Adopted COMMITTEE AMENDMENT NO 1 PROPOSED TO

House Bill No. 1008

BY: Committee

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

- 97 **SECTION 1.** Section 43-13-117, Mississippi Code of 1972, is 98 amended as follows:
- 99 43-13-117. (A) Medicaid as authorized by this article shall 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
- 106 (1) Inpatient hospital services.

state appropriations and federal matching funds:



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108 (* * *a) The division is authorized to implement

109 an All Patient Refined Diagnosis Related Groups (APR-DRG)

110 reimbursement methodology for inpatient hospital services.

111 (* * *b) No service benefits or reimbursement

112 limitations in this subsection (A)(1) shall apply to payments

113 under an APR-DRG or Ambulatory Payment Classification (APC) model

114 or a managed care program or similar model described in subsection

115 (H) of this section unless specifically authorized by the

116 division.

- 117 (2) Outpatient hospital services.
- 118 (a) Emergency services.
- 119 (b) Other outpatient hospital services. The
- 120 division shall allow benefits for other medically necessary
- 121 outpatient hospital services (such as chemotherapy, radiation,
- 122 surgery and therapy), including outpatient services in a clinic or
- 123 other facility that is not located inside the hospital, but that
- 124 has been designated as an outpatient facility by the hospital, and
- 125 that was in operation or under construction on July 1, 2009,
- 126 provided that the costs and charges associated with the operation
- 127 of the hospital clinic are included in the hospital's cost report.
- 128 In addition, the Medicare thirty-five-mile rule will apply to
- 129 those hospital clinics not located inside the hospital that are
- 130 constructed after July 1, 2009. Where the same services are
- 131 reimbursed as clinic services, the division may revise the rate or

- 132 methodology of outpatient reimbursement to maintain consistency,
- 133 efficiency, economy and quality of care.
- 134 (c) The division is authorized to implement an
- 135 Ambulatory Payment Classification (APC) methodology for outpatient
- 136 hospital services. The division may give rural hospitals that
- 137 have fifty (50) or fewer licensed beds the option to not be
- 138 reimbursed for outpatient hospital services using the APC
- 139 methodology, but reimbursement for outpatient hospital services
- 140 provided by those hospitals shall be based on one hundred one
- 141 percent (101%) of the rate established under Medicare for
- 142 outpatient hospital services. Those hospitals choosing to not be
- 143 reimbursed under the APC methodology shall remain under cost-based
- 144 reimbursement for a two-year period.
- 145 (d) No service benefits or reimbursement
- 146 limitations in this subsection (A)(2) shall apply to payments
- 147 under an APR-DRG or APC model or a managed care program or similar
- 148 model described in subsection (H) of this section unless
- 149 specifically authorized by the division.
- 150 (3) Laboratory and x-ray services.
- 151 (4) Nursing facility services.
- 152 (a) The division shall make * * * partial payment
- in an amount not less than fifty percent (50%) of the per diem
- 154 rate, as determined by the division, to nursing facilities for
- 155 each day, not exceeding * * * thirty-five (35) days per year, that
- 156 a patient is absent from the facility on home leave. Payment may

- 157 be made for the following home leave days in addition to the * * *
- 158 thirty-five-day limitation: Christmas, the day before Christmas,
- 159 the day after Christmas, Thanksgiving, the day before Thanksgiving
- 160 and the day after Thanksgiving.
- 161 (b) From and after July 1, 1997, the division
- 162 shall implement the integrated case-mix payment and quality
- 163 monitoring system, which includes the fair rental system for
- 164 property costs and in which recapture of depreciation is
- 165 eliminated. For the purposes of establishing a facility's per
- 166 diem rate, the division may * * * adjust the * * * case mix for
- 167 hospital leave and therapeutic home leave days to the lower of the
- 168 case-mix category as computed for the resident on leave using the
- 169 assessment being utilized for payment at that point in time, or a
- 170 case-mix score of 1.000 for nursing facilities, and shall compute
- 171 case-mix scores of residents so that only services provided at the
- 172 nursing facility are considered in calculating a facility's per
- 173 diem.
- 174 (c) From and after July 1, 1997, all state-owned
- 175 nursing facilities shall be reimbursed on a full reasonable cost
- 176 basis.
- 177 * * *
- 178 (***d) The division shall develop and
- 179 implement, not later than January 1, 2001, a case-mix payment
- 180 add-on determined by time studies and other valid statistical data
- 181 that will reimburse a nursing facility for the additional cost of

- 182 caring for a resident who has a diagnosis of Alzheimer's or other 183 related dementia and exhibits symptoms that require special care. 184 Any such case-mix add-on payment shall be supported by a 185 determination of additional cost. The division shall also develop 186 and implement as part of the fair rental reimbursement system for 187 nursing facility beds, an Alzheimer's resident bed depreciation 188 enhanced reimbursement system that will provide an incentive to encourage nursing facilities to convert or construct beds for 189
- 191 (***<u>e</u>) The division shall develop and implement 192 an assessment process for long-term care services. The division 193 may provide the assessment and related functions directly or 194 through contract with the area agencies on aging.

residents with Alzheimer's or other related dementia.

- 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.
 - 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

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207 services authorized under the federal regulations adopted to 208 implement Title XIX of the federal Social Security Act, as 209 The division, in obtaining physical therapy services, 210 occupational therapy services, and services for individuals with 211 speech, hearing and language disorders, may enter into a 212 cooperative agreement with the State Department of Education for 213 the provision of those services to handicapped students by public 214 school districts using state funds that are provided from the 215 appropriation to the Department of Education to obtain federal 216 matching funds through the division. The division, in obtaining 217 medical and mental health assessments, treatment, care and services for children who are in, or at risk of being put in, the 218 219 custody of the Mississippi Department of Human Services may enter 220 into a cooperative agreement with the Mississippi Department of 221 Human Services for the provision of those services using state 222 funds that are provided from the appropriation to the Department 223 of Human Services to obtain federal matching funds through the 224 division.

225 (6) Physician * * * services. * * * Fees for

226 physician's services that are covered only by Medicaid shall

227 be * * reimbursed at ninety percent (90%) of the rate

228 established on January 1, 2018, and as may be adjusted each July

229 thereafter, under Medicare. The division may provide for a

230 reimbursement rate for physician's services of up to one hundred

231 percent (100%) of the rate established under Medicare for

- 232 physician's services that are provided after the normal working
- 233 hours of the physician, as determined in accordance with
- 234 regulations of the division. The division may reimburse eligible
- 235 providers, as determined by the \star \star division, for certain
- 236 primary care services * * * at one hundred percent (100%) of the
- 237 rate established under Medicare. * * * The division shall
- 238 reimburse obstetricians and gynecologists for certain primary care
- 239 services as defined by the division at one hundred percent (100%)
- 240 of the rate established under Medicare.
- 241 (7) (a) Home health services for eligible persons, not
- 242 to exceed in cost the prevailing cost of nursing facility
- 243 services. All home health visits must be precertified as required
- 244 by the division.
- (b) [Repealed]
- 246 (8) Emergency medical transportation services as
- 247 determined by the division.
- 248 (9) Prescription drugs and other covered drugs and
- 249 services as * * * determined by the division.
- The division shall establish a mandatory preferred drug list.
- 251 Drugs not on the mandatory preferred drug list shall be made
- 252 available by utilizing prior authorization procedures established
- 253 by the division.
- The division may seek to establish relationships with other
- 255 states in order to lower acquisition costs of prescription drugs
- 256 to include single-source and innovator multiple-source drugs or



- generic drugs. In addition, if allowed by federal law or
 regulation, the division may seek to establish relationships with
 and negotiate with other countries to facilitate the acquisition
 of prescription drugs to include single-source and innovator
 multiple-source drugs or generic drugs, if that will lower the
 acquisition costs of those prescription drugs.
- The division may allow for a combination of prescriptions for single-source and innovator multiple-source drugs and generic drugs to meet the needs of the beneficiaries.
- The executive director may approve specific maintenance drugs for beneficiaries with certain medical conditions, which may be prescribed and dispensed in three-month supply increments.
 - Drugs prescribed for a resident of a psychiatric residential treatment facility must be provided in true unit doses when available. The division may require that drugs not covered by Medicare Part D for a resident of a long-term care facility be provided in true unit doses when available. Those drugs that were originally billed to the division but are not used by a resident in any of those facilities shall be returned to the billing pharmacy for credit to the division, in accordance with the guidelines of the State Board of Pharmacy and any requirements of federal law and regulation. Drugs shall be dispensed to a recipient and only one (1) dispensing fee per month may be charged. The division shall develop a methodology for reimbursing for restocked drugs, which shall include a restock fee as

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- determined by the division not exceeding Seven Dollars and Eighty-two Cents (\$7.82).
- Except for those specific maintenance drugs approved by the
 executive director, the division shall not reimburse for any
 portion of a prescription that exceeds a thirty-one-day supply of
 the drug based on the daily dosage.
- The division is authorized to develop and implement a program of payment for additional pharmacist services as * * * determined by the division.
- All claims for drugs for dually eligible Medicare/Medicaid beneficiaries that are paid for by Medicare must be submitted to Medicare for payment before they may be processed by the division's online payment system.
- The division shall develop a pharmacy policy in which drugs in tamper-resistant packaging that are prescribed for a resident of a nursing facility but are not dispensed to the resident shall be returned to the pharmacy and not billed to Medicaid, in accordance with guidelines of the State Board of Pharmacy.
- 300 The division shall develop and implement a method or methods
 301 by which the division will provide on a regular basis to Medicaid
 302 providers who are authorized to prescribe drugs, information about
 303 the costs to the Medicaid program of single-source drugs and
 304 innovator multiple-source drugs, and information about other drugs
 305 that may be prescribed as alternatives to those single-source

306 drugs and innovator multiple-source drugs and the costs to the 307 Medicaid program of those alternative drugs.

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

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

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

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

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

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

- 334 (10) Dental and orthodontic services to be determined by the division.
- 336 This dental services program under this paragraph shall be 337 known as the "James Russell Dumas Medicaid Dental Services 338 Program."
- 339 The Medical Care Advisory Committee, assisted by the Division 340 of Medicaid, shall annually determine the effect of this incentive by evaluating the number of dentists who are Medicaid providers, 341 342 the number who and the degree to which they are actively billing 343 Medicaid, the geographic trends of where dentists are offering 344 what types of Medicaid services and other statistics pertinent to 345 the goals of this legislative intent. This data shall annually be 346 presented to the Chair of the Senate Medicaid Committee and the Chair of the House Medicaid Committee. 347
- 348 The division shall include dental services as a necessary 349 component of overall health services provided to children who are 350 eligible for services.
- 351 (11) Eyeglasses for all Medicaid beneficiaries who have 352 (a) had surgery on the eyeball or ocular muscle that results in a 353 vision change for which eyeglasses or a change in eyeglasses is 354 medically indicated within six (6) months of the surgery and is in



- 355 accordance with policies established by the division, or (b) one
- 356 (1) pair every five (5) years and in accordance with policies
- 357 established by the division. In either instance, the eyeglasses
- 358 must be prescribed by a physician skilled in diseases of the eye
- 359 or an optometrist, whichever the beneficiary may select.
- 360 (12) Intermediate care facility services.
- 361 (a) The division shall make * * * partial payment
- 362 in an amount not less than fifty percent (50%) of the per diem
- 363 rate, as determined by the division, to all intermediate care
- 364 facilities for individuals with intellectual disabilities for each
- 365 day, not exceeding * * * seventy (70) days per year, that a
- 366 patient is absent from the facility on home leave. Payment may be
- 367 made for the following home leave days in addition to the * * *
- 368 seventy-day limitation: Christmas, the day before Christmas, the
- 369 day after Christmas, Thanksgiving, the day before Thanksgiving and
- 370 the day after Thanksgiving.
- 371 (b) All state-owned intermediate care facilities
- 372 for individuals with intellectual disabilities shall be reimbursed
- 373 on a full reasonable cost basis.
- 374 *** * ***
- 375 (13) Family planning services, including drugs,
- 376 supplies and devices, when those services are under the
- 377 supervision of a physician or nurse practitioner.
- 378 (14) Clinic services. * * * Preventive, diagnostic,
- 379 therapeutic, rehabilitative or palliative services that are



380	furnished by a facility that is not part of a hospital but is
381	organized and operated to provide medical care to outpatients.
382	Clinic services include, but are not limited to:
383	(a) Services provided by ambulatory surgical
384	centers (ACSs) as defined in Section 41-75-1(a); and
385	(b) Dialysis center services.
386	(15) Home- and community-based services for the elderly
387	and disabled, as provided under Title XIX of the federal Social
388	Security Act, as amended, under waivers, subject to the
389	availability of funds specifically appropriated for that purpose
390	by the Legislature.
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392	(16) Mental health services. Certain services provided
393	by a psychiatrist shall be reimbursed at up to one hundred percent
394	(100%) of the Medicare rate. Approved therapeutic and case
395	management services (a) provided by an approved regional mental
396	health/intellectual disability center established under Sections
397	41-19-31 through 41-19-39, or by another * * * mental health
398	service provider meeting the requirements of the Department of
399	Mental Health to be an approved mental health/intellectual
400	disability center if determined necessary by the Department of
401	Mental Health, using state funds that are provided in the
402	appropriation to the division to match federal funds, or (b)
403	provided by a facility that is certified by the State Department



of Mental Health to provide therapeutic and case management

services, to be reimbursed on a fee for service basis, or (c) provided in the community by a facility or program operated by the Department of Mental Health, or (d) provided by a mental health service provider accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), or the 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

- 430 the state for disproportionate share hospitals. However, from and
- 431 after January 1, 1999, public hospitals participating in the
- 432 Medicaid disproportionate share program may be required to
- 433 participate in an intergovernmental transfer program as provided
- 434 in Section 1903 of the federal Social Security Act and any
- 435 applicable regulations.
- (b) (i) The division may establish a Medicare
- 437 Upper Payment Limits Program, as defined in Section 1902(a)(30) of
- 438 the federal Social Security Act and any applicable federal
- 439 regulations, or an allowable delivery system or provider payment
- 440 initiative authorized under 42 CFR 438.6(c), for hospitals, * * *
- 441 nursing facilities, * * * physicians employed or contracted
- 442 by * * hospitals, and emergency ambulance transportation
- 443 providers. * * *
- 444 (ii) The division shall assess each
- 445 hospital * * *, * * * nursing facility, and emergency ambulance
- 446 transportation provider for the sole purpose of financing the
- 447 state portion of the Medicare Upper Payment Limits Program or
- 448 other program(s) authorized under this subsection (A)(18)(b). The
- 449 hospital assessment shall be as provided in Section
- 450 43-13-145(4)(a), and the nursing facility \star \star and the emergency
- 451 ambulance transportation assessments, if established, shall be
- 452 based on Medicaid utilization or other appropriate method, as
- 453 determined by the division, consistent with federal regulations.
- 454 The assessments will remain in effect as long as the state



- 455 participates in the Medicare Upper Payment Limits Program <u>or other</u>
- 456 program(s) authorized under this subsection (A)(18)(b). * * * In
- 457 addition to the hospital assessment provided in Section
- 458 43-13-145(4)(a), hospitals with physicians participating in the
- 459 Medicare Upper Payment Limits Program or other program(s)
- 460 authorized under this subsection (A)(18)(b) shall be required to
- 461 participate in an intergovernmental transfer * * * or assessment,
- 462 as determined by the division, for the purpose of financing the
- 463 state portion of the physician UPL payments or other payment(s)
- 464 authorized under this subsection (A)(18)(b).
- * * * (iii) Subject to approval by the
- 466 Centers for Medicare and Medicaid Services (CMS) and the
- 467 provisions of this subsection (A) (18) (b), the division shall make
- 468 additional reimbursement to hospitals * * *, * * nursing
- 469 facilities, and emergency ambulance transportation providers for
- 470 the Medicare Upper Payment Limits Program or other program(s)
- 471 authorized under this subsection (A)(18)(b), and, if the program
- 472 is established for physicians, shall make additional reimbursement
- 473 for physicians, as defined in Section 1902(a)(30) of the federal
- 474 Social Security Act and any applicable federal regulations,
- 475 provided the assessment in this subsection (A)(18)(b) is in
- 476 effect.
- 477 (iv) Notwithstanding any other provision of
- 478 this article to the contrary, effective upon implementation of the
- 479 Mississippi Hospital Access Program (MHAP) provided in



480	subparagraph (c)(i) below, the hospital portion of the inpatient
481	Upper Payment Limits Program shall transition into and be replaced
482	by the MHAP program. However, the division is authorized to
483	develop and implement an alternative fee-for-service Upper Payment
484	Limits model in accordance with federal laws and regulations if
485	necessary to preserve supplemental funding. Further, the
486	division, in consultation with the Mississippi Hospital
487	Association and a governmental hospital located in a county
488	bordering the Gulf of Mexico and the State of Alabama shall
489	develop alternative models for distribution of medical claims and
490	supplemental payments for inpatient and outpatient hospital
491	services, and such models may include, but shall not be limited to
492	the following: increasing rates for inpatient and outpatient
493	services; creating a low-income utilization pool of funds to
494	reimburse hospitals for the costs of uncompensated care, charity
495	care and bad debts as permitted and approved pursuant to federal
496	regulations and the Centers for Medicare and Medicaid Services;
497	supplemental payments based upon Medicaid utilization, quality,
498	service lines and/or costs of providing such services to Medicaid
499	beneficiaries and to uninsured patients. The goals of such
500	payment models shall be to ensure access to inpatient and
501	outpatient care and to maximize any federal funds that are
502	available to reimburse hospitals for services provided. Any such
503	documents required to achieve the goals described in this
504	paragraph shall be submitted to the Centers for Medicare and



505 Medicaid Services, with a proposed effective date of July 1, 2019, 506 to the extent possible, but in no event shall the effective date 507 of such payment models be later than July 1, 2020. The Chairmen 508 of the Senate and House Medicaid Committees shall be provided a 509 copy of the proposed payment model(s) prior to submission. 510 Effective July 1, 2018, and until such time as any payment 511 model(s) as described above become effective, the division, in 512 consultation with the Mississippi Hospital Association and a 513 governmental hospital located in a county bordering the Gulf of Mexico and the State of Alabama is authorized to implement a 514 515 transitional program for inpatient and outpatient payments and/or supplemental payments (including, but not limited to, MHAP and 516 517 directed payments), to redistribute available supplemental funds among hospital providers, provided that when compared to a 518 519 hospital's prior year supplemental payments, supplemental payments made pursuant to any such transitional program shall not result in 520 521 a decrease of more than five percent (5%) and shall not increase by more than the amount needed to maximize the distribution of the 522 523 available funds. 524 (i) Not later than December 1, 2015, the (C) 525 division shall, subject to approval by the Centers for Medicare 526 and Medicaid Services (CMS), establish, implement and operate a 527 Mississippi Hospital Access Program (MHAP) for the purpose of



inpatient reimbursement programs provided in this section designed

protecting patient access to hospital care through hospital

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530 to maintain total hospital reimbursement for inpatient services 531 rendered by in-state hospitals and the out-of-state hospital that 532 is authorized by federal law to submit intergovernmental transfers 533 (IGTs) to the State of Mississippi and is classified as Level I 534 trauma center located in a county contiguous to the state line at 535 the maximum levels permissible under applicable federal statutes 536 and regulations, at which time the current inpatient Medicare Upper Payment Limits (UPL) Program for hospital inpatient services 537 538 shall transition to the MHAP. 539 Subject * * * to approval by the Centers for Medicare and Medicaid Services (CMS) * * *, the MHAP shall 540 provide increased inpatient capitation (PMPM) payments to managed 541

for Medicare and Medicaid Services (CMS) * * *, the MHAP shall provide increased inpatient capitation (PMPM) payments to managed care entities contracting with the division pursuant to subsection (H) of this section to support availability of hospital services or such other payments permissible under federal law necessary to accomplish the intent of this subsection.

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

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554 payments which may be developed under the authority of this 555 paragraph.

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

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

576 (b) Early intervention system services. The
577 division shall cooperate with the State Department of Health,
578 acting as lead agency, in the development and implementation of a

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579 statewide system of delivery of early intervention services, under

580 Part C of the Individuals with Disabilities Education Act (IDEA).

581 The State Department of Health shall certify annually in writing

582 to the executive director of the division the dollar amount of

583 state early intervention funds available that will be utilized as

584 a certified match for Medicaid matching funds. Those funds then

585 shall be used to provide expanded targeted case management

586 services for Medicaid eligible children with special needs who are

587 eligible for the state's early intervention system.

588 Qualifications for persons providing service coordination shall be

determined by the State Department of Health and the Division of

590 Medicaid.

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591 (20) Home- and community-based services for physically

592 disabled approved services as allowed by a waiver from the United

593 States Department of Health and Human Services for home- and

594 community-based services for physically disabled people using

595 state funds that are provided from the appropriation to the State

596 Department of Rehabilitation Services and used to match federal

597 funds under a cooperative agreement between the division and the

department, provided that funds for these services are

599 specifically appropriated to the Department of Rehabilitation

600 Services.

601 (21) Nurse practitioner services. Services furnished

602 by a registered nurse who is licensed and certified by the

603 Mississippi Board of Nursing as a nurse practitioner, including,



but not limited to, nurse anesthetists, nurse midwives, family nurse practitioners, family planning nurse practitioners, pediatric nurse practitioners, obstetrics-gynecology nurse practitioners and neonatal nurse practitioners, under regulations adopted by the division. Reimbursement for those services shall not exceed ninety percent (90%) of the reimbursement rate for comparable services rendered by a physician. The division may provide for a reimbursement rate for nurse practitioner services of up to one hundred percent (100%) of the reimbursement rate for comparable services rendered by a physician for nurse practitioner services that are provided after the normal working hours of the nurse practitioner, as determined in accordance with regulations of the division.

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

629	reimburse FQHCs,	RHCs and C	CMHCs for	both distant	t site and
630	originating site	services w	when such	services are	e appropriately
631	provided by the	same organi	zation.		

632 (23) Inpatient psychiatric services.

633 Inpatient psychiatric services to be (a) 634 determined by the division for recipients under age twenty-one 635 (21) that are provided under the direction of a physician in an 636 inpatient program in a licensed acute care psychiatric facility or 637 in a licensed psychiatric residential treatment facility, before 638 the recipient reaches age twenty-one (21) or, if the recipient was 639 receiving the services immediately before he or she reached age 640 twenty-one (21), before the earlier of the date he or she no 641 longer requires the services or the date he or she reaches age 642 twenty-two (22), as provided by federal regulations. From and after January 1, 2015, the division shall update the fair rental 643 644 reimbursement system for psychiatric residential treatment 645 facilities. Precertification of inpatient days and residential 646 treatment days must be obtained as required by the division. From 647 and after July 1, 2009, all state-owned and state-operated 648 facilities that provide inpatient psychiatric services to persons 649 under age twenty-one (21) who are eligible for Medicaid 650 reimbursement shall be reimbursed for those services on a full reasonable cost basis. 651

652 (b) The division may reimburse for services
653 provided by a licensed freestanding psychiatric hospital to



654	Medi	icaid	reci	ipients	over	the	age	of	twenty	7-01	ne (21)	in a	a meth	<u>od</u>
655	and	manne	er co	onsiste	nt wi	th t	he p	rovi	isions	of	Section	43-	-13-11	7.5.

- 656 (24) [Deleted]
- (25) [Deleted]
- 658 Hospice care. As used in this paragraph, the term (26)659 "hospice care" means a coordinated program of active professional 660 medical attention within the home and outpatient and inpatient care that treats the terminally ill patient and family as a unit, 661 662 employing a medically directed interdisciplinary team. program provides relief of severe pain or other physical symptoms 663 664 and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses 665 666 that are experienced during the final stages of illness and during 667 dying and bereavement and meets the Medicare requirements for 668 participation as a hospice as provided in federal regulations.
- 669 (27) Group health plan premiums and cost-sharing if it 670 is cost-effective as defined by the United States Secretary of 671 Health and Human Services.
- 672 (28) Other health insurance premiums that are
 673 cost-effective as defined by the United States Secretary of Health
 674 and Human Services. Medicare eligible must have Medicare Part B
 675 before other insurance premiums can be paid.
- 676 (29) The Division of Medicaid may apply for a waiver 677 from the United States Department of Health and Human Services for 678 home- and community-based services for developmentally disabled



679 people using state funds that are provided from the appropriation 680 to the State Department of Mental Health and/or funds transferred 681 to the department by a political subdivision or instrumentality of 682 the state and used to match federal funds under a cooperative 683 agreement between the division and the department, provided that 684 funds for these services are specifically appropriated to the 685 Department of Mental Health and/or transferred to the department 686 by a political subdivision or instrumentality of the state.

- (30) Pediatric skilled nursing services * * * <u>as</u> 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.
- 702 (34) Assisted living services as provided through
 703 home- and community-based services under Title XIX of the federal



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- 704 Social Security Act, as amended, subject to the availability of
- 705 funds specifically appropriated for that purpose by the
- 706 Legislature.
- 707 (35) Services and activities authorized in Sections
- 708 43-27-101 and 43-27-103, using state funds that are provided from
- 709 the appropriation to the Mississippi Department of Human Services
- 710 and used to match federal funds under a cooperative agreement
- 711 between the division and the department.
- 712 (36) Nonemergency transportation services for
- 713 Medicaid-eligible persons * * * $\frac{1}{2}$ as determined by the division.
- 714 The PEER Committee shall conduct a performance evaluation of the
- 715 nonemergency transportation program to evaluate the administration
- 716 of the program and the providers of transportation services to
- 717 determine the most cost-effective ways of providing nonemergency
- 718 transportation services to the patients served under the program.
- 719 The performance evaluation shall be completed and provided to the
- 720 members of the Senate Medicaid Committee and the House Medicaid
- 721 Committee not later than January 1, 2019, and every two (2) years
- 722 thereafter.
- 723 (37) [Deleted]
- 724 (38) Chiropractic services. A chiropractor's manual
- 725 manipulation of the spine to correct a subluxation, if x-ray
- 726 demonstrates that a subluxation exists and if the subluxation has
- 727 resulted in a neuromusculoskeletal condition for which
- 728 manipulation is appropriate treatment, and related spinal x-rays



- 729 performed to document these conditions. Reimbursement for
- 730 chiropractic services shall not exceed Seven Hundred Dollars
- 731 (\$700.00) per year per beneficiary.
- 732 (39) Dually eligible Medicare/Medicaid beneficiaries.
- 733 The division shall pay the Medicare deductible and coinsurance
- 734 amounts for services available under Medicare, as determined by
- 735 the division. $\star \star \star$
- 736 (40) [Deleted]
- 737 (41) Services provided by the State Department of
- 738 Rehabilitation Services for the care and rehabilitation of persons
- 739 with spinal cord injuries or traumatic brain injuries, as allowed
- 740 under waivers from the United States Department of Health and
- 741 Human Services, using up to seventy-five percent (75%) of the
- 742 funds that are appropriated to the Department of Rehabilitation
- 743 Services from the Spinal Cord and Head Injury Trust Fund
- 744 established under Section 37-33-261 and used to match federal
- 745 funds under a cooperative agreement between the division and the
- 746 department.
- 747 (42) [Deleted]
- 748 (43) The division shall provide reimbursement,
- 749 according to a payment schedule developed by the division, for
- 750 smoking cessation medications for pregnant women during their
- 751 pregnancy and other Medicaid-eligible women who are of
- 752 child-bearing age.



- 753 (44) Nursing facility services for the severely 754 disabled.
- 755 (a) Severe disabilities include, but are not
- 756 limited to, spinal cord injuries, closed-head injuries and
- 757 ventilator-dependent patients.
- 758 (b) Those services must be provided in a long-term
- 759 care nursing facility dedicated to the care and treatment of
- 760 persons with severe disabilities.
- 761 (45) Physician assistant services. Services furnished
- 762 by a physician assistant who is licensed by the State Board of
- 763 Medical Licensure and is practicing with physician supervision
- 764 under regulations adopted by the board, under regulations adopted
- 765 by the division. Reimbursement for those services shall not
- 766 exceed ninety percent (90%) of the reimbursement rate for
- 767 comparable services rendered by a physician. The division may
- 768 provide for a reimbursement rate for physician assistant services
- 769 of up to one hundred percent (100%) or the reimbursement rate for
- 770 comparable services rendered by a physician for physician
- 771 assistant services that are provided after the normal working
- 772 hours of the physician assistant, as determined in accordance with
- 773 regulations of the division.
- 774 (46) The division shall make application to the federal
- 775 Centers for Medicare and Medicaid Services (CMS) for a waiver to
- 776 develop and provide services for children with serious emotional
- 777 disturbances as defined in Section 43-14-1(1), which may include



- home- and community-based services, case management services or managed care services through mental health providers certified by the Department of Mental Health. The division may implement and provide services under this waivered program only if funds for these services are specifically appropriated for this purpose by the Legislature, or if funds are voluntarily provided by affected agencies.
- 785 (47) (a) The division may develop and implement
 786 disease management programs for individuals with high-cost chronic
 787 diseases and conditions, including the use of grants, waivers,
 788 demonstrations or other projects as necessary.
- 789 (b) Participation in any disease management
 790 program implemented under this paragraph (47) is optional with the
 791 individual. An individual must affirmatively elect to participate
 792 in the disease management program in order to participate, and may
 793 elect to discontinue participation in the program at any time.
 - (48) Pediatric long-term acute care hospital services.
- 795 (a) Pediatric long-term acute care hospital
 796 services means services provided to eligible persons under
 797 twenty-one (21) years of age by a freestanding Medicare-certified
 798 hospital that has an average length of inpatient stay greater than
 799 twenty-five (25) days and that is primarily engaged in providing
 800 chronic or long-term medical care to persons under twenty-one (21)
 801 years of age.



802		(b)	The	serv	rices	unde	r t	his	parag	graph	(48)	shall
803	be reimbursed	as a	sepa	rate	cate	ory o	of :	hosp	oital	servi	ces.	

- (49) The division * * * may establish copayments and/or coinsurance for * * * any Medicaid services for which copayments and/or coinsurance are allowable under federal law or regulation.
- (50) Services provided by the State Department of Rehabilitation Services for the care and rehabilitation of persons who are deaf and blind, as allowed under waivers from the United States Department of Health and Human Services to provide homeand community-based services using state funds that are provided from the appropriation to the State Department of Rehabilitation Services or if funds are voluntarily provided by another agency.
- association with annual redetermination of Medicaid eligibility, beneficiaries shall be encouraged to undertake a physical examination that will establish a base-line level of health and identification of a usual and customary source of care (a medical home) to aid utilization of disease management tools. This physical examination and utilization of these disease management tools shall be consistent with current United States Preventive Services Task Force or other recognized authority recommendations.

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



826	(52) Notwithstanding any provisions of this article,
827	the division may pay enhanced reimbursement fees related to trauma
828	care, as determined by the division in conjunction with the State
829	Department of Health, using funds appropriated to the State
830	Department of Health for trauma care and services and used to
831	match federal funds under a cooperative agreement between the
832	division and the State Department of Health. The division, in
833	conjunction with the State Department of Health, may use grants,
834	waivers, demonstrations, enhanced reimbursements, Upper Payment
835	Limits Programs, supplemental payments, or other projects as
836	necessary in the development and implementation of this
837	reimbursement program.

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- 838 (53)Targeted case management services for high-cost 839 beneficiaries may be developed by the division for all services 840 under this section.
- 841 (54)[Deleted]

842 (55)Therapy services. The plan of care for therapy services may be developed to cover a period of treatment for up to 843 844 six (6) months, but in no event shall the plan of care exceed a 845 six-month period of treatment. The projected period of treatment 846 must be indicated on the initial plan of care and must be updated 847 with each subsequent revised plan of care. Based on medical necessity, the division shall approve certification periods for 848 849 less than or up to six (6) months, but in no event shall the 850 certification period exceed the period of treatment indicated on



- the plan of care. The appeal process for any reduction in therapy services shall be consistent with the appeal process in federal regulations.
- 854 (56) Prescribed pediatric extended care centers
 855 services for medically dependent or technologically dependent
 856 children with complex medical conditions that require continual
 857 care as prescribed by the child's attending physician, as
 858 determined by the division.
- 859 (57) No Medicaid benefit shall restrict coverage for 860 medically appropriate treatment prescribed by a physician and 861 agreed to by a fully informed individual, or if the individual 862 lacks legal capacity to consent by a person who has legal 863 authority to consent on his or her behalf, based on an 864 individual's diagnosis with a terminal condition. As used in this 865 paragraph (57), "terminal condition" means any aggressive 866 malignancy, chronic end-stage cardiovascular or cerebral vascular 867 disease, or any other disease, illness or condition which a 868 physician diagnoses as terminal.
- 869 (58)Treatment services for persons with opioid 870 dependency or other highly addictive substance use disorders. The 871 division is authorized to reimburse eligible providers for 872 treatment of opioid dependency and other highly addictive 873 substance use disorders, as determined by the division. Treatment related to these conditions shall not count against any physician 874 visit limit imposed under this section. 875



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

- 882 (60) Bariatric surgery as determined by the division 883 and as allowed by federal law and regulation.
- (61) The division is authorized and directed to provide 885 up to twelve (12) months of continuous coverage postpartum for any 886 individual who qualifies for Medicaid coverage under this section as a pregnant woman, to the extent allowable under federal law and 887 888 as determined by the division. It is the intent of the 889 Legislature that the division shall reduce the application time 890 and simplify application procedures for pregnant women applying 891 for Medicaid coverage postpartum. Not later than July 1, 2022, 892 the division or its designee shall develop a report to the Legislature evaluating the effectiveness of extending Medicaid 893 894 coverage for pregnant women from sixty (60) days postpartum to three hundred sixty-five (365) days postpartum. 895
- 896 (B) * * * [Deleted]

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897 The division may pay to those providers who participate 898 in and accept patient referrals from the division's emergency room redirection program a percentage, as determined by the division, 899 900 of savings achieved according to the performance measures and



901 reduction of costs required of that program. Federally qualified 902 health centers may participate in the emergency room redirection 903 program, and the division may pay those centers a percentage of 904 any savings to the Medicaid program achieved by the centers' 905 accepting patient referrals through the program, as provided in 906 this subsection (C).

907 (D) [Deleted]

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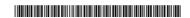
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- (E) Notwithstanding any provision of this article, no new groups or categories of recipients and new types of care and services may be added without enabling legislation from the Mississippi Legislature, except that the division may authorize those changes without enabling legislation when the addition of recipients or services is ordered by a court of proper authority.
 - (F) The executive director shall keep the Governor advised on a timely basis of the funds available for expenditure and the projected expenditures. Notwithstanding any other provisions of this article, if current or projected expenditures of the division are reasonably anticipated to exceed the amount of funds appropriated to the division for any fiscal year, the Governor, after consultation with the executive director, shall take all appropriate measures to reduce costs, which may include, but are not limited to:
- 923 (1) Reducing or discontinuing any or all services that 924 are deemed to be optional under Title XIX of the Social Security 925 Act;



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

- 933 (4) Any additional cost-containment measures deemed 934 appropriate by the Governor.
- 935 Beginning in fiscal year 2010 and in fiscal years thereafter, 936 when Medicaid expenditures are projected to exceed funds available 937 for the fiscal year, the division shall submit the expected 938 shortfall information to the PEER Committee not later than 939 December 1 of the year in which the shortfall is projected to 940 occur. PEER shall review the computations of the division and 941 report its findings to the Legislative Budget Office not later 942 than January 7 in any year.
- 943 (G) Notwithstanding any other provision of this article, it 944 shall be the duty of each provider participating in the Medicaid 945 program to keep and maintain books, documents and other records as 946 prescribed by the Division of Medicaid in * * * accordance with 947 federal laws and regulations.
- 948 (H) (1) Notwithstanding any other provision of this 949 article, the division is authorized to implement (a) a managed 950 care program, (b) a coordinated care program, (c) a coordinated



- care organization program, (d) a health maintenance organization
 program, (e) a patient-centered medical home program, (f) an
 accountable care organization program, (g) provider-sponsored
 health plan, or (h) any combination of the above programs. * * *

 As a condition for the approval of any program under this
 subsection (H)(1), the division shall require that no managed care
 program may:

 (a) Pay providers at a rate that is less than the
- 958 (a) Pay providers at a rate that is less than the 959 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG) 960 reimbursement rate;
- 961 Override the medical decisions of hospital (b) 962 physicians or staff regarding patients admitted to a hospital for 963 an emergency medical condition as defined by 42 US Code Section 964 This restriction (b) does not prohibit the retrospective 965 review of the appropriateness of the determination that an 966 emergency medical condition exists by chart review or coding 967 algorithm, nor does it prohibit prior authorization for 968 nonemergency hospital admissions;
 - (c) Pay providers at a rate that is less than the normal Medicaid reimbursement rate. However, the division may approve use of alternative payment models, including quality and value-based payment arrangements, provided both parties, the health care provider and the organization described in this subsection (H)(1), mutually agree and the Division of Medicaid approves of said models. It is the intent of the Legislature that



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976	all managed care entities described in this subsection (H), in
977	collaboration with the division, develop and implement innovative
978	payment models that incentivize improvements in health care
979	quality, outcomes, or value, as determined by the division.
980	Participation in the provider network of any managed care,
981	coordinated care, provider-sponsored health plan, or similar
982	contractor shall not be conditioned on the provider's agreement to
983	accept such alternative payment models;
984	(d) Implement a prior authorization program for
985	medical services, transportation services and prescription drugs
986	that is more stringent than the prior authorization processes used

988 (e) [Deleted]

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989 (f) Implement a preferred drug list that is more 990 stringent than the mandatory preferred drug list established by 991 the division under subsection (A)(9) of this section;

by the division in its administration of the Medicaid program;

- 992 (g) Implement a policy which denies beneficiaries 993 with hemophilia access to the federally funded hemophilia 994 treatment centers as part of the Medicaid Managed Care network of 995 providers. * * *
- 996 All health maintenance organizations, coordinated care
 997 organizations, provider-sponsored health plans, or other
 998 organization paid for services on a capitated basis by the
 999 division under any managed care program or coordinated care
 1000 program implemented by the division under this section shall



1001	implement a Level of Care Guidelines in the determination of
1002	medical necessity and in all utilization management practices,
1003	including the prior authorization process, concurrent reviews,
1004	retrospective reviews and payments.
1005	(2) Notwithstanding any provision of this section, the
1006	recipients eligible for enrollment into a Medicaid managed care
1007	program authorized under this subsection (H) shall include only
1008	those categories of recipients eligible for participation in the
1009	Medicaid managed care program as of January 1, 2019, and the

1012 a demonstration waiver to extend postpartum coverage for pregnant

Children's Health Insurance Program (CHIP), CMS approved Section

1115 demonstration waivers in operation as of January 1, 2021, and

women up to twelve (12) months or a period of time as may

1014 <u>otherwise be authorized under this article.</u> No expansion of

1015 Medicaid managed care program contracts may be implemented by the

1016 division without enabling legislation from the Mississippi

1017 Legislature. * * *

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1019 (3) (a) Any contractors * * * receiving capitated

1020 payments under a managed care * * * delivery system established in

1021 this section shall provide to the Legislature and the division

1022 statistical data to be shared with provider groups in order to

1023 improve patient access, appropriate utilization, cost savings and

1024 health outcomes not later than October 1 of each year.



Additionally, each contractor shall disclose to the Chairmen of

1026	the Senate and House Medicaid Committees the administrative
1027	expenses costs for the prior calendar year, and the number of
1028	full-equivalent employees located in the State of Mississippi
1029	dedicated to the Medicaid and CHIP lines of business as of June 30
1030	of the current year.
1031	(b) The division and the contractors participating
1032	in the managed care program, a coordinated care program or a
1033	provider-sponsored health plan shall be subject to annual program
1034	reviews or audits performed by the Office of the State Auditor,
1035	the PEER Committee and/or * * * independent third * * * $parties$.
1036	(c) Those * * * reviews shall * * * include, but
1037	<pre>not be limited to, at least two (2) of the following items * * *:</pre>
1038	(i) The financial benefit to the State of
1039	Mississippi of the managed care program,
1040	(ii) The difference between the premiums paid
1041	to the managed care contractors and the payments made by those
1042	contractors to health care providers, * * *
1043	(iii) Compliance with performance measures
1044	required under the contracts,
1045	(iv) Administrative expense allocation
1046	methodologies,
1047	(v) Whether nonprovider payments assigned as
1048	medical expenses are appropriate,
1049	(vi) Capitated arrangements with related
1050	party subcontractors,



1051	(vii) Reasonableness of corporate
1052	allocations,
1053	(viii) Value-added benefits and the extent to
1054	which they are used,
1055	(ix) The effectiveness of subcontractor
1056	oversight, including subcontractor review,
1057	(x) Whether * * * health care outcomes * * *
1058	have been improved, and
1059	(xi) The most common claim denial codes to
1060	determine the reasons for the denials.
1061	* * * $\underline{\text{The}}$ audit reports shall be considered * * * public
1062	documents and shall be posted in * * * $\underline{\text{their}}$ entirety on the
1063	division's website.
1064	(4) * * * [Deleted]
1065	(5) No health maintenance organization, coordinated
1066	care organization, provider-sponsored health plan, or other
1067	organization paid for services on a capitated basis by the
1068	division under any managed care program or coordinated care
1069	program implemented by the division under this section shall
1070	require its providers or beneficiaries to use any pharmacy that
1071	ships, mails or delivers prescription drugs or legend drugs or
1072	devices.
1073	(6) Not later than July 1, 2022, any contractors
1074	receiving capitated payments under a managed care delivery system
1075	established in this section shall develop and implement a uniform



1076	credentialing process by which all providers will be credentialed
1077	If the provisions of this subsection are not met by July 1, 2022,
1078	the division shall establish a uniform credentialing or screening
1079	process, and no health maintenance organization, coordinated care
1080	organization, provider-sponsored health plan, or other
1081	organization paid for services on a capitated basis by the
1082	division under any managed care program or coordinated care
1083	program implemented by the division under this section shall
1084	require its providers to be credentialed by the organization in
1085	order to receive reimbursement from the organization, but those
1086	organizations shall recognize the credentialing or screening of
1087	the providers by the division.

- 1088 (7) It is the intent of the Legislature that the
 1089 division evaluate the feasibility of continuing to administer
 1090 pharmacy benefits under the fee-for-service delivery system.
- 1091 (8) It is the intent of the Legislature that the
 1092 division evaluate the feasibility of utilizing a single vendor to
 1093 administer dental benefits provided under a managed care delivery
 1094 system established in this section.
 - (9) It is the intent of the Legislature that any contractor receiving capitated payments under a managed care delivery system established in this section shall implement innovative programs to improve the health and well-being of members diagnosed with prediabetes and diabetes.
- 1100 (I) [Deleted]

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- 1101 (J) * * * [Deleted]
- 1102 (K) In the negotiation and execution of such contracts
- 1103 involving services performed by actuarial firms, the Executive
- 1104 Director of the Division of Medicaid may negotiate a limitation on
- 1105 liability to the state of prospective contractors.
- 1106 (* * *L) This section shall stand repealed on July 1, * * *
- 1107 2022.
- 1108 **SECTION 2.** Section 43-13-145, Mississippi Code of 1972, is
- 1109 amended as follows:
- 1110 43-13-145. (1) (a) Upon each nursing facility licensed by
- 1111 the State of Mississippi, there is levied an assessment in an
- 1112 amount set by the division, equal to the maximum rate allowed by
- 1113 federal law or regulation, for each licensed and occupied bed of
- 1114 the facility.
- 1115 (b) A nursing facility is exempt from the assessment
- 1116 levied under this subsection if the facility is operated under the
- 1117 direction and control of:
- 1118 (i) The United States Veterans Administration or
- 1119 other agency or department of the United States government; or
- 1120 (ii) The State Veterans Affairs Board * * *.
- 1121 * * *
- 1122 (2) (a) Upon each intermediate care facility for
- 1123 individuals with intellectual disabilities licensed by the State
- 1124 of Mississippi, there is levied an assessment in an amount set by



- 1125 the division, equal to the maximum rate allowed by federal law or
- 1126 regulation, for each licensed and occupied bed of the facility.
- 1127 (b) An intermediate care facility for individuals with
- 1128 intellectual disabilities is exempt from the assessment levied
- 1129 under this subsection if the facility is operated under the
- 1130 direction and control of:
- 1131 (i) The United States Veterans Administration or
- 1132 other agency or department of the United States government;
- 1133 (ii) The State Veterans Affairs Board; or
- 1134 (iii) The University of Mississippi Medical
- 1135 Center.
- 1136 (3) (a) Upon each psychiatric residential treatment
- 1137 facility licensed by the State of Mississippi, there is levied an
- 1138 assessment in an amount set by the division, equal to the maximum
- 1139 rate allowed by federal law or regulation, for each licensed and
- 1140 occupied bed of the facility.
- 1141 (b) A psychiatric residential treatment facility is
- 1142 exempt from the assessment levied under this subsection if the
- 1143 facility is operated under the direction and control of:
- 1144 (i) The United States Veterans Administration or
- 1145 other agency or department of the United States government;
- 1146 (ii) The University of Mississippi Medical Center;
- 1147 or



- 1148 (iii) A state agency or a state facility that
 1149 either provides its own state match through intergovernmental
 1150 transfer or certification of funds to the division.
- 1151 (4) Hospital assessment.
- 1152 Subject to and upon fulfillment of the (i) 1153 requirements and conditions of paragraph (f) below, and 1154 notwithstanding any other provisions of this section, * * * an 1155 annual assessment on each hospital licensed in the state is 1156 imposed on each non-Medicare hospital inpatient day as defined 1157 below at a rate that is determined by dividing the sum prescribed 1158 in this subparagraph (i), plus the nonfederal share necessary to 1159 maximize the Disproportionate Share Hospital (DSH) and Medicare 1160 Upper Payment Limits (UPL) Program payments and hospital access 1161 payments and such other supplemental payments as may be developed 1162 pursuant to Section 43-13-117(A)(18), by the total number of 1163 non-Medicare hospital inpatient days as defined below for all 1164 licensed Mississippi hospitals, except as provided in paragraph 1165 (d) below. If the state-matching funds percentage for the 1166 Mississippi Medicaid program is sixteen percent (16%) or less, the 1167 sum used in the formula under this subparagraph (i) shall be 1168 Seventy-four Million Dollars (\$74,000,000.00). 1169 state-matching funds percentage for the Mississippi Medicaid 1170 program is twenty-four percent (24%) or higher, the sum used in 1171 the formula under this subparagraph (i) shall be One Hundred Four Million Dollars (\$104,000,000.00). If the state-matching funds 1172

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      percentage for the Mississippi Medicaid program is between sixteen
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      percent (16%) and twenty-four percent (24%), the sum used in the
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      formula under this subparagraph (i) shall be a pro rata amount
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      determined as follows: the current state-matching funds
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      percentage rate minus sixteen percent (16%) divided by eight
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      percent (8%) multiplied by Thirty Million Dollars ($30,000,000.00)
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      and add that amount to Seventy-four Million Dollars
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      ($74,000,000.00). However, no assessment in a quarter under this
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      subparagraph (i) may exceed the assessment in the previous quarter
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      by more than Three Million Seven Hundred Fifty Thousand Dollars
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      ($3,750,000.00) (which would be Fifteen Million Dollars
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      ($15,000,000.00) on an annualized basis). The division shall
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      publish the state-matching funds percentage rate applicable to the
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      Mississippi Medicaid program on the tenth day of the first month
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      of each quarter and the assessment determined under the formula
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      prescribed above shall be applicable in the quarter following any
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      adjustment in that state-matching funds percentage rate.
      division shall notify each hospital licensed in the state as to
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      any projected increases or decreases in the assessment determined
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      under this subparagraph (i). However, if the Centers for Medicare
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      and Medicaid Services (CMS) does not approve the provision in
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      Section 43-13-117(39) requiring the division to reimburse
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      crossover claims for inpatient hospital services and crossover
      claims covered under Medicare Part B for dually eligible
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      beneficiaries in the same manner that was in effect on January 1,
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- 2008, the sum that otherwise would have been used in the formula under this subparagraph (i) shall be reduced by Seven Million

 Dollars (\$7,000,000.00).
- 1201 (ii) In addition to the assessment provided under
 1202 subparagraph (i), * * * an additional annual assessment on each
- 1203 hospital licensed in the state is imposed on each non-Medicare
- 1204 hospital inpatient day as defined below at a rate that is
- 1205 determined by dividing twenty-five percent (25%) of any provider
- 1206 reductions in the Medicaid program as authorized in Section
- 1207 43-13-117(F) for that fiscal year up to the following maximum
- 1208 amount, plus the nonfederal share necessary to maximize the
- 1209 Disproportionate Share Hospital (DSH) and inpatient Medicare Upper
- 1210 Payment Limits (UPL) Program payments and inpatient hospital
- 1211 access payments, by the total number of non-Medicare hospital
- 1212 inpatient days as defined below for all licensed Mississippi
- 1213 hospitals: in fiscal year 2010, the maximum amount shall be
- 1214 Twenty-four Million Dollars (\$24,000,000.00); in fiscal year 2011,
- 1215 the maximum amount shall be Thirty-two Million Dollars
- 1216 (\$32,000,000.00); and in fiscal year 2012 and thereafter, the
- 1217 maximum amount shall be Forty Million Dollars (\$40,000,000.00).
- 1218 Any such deficit in the Medicaid program shall be reviewed by the
- 1219 PEER Committee as provided in Section 43-13-117(F).
- 1220 (iii) In addition to the assessments provided in
- 1221 subparagraphs (i) and (ii), * * * an additional annual assessment
- 1222 on each hospital licensed in the state is imposed pursuant to the

1223 provisions of Section 43-13-117(F) if the cost-containment 1224 measures described therein have been implemented and there are 1225 insufficient funds in the Health Care Trust Fund to reconcile any 1226 remaining deficit in any fiscal year. If the Governor institutes 1227 any other additional cost-containment measures on any program or 1228 programs authorized under the Medicaid program pursuant to Section 1229 43-13-117(F), hospitals shall be responsible for twenty-five 1230 percent (25%) of any such additional imposed provider cuts, which 1231 shall be in the form of an additional assessment not to exceed the 1232 twenty-five percent (25%) of provider expenditure reductions. 1233 Such additional assessment shall be imposed on each non-Medicare 1234 hospital inpatient day in the same manner as assessments are 1235 imposed under subparagraphs (i) and (ii). 1236 (b) * * * Definitions. 1237 (i) * * * [Deleted] 1238 (ii) * * * For purposes of this subsection (4): 1239 "Non-Medicare hospital inpatient day" 1240 means total hospital inpatient days including subcomponent days 1241 less Medicare inpatient days including subcomponent days from the 1242 hospital's most recent Medicare cost report for the second 1243 calendar year preceding the beginning of the state fiscal year, on 1244 file with CMS per the CMS HCRIS database, or cost report submitted

to the Division if the HCRIS database is not available to the

division, as of June 1 of each year.

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- 1247 Total hospital inpatient days shall 1248 be the sum of Worksheet S-3, Part 1, column 8 row 14, column 8 row 16, and column 8 row 17, excluding column 8 rows 5 and 6. 1249 1250 Hospital Medicare inpatient days 1251 shall be the sum of Worksheet S-3, Part 1, column 6 row 14, column 1252 6 row 16.00, and column 6 row 17, excluding column 6 rows 5 and 6. 1253 c. Inpatient days shall not include 1254 residential treatment or long-term care days. 1255 2. "Subcomponent inpatient day" means the 1256 number of days of care charged to a beneficiary for inpatient 1257 hospital rehabilitation and psychiatric care services in units of 1258 full days. A day begins at midnight and ends twenty-four (24) 1259 hours later. A part of a day, including the day of admission and day on which a patient returns from leave of absence, counts as a 1260 1261 full day. However, the day of discharge, death, or a day on which 1262 a patient begins a leave of absence is not counted as a day unless 1263 discharge or death occur on the day of admission. If admission 1264 and discharge or death occur on the same day, the day is 1265 considered a day of admission and counts as one (1) subcomponent 1266 inpatient day. 1267 The assessment provided in this subsection is
- 1267 (c) The assessment provided in this subsection is
 1268 intended to satisfy and not be in addition to the assessment and
 1269 intergovernmental transfers provided in Section 43-13-117(A)(18).
 1270 Nothing in this section shall be construed to authorize any state
 1271 agency, division or department, or county, municipality or other

- 1272 local governmental unit to license for revenue, levy or impose any
- 1273 other tax, fee or assessment upon hospitals in this state not
- 1274 authorized by a specific statute.
- 1275 (d) Hospitals operated by the United States Department
- 1276 of Veterans Affairs and state-operated facilities that provide
- 1277 only inpatient and outpatient psychiatric services shall not be
- 1278 subject to the hospital assessment provided in this subsection.
- 1279 (e) Multihospital systems, closure, merger, change of
- 1280 ownership and new hospitals.
- 1281 (i) If a hospital conducts, operates or maintains
- 1282 more than one (1) hospital licensed by the State Department of
- 1283 Health, the provider shall pay the hospital assessment for each
- 1284 hospital separately.
- 1285 (ii) Notwithstanding any other provision in this
- 1286 section, if a hospital subject to this assessment operates or
- 1287 conducts business only for a portion of a fiscal year, the
- 1288 assessment for the state fiscal year shall be adjusted by
- 1289 multiplying the assessment by a fraction, the numerator of which
- 1290 is the number of days in the year during which the hospital
- 1291 operates, and the denominator of which is three hundred sixty-five
- 1292 (365). Immediately upon ceasing to operate, the hospital shall
- 1293 pay the assessment for the year as so adjusted (to the extent not
- 1294 previously paid).
- 1295 (iii) The division shall determine the tax for new
- 1296 hospitals and hospitals that undergo a change of ownership in

- 1297 accordance with this section, using the best available
- 1298 information, as determined by the division.
- 1299 (f) Applicability.
- The hospital assessment imposed by this subsection shall not
- 1301 take effect and/or shall cease to be imposed if:
- 1302 (i) The assessment is determined to be an
- 1303 impermissible tax under Title XIX of the Social Security Act; or
- 1304 (ii) CMS revokes its approval of the division's
- 1305 2009 Medicaid State Plan Amendment for the methodology for DSH
- 1306 payments to hospitals under Section 43-13-117(A)(18).
- 1307 * * *
- 1308 (5) Each health care facility that is subject to the
- 1309 provisions of this section shall keep and preserve such suitable
- 1310 books and records as may be necessary to determine the amount of
- 1311 assessment for which it is liable under this section. The books
- 1312 and records shall be kept and preserved for a period of not less
- 1313 than five (5) years, during which time those books and records
- 1314 shall be open for examination during business hours by the
- 1315 division, the Department of Revenue, the Office of the Attorney
- 1316 General and the State Department of Health.
- 1317 (6) * * * [Deleted]
- 1318 (7) All assessments collected under this section shall be
- 1319 deposited in the Medical Care Fund created by Section 43-13-143.
- 1320 (8) The assessment levied under this section shall be in
- 1321 addition to any other assessments, taxes or fees levied by law,



and the assessment shall constitute a debt due the State of

Mississippi from the time the assessment is due until it is paid.

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

(b) As an additional or alternative method for collecting unpaid assessments levied by the division, if a health care facility fails or refuses to pay the assessment after receiving notice and demand from the division, the division may

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1347 file a notice of a tax lien with the chancery clerk of the county in which the health care facility is located, for the amount of 1348 the unpaid assessment and a penalty of ten percent (10%) of the 1349 1350 amount of the assessment, plus the legal rate of interest until 1351 the assessment is paid in full. Immediately upon receipt of 1352 notice of the tax lien for the assessment, the chancery clerk shall forward the notice to the circuit clerk who shall enter the 1353 1354 notice of the tax lien as a judgment upon the judgment roll and 1355 show in the appropriate columns the name of the health care 1356 facility as judgment debtor, the name of the division as judgment 1357 creditor, the amount of the unpaid assessment, and the date and 1358 time of enrollment. The judgment shall be valid as against 1359 mortgagees, pledgees, entrusters, purchasers, judgment creditors 1360 and other persons from the time of filing with the clerk. 1361 amount of the judgment shall be a debt due the State of 1362 Mississippi and remain a lien upon the tangible property of the 1363 health care facility until the judgment is satisfied. 1364 judgment shall be the equivalent of any enrolled judgment of a 1365 court of record and shall serve as authority for the issuance of writs of execution, writs of attachment or other remedial writs. 1366 1367 (a) To further the provisions of Section 43-13-117(A)(18), the Division of Medicaid shall submit to the 1368 1369 Centers for Medicare and Medicaid Services (CMS) any documents 1370 regarding the hospital assessment established under subsection (4) 1371 of this section. In addition to defining the assessment

- established in subsection (4) of this section if necessary, the
 documents shall describe any supplement payment programs and/or
 payment methodologies as authorized in Section 43-13-117(A)(18) if
 necessary.
- 1376 All hospitals satisfying the minimum federal DSH 1377 eligibility requirements (Section 1923(d) of the Social Security 1378 Act) may, subject to OBRA 1993 payment limitations, receive a DSH 1379 payment. This DSH payment shall expend the balance of the federal 1380 DSH allotment and associated state share not utilized in DSH payments to state-owned institutions for treatment of mental 1381 1382 diseases. The payment to each hospital shall be calculated by 1383 applying a uniform percentage to the uninsured costs of each 1384 eligible hospital, excluding state-owned institutions for 1385 treatment of mental diseases; however, that percentage for a 1386 state-owned teaching hospital located in Hinds County shall be 1387 multiplied by a factor of two (2).
- 1388 (11) The division shall implement DSH and supplemental
 1389 payment calculation methodologies that result in the maximization
 1390 of available federal funds.
- 1391 (12) The DSH payments shall be paid on or before December
 1392 31, March 31, and June 30 of each fiscal year, in increments of
 1393 one-third (1/3) of the total calculated DSH amounts. Supplemental
 1394 payments developed pursuant to Section 43-13-117(A) (18) shall be
 1395 paid monthly.
- 1396 (13) * * * Payment.



1397	(a) The hospital assessment as described in subsection
1398	(4) for the nonfederal share necessary to maximize the Medicare
1399	Upper Payments Limits (UPL) Program payments and hospital access
1400	payments and such other supplemental payments as may be developed
1401	pursuant to Section 43-3-117(A)(18) shall be assessed and
1402	collected monthly no later than the fifteenth calendar day of each
1403	month.
1404	(b) The hospital assessment as described in subsection
1405	(4) for the nonfederal share necessary to maximize the
1406	Disproportionate Share Hospital (DSH) payments shall be assessed
1407	and collected on December 15, March 15 and June 15.
1408	(c) The annual hospital assessment and any additional
1409	hospital assessment as described in subsection (4) shall be
1410	assessed and collected on September 15 and on the 15th of each
1411	month from December through June.
1412	(14) If for any reason any part of the plan for annual DSH
1413	and supplemental payment programs to hospitals provided under
1414	subsection (10) of this section and/or developed pursuant to
1415	Section 43-13-117(A)(18) is not approved by CMS, the remainder of
1416	the plan shall remain in full force and effect.
1417	(15) Nothing in this section shall prevent the Division of
1418	Medicaid from facilitating participation in Medicaid supplemental
1419	hospital payment programs by a hospital located in a county
1420	contiguous to the State of Mississippi that is also authorized by
1421	federal law to submit intergovernmental transfers (IGTs) to the



- 1422 State of Mississippi to fund the state share of the hospital's
- 1423 supplemental and/or MHAP payments.
- 1424 (16) Subsections (10) through (15) of this section shall
- 1425 stand repealed on July 1, * * * 2022.
- 1426 **SECTION 3.** Section 41-7-191, Mississippi Code of 1972, is
- 1427 amended as follows:
- 1428 41-7-191. (1) No person shall engage in any of the
- 1429 following activities without obtaining the required certificate of
- 1430 need:
- 1431 (a) The construction, development or other
- 1432 establishment of a new health care facility, which establishment
- 1433 shall include the reopening of a health care facility that has
- 1434 ceased to operate for a period of sixty (60) months or more;
- 1435 (b) The relocation of a health care facility or portion
- 1436 thereof, or major medical equipment, unless such relocation of a
- 1437 health care facility or portion thereof, or major medical
- 1438 equipment, which does not involve a capital expenditure by or on
- 1439 behalf of a health care facility, is within five thousand two
- 1440 hundred eighty (5,280) feet from the main entrance of the health
- 1441 care facility;
- 1442 (c) Any change in the existing bed complement of any
- 1443 health care facility through the addition or conversion of any
- 1444 beds or the alteration, modernizing or refurbishing of any unit or
- 1445 department in which the beds may be located; however, if a health
- 1446 care facility has voluntarily delicensed some of its existing bed



1447	complement, it may later relicense some or all of its delicensed
1448	beds without the necessity of having to acquire a certificate of
1449	need. The State Department of Health shall maintain a record of
1450	the delicensing health care facility and its voluntarily
1451	delicensed beds and continue counting those beds as part of the
1452	state's total bed count for health care planning purposes. If a
1453	health care facility that has voluntarily delicensed some of its
1454	beds later desires to relicense some or all of its voluntarily
1455	delicensed beds, it shall notify the State Department of Health of
1456	its intent to increase the number of its licensed beds. The State
1457	Department of Health shall survey the health care facility within
1458	thirty (30) days of that notice and, if appropriate, issue the
1459	health care facility a new license reflecting the new contingent
1460	of beds. However, in no event may a health care facility that has
1461	voluntarily delicensed some of its beds be reissued a license to
1462	operate beds in excess of its bed count before the voluntary
1463	delicensure of some of its beds without seeking certificate of
1464	need approval;

- (d) Offering of the following health services if those services have not been provided on a regular basis by the proposed provider of such services within the period of twelve (12) months prior to the time such services would be offered:
 - (i) Open-heart surgery services;
- 1470 (ii) Cardiac catheterization services;



1471	(iii) Comprehensive inpatient rehabilitation
1472	services;
1473	(iv) Licensed psychiatric services;
1474	(v) Licensed chemical dependency services;
1475	(vi) Radiation therapy services;
1476	(vii) Diagnostic imaging services of an invasive
1477	nature, i.e. invasive digital angiography;
1478	(viii) Nursing home care as defined in
1479	subparagraphs (iv), (vi) and (viii) of Section 41-7-173(h);
1480	(ix) Home health services;
1481	(x) Swing-bed services;
1482	(xi) Ambulatory surgical services;
1483	(xii) Magnetic resonance imaging services;
1484	(xiii) [Deleted]
1485	(xiv) Long-term care hospital services;
1486	(xv) Positron emission tomography (PET) services;
1487	(e) The relocation of one or more health services from
1488	one physical facility or site to another physical facility or
1489	site, unless such relocation, which does not involve a capital
1490	expenditure by or on behalf of a health care facility, (i) is to a
1491	physical facility or site within five thousand two hundred eighty
1492	(5,280) feet from the main entrance of the health care facility
1493	where the health care service is located, or (ii) is the result of
1494	an order of a court of appropriate jurisdiction or a result of
1495	pending litigation in such court, or by order of the State



Department of Health, or by order of any other agency or legal entity of the state, the federal government, or any political subdivision of either, whose order is also approved by the State Department of Health;

- medical equipment for the provision of medical services; however,

 (i) the acquisition of any major medical equipment used only for research purposes, and (ii) the acquisition of major medical equipment to replace medical equipment for which a facility is already providing medical services and for which the State

 Department of Health has been notified before the date of such acquisition shall be exempt from this paragraph; an acquisition for less than fair market value must be reviewed, if the acquisition at fair market value would be subject to review;
- 1510 Changes of ownership of existing health care 1511 facilities in which a notice of intent is not filed with the State 1512 Department of Health at least thirty (30) days prior to the date such change of ownership occurs, or a change in services or bed 1513 1514 capacity as prescribed in paragraph (c) or (d) of this subsection 1515 as a result of the change of ownership; an acquisition for less 1516 than fair market value must be reviewed, if the acquisition at 1517 fair market value would be subject to review;
- 1518 (h) The change of ownership of any health care facility
 1519 defined in subparagraphs (iv), (vi) and (viii) of Section
 1520 41-7-173(h), in which a notice of intent as described in paragraph



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- 1521 (g) has not been filed and if the Executive Director, Division of
- 1522 Medicaid, Office of the Governor, has not certified in writing
- 1523 that there will be no increase in allowable costs to Medicaid from
- 1524 revaluation of the assets or from increased interest and
- 1525 depreciation as a result of the proposed change of ownership;
- 1526 (i) Any activity described in paragraphs (a) through
- 1527 (h) if undertaken by any person if that same activity would
- 1528 require certificate of need approval if undertaken by a health
- 1529 care facility;
- 1530 (j) Any capital expenditure or deferred capital
- 1531 expenditure by or on behalf of a health care facility not covered
- 1532 by paragraphs (a) through (h);
- 1533 (k) The contracting of a health care facility as
- 1534 defined in subparagraphs (i) through (viii) of Section 41-7-173(h)
- 1535 to establish a home office, subunit, or branch office in the space
- 1536 operated as a health care facility through a formal arrangement
- 1537 with an existing health care facility as defined in subparagraph
- 1538 (ix) of Section 41-7-173 (h);
- 1539 (1) The replacement or relocation of a health care
- 1540 facility designated as a critical access hospital shall be exempt
- 1541 from subsection (1) of this section so long as the critical access
- 1542 hospital complies with all applicable federal law and regulations
- 1543 regarding such replacement or relocation;
- 1544 (m) Reopening a health care facility that has ceased to
- 1545 operate for a period of sixty (60) months or more, which reopening



1546 requires a certificate of need for the establishment of a new 1547 health care facility.

- (2) The State Department of Health shall not grant approval for or issue a certificate of need to any person proposing the new construction of, addition to, or expansion of any health care facility defined in subparagraphs (iv) (skilled nursing facility) and (vi) (intermediate care facility) of Section 41-7-173(h) or the conversion of vacant hospital beds to provide skilled or intermediate nursing home care, except as hereinafter authorized:
- (a) The department may issue a certificate of need to any person proposing the new construction of any health care facility defined in subparagraphs (iv) and (vi) of Section 41-7-173(h) as part of a life care retirement facility, in any county bordering on the Gulf of Mexico in which is located a National Aeronautics and Space Administration facility, not to exceed forty (40) beds. From and after July 1, 1999, there shall be no prohibition or restrictions on participation in the Medicaid program (Section 43-13-101 et seq.) for the beds in the health care facility that were authorized under this paragraph (a).
- 1565 (b) The department may issue certificates of need in
 1566 Harrison County to provide skilled nursing home care for
 1567 Alzheimer's disease patients and other patients, not to exceed one
 1568 hundred fifty (150) beds. From and after July 1, 1999, there
 1569 shall be no prohibition or restrictions on participation in the



Medicaid program (Section 43-13-101 et seq.) for the beds in the nursing facilities that were authorized under this paragraph (b).

The department may issue a certificate of need for the addition to or expansion of any skilled nursing facility that is part of an existing continuing care retirement community located in Madison County, 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 shall be fully binding on any subsequent owner of the skilled nursing facility, if the ownership of the facility is transferred at any time after the issuance of the certificate of need. Agreement that the skilled nursing facility will not participate in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this paragraph (c), and if such skilled nursing facility at any time after the issuance of the certificate of need, regardless of the ownership of the facility, participates in the Medicaid program or admits or keeps any patients in the facility who are participating in the Medicaid program, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or revoke the license of the skilled nursing facility, at the time that the department determines, after a hearing

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complying with due process, that the facility has failed to comply with any of the conditions upon which the certificate of need was issued, as provided in this paragraph and in the written agreement by the recipient of the certificate of need. The total number of beds that may be authorized under the authority of this paragraph (c) shall not exceed sixty (60) beds.

- 1601 The State Department of Health may issue a (d) 1602 certificate of need to any hospital located in DeSoto County for the new construction of a skilled nursing facility, not to exceed 1603 1604 one hundred twenty (120) beds, in DeSoto County. From and after 1605 July 1, 1999, there shall be no prohibition or restrictions on participation in the Medicaid program (Section 43-13-101 et seq.) 1606 1607 for the beds in the nursing facility that were authorized under 1608 this paragraph (d).
- 1609 The State Department of Health may issue a 1610 certificate of need for the construction of a nursing facility or 1611 the conversion of beds to nursing facility beds at a personal care 1612 facility for the elderly in Lowndes County that is owned and 1613 operated by a Mississippi nonprofit corporation, not to exceed 1614 sixty (60) beds. From and after July 1, 1999, there shall be no 1615 prohibition or restrictions on participation in the Medicaid program (Section 43-13-101 et seq.) for the beds in the nursing 1616 1617 facility that were authorized under this paragraph (e).
- 1618 (f) The State Department of Health may issue a
 1619 certificate of need for conversion of a county hospital facility

- in Itawamba County to a nursing facility, not to exceed sixty (60) beds, including any necessary construction, renovation or expansion. From and after July 1, 1999, there shall be no prohibition or restrictions on participation in the Medicaid
- 1624 program (Section 43-13-101 et seq.) for the beds in the nursing
- 1625 facility that were authorized under this paragraph (f).
- 1626 (g) The State Department of Health may issue a

 1627 certificate of need for the construction or expansion of nursing

 1628 facility beds or the conversion of other beds to nursing facility

 1629 beds in either Hinds, Madison or Rankin County, not to exceed

 1630 sixty (60) beds. From and after July 1, 1999, there shall be no

 1631 prohibition or restrictions on participation in the Medicaid
- 1632 program (Section 43-13-101 et seq.) for the beds in the nursing
- 1633 facility that were authorized under this paragraph (g).
- (h) The State Department of Health may issue a certificate of need for the construction or expansion of nursing facility beds or the conversion of other beds to nursing facility beds in either Hancock, Harrison or Jackson County, not to exceed sixty (60) beds. From and after July 1, 1999, there shall be no prohibition or restrictions on participation in the Medicaid
- 1640 program (Section 43-13-101 et seq.) for the beds in the facility
- 1641 that were authorized under this paragraph (h).
- 1642 (i) The department may issue a certificate of need for
- 1643 the new construction of a skilled nursing facility in Leake
- 1644 County, provided that the recipient of the certificate of need



1645 agrees in writing that the skilled nursing facility will not at 1646 any time participate in the Medicaid program (Section 43-13-101 et 1647 seq.) or admit or keep any patients in the skilled nursing facility who are participating in the Medicaid program. 1648 1649 written agreement by the recipient of the certificate of need 1650 shall be fully binding on any subsequent owner of the skilled 1651 nursing facility, if the ownership of the facility is transferred 1652 at any time after the issuance of the certificate of need. Agreement that the skilled nursing facility will not participate 1653 in the Medicaid program shall be a condition of the issuance of a 1654 1655 certificate of need to any person under this paragraph (i), and if 1656 such skilled nursing facility at any time after the issuance of 1657 the certificate of need, regardless of the ownership of the 1658 facility, participates in the Medicaid program or admits or keeps 1659 any patients in the facility who are participating in the Medicaid 1660 program, the State Department of Health shall revoke the 1661 certificate of need, if it is still outstanding, and shall deny or 1662 revoke the license of the skilled nursing facility, at the time 1663 that the department determines, after a hearing complying with due process, that the facility has failed to comply with any of the 1664 1665 conditions upon which the certificate of need was issued, as 1666 provided in this paragraph and in the written agreement by the recipient of the certificate of need. The provision of Section 1667 41-7-193(1) regarding substantial compliance of the projection of 1668 1669 need as reported in the current State Health Plan is waived for



1670 the purposes of this paragraph. The total number of nursing 1671 facility beds that may be authorized by any certificate of need 1672 issued under this paragraph (i) shall not exceed sixty (60) beds. 1673 If the skilled nursing facility authorized by the certificate of 1674 need issued under this paragraph is not constructed and fully 1675 operational within eighteen (18) months after July 1, 1994, the 1676 State Department of Health, after a hearing complying with due process, shall revoke the certificate of need, if it is still 1677 outstanding, and shall not issue a license for the skilled nursing 1678 1679 facility at any time after the expiration of the eighteen-month 1680 period.

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

1692 (k) The department may issue a certificate of need for 1693 the construction of a nursing facility at a continuing care 1694 retirement community in Lowndes County. The total number of beds



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that may be authorized under the authority of this paragraph (k)
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      shall not exceed sixty (60) beds. From and after July 1, 2001,
      the prohibition on the facility participating in the Medicaid
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      program (Section 43-13-101 et seq.) that was a condition of
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      issuance of the certificate of need under this paragraph (k) shall
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      be revised as follows: The nursing facility may participate in
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      the Medicaid program from and after July 1, 2001, if the owner of
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      the facility on July 1, 2001, agrees in writing that no more than
      thirty (30) of the beds at the facility will be certified for
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      participation in the Medicaid program, and that no claim will be
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      submitted for Medicaid reimbursement for more than thirty (30)
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      patients in the facility in any month or for any patient in the
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      facility who is in a bed that is not Medicaid-certified.
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      written agreement by the owner of the facility shall be a
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      condition of licensure of the facility, and the agreement shall be
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      fully binding on any subsequent owner of the facility if the
      ownership of the facility is transferred at any time after July 1,
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      2001. After this written agreement is executed, the Division of
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      Medicaid and the State Department of Health shall not certify more
      than thirty (30) of the beds in the facility for participation in
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      the Medicaid program. If the facility violates the terms of the
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      written agreement by admitting or keeping in the facility on a
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      regular or continuing basis more than thirty (30) patients who are
      participating in the Medicaid program, the State Department of
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      Health shall revoke the license of the facility, at the time that
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the department determines, after a hearing complying with due process, that the facility has violated the written agreement.

- therefor by the Legislature, the department may issue a certificate of need to a rehabilitation hospital in Hinds County for the construction of a sixty-bed long-term care nursing facility dedicated to the care and treatment of persons with severe disabilities including persons with spinal cord and closed-head injuries and ventilator dependent patients. The provisions of Section 41-7-193(1) regarding substantial compliance with projection of need as reported in the current State Health Plan are waived for the purpose of this paragraph.
- 1732 The State Department of Health may issue a certificate of need to a county-owned hospital in the Second 1733 1734 Judicial District of Panola County for the conversion of not more 1735 than seventy-two (72) hospital beds to nursing facility beds, 1736 provided that the recipient of the certificate of need agrees in 1737 writing that none of the beds at the nursing facility will be 1738 certified for participation in the Medicaid program (Section 43-13-101 et seq.), and that no claim will be submitted for 1739 1740 Medicaid reimbursement in the nursing facility in any day or for 1741 any patient in the nursing facility. This written agreement by 1742 the recipient of the certificate of need shall be a condition of the issuance of the certificate of need under this paragraph, and 1743 1744 the agreement shall be fully binding on any subsequent owner of

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1745 the nursing facility if the ownership of the nursing facility is 1746 transferred at any time after the issuance of the certificate of 1747 need. After this written agreement is executed, the Division of Medicaid and the State Department of Health shall not certify any 1748 1749 of the beds in the nursing facility for participation in the 1750 Medicaid program. If the nursing facility violates the terms of the written agreement by admitting or keeping in the nursing 1751 1752 facility on a regular or continuing basis any patients who are participating in the Medicaid program, the State Department of 1753 1754 Health shall revoke the license of the nursing facility, at the 1755 time that the department determines, after a hearing complying 1756 with due process, that the nursing facility has violated the 1757 condition upon which the certificate of need was issued, as provided in this paragraph and in the written agreement. If the 1758 1759 certificate of need authorized under this paragraph is not issued 1760 within twelve (12) months after July 1, 2001, the department shall 1761 deny the application for the certificate of need and shall not 1762 issue the certificate of need at any time after the twelve-month 1763 period, unless the issuance is contested. If the certificate of 1764 need is issued and substantial construction of the nursing 1765 facility beds has not commenced within eighteen (18) months after 1766 July 1, 2001, the State Department of Health, after a hearing complying with due process, shall revoke the certificate of need 1767 if it is still outstanding, and the department shall not issue a 1768 license for the nursing facility at any time after the 1769



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.

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

1795 shall deny or revoke the license of the skilled nursing facility, 1796 at the time that the department determines, after a hearing complying with due process, that the facility has failed to comply 1797 1798 with any of the conditions upon which the certificate of need was 1799 issued, as provided in this paragraph and in the written agreement 1800 by the recipient of the certificate of need. The total number of 1801 nursing facility beds that may be authorized by any certificate of 1802 need issued under this paragraph (n) shall not exceed sixty (60) 1803 If the certificate of need authorized under this paragraph 1804 is not issued within twelve (12) months after July 1, 1998, the 1805 department shall deny the application for the certificate of need 1806 and shall not issue the certificate of need at any time after the 1807 twelve-month period, unless the issuance is contested. certificate of need is issued and substantial construction of the 1808 1809 nursing facility beds has not commenced within eighteen (18) 1810 months after July 1, 1998, the State Department of Health, after a 1811 hearing complying with due process, shall revoke the certificate 1812 of need if it is still outstanding, and the department shall not 1813 issue a license for the nursing facility at any time after the eighteen-month period. However, if the issuance of the 1814 1815 certificate of need is contested, the department shall require 1816 substantial construction of the nursing facility beds within six 1817 (6) months after final adjudication on the issuance of the certificate of need. 1818



1819	(o) The department may issue a certificate of need for
1820	the new construction, addition or conversion of skilled nursing
1821	facility beds in Leake County, provided that the recipient of the
1822	certificate of need agrees in writing that the skilled nursing
1823	facility will not at any time participate in the Medicaid program
1824	(Section 43-13-101 et seq.) or admit or keep any patients in the
1825	skilled nursing facility who are participating in the Medicaid
1826	program. This written agreement by the recipient of the
1827	certificate of need shall be fully binding on any subsequent owner
1828	of the skilled nursing facility, if the ownership of the facility
1829	is transferred at any time after the issuance of the certificate
1830	of need. Agreement that the skilled nursing facility will not
1831	participate in the Medicaid program shall be a condition of the
1832	issuance of a certificate of need to any person under this
1833	paragraph (o), and if such skilled nursing facility at any time
1834	after the issuance of the certificate of need, regardless of the
1835	ownership of the facility, participates in the Medicaid program or
1836	admits or keeps any patients in the facility who are participating
1837	in the Medicaid program, the State Department of Health shall
1838	revoke the certificate of need, if it is still outstanding, and
1839	shall deny or revoke the license of the skilled nursing facility,
1840	at the time that the department determines, after a hearing
1841	complying with due process, that the facility has failed to comply
1842	with any of the conditions upon which the certificate of need was
1843	issued, as provided in this paragraph and in the written agreement

1844 by the recipient of the certificate of need. The total number of 1845 nursing facility beds that may be authorized by any certificate of need issued under this paragraph (o) shall not exceed sixty (60) 1846 If the certificate of need authorized under this paragraph 1847 1848 is not issued within twelve (12) months after July 1, 2001, the 1849 department shall deny the application for the certificate of need 1850 and shall not issue the certificate of need at any time after the 1851 twelve-month period, unless the issuance is contested. certificate of need is issued and substantial construction of the 1852 1853 nursing facility beds has not commenced within eighteen (18) 1854 months after July 1, 2001, the State Department of Health, after a hearing complying with due process, shall revoke the certificate 1855 1856 of need if it is still outstanding, and the department shall not issue a license for the nursing facility at any time after the 1857 1858 eighteen-month period. However, if the issuance of the 1859 certificate of need is contested, the department shall require 1860 substantial construction of the nursing facility beds within six 1861 (6) months after final adjudication on the issuance of the 1862 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



1869 seq.) or admit or keep any patients in the skilled nursing 1870 facility who are participating in the Medicaid program. written agreement by the recipient of the certificate of need 1871 1872 shall be fully binding on any subsequent owner of the skilled 1873 nursing facility, if the ownership of the facility is transferred 1874 at any time after the issuance of the certificate of need. 1875 Agreement that the skilled nursing facility will not participate 1876 in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this paragraph (p), and if 1877 1878 such skilled nursing facility at any time after the issuance of 1879 the certificate of need, regardless of the ownership of the 1880 facility, participates in the Medicaid program or admits or keeps 1881 any patients in the facility who are participating in the Medicaid program, the State Department of Health shall revoke the 1882 1883 certificate of need, if it is still outstanding, and shall deny or 1884 revoke the license of the skilled nursing facility, at the time 1885 that the department determines, after a hearing complying with due process, that the facility has failed to comply with any of the 1886 1887 conditions upon which the certificate of need was issued, as 1888 provided in this paragraph and in the written agreement by the 1889 recipient of the certificate of need. The provision of Section 1890 41-7-193(1) regarding substantial compliance of the projection of 1891 need as reported in the current State Health Plan is waived for the purposes of this paragraph. If the certificate of need 1892 1893 authorized under this paragraph is not issued within twelve (12)



1894 months after July 1, 1998, the department shall deny the 1895 application for the certificate of need and shall not issue the 1896 certificate of need at any time after the twelve-month period, 1897 unless the issuance is contested. If the certificate of need is 1898 issued and substantial construction of the nursing facility beds 1899 has not commenced within eighteen (18) months after July 1, 1998, 1900 the State Department of Health, after a hearing complying with due 1901 process, shall revoke the certificate of need if it is still 1902 outstanding, and the department shall not issue a license for the 1903 nursing facility at any time after the eighteen-month period. 1904 However, if the issuance of the certificate of need is contested, 1905 the department shall require substantial construction of the 1906 nursing facility beds within six (6) months after final 1907 adjudication on the issuance of the certificate of need. (i) Beginning on July 1, 1999, the State 1908 1909 Department of Health shall issue certificates of need during each 1910 of the next four (4) fiscal years for the construction or expansion of nursing facility beds or the conversion of other beds 1911 1912 to nursing facility beds in each county in the state having a need for fifty (50) or more additional nursing facility beds, as shown 1913 1914 in the fiscal year 1999 State Health Plan, in the manner provided 1915 in this paragraph (q). The total number of nursing facility beds 1916 that may be authorized by any certificate of need authorized under 1917 this paragraph (q) shall not exceed sixty (60) beds.



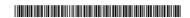
1918	(ii) Subject to the provisions of subparagraph
1919	(v), during each of the next four (4) fiscal years, the department
1920	shall issue six (6) certificates of need for new nursing facility
1921	beds, as follows: During fiscal years 2000, 2001 and 2002, one
1922	(1) certificate of need shall be issued for new nursing facility
1923	beds in the county in each of the four (4) Long-Term Care Planning
1924	Districts designated in the fiscal year 1999 State Health Plan
1925	that has the highest need in the district for those beds; and two
1926	(2) certificates of need shall be issued for new nursing facility
1927	beds in the two (2) counties from the state at large that have the
1928	highest need in the state for those beds, when considering the
1929	need on a statewide basis and without regard to the Long-Term Care
1930	Planning Districts in which the counties are located. During
1931	fiscal year 2003, one (1) certificate of need shall be issued for
1932	new nursing facility beds in any county having a need for fifty
1933	(50) or more additional nursing facility beds, as shown in the
1934	fiscal year 1999 State Health Plan, that has not received a
1935	certificate of need under this paragraph (q) during the three (3)
1936	previous fiscal years. During fiscal year 2000, in addition to
1937	the six (6) certificates of need authorized in this subparagraph,
1938	the department also shall issue a certificate of need for new
1939	nursing facility beds in Amite County and a certificate of need
1940	for new nursing facility beds in Carroll County.
1941	(iii) Subject to the provisions of subparagraph
1942	(v), the certificate of need issued under subparagraph (ii) for

1943 nursing facility beds in each Long-Term Care Planning District 1944 during each fiscal year shall first be available for nursing facility beds in the county in the district having the highest 1945 need for those beds, as shown in the fiscal year 1999 State Health 1946 1947 Plan. If there are no applications for a certificate of need for 1948 nursing facility beds in the county having the highest need for those beds by the date specified by the department, then the 1949 1950 certificate of need shall be available for nursing facility beds 1951 in other counties in the district in descending order of the need 1952 for those beds, from the county with the second highest need to 1953 the county with the lowest need, until an application is received 1954 for nursing facility beds in an eligible county in the district. 1955 (iv) Subject to the provisions of subparagraph 1956 (v), the certificate of need issued under subparagraph (ii) for 1957 nursing facility beds in the two (2) counties from the state at 1958 large during each fiscal year shall first be available for nursing 1959 facility beds in the two (2) counties that have the highest need in the state for those beds, as shown in the fiscal year 1999 1960 1961 State Health Plan, when considering the need on a statewide basis and without regard to the Long-Term Care Planning Districts in 1962 1963 which the counties are located. If there are no applications for 1964 a certificate of need for nursing facility beds in either of the 1965 two (2) counties having the highest need for those beds on a statewide basis by the date specified by the department, then the 1966 certificate of need shall be available for nursing facility beds 1967

in other counties from the state at large in descending order of
the need for those beds on a statewide basis, from the county with
the second highest need to the county with the lowest need, until
an application is received for nursing facility beds in an
eligible county from the state at large.

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

1990 (vi) If more than one (1) application is made for
1991 a certificate of need for nursing home facility beds available
1992 under this paragraph (q), in Yalobusha, Newton or Tallahatchie



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- 1993 County, and one (1) of the applicants is a county-owned hospital
- 1994 located in the county where the nursing facility beds are
- 1995 available, the department shall give priority to the county-owned
- 1996 hospital in granting the certificate of need if the following
- 1997 conditions are met:
- 1998 1. The county-owned hospital fully meets all
- 1999 applicable criteria and standards required to obtain a certificate
- 2000 of need for the nursing facility beds; and
- 2001 2. The county-owned hospital's qualifications
- 2002 for the certificate of need, as shown in its application and as
- 2003 determined by the department, are at least equal to the
- 2004 qualifications of the other applicants for the certificate of
- 2005 need.
- 2006 (r) (i) Beginning on July 1, 1999, the State
- 2007 Department of Health shall issue certificates of need during each
- 2008 of the next two (2) fiscal years for the construction or expansion
- 2009 of nursing facility beds or the conversion of other beds to
- 2010 nursing facility beds in each of the four (4) Long-Term Care
- 2011 Planning Districts designated in the fiscal year 1999 State Health
- 2012 Plan, to provide care exclusively to patients with Alzheimer's
- 2013 disease.
- 2014 (ii) Not more than twenty (20) beds may be
- 2015 authorized by any certificate of need issued under this paragraph
- 2016 (r), and not more than a total of sixty (60) beds may be
- 2017 authorized in any Long-Term Care Planning District by all



2018 certificates of need issued under this paragraph (r). However, 2019 the total number of beds that may be authorized by all 2020 certificates of need issued under this paragraph (r) during any 2021 fiscal year shall not exceed one hundred twenty (120) beds, and 2022 the total number of beds that may be authorized in any Long-Term 2023 Care Planning District during any fiscal year shall not exceed 2024 forty (40) beds. Of the certificates of need that are issued for 2025 each Long-Term Care Planning District during the next two (2) 2026 fiscal years, at least one (1) shall be issued for beds in the 2027 northern part of the district, at least one (1) shall be issued 2028 for beds in the central part of the district, and at least one (1) 2029 shall be issued for beds in the southern part of the district. 2030 The State Department of Health, in (iii) 2031 consultation with the Department of Mental Health and the Division 2032 of Medicaid, shall develop and prescribe the staffing levels, 2033 space requirements and other standards and requirements that must 2034 be met with regard to the nursing facility beds authorized under 2035 this paragraph (r) to provide care exclusively to patients with 2036 Alzheimer's disease. 2037

2037 (s) The State Department of Health may issue a
2038 certificate of need to a nonprofit skilled nursing facility using
2039 the Green House model of skilled nursing care and located in Yazoo
2040 City, Yazoo County, Mississippi, for the construction, expansion
2041 or conversion of not more than nineteen (19) nursing facility
2042 beds. For purposes of this paragraph (s), the provisions of



Section 41-7-193(1) requiring substantial compliance with the

2044 projection of need as reported in the current State Health Plan

2045 and the provisions of Section 41-7-197 requiring a formal

2046 certificate of need hearing process are waived. There shall be no

2047 prohibition or restrictions on participation in the Medicaid

2048 program for the person receiving the certificate of need

2049 authorized under this paragraph (s).

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



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2068 the Harrison County facility will be certified for participation 2069 in the Medicaid program, and that no claim will be submitted for 2070 Medicaid reimbursement for more than fifty (50) patients in the 2071 Hancock County facility in any month, or for more than forty-nine 2072 (49) patients in the Harrison County facility in any month, or for 2073 any patient in either facility who is in a bed that is not 2074 Medicaid-certified. This written agreement by the owner of the nursing facilities shall be a condition of the issuance of the 2075 2076 certificates of need under this paragraph (t), and the agreement 2077 shall be fully binding on any later owner or owners of either 2078 facility if the ownership of either facility is transferred at any time after the certificates of need are issued. After this 2079 2080 written agreement is executed, the Division of Medicaid and the 2081 State Department of Health shall not certify more than fifty (50) 2082 of the beds at the Hancock County facility or more than forty-nine 2083 (49) of the beds at the Harrison County facility for participation 2084 in the Medicaid program. If the Hancock County facility violates 2085 the terms of the written agreement by admitting or keeping in the 2086 facility on a regular or continuing basis more than fifty (50) 2087 patients who are participating in the Medicaid program, or if the 2088 Harrison County facility violates the terms of the written 2089 agreement by admitting or keeping in the facility on a regular or 2090 continuing basis more than forty-nine (49) patients who are participating in the Medicaid program, the State Department of 2091 2092 Health shall revoke the license of the facility that is in



violation of the agreement, at the time that the department
determines, after a hearing complying with due process, that the
facility has violated the agreement.

2096 (11) The State Department of Health shall issue a 2097 certificate of need to a nonprofit venture for the establishment, 2098 construction and operation of a skilled nursing facility of not 2099 more than sixty (60) beds to provide skilled nursing care for 2100 ventilator dependent or otherwise medically dependent pediatric 2101 patients who require medical and nursing care or rehabilitation 2102 services to be located in a county in which an academic medical 2103 center and a children's hospital are located, and for any 2104 construction and for the acquisition of equipment related to those 2105 The facility shall be authorized to keep such ventilator 2106 dependent or otherwise medically dependent pediatric patients 2107 beyond age twenty-one (21) in accordance with regulations of the 2108 State Board of Health. For purposes of this paragraph (u), the 2109 provisions of Section 41-7-193(1) requiring substantial compliance 2110 with the projection of need as reported in the current State 2111 Health Plan are waived, and the provisions of Section 41-7-197 2112 requiring a formal certificate of need hearing process are waived. 2113 The beds authorized by this paragraph shall be counted as 2114 pediatric skilled nursing facility beds for health planning 2115 purposes under Section 41-7-171 et seq. There shall be no 2116 prohibition of or restrictions on participation in the Medicaid



- 2117 program for the person receiving the certificate of need 2118 authorized by this paragraph.
- 2119 (3) The State Department of Health may grant approval for
- 2120 and issue certificates of need to any person proposing the new
- 2121 construction of, addition to, conversion of beds of or expansion
- 2122 of any health care facility defined in subparagraph (x)
- 2123 (psychiatric residential treatment facility) of Section
- 2124 41-7-173(h). The total number of beds which may be authorized by
- 2125 such certificates of need shall not exceed three hundred
- 2126 thirty-four (334) beds for the entire state.
- 2127 (a) Of the total number of beds authorized under this
- 2128 subsection, the department shall issue a certificate of need to a
- 2129 privately owned psychiatric residential treatment facility in
- 2130 Simpson County for the conversion of sixteen (16) intermediate
- 2131 care facility for the mentally retarded (ICF-MR) beds to
- 2132 psychiatric residential treatment facility beds, provided that
- 2133 facility agrees in writing that the facility shall give priority
- 2134 for the use of those sixteen (16) beds to Mississippi residents
- 2135 who are presently being treated in out-of-state facilities.
- 2136 (b) Of the total number of beds authorized under this
- 2137 subsection, the department may issue a certificate or certificates
- 2138 of need for the construction or expansion of psychiatric
- 2139 residential treatment facility beds or the conversion of other
- 2140 beds to psychiatric residential treatment facility beds in Warren
- 2141 County, not to exceed sixty (60) psychiatric residential treatment



2142	facility beds, provided that the facility agrees in writing that
2143	no more than thirty (30) of the beds at the psychiatric
2144	residential treatment facility will be certified for participation
2145	in the Medicaid program (Section 43-13-101 et seq.) for the use of
2146	any patients other than those who are participating only in the
2147	Medicaid program of another state, and that no claim will be
2148	submitted to the Division of Medicaid for Medicaid reimbursement
2149	for more than thirty (30) patients in the psychiatric residential
2150	treatment facility in any day or for any patient in the
2151	psychiatric residential treatment facility who is in a bed that is
2152	not Medicaid-certified. This written agreement by the recipient
2153	of the certificate of need shall be a condition of the issuance of
2154	the certificate of need under this paragraph, and the agreement
2155	shall be fully binding on any subsequent owner of the psychiatric
2156	residential treatment facility if the ownership of the facility is
2157	transferred at any time after the issuance of the certificate of
2158	need. After this written agreement is executed, the Division of
2159	Medicaid and the State Department of Health shall not certify more
2160	than thirty (30) of the beds in the psychiatric residential
2161	treatment facility for participation in the Medicaid program for
2162	the use of any patients other than those who are participating
2163	only in the Medicaid program of another state. If the psychiatric
2164	residential treatment facility violates the terms of the written
2165	agreement by admitting or keeping in the facility on a regular or
2166	continuing basis more than thirty (30) patients who are



participating in the Mississippi Medicaid program, the State

Department of Health shall revoke the license of the facility, at

the time that the department determines, after a hearing complying

with due process, that the facility has violated the condition

upon which the certificate of need was issued, as provided in this

paragraph and in the written agreement.

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

Of the total number of beds authorized under this (C) subsection, the department shall issue a certificate of need to a hospital currently operating Medicaid-certified acute psychiatric beds for adolescents in DeSoto County, for the establishment of a forty-bed psychiatric residential treatment facility in DeSoto County, provided that the hospital agrees in writing (i) that the hospital shall give priority for the use of those forty (40) beds to Mississippi residents who are presently being treated in out-of-state facilities, and (ii) that no more than fifteen (15) of the beds at the psychiatric residential treatment facility will be certified for participation in the Medicaid program (Section 43-13-101 et seq.), and that no claim will be submitted for Medicaid reimbursement for more than fifteen (15) patients in the psychiatric residential treatment facility in any day or for any patient in the psychiatric residential treatment facility who is

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2192 in a bed that is not Medicaid-certified. This written agreement 2193 by the recipient of the certificate of need shall be a condition of the issuance of the certificate of need under this paragraph, 2194 2195 and the agreement shall be fully binding on any subsequent owner 2196 of the psychiatric residential treatment facility if the ownership 2197 of the facility is transferred at any time after the issuance of 2198 the certificate of need. After this written agreement is 2199 executed, the Division of Medicaid and the State Department of 2200 Health shall not certify more than fifteen (15) of the beds in the 2201 psychiatric residential treatment facility for participation in the Medicaid program. If the psychiatric residential treatment 2202 2203 facility violates the terms of the written agreement by admitting 2204 or keeping in the facility on a regular or continuing basis more 2205 than fifteen (15) patients who are participating in the Medicaid 2206 program, the State Department of Health shall revoke the license 2207 of the facility, at the time that the department determines, after 2208 a hearing complying with due process, that the facility has 2209 violated the condition upon which the certificate of need was 2210 issued, as provided in this paragraph and in the written 2211 agreement.

2212 (d) Of the total number of beds authorized under this
2213 subsection, the department may issue a certificate or certificates
2214 of need for the construction or expansion of psychiatric
2215 residential treatment facility beds or the conversion of other
2216 beds to psychiatric treatment facility beds, not to exceed thirty



- 2217 (30) psychiatric residential treatment facility beds, in either
- 2218 Alcorn, Tishomingo, Prentiss, Lee, Itawamba, Monroe, Chickasaw,
- 2219 Pontotoc, Calhoun, Lafayette, Union, Benton or Tippah County.
- (e) Of the total number of beds authorized under this
- 2221 subsection (3) the department shall issue a certificate of need to
- 2222 a privately owned, nonprofit psychiatric residential treatment
- 2223 facility in Hinds County for an eight-bed expansion of the
- 2224 facility, provided that the facility agrees in writing that the
- 2225 facility shall give priority for the use of those eight (8) beds
- 2226 to Mississippi residents who are presently being treated in
- 2227 out-of-state facilities.
- 2228 (f) The department shall issue a certificate of need to
- 2229 a one-hundred-thirty-four-bed specialty hospital located on
- 2230 twenty-nine and forty-four one-hundredths (29.44) commercial acres
- 2231 at 5900 Highway 39 North in Meridian (Lauderdale County),
- 2232 Mississippi, for the addition, construction or expansion of
- 2233 child/adolescent psychiatric residential treatment facility beds
- 2234 in Lauderdale County. As a condition of issuance of the
- 2235 certificate of need under this paragraph, the facility shall give
- 2236 priority in admissions to the child/adolescent psychiatric
- 2237 residential treatment facility beds authorized under this
- 2238 paragraph to patients who otherwise would require out-of-state
- 2239 placement. The Division of Medicaid, in conjunction with the
- 2240 Department of Human Services, shall furnish the facility a list of
- 2241 all out-of-state patients on a quarterly basis. Furthermore,



- 2242 notice shall also be provided to the parent, custodial parent or 2243 guardian of each out-of-state patient notifying them of the priority status granted by this paragraph. For purposes of this 2244 2245 paragraph, the provisions of Section 41-7-193(1) requiring 2246 substantial compliance with the projection of need as reported in the current State Health Plan are waived. The total number of 2247 2248 child/adolescent psychiatric residential treatment facility beds 2249 that may be authorized under the authority of this paragraph shall 2250 be sixty (60) beds. There shall be no prohibition or restrictions 2251 on participation in the Medicaid program (Section 43-13-101 et 2252 seq.) for the person receiving the certificate of need authorized 2253 under this paragraph or for the beds converted pursuant to the 2254 authority of that certificate of need.
- 2255 (a) From and after * * * passage of this act, the 2256 department * * * may issue a certificate of need to any person for 2257 the new construction of any hospital, psychiatric hospital or 2258 chemical dependency hospital that will contain any child/adolescent psychiatric or child/adolescent chemical 2259 2260 dependency beds, or for the conversion of any other health care 2261 facility to a hospital, psychiatric hospital or chemical 2262 dependency hospital that will contain any child/adolescent 2263 psychiatric or child/adolescent chemical dependency beds, or for 2264 the addition of any child/adolescent psychiatric or child/adolescent chemical dependency beds in any hospital, 2265 2266 psychiatric hospital or chemical dependency hospital, or for the



conversion of any beds of another category in any hospital, psychiatric hospital or chemical dependency hospital to child/adolescent psychiatric or child/adolescent chemical There shall be no prohibition or restrictions on dependency beds. participation in the Medicaid program (Section 43-13-101 et seq.) for the person(s) receiving the certificate(s) of need authorized under this paragraph (a) or for the beds converted pursuant to the authority of that certificate of need.

(i) * * * (Deleted)

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

(iii) The department may issue a certificate or

child/adolescent psychiatric beds or the conversion of other beds

certificates of need for the construction or expansion of

to child/adolescent psychiatric beds in Warren County. purposes of this subparagraph (iii), the provisions of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in the current State Health Plan are waived. The total number of beds that may be authorized under the authority of this subparagraph shall not exceed twenty (20) beds. There shall be no prohibition or restrictions on participation in the Medicaid program (Section 43-13-101 et seq.) for the person receiving the certificate of need authorized under this subparagraph or for the beds converted pursuant to the authority of that certificate of need.

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

(iv) The department shall issue a certificate of need to the Region 7 Mental Health/Retardation Commission for the construction or expansion of child/adolescent psychiatric beds or



the conversion of other beds to child/adolescent psychiatric beds in any of the counties served by the commission. For purposes of this subparagraph (iv), the provisions of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in the current State Health Plan are waived. The total number of beds that may be authorized under the authority of this subparagraph shall not exceed twenty (20) beds. There shall be no prohibition or restrictions on participation in the Medicaid program (Section 43-13-101 et seq.) for the person receiving the certificate of need authorized under this subparagraph or for the beds converted pursuant to the authority of that certificate of need.

to any county hospital located in Leflore County for the construction or expansion of adult psychiatric beds or the conversion of other beds to adult psychiatric beds, not to exceed twenty (20) beds, provided that the recipient of the certificate of need agrees in writing that the adult psychiatric beds will not at any time be certified for participation in the Medicaid program and that the hospital will not admit or keep any patients who are participating in the Medicaid program in any of such adult psychiatric beds. This written agreement by the recipient of the certificate of need shall be fully binding on any subsequent owner of the hospital if the ownership of the hospital is transferred at any time after the issuance of the certificate of need. Agreement

2343 participation in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this 2344 subparagraph (v), and if such hospital at any time after the 2345 2346 issuance of the certificate of need, regardless of the ownership 2347 of the hospital, has any of such adult psychiatric beds certified for participation in the Medicaid program or admits or keeps any 2348 2349 Medicaid patients in such adult psychiatric beds, the State Department of Health shall revoke the certificate of need, if it 2350 2351 is still outstanding, and shall deny or revoke the license of the 2352 hospital at the time that the department determines, after a hearing complying with due process, that the hospital has failed 2353 2354 to comply with any of the conditions upon which the certificate of 2355 need was issued, as provided in this subparagraph and in the 2356 written agreement by the recipient of the certificate of need. 2357 (vi) The department may issue a certificate or 2358 certificates of need for the expansion of child psychiatric beds or the conversion of other beds to child psychiatric beds at the 2359 2360 University of Mississippi Medical Center. For purposes of this subparagraph (vi), the provisions of Section 41-7-193(1) requiring 2361 2362 substantial compliance with the projection of need as reported in 2363 the current State Health Plan are waived. The total number of 2364 beds that may be authorized under the authority of this subparagraph shall not exceed fifteen (15) beds. There shall be 2365 2366 no prohibition or restrictions on participation in the Medicaid

that the adult psychiatric beds will not be certified for



- program (Section 43-13-101 et seq.) for the hospital receiving the certificate of need authorized under this subparagraph or for the beds converted pursuant to the authority of that certificate of need.
- 2371 From and after July 1, 1990, no hospital, 2372 psychiatric hospital or chemical dependency hospital shall be 2373 authorized to add any child/adolescent psychiatric or 2374 child/adolescent chemical dependency beds or convert any beds of another category to child/adolescent psychiatric or 2375 child/adolescent chemical dependency beds without a certificate of 2376 2377 need under the authority of subsection (1)(c) and subsection 2378 (4)(a) of this section.
- 2379 (5) The department may issue a certificate of need to a 2380 county hospital in Winston County for the conversion of fifteen 2381 (15) acute care beds to geriatric psychiatric care beds.
- 2382 The State Department of Health shall issue a certificate 2383 of need to a Mississippi corporation qualified to manage a long-term care hospital as defined in Section 41-7-173(h)(xii) in 2384 2385 Harrison County, not to exceed eighty (80) beds, including any necessary renovation or construction required for licensure and 2386 certification, provided that the recipient of the certificate of 2387 2388 need agrees in writing that the long-term care hospital will not 2389 at any time participate in the Medicaid program (Section 43-13-101 2390 et seq.) or admit or keep any patients in the long-term care hospital who are participating in the Medicaid program. 2391

2392 written agreement by the recipient of the certificate of need 2393 shall be fully binding on any subsequent owner of the long-term care hospital, if the ownership of the facility is transferred at 2394 2395 any time after the issuance of the certificate of need. Agreement 2396 that the long-term care hospital will not participate in the 2397 Medicaid program shall be a condition of the issuance of a certificate of need to any person under this subsection (6), and 2398 2399 if such long-term care hospital at any time after the issuance of 2400 the certificate of need, regardless of the ownership of the 2401 facility, participates in the Medicaid program or admits or keeps 2402 any patients in the facility who are participating in the Medicaid program, the State Department of Health shall revoke the 2403 2404 certificate of need, if it is still outstanding, and shall deny or 2405 revoke the license of the long-term care hospital, at the time 2406 that the department determines, after a hearing complying with due 2407 process, that the facility has failed to comply with any of the 2408 conditions upon which the certificate of need was issued, as provided in this subsection and in the written agreement by the 2409 2410 recipient of the certificate of need. For purposes of this 2411 subsection, the provisions of Section 41-7-193(1) requiring 2412 substantial compliance with the projection of need as reported in 2413 the current State Health Plan are waived.

(7) The State Department of Health may issue a certificate of need to any hospital in the state to utilize a portion of its beds for the "swing-bed" concept. Any such hospital must be in



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2417 conformance with the federal regulations regarding such swing-bed 2418 concept at the time it submits its application for a certificate of need to the State Department of Health, except that such 2419 hospital may have more licensed beds or a higher average daily 2420 2421 census (ADC) than the maximum number specified in federal 2422 regulations for participation in the swing-bed program. 2423 hospital meeting all federal requirements for participation in the 2424 swing-bed program which receives such certificate of need shall 2425 render services provided under the swing-bed concept to any 2426 patient eligible for Medicare (Title XVIII of the Social Security 2427 Act) who is certified by a physician to be in need of such 2428 services, and no such hospital shall permit any patient who is 2429 eligible for both Medicaid and Medicare or eligible only for 2430 Medicaid to stay in the swing beds of the hospital for more than 2431 thirty (30) days per admission unless the hospital receives prior 2432 approval for such patient from the Division of Medicaid, Office of 2433 the Governor. Any hospital having more licensed beds or a higher 2434 average daily census (ADC) than the maximum number specified in 2435 federal regulations for participation in the swing-bed program 2436 which receives such certificate of need shall develop a procedure 2437 to insure that before a patient is allowed to stay in the swing beds of the hospital, there are no vacant nursing home beds 2438 2439 available for that patient located within a fifty-mile radius of the hospital. When any such hospital has a patient staying in the 2440 swing beds of the hospital and the hospital receives notice from a 2441



2442 nursing home located within such radius that there is a vacant bed 2443 available for that patient, the hospital shall transfer the patient to the nursing home within a reasonable time after receipt 2444 2445 of the notice. Any hospital which is subject to the requirements 2446 of the two (2) preceding sentences of this subsection may be 2447 suspended from participation in the swing-bed program for a reasonable period of time by the State Department of Health if the 2448 2449 department, after a hearing complying with due process, determines 2450 that the hospital has failed to comply with any of those 2451 requirements.

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

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- 2467 participation in the Medicaid program for the person receiving the 2468 certificate of need authorized under this subsection (8).
- 2470 issue a certificate of need to any person proposing the
 2471 establishment of, or expansion of the currently approved territory
 2472 of, or the contracting to establish a home office, subunit or
 2473 branch office within the space operated as a health care facility
 2474 as defined in Section 41-7-173(h)(i) through (viii) by a health
 2475 care facility as defined in subparagraph (ix) of Section
- 2477 (10) Health care facilities owned and/or operated by the 2478 state or its agencies are exempt from the restraints in this 2479 section against issuance of a certificate of need if such addition or expansion consists of repairing or renovation necessary to 2480 2.481 comply with the state licensure law. This exception shall not 2482 apply to the new construction of any building by such state 2483 facility. This exception shall not apply to any health care facilities owned and/or operated by counties, municipalities, 2484 2485 districts, unincorporated areas, other defined persons, or any 2486 combination thereof.
- 2487 (11) The new construction, renovation or expansion of or 2488 addition to any health care facility defined in subparagraph (ii) 2489 (psychiatric hospital), subparagraph (iv) (skilled nursing 2490 facility), subparagraph (vi) (intermediate care facility), 2491 subparagraph (viii) (intermediate care facility for the mentally

41-7-173 (h).

- 2492 retarded) and subparagraph (x) (psychiatric residential treatment 2493 facility) of Section 41-7-173(h) which is owned by the State of Mississippi and under the direction and control of the State 2494 2495 Department of Mental Health, and the addition of new beds or the 2496 conversion of beds from one category to another in any such 2497 defined health care facility which is owned by the State of 2498 Mississippi and under the direction and control of the State 2499 Department of Mental Health, shall not require the issuance of a 2500 certificate of need under Section 41-7-171 et seq., 2501 notwithstanding any provision in Section 41-7-171 et seq. to the 2502 contrary.
- 2503 (12) The new construction, renovation or expansion of or 2504 addition to any veterans homes or domiciliaries for eligible 2505 veterans of the State of Mississippi as authorized under Section 2506 35-1-19 shall not require the issuance of a certificate of need, 2507 notwithstanding any provision in Section 41-7-171 et seq. to the 2508 contrary.
- (13) The repair or the rebuilding of an existing, operating health care facility that sustained significant damage from a natural disaster that occurred after April 15, 2014, in an area that is proclaimed a disaster area or subject to a state of emergency by the Governor or by the President of the United States shall be exempt from all of the requirements of the Mississippi Certificate of Need Law (Section 41-7-171 et seq.) and any and all



rules and regulations promulgated under that law, subject to the following conditions:

- (a) The repair or the rebuilding of any such damaged health care facility must be within one (1) mile of the pre-disaster location of the campus of the damaged health care facility, except that any temporary post-disaster health care facility operating location may be within five (5) miles of the pre-disaster location of the damaged health care facility;
- (b) The repair or the rebuilding of the damaged health care facility (i) does not increase or change the complement of its bed capacity that it had before the Governor's or the President's proclamation, (ii) does not increase or change its levels and types of health care services that it provided before the Governor's or the President's proclamation, and (iii) does not rebuild in a different county; however, this paragraph does not restrict or prevent a health care facility from decreasing its bed capacity that it had before the Governor's or the President's proclamation, or from decreasing the levels of or decreasing or eliminating the types of health care services that it provided before the Governor's or the President's proclamation, when the damaged health care facility is repaired or rebuilt;
- 2537 (c) The exemption from Certificate of Need Law provided 2538 under this subsection (13) is valid for only five (5) years from 2539 the date of the Governor's or the President's proclamation. If



actual construction has not begun within that five-year period,
the exemption provided under this subsection is inapplicable; and

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

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

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

2563 (15) The State Department of Health may authorize the 2564 transfer of hospital beds, not to exceed sixty (60) beds, from the



North Panola Community Hospital to the South Panola Community

Hospital. The authorization for the transfer of those beds shall

be exempt from the certificate of need review process.

2568 (16)The State Department of Health shall issue any 2569 certificates of need necessary for Mississippi State University 2570 and a public or private health care provider to jointly acquire 2571 and operate a linear accelerator and a magnetic resonance imaging 2572 unit. Those certificates of need shall cover all capital expenditures related to the project between Mississippi State 2573 2574 University and the health care provider, including, but not 2575 limited to, the acquisition of the linear accelerator, the 2576 magnetic resonance imaging unit and other radiological modalities; 2577 the offering of linear accelerator and magnetic resonance imaging 2578 services; and the cost of construction of facilities in which to locate these services. The linear accelerator and the magnetic 2579 2580 resonance imaging unit shall be (a) located in the City of 2581 Starkville, Oktibbeha County, Mississippi; (b) operated jointly by 2582 Mississippi State University and the public or private health care 2583 provider selected by Mississippi State University through a 2584 request for proposals (RFP) process in which Mississippi State 2585 University selects, and the Board of Trustees of State 2586 Institutions of Higher Learning approves, the health care provider 2587 that makes the best overall proposal; (c) available to Mississippi State University for research purposes two-thirds (2/3) of the 2588 2589 time that the linear accelerator and magnetic resonance imaging



2590 unit are operational; and (d) available to the public or private 2591 health care provider selected by Mississippi State University and 2592 approved by the Board of Trustees of State Institutions of Higher 2593 Learning one-third (1/3) of the time for clinical, diagnostic and 2594 treatment purposes. For purposes of this subsection, the 2595 provisions of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in the current State 2596 2597 Health Plan are waived.

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



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- 2614 The planning, design, construction, renovation, 2615 addition, furnishing and equipping of a clinical research unit at any health care facility defined in Section 41-7-173(h) that is 2616 2617 under the direction and control of the University of Mississippi 2618 Medical Center and located in Jackson, Mississippi, and the 2619 addition of new beds or the conversion of beds from one (1) 2620 category to another in any such clinical research unit, shall not require the issuance of a certificate of need under Section 2621 2622 41-7-171 et seq., notwithstanding any provision in Section 2623 41-7-171 et seq. to the contrary.
- 2624 (19) [Repealed]
- 2625 (20) Nothing in this section or in any other provision of
 2626 Section 41-7-171 et seq. shall prevent any nursing facility from
 2627 designating an appropriate number of existing beds in the facility
 2628 as beds for providing care exclusively to patients with
 2629 Alzheimer's disease.
- 2630 (21) Nothing in this section or any other provision of 2631 Section 41-7-171 et seq. shall prevent any health care facility 2632 from the new construction, renovation, conversion or expansion of new beds in the facility designated as intensive care units, 2633 2634 negative pressure rooms, or isolation rooms pursuant to the 2635 provisions of Sections 41-14-1 through 41-14-11. For purposes of 2636 this subsection, the provisions of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in 2637 the current State Health Plan and the provisions of Section 2638



- 2639 41-7-197 requiring a formal certificate of need hearing process are waived.
- SECTION 4. Section 41-75-5, Mississippi Code of 1972, is amended as follows:
- 41-75-5. No person as defined in Section 41-7-173, acting severally or jointly with any other person, shall establish, conduct, operate or maintain an ambulatory surgical facility or an abortion facility or a freestanding emergency room or a post-acute residential brain injury rehabilitation facility in this state without a license under this chapter.
- 2649 * * *
- 2650 **SECTION 5.** Section 83-9-353, Mississippi Code of 1972, is amended as follows:
- 2652 83-9-353. (1) As used in this section:
- 2653 (a) "Employee benefit plan" means any plan, fund or
 2654 program established or maintained by an employer or by an employee
 2655 organization, or both, to the extent that such plan, fund or
 2656 program was established or is maintained for the purpose of
 2657 providing for its participants or their beneficiaries, through the
 2658 purchase of insurance or otherwise, medical, surgical, hospital
 2659 care or other benefits.
- 2660 (b) "Health insurance plan" means any health insurance 2661 policy or health benefit plan offered by a health insurer, and 2662 includes the State and School Employees Health Insurance Plan and 2663 any other public health care assistance program offered or



administered by the state or any political subdivision or
instrumentality of the state. The term does not include policies
or plans providing coverage for specified disease or other limited
benefit coverage.

- 2668 "Health insurer" means any health insurance 2669 company, nonprofit hospital and medical service corporation, 2670 health maintenance organization, preferred provider organization, 2671 managed care organization, pharmacy benefit manager, and, to the extent permitted under federal law, any administrator of an 2672 2673 insured, self-insured or publicly funded health care benefit plan 2674 offered by public and private entities, and other parties that are 2675 by statute, contract, or agreement, legally responsible for 2676 payment of a claim for a health care item or service.
- 2677 "Store-and-forward telemedicine services" means the 2.678 use of asynchronous computer-based communication between a patient 2679 and a consulting provider or a referring health care provider and 2680 a medical specialist at a distant site for the purpose of 2681 diagnostic and therapeutic assistance in the care of patients who 2682 otherwise have no access to specialty care. Store-and-forward 2683 telemedicine services involve the transferring of medical data 2684 from one (1) site to another through the use of a camera or 2685 similar device that records (stores) an image that is sent 2686 (forwarded) via telecommunication to another site for 2687 consultation.



2688		(e)	"Remote	patient	monito	ring	services	s" mean	ns the
2689	delivery	of ho	me healt	h servic	es usir	ng tel	ecommuni	icatio	ns
2690	technolog	y to	enhance	the deli	very of	home	health	care,	including:

- 2691 (i) Monitoring of clinical patient data such as
 2692 weight, blood pressure, pulse, pulse oximetry and other
 2693 condition-specific data, such as blood glucose;
- 2694 (ii) Medication adherence monitoring; and
 2695 (iii) Interactive video conferencing with or
 2696 without digital image upload as needed.
- (f) "Mediation adherence management services" means the monitoring of a patient's conformance with the clinician's medication plan with respect to timing, dosing and frequency of medication-taking through electronic transmission of data in a home telemonitoring program.
 - (2) Store-and-forward telemedicine services allow a health care provider trained and licensed in his or her given specialty to review forwarded images and patient history in order to provide diagnostic and therapeutic assistance in the care of the patient without the patient being present in real time. Treatment recommendations made via electronic means shall be held to the same standards of appropriate practice as those in traditional provider-patient setting.
- 2710 (3) Any patient receiving medical care by store-and-forward 2711 telemedicine services shall be notified of the right to receive 2712 interactive communication with the distant specialist health care



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- provider and shall receive an interactive communication with the distant specialist upon request. If requested, communication with the distant specialist may occur at the time of the consultation or within thirty (30) days of the patient's notification of the request of the consultation. Telemedicine networks unable to offer the interactive consultation shall not be reimbursed for store-and-forward telemedicine services.
- 2720 Remote patient monitoring services aim to allow more 2721 people to remain at home or in other residential settings and to 2722 improve the quality and cost of their care, including prevention 2723 of more costly care. Remote patient monitoring services via telehealth aim to coordinate primary, acute, behavioral and 2724 2725 long-term social service needs for high-need, high-cost patients. 2726 Specific patient criteria must be met in order for reimbursement 2727 to occur.
- 2728 (5) Qualifying patients for remote patient monitoring 2729 services must meet all the following criteria:
- 2730 (a) Be diagnosed, in the last eighteen (18) months,
 2731 with one or more chronic conditions, as defined by the Centers for
 2732 Medicare and Medicaid Services (CMS), which include, but are not
 2733 limited to, sickle cell, mental health, asthma, diabetes, and
 2734 heart disease; and
- 2735 * * *
- 2736 (***\bar{b}) The patient's health care provider recommends 2737 disease management services via remote patient monitoring.



- 2738 (6) A remote patient monitoring prior authorization request
- 2739 form * * * may be required for approval of telemonitoring
- 2740 services. * * * Any such request * * * may include the following:
- 2741 (a) An order for home telemonitoring services, signed
- 2742 and dated by the prescribing physician;
- (b) A plan of care, signed and dated by the prescribing
- 2744 physician, that includes telemonitoring transmission frequency and
- 2745 duration of monitoring requested;
- 2746 (c) The client's diagnosis and risk factors that
- 2747 qualify the client for home telemonitoring services;
- 2748 (d) Attestation that the client is sufficiently
- 2749 cognitively intact and able to operate the equipment or has a
- 2750 willing and able person to assist in completing electronic
- 2751 transmission of data; and
- 2752 (e) Attestation that the client is not receiving
- 2753 duplicative services via disease management services.
- 2754 (7) The entity that will provide the remote monitoring must
- 2755 be a Mississippi-based entity and have protocols in place to
- 2756 address all of the following:
- 2757 (a) Authentication and authorization of users;
- (b) A mechanism for monitoring, tracking and responding
- 2759 to changes in a client's clinical condition;
- 2760 (c) A standard of acceptable and unacceptable
- 2761 parameters for client's clinical parameters, which can be adjusted
- 2762 based on the client's condition;



- 2763 (d) How monitoring staff will respond to abnormal
- 2764 parameters for client's vital signs, symptoms and/or lab results;
- 2765 (e) The monitoring, tracking and responding to changes
- 2766 in client's clinical condition;
- 2767 (f) The process for notifying the prescribing physician
- 2768 for significant changes in the client's clinical signs and
- 2769 symptoms;
- 2770 (g) The prevention of unauthorized access to the system
- 2771 or information;
- 2772 (h) System security, including the integrity of
- 2773 information that is collected, program integrity and system
- 2774 integrity;
- 2775 (i) Information storage, maintenance and transmission;
- 2776 (j) Synchronization and verification of patient profile
- 2777 data; and
- 2778 (k) Notification of the client's discharge from remote
- 2779 patient monitoring services or the de-installation of the remote
- 2780 patient monitoring unit.
- 2781 (8) The telemonitoring equipment must:
- 2782 (a) Be capable of monitoring any data parameters in the
- 2783 plan of care; and
- 2784 (b) Be a FDA Class II hospital-grade medical device.
- 2785 (9) Monitoring of the client's data shall not be duplicated
- 2786 by another provider.



2787	(10)	To rec	eive p	payment	for	the	delivery	of	remote	patient
2788	monitoring	servic	es via	telehe	ealth	ı, th	ne service	e mi	ıst invo	olve:

- 2789 (a) An assessment, problem identification, and 2790 evaluation that includes:
- 2791 (i) Assessment and monitoring of clinical data 2792 including, but not limited to, appropriate vital signs, pain 2793 levels and other biometric measures specified in the plan of care, 2794 and also includes assessment of response to previous changes in 2795 the plan of care; and
- 2796 (ii) Detection of condition changes based on the 2797 telemedicine encounter that may indicate the need for a change in 2798 the plan of care.
- 2799 (b) Implementation of a management plan through one or 2800 more of the following:
- 2801 (i) Teaching regarding medication management as 2802 appropriate based on the telemedicine findings for that encounter;
- 2803 (ii) Teaching regarding other interventions as 2804 appropriate to both the patient and the caregiver;
- 2805 (iii) Management and evaluation of the plan of 2806 care including changes in visit frequency or addition of other 2807 skilled services;
- 2808 (iv) Coordination of care with the ordering health 2809 care provider regarding telemedicine findings;
- 2810 (v) Coordination and referral to other medical 2811 providers as needed; and



2812			(v:	i)	Referral	for	an	in-person	visit	or	the
2813	emergency	room	as	nee	eded.						

- 2814 (11) The telemedicine equipment and network used for remote 2815 patient monitoring services should meet the following 2816 requirements:
- 2817 (a) Comply with applicable standards of the United 2818 States Food and Drug Administration;
- 2819 (b) Telehealth equipment be maintained in good repair 2820 and free from safety hazards;
- 2821 (c) Telehealth equipment be new or sanitized before 2822 installation in the patient's home setting;
- 2823 (d) Accommodate non-English language options; and
- 2824 (e) Have 24/7 technical and clinical support services available for the patient user.
- 2826 (12) All health insurance and employee benefit plans in this
 2827 state must provide coverage and reimbursement for the asynchronous
 2828 telemedicine services of store-and-forward telemedicine services
 2829 and remote patient monitoring services based on the criteria set
 2830 out in this section. Store-and-forward telemedicine services
 2831 shall be reimbursed to the same extent that the services would be
 2832 covered if they were provided through in-person consultation.
- 2833 (13) Remote patient monitoring services shall include
 2834 reimbursement for a daily monitoring rate at a minimum of Ten
 2835 Dollars (\$10.00) per day each month and Sixteen Dollars (\$16.00)
 2836 per day when medication adherence management services are



- included, not to exceed thirty-one (31) days per month. These reimbursement rates are only eligible to Mississippi-based telehealth programs affiliated with a Mississippi health care facility.
- 2841 (14) A one-time telehealth installation/training fee for
 2842 remote patient monitoring services will also be reimbursed at a
 2843 minimum rate of Fifty Dollars (\$50.00) per patient, with a maximum
 2844 of two (2) installation/training fees/calendar year. These
 2845 reimbursement rates are only eligible to Mississippi-based
 2846 telehealth programs affiliated with a Mississippi health care
 2847 facility.
- 2848 (15) No geographic restrictions shall be placed on the 2849 delivery of telemedicine services in the home setting other than 2850 requiring the patient reside within the State of Mississippi.
- 2851 Health care providers seeking reimbursement for 2852 store-and-forward telemedicine services must be licensed 2853 Mississippi providers that are affiliated with an established 2854 Mississippi health care facility in order to qualify for 2855 reimbursement of telemedicine services in the state. If a service 2856 is not available in Mississippi, then a health insurance or 2857 employee benefit plan may decide to allow a non-Mississippi-based 2858 provider who is licensed to practice in Mississippi reimbursement for those services. 2859
- 2860 (17) A health insurance or employee benefit plan may charge 2861 a deductible, co-payment, or coinsurance for a health care service



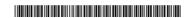
2862	provided through store-and-forward telemedicine services or remote
2863	patient monitoring services so long as it does not exceed the
2864	deductible, co-payment, or coinsurance applicable to an in-person
2865	consultation.

- 2866 (18) A health insurance or employee benefit plan may limit
 2867 coverage to health care providers in a telemedicine network
 2868 approved by the plan.
- 2869 (19) Nothing in this section shall be construed to prohibit
 2870 a health insurance or employee benefit plan from providing
 2871 coverage for only those services that are medically necessary,
 2872 subject to the terms and conditions of the covered person's
 2873 policy.
- 2874 (20) In a claim for the services provided, the appropriate procedure code for the covered service shall be included with the appropriate modifier indicating telemedicine services were used.

 2877 A "GO" modifier is required for asynchronous telemedicine services
- 2877 A "GQ" modifier is required for asynchronous telemedicine services 2878 such as store-and-forward and remote patient monitoring.
- 2879 (21) The originating site is eligible to receive a facility 2880 fee, but facility fees are not payable to the distant site.
- 2881 **SECTION 6.** This act shall take effect and be in force from 2882 and after its passage.

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

AN ACT RELATING TO THE MISSISSIPPI MEDICAID PROGRAM; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, RELATING TO



- REIMBURSEMENT FOR CARE AND SERVICES UNDER THE MEDICAID PROGRAM; TO
 DELETE CERTAIN OUTDATED PROVISIONS RELATING TO REIMBURSEMENT OF
 INPATIENT HOSPITAL SERVICES; TO PROVIDE THAT MEDICAID IS
 AUTHORIZED TO MAKE PARTIAL PAYMENTS FOR NURSING SERVICES; TO
 PROVIDE FOR NURSING FACILITY REIMBURSEMENT FOR HOME LEAVE DAYS; TO
 DELETE CERTAIN OUTDATED PROVISIONS RELATING TO REIMBURSEMENT OF
 NURSING FACILITY SERVICES; TO PROVIDE FOR REIMBURSEMENT FOR FEES
- 10 FOR PHYSICIAN SERVICES COVERED ONLY BY MEDICAID; TO AUTHORIZE THE
- DIVISION TO REIMBURSE OBSTETRICIANS AND GYNECOLOGISTS FOR CERTAIN PRIMARY CARE SERVICES AT 100% OF THE MEDICARE RATE; TO DELETE THE
- 13 PROVISION THAT REQUIRES THE DIVISION TO ALLOW
- 14 PHYSICIAN-ADMINISTERED DRUGS TO BE BILLED AND REIMBURSED AS A
- 15 MEDICAL CLAIM OR PHARMACY POINT-OF-SALE; TO PROVIDE THAT THE
- 16 DIVISION SHALL MAKE PARTIAL PAYMENTS, AS DETERMINED BY THE
- 17 DIVISION, TO INTERMEDIATE CARE FACILITY SERVICES AND TO DELETE
- 18 CERTAIN PROVISIONS RELATING TO FAIR RENTAL REIMBURSEMENT FOR SUCH
- 19 FACILITIES; TO DEFINE CLINIC SERVICES AS IT RELATES TO THE
- 20 REIMBURSEMENTS BY MEDICAID FOR THOSE SERVICES; TO AUTHORIZE
- 21 MEDICAID REIMBURSEMENT FOR THERAPEUTIC AND CASE MANAGEMENT MENTAL
- 22 HEALTH SERVICES PROVIDED BY SERVICE PROVIDERS ACCREDITED BY THE
- 23 JOINT COMMISSION OR CERTAIN OTHER ACCREDITING AGENCIES; TO PROVIDE
- 24 THAT MEDICAID MAY ESTABLISH AN UPPER PAYMENT LIMITS PROGRAM FOR
- 25 AMBULANCE TRANSPORTATION AND ASSESS PROVIDERS OF SUCH SERVICE; TO
- 26 REQUIRE THE DIVISION OF MEDICAID TO RECOGNIZE FEDERALLY QUALIFIED
- 27 HEALTH CENTERS (FQHC), RURAL HEALTH CLINICS (RHC) AND COMMUNITY
- 28 MENTAL HEALTH CENTERS (CMHC) AS BOTH AN ORIGINATING AND DISTANT
- 29 SITE PROVIDER FOR THE PURPOSES OF TELEHEALTH REIMBURSEMENT; TO
- 30 DELETE THE PROVISIONS RELATING TO MEDICAID'S DEVELOPMENT OF AN
- 31 ALTERNATIVE MODEL FOR DISTRIBUTION OF MEDICAL CLAIMS AND
- 32 SUPPLEMENTAL PAYMENTS FOR SERVICES; TO AUTHORIZE REIMBURSEMENT FOR
- 33 CERTAIN PSYCHIATRIC SERVICES; TO CLARIFY THE REIMBURSEMENT OF
- 34 PEDIATRIC SKILLED NURSING SERVICES, INPATIENT PSYCHIATRIST
- 35 SERVICES AND NONEMERGENCY TRANSPORTATION SERVICES; TO DELETE THE
- 36 PROVISION THAT REQUIRES MEDICAID TO REIMBURSE CROSSOVER CLAIMS FOR
- 37 INPATIENT HOSPITAL SERVICES AND THOSE UNDER MEDICARE PART B; TO
- 38 DELETE CERTAIN PROVISIONS RELATING TO THE REIMBURSEMENT OF
- 39 PHYSICIAN ASSISTANT SERVICES; TO PROVIDE THAT THE DIVISION MAY
- 40 ESTABLISH COPAYMENTS AND COINSURANCE FOR ANY MEDICAID SERVICES; TO
- 41 ALLOW THE DIVISION TO USE ENHANCED REIMBURSEMENTS AND UPPER
- 42 PAYMENT LIMIT PROGRAMS FOR ITS REIMBURSEMENT PROGRAM; TO AUTHORIZE
- 43 REIMBURSEMENT FOR A BARIATRIC SURGERY PROGRAM; TO DELETE THE
- 44 PROVISION THAT REQUIRES MEDICAID TO REDUCE THE RATE OF
- 45 REIMBURSEMENT TO CERTAIN PROVIDERS FOR SERVICES BY 5% OF THE
- 46 ALLOWED AMOUNT FOR THAT SERVICE; TO REQUIRE PROVIDERS TO MAINTAIN
- 47 RECORDS AS PRESCRIBED BY THE DIVISION AND IN ACCORDANCE WITH
- 48 FEDERAL LAW; TO DELETE CERTAIN ENROLLMENT LIMITATIONS AND
- 49 PROVISIONS RELATING TO MANAGED CARE PROGRAMS; TO ALLOW THE
- 50 DIVISION OF MEDICAID TO APPROVE THE USE OF ALTERNATIVE PAYMENT
- 51 MODELS FOR REIMBURSEMENT RATES; TO CLARIFY LIMITATIONS ON MEDICAID
- 52 ELIGIBILITY FOR ENROLLMENT IN MANAGED CARE PROGRAMS; TO DELETE THE

53 PROVISIONS THAT PROVIDE FOR THE COMMISSION ON EXPANDING MEDICAID 54 MANAGED CARE; TO REQUIRE CONTRACTORS RECEIVING PAYMENTS UNDER A 55 MANAGED CARE DELIVERY SYSTEM TO DISCLOSE TO THE CHAIRMEN OF THE 56 SENATE AND HOUSE MEDICAID COMMITTEES THE ADMINISTRATIVE EXPENSES 57 FOR THE PRIOR YEAR, AND THE NUMBER OF EMPLOYEES IN MISSISSIPPI WHO 58 ARE DEDICATED TO MEDICAID AND CHIP LINES OF BUSINESS AS OF JUNE 30 59 OF EACH YEAR; TO PROVIDE FOR REVIEWS OF THE MANAGED CARE PROGRAMS 60 BY THE STATE AUDITOR; TO REQUIRE THAT ALL MANAGED CARE CONTRACTORS 61 SHALL DEVELOP AND IMPLEMENT A UNIFORM CREDENTIALING PROCESS BY 62 WHICH ALL PROVIDERS ARE CREDENTIALED BY JULY 1, 2022; TO DELETE 63 THE PROVISION THAT THERE SHALL NOT BE CUTS TO INPATIENT AND 64 OUTPATIENT HOSPITAL PAYMENTS; TO EXTEND THE AUTOMATIC REPEALER ON 65 THIS SECTION; TO DIRECT THE DIVISION TO EVALUATE THE FEASIBILITY 66 OF CONTINUING TO ADMINISTER PHARMACY BENEFITS UNDER 67 FEE-FOR-SERVICE AND DENTAL BENEFITS UNDER MANAGED CARE; TO DIRECT 68 MANAGED CARE CONTRACTORS TO IMPLEMENT INNOVATIVE PROGRAMS FOR MEMBERS WITH PREDIABETES AND DIABETES; TO AUTHORIZE THE DIVISION 69 70 TO NEGOTIATE A LIMITATION ON LIABILITY TO THE STATE OF CERTAIN 71 PROSPECTIVE CONTRACTORS; TO AMEND SECTION 43-13-145, MISSISSIPPI 72 CODE OF 1972, TO PROVIDE THAT NURSING FACILITIES OPERATED BY THE 7.3 UNIVERSITY OF MISSISSIPPI MEDICAL CENTER ARE NOT EXEMPT FROM THE 74 ANNUAL ASSESSMENT FOR THE SUPPORT OF THE MEDICAID PROGRAM, TO 75 DELETE CERTAIN TECHNICAL PROVISIONS RELATING TO THE ASSESSMENT AND 76 COLLECTION OF THE HOSPITAL ASSESSMENT, TO CLARIFY THE PROCEDURE 77 FOR PAYMENT OF THE HOSPITAL ASSESSMENT FOR THE NONFEDERAL SHARE 78 NECESSARY FOR THE MEDICARE UPPER PAYMENT LIMITS (UPL) PROGRAM AND 79 THE DISPROPORTIONATE SHARE HOSPITAL (DSH) PROGRAM; TO AUTHORIZE AND DIRECT THE DIVISION OF MEDICAID TO PROVIDE UP TO 12 MONTHS OF 80 81 CONTINUOUS COVERAGE POSTPARTUM FOR ANY INDIVIDUAL WHO QUALIFIES 82 FOR MEDICAID AS A PREGNANT WOMAN TO THE EXTENT ALLOWABLE UNDER FEDERAL LAW; TO EXTEND THE AUTOMATIC REPEALER ON THIS SECTION; TO 83 84 AMEND SECTION 41-7-191, MISSISSIPPI CODE OF 1972, TO DELETE THE 85 MORATORIUM ON THE AUTHORITY OF THE STATE DEPARTMENT OF HEALTH TO 86 ISSUE A HEALTH CARE CERTIFICATE OF NEED FOR THE CONSTRUCTION OR 87 CONVERSION OF CHILD/ADOLESCENT PSYCHIATRIC OR CHEMICAL DEPENDENCY 88 BEDS PARTICIPATING IN THE MEDICAID PROGRAM AND TO DELETE CERTAIN 89 RESTRICTIONS ON MEDICAID REIMBURSEMENT FOR SUCH BEDS; TO AMEND 90 SECTION 41-75-5, MISSISSIPPI CODE OF 1972, TO DELETE THE 91 RESTRICTION ON POST ACUTE RESIDENTIAL BRAIN INJURY REHABILITATION 92 FACILITIES PARTICIPATION IN THE MEDICAID PROGRAM; TO AMEND SECTION 83-9-353, MISSISSIPPI CODE OF 1972, TO DELETE CERTAIN RESTRICTIONS 94 ON REMOTE PATIENT TELEMONITORING SERVICES; AND FOR RELATED 95 PURPOSES.

