not be reimbursed for  
2946 store-and-forward telemedicine services.

2947 (4) Remote patient monitoring services aim to allow more  
2948 people to remain at home or in other residential settings and to  
2949 improve the quality and cost of their care, including prevention  
2950 of more costly care. Remote patient monitoring services via  
2951 telehealth aim to coordinate primary, acute, behavioral and  
2952 long-term social service needs for high-need, high-cost patients.  
2953 Specific patient criteria must be met in order for reimbursement  
2954 to occur.

2955 (5) Qualifying patients for remote patient monitoring  
2956 services must meet all the following criteria:

2957 (a) Be diagnosed, in the last eighteen (18) months,  
2958 with one or more chronic conditions, as defined by the Centers for  
2959 Medicare and Medicaid Services (CMS), which include, but are not  
2960 limited to, sickle cell, mental health, asthma, diabetes, and  
2961 heart disease; and

2962 \* \* \*

2963 ( \* \* \* b) The patient's health care provider recommends  
2964 disease management services via remote patient monitoring.

2965 (6) A remote patient monitoring prior authorization request  
2966 form \* \* \* may be required for approval of telemonitoring  
2967 services. \* \* \* Any such request \* \* \* may include the following:



2968                   (a) An order for home telemonitoring services, signed  
2969 and dated by the prescribing physician;  
2970                   (b) A plan of care, signed and dated by the prescribing  
2971 physician, that includes telemonitoring transmission frequency and  
2972 duration of monitoring requested;  
2973                   (c) The client's diagnosis and risk factors that  
2974 qualify the client for home telemonitoring services;  
2975                   (d) Attestation that the client is sufficiently  
2976 cognitively intact and able to operate the equipment or has a  
2977 willing and able person to assist in completing electronic  
2978 transmission of data; and  
2979                   (e) Attestation that the client is not receiving  
2980 duplicative services via disease management services.  
2981           (7) The entity that will provide the remote monitoring must  
2982 be a Mississippi-based entity and have protocols in place to  
2983 address all of the following:  
2984                   (a) Authentication and authorization of users;  
2985                   (b) A mechanism for monitoring, tracking and responding  
2986 to changes in a client's clinical condition;  
2987                   (c) A standard of acceptable and unacceptable  
2988 parameters for client's clinical parameters, which can be adjusted  
2989 based on the client's condition;  
2990                   (d) How monitoring staff will respond to abnormal  
2991 parameters for client's vital signs, symptoms and/or lab results;



2992 (e) The monitoring, tracking and responding to changes  
2993 in client's clinical condition;

2994 (f) The process for notifying the prescribing physician  
2995 for significant changes in the client's clinical signs and  
2996 symptoms;

2997 (g) The prevention of unauthorized access to the system  
2998 or information;

2999 (h) System security, including the integrity of  
3000 information that is collected, program integrity and system  
3001 integrity;

3002 (i) Information storage, maintenance and transmission;

3003 (j) Synchronization and verification of patient profile  
3004 data; and

3005 (k) Notification of the client's discharge from remote  
3006 patient monitoring services or the de-installation of the remote  
3007 patient monitoring unit.

3008 (8) The telemonitoring equipment must:

3009 (a) Be capable of monitoring any data parameters in the  
3010 plan of care; and

3011 (b) Be a FDA Class II hospital-grade medical device.

3012 (9) Monitoring of the client's data shall not be duplicated  
3013 by another provider.

3014 (10) To receive payment for the delivery of remote patient  
3015 monitoring services via telehealth, the service must involve:





3016 (a) An assessment, problem identification, and  
3017 evaluation that includes:  
3018 (i) Assessment and monitoring of clinical data  
3019 including, but not limited to, appropriate vital signs, pain  
3020 levels and other biometric measures specified in the plan of care,  
3021 and also includes assessment of response to previous changes in  
3022 the plan of care; and  
3023 (ii) Detection of condition changes based on the  
3024 telemedicine encounter that may indicate the need for a change in  
3025 the plan of care.  
3026 (b) Implementation of a management plan through one or  
3027 more of the following:  
3028 (i) Teaching regarding medication management as  
3029 appropriate based on the telemedicine findings for that encounter;  
3030 (ii) Teaching regarding other interventions as  
3031 appropriate to both the patient and the caregiver;  
3032 (iii) Management and evaluation of the plan of  
3033 care including changes in visit frequency or addition of other  
3034 skilled services;  
3035 (iv) Coordination of care with the ordering health  
3036 care provider regarding telemedicine findings;  
3037 (v) Coordination and referral to other medical  
3038 providers as needed; and  
3039 (vi) Referral for an in-person visit or the  
3040 emergency room as needed.



3041           (11) The telemedicine equipment and network used for remote  
3042 patient monitoring services should meet the following  
3043 requirements:

3044                   (a) Comply with applicable standards of the United  
3045 States Food and Drug Administration;

3046                   (b) Telehealth equipment be maintained in good repair  
3047 and free from safety hazards;

3048                   (c) Telehealth equipment be new or sanitized before  
3049 installation in the patient's home setting;

3050                   (d) Accommodate non-English language options; and

3051                   (e) Have 24/7 technical and clinical support services  
3052 available for the patient user.

3053           (12) All health insurance and employee benefit plans in this  
3054 state must provide coverage and reimbursement for the asynchronous  
3055 telemedicine services of store-and-forward telemedicine services  
3056 and remote patient monitoring services based on the criteria set  
3057 out in this section. Store-and-forward telemedicine services  
3058 shall be reimbursed to the same extent that the services would be  
3059 covered if they were provided through in-person consultation.

3060           (13) Remote patient monitoring services shall include  
3061 reimbursement for a daily monitoring rate at a minimum of Ten  
3062 Dollars (\$10.00) per day each month and Sixteen Dollars (\$16.00)  
3063 per day when medication adherence management services are  
3064 included, not to exceed thirty-one (31) days per month. These  
3065 reimbursement rates are only eligible to Mississippi-based



3066 telehealth programs affiliated with a Mississippi health care  
3067 facility.

3068       (14) A one-time telehealth installation/training fee for  
3069 remote patient monitoring services will also be reimbursed at a  
3070 minimum rate of Fifty Dollars (\$50.00) per patient, with a maximum  
3071 of two (2) installation/training fees/calendar year. These  
3072 reimbursement rates are only eligible to Mississippi-based  
3073 telehealth programs affiliated with a Mississippi health care  
3074 facility.

3075       (15) No geographic restrictions shall be placed on the  
3076 delivery of telemedicine services in the home setting other than  
3077 requiring the patient reside within the State of Mississippi.

3078       (16) Health care providers seeking reimbursement for  
3079 store-and-forward telemedicine services must be licensed  
3080 Mississippi providers that are affiliated with an established  
3081 Mississippi health care facility in order to qualify for  
3082 reimbursement of telemedicine services in the state. If a service  
3083 is not available in Mississippi, then a health insurance or  
3084 employee benefit plan may decide to allow a non-Mississippi-based  
3085 provider who is licensed to practice in Mississippi reimbursement  
3086 for those services.

3087       (17) A health insurance or employee benefit plan may charge  
3088 a deductible, co-payment, or coinsurance for a health care service  
3089 provided through store-and-forward telemedicine services or remote  
3090 patient monitoring services so long as it does not exceed the



3091 deductible, co-payment, or coinsurance applicable to an in-person  
3092 consultation.

3093       (18) A health insurance or employee benefit plan may limit  
3094 coverage to health care providers in a telemedicine network  
3095 approved by the plan.

3096       (19) Nothing in this section shall be construed to prohibit  
3097 a health insurance or employee benefit plan from providing  
3098 coverage for only those services that are medically necessary,  
3099 subject to the terms and conditions of the covered person's  
3100 policy.

3101       (20) In a claim for the services provided, the appropriate  
3102 procedure code for the covered service shall be included with the  
3103 appropriate modifier indicating telemedicine services were used.  
3104 A "GQ" modifier is required for asynchronous telemedicine services  
3105 such as store-and-forward and remote patient monitoring.

3106       (21) The originating site is eligible to receive a facility  
3107 fee, but facility fees are not payable to the distant site.

3108       **SECTION 7.** This act shall take effect and be in force from  
3109 and after its passage.

