To: Medicaid

By: Senator(s) Blackwell

COMMITTEE SUBSTITUTE FOR SENATE BILL NO. 2867

AN ACT TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972, TO MAKE CERTAIN TECHNICAL AMENDMENTS TO THE PROVISIONS THAT PROVIDE FOR MEDICAID ELIGIBILITY, TO MODIFY AGE AND INCOME ELIGIBILITY CRITERIA, AND TO CONFORM WITH FEDERAL LAW TO ALLOW 5 CHILDREN IN FOSTER CARE TO BE ELIGIBLE UNTIL THEIR 26TH BIRTHDAY; TO AUTHORIZE THE DIVISION OF MEDICAID TO APPLY FOR A FEDERAL FAMILY PLANNING WAIVER; TO ELIMINATE THE REQUIREMENT THAT THE 7 DIVISION MUST APPLY TO THE CENTER FOR MEDICARE AND MEDICAID 8 9 SERVICES (CMS) FOR WAIVERS TO PROVIDE SERVICES FOR CERTAIN 10 INDIVIDUALS WHO ARE END STAGE RENAL DISEASE PATIENTS ON DIALYSIS, 11 CANCER PATIENTS ON CHEMOTHERAPY OR ORGAN TRANSPLANT RECIPIENTS ON 12 ANTIREJECTION DRUGS; TO AUTHORIZE THE DIVISION TO CONDUCT LESS FREQUENT MEDICAL REDETERMINATIONS FOR ELIGIBLE CHILDREN WHO HAVE CERTAIN LONG-TERM OR CHRONIC CONDITIONS THAT DO NOT NEED TO BE 14 REIDENTIFIED EVERY YEAR; TO AMEND SECTION 43-13-117, MISSISSIPPI 1.5 CODE OF 1972, AS AMENDED BY HOUSE BILL NO. 970, 2024 REGULAR 16 17 SESSION, TO MAKE CERTAIN TECHNICAL AMENDMENTS TO THE PROVISIONS 18 THAT PROVIDE FOR MEDICAID SERVICES, TO COMPLY WITH FEDERAL LAW; TO 19 PROVIDE THAT THE DIVISION SHALL REIMBURSE FOR ONE PAIR OF 20 EYEGLASSES EVERY TWO YEARS INSTEAD OF EVERY FIVE YEARS FOR CERTAIN 21 BENEFICIARIES; TO ELIMINATE THE OPTION FOR CERTAIN RURAL HOSPITALS 22 TO ELECT AGAINST REIMBURSEMENT FOR OUTPATIENT HOSPITAL SERVICES 23 USING THE AMBULATORY PAYMENT CLASSIFICATION (APC) METHODOLOGY; TO 24 PROVIDE THAT THE DIVISION SHALL UPDATE THE CASE MIX PAYMENT SYSTEM 25 AND FAIR RENTAL REIMBURSEMENT SYSTEM AS NECESSARY TO MAINTAIN 26 COMPLIANCE WITH FEDERAL LAW; TO PROVIDE THAT THE DIVISION OF 27 MEDICAID MAY IMPLEMENT A OUALITY OR VALUE-BASED COMPONENT TO THE 28 NURSING FACILITY PAYMENT SYSTEM; TO REQUIRE THE DIVISION TO 29 REIMBURSE PEDIATRICIANS FOR CERTAIN PRIMARY CARE SERVICES AS 30 DEFINED BY THE DIVISION AT 100% OF THE RATE ESTABLISHED UNDER 31 MEDICARE; TO PROVIDE THAT THE DIVISION MAY REIMBURSE AMBULATORY 32 SURGICAL CARE (ASC) BASED ON 100% OF THE MEDICARE ASC PAYMENT SYSTEM RATE IN EFFECT JULY 1 OF EACH YEAR AS SET BY CMS; TO 33 34 AUTHORIZE THE DIVISION TO PROVIDE REIMBURSEMENT FOR NEUROMUSCULAR

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    TONGUE MUSCLE STIMULATORS AND/OR FOR ALTERNATIVE METHODS FOR THE
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    REDUCTION OF SNORING AND OBSTRUCTIVE SLEEP APNEA; TO INCLUDE
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    ADDITIONAL LICENSED PROVIDERS IN THE DIVISION'S UPPER PAYMENT
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    LIMITS PROGRAM; TO AUTHORIZE THAT THE DIVISION MAY, IN
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    CONSULTATION WITH THE MISSISSIPPI HOSPITAL ASSOCIATION, DEVELOP
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    ALTERNATIVE MODELS FOR DISTRIBUTION OF MEDICAL CLAIMS AND
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    SUPPLEMENTAL PAYMENTS FOR INPATIENT AND OUTPATIENT HOSPITAL
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    SERVICES; TO PROVIDE THAT THE DIVISION MAY, TO THE FULLEST EXTENT
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    FEASIBLE, REPLACE THE ADDITIONAL REIMBURSEMENT FOR HOSPITAL
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    INPATIENT SERVICES UNDER THE INPATIENT MEDICARE UPPER PAYMENT
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    LIMITS (UPL) PROGRAM WITH ADDITIONAL REIMBURSEMENT UNDER THE MHAP
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    AND OTHER PAYMENT PROGRAMS; TO DELETE TECHNICAL PROVISIONS RELATED
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    TO THE MISSISSIPPI HOSPITAL ACCESS PROGRAM (MHAP); TO PROVIDE THAT
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    THE DIVISION SHALL CONTRACT WITH THE STATE DEPARTMENT OF HEALTH TO
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    PROVIDE FOR A PERINATAL HIGH RISK MANAGEMENT/INFANT SERVICES
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    SYSTEM FOR ANY ELIGIBLE BENEFICIARY THAT CANNOT RECEIVE SUCH
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    SERVICES UNDER A DIFFERENT PROGRAM; TO AUTHORIZE THE DIVISION TO
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    REIMBURSE FOR SERVICES AT CERTIFIED COMMUNITY BEHAVIORAL HEALTH
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    CENTERS; TO EXTEND THE DATE OF REPEAL ON THE PROVISION OF LAW THAT
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    PROVIDES THAT THE DIVISION SHALL REIMBURSE FOR OUTPATIENT HOSPITAL
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    SERVICES PROVIDED TO ELIGIBLE MEDICAID BENEFICIARIES UNDER THE AGE
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    OF 21 BY BORDER CITY UNIVERSITY AFFILIATED PEDIATRIC TEACHING
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    HOSPITALS, WHICH WAS REPEALED BY OPERATION OF LAW IN 2024; TO
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    REQUIRE THE DIVISION TO DEVELOP AND IMPLEMENT A METHOD FOR
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    REIMBURSEMENT OF AUTISM SPECTRUM DISORDER SERVICES BASED ON A
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    CONTINUUM OF CARE FOR BEST PRACTICES IN MEDICALLY NECESSARY EARLY
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    INTERVENTION TREATMENT; TO REDUCE THE LENGTH OF NOTICE THE
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    DIVISION MUST PROVIDE THE MEDICAID COMMITTEE CHAIRMEN FOR PROPOSED
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    RATE CHANGES AND TO PROVIDE THAT SUCH LEGISLATIVE NOTICE MAY BE
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    EXPEDITED; TO PROVIDE THAT THE DIVISION SHALL REIMBURSE FOR
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    PREPARTICIPATION PHYSICAL EVALUATIONS; TO PROVIDE THAT THE
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    DIVISION SHALL REIMBURSE FOR UNITED STATES FOOD AND DRUG
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    ADMINISTRATION APPROVED GLUCAGON-LIKE PEPTIDE-1 (GLP-1) AGONIST
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    MEDICATIONS FOR CHRONIC WEIGHT MANAGEMENT OR FOR ADDITIONAL
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    CONDITIONS IN THE DISCRETION OF THE MEDICAL PROVIDER; TO PROHIBIT
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    THE DIVISION OF MEDICAID AND CERTAIN MANAGED CARE ENTITIES FROM
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    REOUIRING OR IMPOSING ANY STEP THERAPY PROTOCOL WITH RESPECT TO A
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    DRUG THAT IS APPROVED BY THE UNITED STATES FDA FOR THE TREATMENT
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    OF POSTPARTUM DEPRESSION; TO REQUIRE THE DIVISION TO PROVIDE
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    COVERAGE AND REIMBURSEMENT FOR POSTPARTUM DEPRESSION SCREENING; TO
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    REQUIRE THE DIVISION TO PROVIDE COVERAGE AND TO REIMBURSE FOR ANY
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    NONSTATIN MEDICATION THAT HAS A UNIQUE INDICATION TO REDUCE THE
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    RISK OF A MAJOR CARDIOVASCULAR EVENT IN PRIMARY PREVENTION AND
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    SECONDARY PREVENTION PATIENTS; TO REQUIRE THE DIVISION TO
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    REIMBURSE AMBULANCE TRANSPORTATION SERVICE PROVIDERS THAT PROVIDE
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    AN ASSESSMENT, TRIAGE OR TREATMENT FOR ELIGIBLE MEDICAID
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    BENEFICIARIES; TO SET CERTAIN REIMBURSEMENT LEVELS FOR SUCH
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    PROVIDERS; TO PROVIDE THAT THE DIVISION IS AUTHORIZED TO EXTEND
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    ITS MEDICAID ENTERPRISE SYSTEM AND FISCAL AGENT SERVICES,
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    INCLUDING ALL RELATED COMPONENTS AND SERVICES, CONTRACTS IN EFFECT
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ON JUNE 30, 2025, FOR ADDITIONAL FIVE-YEAR PERIODS IF THE SYSTEM

86 CONTINUES TO MEET THE NEEDS OF THE STATE, THE ANNUAL COST 87 CONTINUES TO BE A FAIR MARKET VALUE, AND THE RATE OF INCREASE IS 88 NO MORE THAN FIVE PERCENT OR THE CURRENT CONSUMER PRICE INDEX, 89 WHICHEVER IS LESS; TO EXTEND THE DATE OF REPEAL ON SUCH SECTION; 90 TO AMEND SECTION 43-13-121, MISSISSIPPI CODE OF 1972, TO REDUCE 91 THE LENGTH OF NOTICE THE DIVISION MUST PROVIDE THE MEDICAID 92 COMMITTEE CHAIRMEN FOR A PROPOSED STATE PLAN AMENDMENT AND TO 93 PROVIDE THAT SUCH LEGISLATIVE NOTICE MAY BE EXPEDITED; TO 94 AUTHORIZE THE DIVISION TO ENTER INTO A TWO-YEAR CONTRACT WITH A 95 VENDOR TO PROVIDE SUPPORT OF THE DIVISION'S ELIGIBILITY SYSTEM; TO 96 AMEND SECTION 43-13-305, MISSISSIPPI CODE OF 1972, TO REVISE 97 CERTAIN PROVISIONS RELATED TO MEDICAID AND THIRD-PARTY BENEFITS TO 98 COMPLY WITH FEDERAL LAW; TO AMEND SECTION 43-11-1, MISSISSIPPI 99 CODE OF 1972, TO DEFINE ADULT DAY CARE FACILITY; TO AMEND SECTION 100 43-11-8, MISSISSIPPI CODE OF 1972, TO PROVIDE FEES FOR ADULT DAY 101 CARE FACILITY LICENSURE AND LICENSE RENEWAL; TO AMEND SECTION 43-11-13, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT BEGINNING JULY 102 103 1, 2026, TO OPERATE AN ADULT DAY CARE CENTER IN MISSISSIPPI, A 104 FACILITY PROVIDER SHALL BE LICENSED WITH THE LICENSING DIVISION OF THE STATE DEPARTMENT OF HEALTH; TO ESTABLISH THAT MISSISSIPPI 105 106 MEDICAID WAIVER PROVIDERS ARE REQUIRED TO HAVE A STATE LICENSE AND 107 HAVE A MEDICAID PROVIDER CONTRACT WITH THE DIVISION OF MEDICAID; 108 TO AMEND SECTION 43-13-117.1, MISSISSIPPI CODE OF 1972, TO MAKE 109 MINOR, NONSUBSTANTIVE REVISIONS; TO AMEND SECTION 43-13-117.7, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT THE DIVISION SHALL NOT 110 111 REIMBURSE OR PROVIDE COVERAGE FOR GENDER TRANSITION PROCEDURES FOR 112 ANY PERSON; TO AMEND SECTION 37-33-167, MISSISSIPPI CODE OF 1972, TO MAKE A MINOR, NONSUBSTANTIVE REVISION; TO AMEND SECTION 113 114 43-13-145, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT A QUARTERLY 115 HOSPITAL ASSESSMENT MAY EXCEED THE ASSESSMENT IN THE PRIOR QUARTER 116 BY MORE THAN \$3,750,000.00 IF SUCH INCREASE IS TO MAXIMIZE FEDERAL 117 FUNDS THAT ARE AVAILABLE TO REIMBURSE HOSPITALS FOR SERVICES 118 PROVIDED UNDER NEW PROGRAMS FOR HOSPITALS, FOR INCREASED 119 SUPPLEMENTAL PAYMENT PROGRAMS FOR HOSPITALS OR TO ASSIST WITH 120 STATE MATCHING FUNDS AS AUTHORIZED BY THE LEGISLATURE; TO AMEND SECTION 43-13-115.1, MISSISSIPPI CODE OF 1972, TO REMOVE THE 121 REQUIREMENT THAT A PREGNANT WOMAN MUST PROVIDE PROOF OF HER 122 123 PREGNANCY AND DOCUMENTATION OF HER MONTHLY FAMILY INCOME WHEN 124 SEEKING A DETERMINATION OF PRESUMPTIVE ELIGIBILITY; TO AMEND 125 SECTION 41-7-191, MISSISSIPPI CODE OF 1972, TO REVISE CERTAIN 126 PROVISIONS RELATING TO A HOSPITAL THAT HAS A CERTIFICATE OF NEED FOR A FORTY-BED PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY IN 127 128 DESOTO COUNTY; TO PROVIDE THAT THERE SHALL BE NO PROHIBITION OR 129 RESTRICTIONS ON PARTICIPATION IN THE MEDICAID PROGRAM FOR SUCH 130 FACILITY THAT WOULD NOT OTHERWISE APPLY TO ANY OTHER SUCH FACILITY; TO PROVIDE THAT A CERTAIN LONG-TERM CARE HOSPITAL IN 131 132 HARRISON COUNTY MAY NOT PARTICIPATE IN THE MEDICAID PROGRAM EXCEPT 133 AS A CROSSOVER ENROLLED PROVIDER; TO CREATE NEW SECTION 83-9-47, 134 MISSISSIPPI CODE OF 1972, TO PROHIBIT INSURERS PROVIDING 135 PRESCRIPTION DRUG COVERAGE FROM REQUIRING OR IMPOSING ANY STEP 136 THERAPY PROTOCOL WITH RESPECT TO DRUGS APPROVED BY THE UNITED

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137 STATES FOOD AND DRUG ADMINISTRATION (FDA) FOR THE TREATMENT OF
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- 138 POSTPARTUM DEPRESSION; TO CREATE NEW SECTION 41-140-1, MISSISSIPPI
- 139 CODE OF 1972, TO DEFINE TERMS; TO CREATE NEW SECTION 41-140-3,
- 140 MISSISSIPPI CODE OF 1972, TO REQUIRE THE STATE DEPARTMENT OF
- 141 HEALTH TO DEVELOP AND PROMULGATE WRITTEN EDUCATIONAL MATERIALS AND
- 142 INFORMATION FOR HEALTH CARE PROFESSIONALS AND PATIENTS ABOUT
- 143 MATERNAL MENTAL HEALTH CONDITIONS; TO REQUIRE HOSPITALS PROVIDING
- 144 BIRTH SERVICES TO PROVIDE SUCH EDUCATIONAL MATERIALS TO NEW
- 145 PARENTS AND, AS APPROPRIATE, OTHER FAMILY MEMBERS; TO REQUIRE SUCH
- 146 MATERIALS BE PROVIDED TO ANY WOMAN WHO PRESENTS WITH SIGNS OF A
- 147 MATERNAL MENTAL HEALTH DISORDER; TO CREATE NEW SECTION 41-140-5,
- 148 MISSISSIPPI CODE OF 1972, TO REQUIRE ANY HEALTH CARE PROVIDER OR
- 149 NURSE MIDWIFE WHO RENDERS POSTNATAL CARE OR PEDIATRIC INFANT CARE
- 150 TO ENSURE THAT THE POSTNATAL CARE PATIENT OR BIRTHING MOTHER OF
- 151 THE PEDIATRIC INFANT CARE PATIENT, AS APPLICABLE, IS OFFERED
- 152 SCREENING FOR POSTPARTUM DEPRESSION AND TO PROVIDE APPROPRIATE
- 153 REFERRALS IF SUCH PATIENT OR MOTHER IS DEEMED LIKELY TO BE
- 154 SUFFERING FROM POSTPARTUM DEPRESSION; TO CREATE NEW SECTION
- 155 83-9-48, MISSISSIPPI CODE OF 1972, TO DEFINE "INSURER" AND REQUIRE
- 156 INSURERS TO PROVIDE COVERAGE FOR POSTPARTUM DEPRESSION SCREENING;
- 157 AND FOR RELATED PURPOSES.
- 158 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:
- 159 **SECTION 1.** Section 43-13-115, Mississippi Code of 1972, is
- 160 amended as follows:
- 161 43-13-115. Recipients of Medicaid shall be the following
- 162 persons only:
- 163 (1) Those who are qualified for public assistance
- 164 grants under provisions of Title IV-A and E of the federal Social
- 165 Security Act, as amended, including those statutorily deemed to be
- 166 IV-A and low income families and children under Section 1931 of
- 167 the federal Social Security Act. For the purposes of this
- 168 paragraph (1) and paragraphs (8), (17) and (18) of this section,
- 169 any reference to Title IV-A or to Part A of Title IV of the
- 170 federal Social Security Act, as amended, or the state plan under
- 171 Title IV-A or Part A of Title IV, shall be considered as a
- 172 reference to Title IV-A of the federal Social Security Act, as

- 173 amended, and the state plan under Title IV-A, including the income 174 and resource standards and methodologies under Title IV-A and the 175 state plan, as they existed on July 16, 1996. The Department of 176 Human Services shall determine Medicaid eligibility for children 177 receiving public assistance grants under Title IV-E. The division 178 shall determine eligibility for low income families under Section 1931 of the federal Social Security Act and shall redetermine 179 180 eligibility for those continuing under Title IV-A grants.
- (2) Those qualified for Supplemental Security Income

 (SSI) benefits under Title XVI of the federal Social Security Act,

 as amended, and those who are deemed SSI eligible as contained in

 federal statute. The eligibility of individuals covered in this

 paragraph shall be determined by the Social Security

 Administration and certified to the Division of Medicaid.
- 187 (3) Qualified pregnant women who would be eligible for
 188 Medicaid as a low income family member under Section 1931 of the
 189 federal Social Security Act if her child were born. The
 190 eligibility of the individuals covered under this paragraph shall
 191 be determined by the division.
- 192 (4) [Deleted]
- 193 (5) A child born on or after October 1, 1984, to a

 194 woman eligible for and receiving Medicaid under the state plan on

 195 the date of the child's birth shall be deemed to have applied for

 196 Medicaid and to have been found eligible for Medicaid under the

 197 plan on the date of that birth, and will remain eligible for

- 198 Medicaid for a period of one (1) year so long as the child is a 199 member of the woman's household and the woman remains eligible for 200 Medicaid or would be eligible for Medicaid if pregnant. 201 eligibility of individuals covered in this paragraph shall be 202 determined by the Division of Medicaid.
- 203 Children certified by the State Department of Human 204 Services to the Division of Medicaid of whom the state and county 205 departments of human services have custody and financial 206 responsibility, and children who are in adoptions subsidized in 207 full or part by the Department of Human Services, including 208 special needs children in non-Title IV-E adoption assistance, who 209 are approvable under Title XIX of the Medicaid program. 210 eligibility of the children covered under this paragraph shall be 211 determined by the State Department of Human Services.
 - Persons certified by the Division of Medicaid who are patients in a medical facility (nursing home, hospital, tuberculosis sanatorium or institution for treatment of mental diseases), and who, except for the fact that they are patients in that medical facility, would qualify for grants under Title IV, Supplementary Security Income (SSI) benefits under Title XVI or state supplements, and those aged, blind and disabled persons who would not be eligible for Supplemental Security Income (SSI) benefits under Title XVI or state supplements if they were not institutionalized in a medical facility but whose income is below

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- 222 the maximum standard set by the Division of Medicaid, which
- 223 standard shall not exceed that prescribed by federal regulation.
- 224 (8) Children under eighteen (18) years of age and
- 225 pregnant women (including those in intact families) who meet the
- 226 financial standards of the state plan approved under Title IV-A of
- 227 the federal Social Security Act, as amended. The eligibility of
- 228 children covered under this paragraph shall be determined by the
- 229 Division of Medicaid.
- 230 (9) Individuals who are:
- 231 (a) Children born after September 30, 1983, * * *
- 232 between the ages of six (6) and nineteen (19), with family income
- 233 that does not exceed * * * one hundred thirty-three percent (133%)
- 234 of the * * * federal poverty level;
- 235 (b) Pregnant women, infants and children * * *
- 236 between the ages of one (1) and six (6), with family income that
- 237 does not exceed * * * one hundred forty-three percent (143%) of
- 238 the federal poverty level; and
- (c) Pregnant women and infants who have not
- 240 attained the age of one (1), with family income that does not
- 241 exceed * * * one hundred ninety-four percent (194%) of the federal
- 242 poverty level.
- The eligibility of individuals covered in (a), (b) and (c) of
- 244 this paragraph shall be determined by the division.
- 245 (10) Certain disabled children age eighteen (18) or
- 246 under who are living at home, who would be eligible, if in a

247 medical institution, for SSI or a state supplemental payment under 248 Title XVI of the federal Social Security Act, as amended, and 249 therefore for Medicaid under the plan, and for whom the state has 250 made a determination as required under Section 1902(e)(3)(b) of 251 the federal Social Security Act, as amended. The eligibility of 252 individuals under this paragraph shall be determined by the 253 The division may conduct less frequent Division of Medicaid. 254 medical redeterminations for children eligible under this 255 subsection who have certain long-term or chronic conditions that 256 do not need to be reidentified every year. 257 (11) * * * Individuals who are sixty-five (65) years of 258 age or older or are disabled as determined under Section

259 1614(a)(3) of the federal Social Security Act, as amended, and 260 whose income does not exceed one hundred thirty-five percent (135%) of the * * * federal poverty level, and whose resources do 261 262 not exceed those established by the Division of Medicaid. 263 eligibility of individuals covered under this paragraph shall be 264 determined by the Division of Medicaid. * * * Only those 265 individuals covered under the 1115(c) Healthier Mississippi waiver 266 will be covered under this category.

Any individual who applied for Medicaid during the period
from July 1, 2004, through March 31, 2005, who otherwise would
have been eligible for coverage under this paragraph (11) if it
had been in effect at the time the individual submitted his or her
application and is still eligible for coverage under this

- 272 paragraph (11) on March 31, 2005, shall be eligible for Medicaid
- 273 coverage under this paragraph (11) from March 31, 2005, through
- 274 December 31, 2005. The division shall give priority in processing
- 275 the applications for those individuals to determine their
- 276 eligibility under this paragraph (11).
- 277 (12) Individuals who are qualified Medicare
- 278 beneficiaries (QMB) entitled to Part A Medicare as defined under
- 279 Section 301, Public Law 100-360, known as the Medicare
- 280 Catastrophic Coverage Act of 1988, and whose income does not
- 281 exceed one hundred percent (100%) of the * * * federal poverty
- 282 level.
- The eligibility of individuals covered under this paragraph
- 284 shall be determined by the Division of Medicaid, and those
- 285 individuals determined eligible shall receive Medicare
- 286 cost-sharing expenses only as more fully defined by the Medicare
- 287 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
- 288 1997.
- 289 (13) (a) Individuals who are entitled to Medicare Part
- 290 A as defined in Section 4501 of the Omnibus Budget Reconciliation
- 291 Act of 1990, and whose income does not exceed one hundred twenty
- 292 percent (120%) of the * * * federal poverty level. Eligibility
- 293 for Medicaid benefits is limited to full payment of Medicare Part
- 294 B premiums.
- 295 (b) Individuals entitled to Part A of Medicare,

296 with income above one hundred twenty percent (120%), but less than

- one hundred thirty-five percent (135%) of the federal poverty
 level, and not otherwise eligible for Medicaid. Eligibility for
 Medicaid benefits is limited to full payment of Medicare Part B
 premiums. The number of eligible individuals is limited by the
 availability of the federal capped allocation at one hundred
 percent (100%) of federal matching funds, as more fully defined in
 the Balanced Budget Act of 1997.
- The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid.
- 306 (14) [Deleted]
- 307 (15)Disabled workers who are eligible to enroll in 308 Part A Medicare as required by Public Law 101-239, known as the 309 Omnibus Budget Reconciliation Act of 1989, and whose income does 310 not exceed two hundred percent (200%) of the federal poverty level as determined in accordance with the Supplemental Security Income 311 312 (SSI) program. The eligibility of individuals covered under this 313 paragraph shall be determined by the Division of Medicaid and 314 those individuals shall be entitled to buy-in coverage of Medicare 315 Part A premiums only under the provisions of this paragraph (15).
- 316 (16) In accordance with the terms and conditions of
 317 approved Title XIX waiver from the United States Department of
 318 Health and Human Services, persons provided home- and
 319 community-based services who are physically disabled and certified
 320 by the Division of Medicaid as eligible due to applying the income
 321 and deeming requirements as if they were institutionalized.

322 (17)In accordance with the terms of the federal 323 Personal Responsibility and Work Opportunity Reconciliation Act of 324 1996 (Public Law 104-193), persons who become ineligible for 325 assistance under Title IV-A of the federal Social Security Act, as 326 amended, because of increased income from or hours of employment 327 of the caretaker relative or because of the expiration of the 328 applicable earned income disregards, who were eligible for 329 Medicaid for at least three (3) of the six (6) months preceding 330 the month in which the ineligibility begins, shall be eligible for Medicaid for up to twelve (12) months. The eligibility of the 331 332 individuals covered under this paragraph shall be determined by 333 the division.

334 Persons who become ineligible for assistance under 335 Title IV-A of the federal Social Security Act, as amended, as a 336 result, in whole or in part, of the collection or increased 337 collection of child or spousal support under Title IV-D of the 338 federal Social Security Act, as amended, who were eligible for 339 Medicaid for at least three (3) of the six (6) months immediately 340 preceding the month in which the ineligibility begins, shall be 341 eligible for Medicaid for an additional four (4) months beginning 342 with the month in which the ineligibility begins. The eligibility 343 of the individuals covered under this paragraph shall be 344 determined by the division.

345 (19) Disabled workers, whose incomes are above the 346 Medicaid eligibility limits, but below two hundred fifty percent

- 347 (250%) of the federal poverty level, shall be allowed to purchase
- 348 Medicaid coverage on a sliding fee scale developed by the Division
- 349 of Medicaid.
- 350 (20) Medicaid eligible children under age eighteen (18)
- 351 shall remain eligible for Medicaid benefits until the end of a
- 352 period of twelve (12) months following an eligibility
- 353 determination, or until such time that the individual exceeds age
- 354 eighteen (18).
- 355 (21) Women and men of * * * reproductive age whose
- 356 family income does not exceed * * * one hundred ninety-four
- 357 percent (194%) of the federal poverty level. The eligibility of
- 358 individuals covered under this paragraph (21) shall be determined
- 359 by the Division of Medicaid, and those individuals determined
- 360 eligible shall only receive family planning services covered under
- 361 Section 43-13-117(13) and not any other services covered under
- 362 Medicaid. However, any individual eligible under this paragraph
- 363 (21) who is also eliqible under any other provision of this
- 364 section shall receive the benefits to which he or she is entitled
- 365 under that other provision, in addition to family planning
- 366 services covered under Section 43-13-117(13).
- 367 The Division of Medicaid * * * $\frac{1}{2}$ may apply to the United States
- 368 Secretary of Health and Human Services for a federal waiver of the
- 369 applicable provisions of Title XIX of the federal Social Security
- 370 Act, as amended, and any other applicable provisions of federal

- 371 law as necessary to allow for the implementation of this paragraph
- 372 (21). * * *
- 373 (22) Persons who are workers with a potentially severe
- 374 disability, as determined by the division, shall be allowed to
- 375 purchase Medicaid coverage. The term "worker with a potentially
- 376 severe disability" means a person who is at least sixteen (16)
- 377 years of age but under sixty-five (65) years of age, who has a
- 378 physical or mental impairment that is reasonably expected to cause
- 379 the person to become blind or disabled as defined under Section
- 380 1614(a) of the federal Social Security Act, as amended, if the
- 381 person does not receive items and services provided under
- 382 Medicaid.
- 383 The eligibility of persons under this paragraph (22) shall be
- 384 conducted as a demonstration project that is consistent with
- 385 Section 204 of the Ticket to Work and Work Incentives Improvement
- 386 Act of 1999, Public Law 106-170, for a certain number of persons
- 387 as specified by the division. The eligibility of individuals
- 388 covered under this paragraph (22) shall be determined by the
- 389 Division of Medicaid.
- 390 (23) Children certified by the Mississippi Department
- 391 of Human Services for whom the state and county departments of
- 392 human services have custody and financial responsibility who are
- 393 in foster care on their eighteenth birthday as reported by the
- 394 Mississippi Department of Human Services shall be certified
- 395 Medicaid eligible by the Division of Medicaid until their * * *

396 <u>twenty-sixth</u> birthday. <u>Children who have aged out of foster care</u>
397 <u>while on Medicaid in other states shall qualify until their</u>

398 <u>twenty-sixth birthday.</u>

- 399 Individuals who have not attained age sixty-five (24)400 (65), are not otherwise covered by creditable coverage as defined 401 in the Public Health Services Act, and have been screened for 402 breast and cervical cancer under the Centers for Disease Control 403 and Prevention Breast and Cervical Cancer Early Detection Program 404 established under Title XV of the Public Health Service Act in 405 accordance with the requirements of that act and who need 406 treatment for breast or cervical cancer. Eligibility of 407 individuals under this paragraph (24) shall be determined by the Division of Medicaid. 408
- 409 The division shall apply to the Centers for 410 Medicare and Medicaid Services (CMS) for any necessary waivers to 411 provide services to individuals who are sixty-five (65) years of 412 age or older or are disabled as determined under Section 413 1614(a)(3) of the federal Social Security Act, as amended, and 414 whose income does not exceed one hundred thirty-five percent 415 (135%) of the * * * federal poverty level, and whose resources do 416 not exceed those established by the Division of Medicaid, and who 417 are not otherwise covered by Medicare. Nothing contained in this paragraph (25) shall entitle an individual to benefits. 418 419 eligibility of individuals covered under this paragraph shall be 420 determined by the Division of Medicaid.

421	(26)	* * *	[Deleted]
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- 422 (27) Individuals who are entitled to Medicare Part D
 423 and whose income does not exceed one hundred fifty percent (150%)
- 424 of the * * * $\frac{1}{2}$ federal poverty level. Eligibility for payment of
- 425 the Medicare Part D subsidy under this paragraph shall be
- 426 determined by the division.
- 427 (28) The division is authorized and directed to provide
- 428 up to twelve (12) months of continuous coverage postpartum for any
- 429 individual who qualifies for Medicaid coverage under this section
- 430 as a pregnant woman, to the extent allowable under federal law and
- 431 as determined by the division.
- The division shall redetermine eligibility for all categories
- 433 of recipients described in each paragraph of this section not less
- 434 frequently than required by federal law.
- 435 **SECTION 2.** Section 43-13-117, Mississippi Code of 1972, is
- 436 amended as follows:
- 437 43-13-117. (A) Medicaid as authorized by this article shall
- 438 include payment of part or all of the costs, at the discretion of
- 439 the division, with approval of the Governor and the Centers for
- 440 Medicare and Medicaid Services, of the following types of care and
- 441 services rendered to eligible applicants who have been determined
- 442 to be eliqible for that care and services, within the limits of
- 443 state appropriations and federal matching funds:
- 444 (1) Inpatient hospital services.

445		(a) The	division	is auth	orized to	implement	an All
446	Patient Refined	d Diagnos	is Related	d Groups	(APR-DRG)) reimburs	ement
447	methodology for	r inpatie	nt hospita	al servi	ces.		

- (b) No service benefits or reimbursement
 limitations in this subsection (A)(1) shall apply to payments
 under an APR-DRG or Ambulatory Payment Classification (APC) model
 or a managed care program or similar model described in subsection
 (H) of this section unless specifically authorized by the
 division.
- 454 (2) Outpatient hospital services.
- 455 (a) Emergency services.
 - (b) Other outpatient hospital services. The division shall allow benefits for other medically necessary outpatient hospital services (such as chemotherapy, radiation, surgery and therapy), including outpatient services in a clinic or other facility that is not located inside the hospital, but that has been designated as an outpatient facility by the hospital, and that was in operation or under construction on July 1, 2009, provided that the costs and charges associated with the operation of the hospital clinic are included in the hospital's cost report. In addition, the Medicare thirty-five-mile rule will apply to those hospital clinics not located inside the hospital that are constructed after July 1, 2009. Where the same services are reimbursed as clinic services, the division may revise the rate or

469	methodology	of	outpatient	reimbursement	to	maintain	consistency,
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- 470 efficiency, economy and quality of care.
- 471 (c) The division is authorized to implement an
- 472 Ambulatory Payment Classification (APC) methodology for outpatient
- 473 hospital services. * * *
- 474 (d) No service benefits or reimbursement
- 475 limitations in this subsection (A)(2) shall apply to payments
- 476 under an APR-DRG or APC model or a managed care program or similar
- 477 model described in subsection (H) of this section unless
- 478 specifically authorized by the division.
- 479 (3) Laboratory and x-ray services.
- 480 (4) Nursing facility services.
- 481 (a) The division shall make full payment to
- 482 nursing facilities for each day, not exceeding forty-two (42) days
- 483 per year, that a patient is absent from the facility on home
- 484 leave. Payment may be made for the following home leave days in
- 485 addition to the forty-two-day limitation: Christmas, the day
- 486 before Christmas, the day after Christmas, Thanksgiving, the day
- 487 before Thanksgiving and the day after Thanksgiving.
- 488 (b) From and after July 1, 1997, the division
- 489 shall implement the integrated case-mix payment and quality
- 490 monitoring system, which includes the fair rental system for
- 491 property costs and in which recapture of depreciation is
- 492 eliminated. The division may reduce the payment for hospital
- 493 leave and therapeutic home leave days to the lower of the case-mix

assessment being utilized for payment at that point in time, or a case-mix score of 1.000 for nursing facilities, and shall compute case-mix scores of residents so that only services provided at the nursing facility are considered in calculating a facility's per diem.

- 500 (c) From and after July 1, 1997, all state-owned 501 nursing facilities shall be reimbursed on a full reasonable cost 502 basis.
- (d) * * * The division shall update the case-mix

 payment system * * * and fair rental reimbursement system as

 necessary to maintain compliance with federal law. The division

 shall develop and implement a payment add-on to reimburse nursing

 facilities for ventilator-dependent resident services.
- 508 The division shall develop and implement, not (e) 509 later than January 1, 2001, a case-mix payment add-on determined 510 by time studies and other valid statistical data that will reimburse a nursing facility for the additional cost of caring for 511 512 a resident who has a diagnosis of Alzheimer's or other related 513 dementia and exhibits symptoms that require special care. 514 such case-mix add-on payment shall be supported by a determination 515 of additional cost. The division shall also develop and implement 516 as part of the fair rental reimbursement system for nursing 517 facility beds, an Alzheimer's resident bed depreciation enhanced reimbursement system that will provide an incentive to encourage 518

519	nursing	facilities	to	convert	or	construct	beds	for	residents	with
520	Alzheime	er's or othe	er :	related o	deme	entia.				

- (f) The division shall develop and implement an assessment process for long-term care services. The division may provide the assessment and related functions directly or through contract with the area agencies on aging.
- 525 (g) The division may implement a quality or
 526 value-based component to the nursing facility payment system.

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 services authorized under the federal regulations adopted to implement Title XIX of the federal Social Security Act, as amended. The division, in obtaining physical therapy services, occupational therapy services, and services for individuals with speech, hearing and language disorders, may enter into a

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

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

569	reimburse obstetricians * * * $\underline{}$ gynecologists <u>and pediatricians</u> for
570	certain primary care services as defined by the division at one
571	hundred percent (100%) of the rate established under Medicare.

- 572 (a) Home health services for eligible persons, not (7) 573 to exceed in cost the prevailing cost of nursing facility 574 services. All home health visits must be precertified as required by the division. In addition to physicians, certified registered 575 576 nurse practitioners, physician assistants and clinical nurse 577 specialists are authorized to prescribe or order home health 578 services and plans of care, sign home health plans of care, 579 certify and recertify eligibility for home health services and 580 conduct the required initial face-to-face visit with the recipient 581 of the services.
- 582 (b) [Repealed]
- 583 (8) Emergency medical transportation services as determined by the division.
- 585 (9) Prescription drugs and other covered drugs and 586 services as determined by the division.
- The division shall establish a mandatory preferred drug list.
- 588 Drugs not on the mandatory preferred drug list shall be made
- 589 available by utilizing prior authorization procedures established
- 590 by the division.
- The division may seek to establish relationships with other
- 592 states in order to lower acquisition costs of prescription drugs
- 593 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

619	determined	bу	the	division	not	exceeding	Seven	Dollars	and
620	Eighty-two	Cer	nts	(\$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.
- The division shall develop and implement a method or methods
 by which the division will provide on a regular basis to Medicaid
 providers who are authorized to prescribe drugs, information about
 the costs to the Medicaid program of single-source drugs and
 innovator multiple-source drugs, and information about other drugs
 that may be prescribed as alternatives to those single-source

643	drugs	and	innovat	cor	multip	ole-source	dru	ıgs a	nd	the	costs	to	the
644	Medica	id r	orogram	of	those	alternativ	ze d	lrugs					

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.

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

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

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

The division shall allow certain drugs, including physician-administered drugs, and 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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668	The division and any managed care entity described in
669	subsection (H) of this section shall not require or impose any
670	step therapy protocol with respect to a drug that is approved by
671	the United States Food and Drug Administration for the treatment
672	of postpartum depression.
673	(10) Dental and orthodontic services to be determined
674	by the division.
675	The division shall increase the amount of the reimbursement
676	rate for diagnostic and preventative dental services for each of
677	the fiscal years 2022, 2023 and 2024 by five percent (5%) above
678	the amount of the reimbursement rate for the previous fiscal year.
679	The division shall increase the amount of the reimbursement rate
680	for restorative dental services for each of the fiscal years 2023,
681	2024 and 2025 by five percent (5%) above the amount of the
682	reimbursement rate for the previous fiscal year. It is the intent
683	of the Legislature that the reimbursement rate revision for
684	preventative dental services will be an incentive to increase the
685	number of dentists who actively provide Medicaid services. This
686	dental services reimbursement rate revision shall be known as the
687	"James Russell Dumas Medicaid Dental Services Incentive Program."
688	The Medical Care Advisory Committee, assisted by the Division
689	of Medicaid, shall annually determine the effect of this incentive
690	by evaluating the number of dentists who are Medicaid providers,
691	the number who and the degree to which they are actively billing
692	Medicaid, the geographic trends of where dentists are offering

693 what types of Medicaid services and other statistics pertinent to

694 the goals of this legislative intent. This data shall annually be

695 presented to the Chair of the Senate Medicaid Committee and the

696 Chair of the House Medicaid Committee.

The division shall include dental services as a necessary component of overall health services provided to children who are

699 eligible for services.

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- (a) had surgery on the eyeball or ocular muscle that results in a vision change for which eyeglasses or a change in eyeglasses is medically indicated within six (6) months of the surgery and is in accordance with policies established by the division, or (b) one (1) pair every * * * two (2) years and in accordance with policies established by the division. In either instance, the eyeglasses must be prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the beneficiary may select.
 - (12) Intermediate care facility services.
- 710 (a) The division shall make full payment to all
- 711 intermediate care facilities for individuals with intellectual
- 712 disabilities for each day, not exceeding sixty-three (63) days per
- 713 year, that a patient is absent from the facility on home leave.
- 714 Payment may be made for the following home leave days in addition
- 715 to the sixty-three-day limitation: Christmas, the day before
- 716 Christmas, the day after Christmas, Thanksgiving, the day before
- 717 Thanksgiving and the day after Thanksgiving.

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

- 721 (c) Effective January 1, 2015, the division shall
 722 update the fair rental reimbursement system for intermediate care
 723 facilities for individuals with intellectual disabilities.
- 724 (13) Family planning services, including drugs,
 725 supplies and devices, when those services are under the
 726 supervision of a physician or nurse practitioner.
- 727 (14) Clinic services. Preventive, diagnostic,
 728 therapeutic, rehabilitative or palliative services that are
 729 furnished by a facility that is not part of a hospital but is
 730 organized and operated to provide medical care to outpatients.
- 731 Clinic services include, but are not limited to:
- 732 (a) Services provided by ambulatory surgical 733 centers (ACSs) as defined in Section 41-75-1(a); and
- 734 (b) Dialysis center services.
- Ambulatory Surgical Care (ASCs) may be reimbursed by the

 division based on one hundred percent (100%) of the Medicare ASC

 Payment System rate in effect July 1 of each year as set by the

 Center for Medicare and Medicaid Services.
- 739 (15) Home- and community-based services for the elderly 740 and disabled, as provided under Title XIX of the federal Social 741 Security Act, as amended, under waivers, subject to the

availability of funds specifically appropriated for that purpose by the Legislature.

744 Mental health services. Certain services provided (16)745 by a psychiatrist shall be reimbursed at up to one hundred percent 746 (100%) of the Medicare rate. Approved therapeutic and case 747 management services (a) provided by an approved regional mental 748 health/intellectual disability center established under Sections 749 41-19-31 through 41-19-39, or by another community mental health 750 service provider meeting the requirements of the Department of 751 Mental Health to be an approved mental health/intellectual 752 disability center if determined necessary by the Department of 753 Mental Health, using state funds that are provided in the appropriation to the division to match federal funds, or (b) 754 755 provided by a facility that is certified by the State Department 756 of Mental Health to provide therapeutic and case management 757 services, to be reimbursed on a fee for service basis, or (c) 758 provided in the community by a facility or program operated by the 759 Department of Mental Health. Any such services provided by a 760 facility described in subparagraph (b) must have the prior 761 approval of the division to be reimbursable under this section.

762 (17) Durable medical equipment services and medical supplies. Precertification of durable medical equipment and 764 medical supplies must be obtained as required by the division. 765 The Division of Medicaid may require durable medical equipment 766 providers to obtain a surety bond in the amount and to the

767 specifications as established by the Balanced Budget Act of 1997. 768 A maximum dollar amount of reimbursement for noninvasive 769 ventilators or ventilation treatments properly ordered and being 770 used in an appropriate care setting shall not be set by any health 771 maintenance organization, coordinated care organization, 772 provider-sponsored health plan, or other organization paid for 773 services on a capitated basis by the division under any managed 774 care program or coordinated care program implemented by the 775 division under this section. Reimbursement by these organizations 776 to durable medical equipment suppliers for home use of noninvasive 777 and invasive ventilators shall be on a continuous monthly payment 778 basis for the duration of medical need throughout a patient's 779 valid prescription period.

The division may provide reimbursement for neuromuscular
tongue muscle stimulators and/or for alternative methods for the
reduction of snoring and obstructive sleep apnea.

(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

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- 792 the state for disproportionate share hospitals. However, from and
- 793 after January 1, 1999, public hospitals participating in the
- 794 Medicaid disproportionate share program may be required to
- 795 participate in an intergovernmental transfer program as provided
- 796 in Section 1903 of the federal Social Security Act and any
- 797 applicable regulations.
- 798 (b) (i) 1. The division may establish a Medicare
- 799 Upper Payment Limits Program, as defined in Section 1902(a)(30) of
- 800 the federal Social Security Act and any applicable federal
- 801 regulations, or an allowable delivery system or provider payment
- 802 initiative authorized under 42 CFR 438.6(c), for hospitals,
- 803 nursing facilities \star \star , physicians and other eligible licensed
- 804 providers as determined by the division employed or contracted by
- 805 hospitals.
- 806 2. The division shall establish a
- 807 Medicaid Supplemental Payment Program, as permitted by the federal
- 808 Social Security Act and a comparable allowable delivery system or
- 809 provider payment initiative authorized under 42 CFR 438.6(c), for
- 810 emergency ambulance transportation providers in accordance with
- 811 this subsection (A)(18)(b).
- 812 (ii) The division shall assess each hospital,
- 813 nursing facility, and emergency ambulance transportation provider
- 814 for the sole purpose of financing the state portion of the
- 815 Medicare Upper Payment Limits Program or other program(s)
- 816 authorized under this subsection (A)(18)(b). The hospital

817	assessment shall be as provided in Section $43-13-145(4)(a)$, and
818	the nursing facility and the emergency ambulance transportation
819	assessments, if established, shall be based on Medicaid
820	utilization or other appropriate method, as determined by the
821	division, consistent with federal regulations. The assessments
822	will remain in effect as long as the state participates in the
823	Medicare Upper Payment Limits Program or other program(s)
824	authorized under this subsection (A)(18)(b). In addition to the
825	hospital assessment provided in Section 43-13-145(4)(a), hospitals
826	with physicians and other eligible licensed providers as
827	determined by the division participating in the Medicare Upper
828	Payment Limits Program or other program(s) authorized under this
829	subsection (A)(18)(b) shall be required to participate in an
830	intergovernmental transfer or assessment, as determined by the
831	division, for the purpose of financing the state portion of the
832	physician UPL payments or other payment(s) authorized under this
833	subsection (A)(18)(b).
834	(iii) Subject to approval by the Centers for
835	Medicare and Medicaid Services (CMS) and the provisions of this
836	subsection (A)(18)(b), the division shall make additional
837	reimbursement to hospitals, nursing facilities, and emergency
838	ambulance transportation providers for the Medicare Upper Payment
839	Limits Program or other program(s) authorized under this
840	subsection (A)(18)(b), and, if the program is established for
841	physicians and other eligible licensed providers as determined by

842	the division, shall make additional reimbursement for physicians
843	and other eligible licensed providers as determined by the
844	division, as defined in Section 1902(a)(30) of the federal Social
845	Security Act and any applicable federal regulations, provided the
846	assessment in this subsection (A)(18)(b) is in effect.
847	(iv) * * * The division is authorized to
848	develop and implement an alternative fee-for-service Upper Payment
849	Limits model in accordance with federal laws and regulations if
850	necessary to preserve supplemental funding. * * * The division,
851	in consultation with the Mississippi Hospital Association, may
852	develop alternative models for distribution of medical claims and
853	supplemental payments for inpatient and outpatient hospital
854	services, and such models may include, but shall not be limited
855	to, the following: increasing rates for inpatient and outpatient
856	services; creating a low-income utilization pool of funds to
857	reimburse hospitals for the costs of uncompensated care, charity
858	care and bad debts as permitted and approved pursuant to federal
859	regulations and the Centers for Medicare and Medicaid Services;
860	supplemental payments based upon Medicaid utilization, quality,
861	service lines and/or costs of providing such services to Medicaid
862	beneficiaries and to uninsured patients. The goals of such
863	payment models shall be to ensure access to inpatient and
864	outpatient care and to maximize any federal funds that are
865	available to reimburse hospitals for services provided. The
866	Chairman of the Senate and House Medicaid Committees shall be

867	provided	copies	of	the	proposed	payment	model(s)	prior	to
868	submissio	on.							

(v) 1. To preserve and improve access to ambulance transportation provider services, the division shall seek CMS approval to make ambulance service access payments as set forth in this subsection (A)(18)(b) for all covered emergency ambulance services rendered on or after July 1, 2022, and shall make such ambulance service access payments for all covered services rendered on or after the effective date of CMS approval.

2. The division shall calculate the ambulance service access payment amount as the balance of the portion of the Medical Care Fund related to ambulance transportation service provider assessments plus any federal matching funds earned on the balance, up to, but not to exceed, the upper payment limit gap for all emergency ambulance service providers.

3. a. Except for ambulance services exempt from the assessment provided in this paragraph (18)(b), all ambulance transportation service providers shall be eligible for ambulance service access payments each state fiscal year as set forth in this paragraph (18)(b).

b. In addition to any other funds paid to ambulance transportation service providers for emergency medical services provided to Medicaid beneficiaries, each eligible ambulance transportation service provider shall receive ambulance

service access payments each state fiscal year equal to the
ambulance transportation service provider's upper payment limit
gap. Subject to approval by the Centers for Medicare and Medicaid
Services, ambulance service access payments shall be made no less
than on a quarterly basis.

c. As used in this paragraph

(18) (b) (v), the term "upper payment limit gap" means the

difference between the total amount that the ambulance

transportation service provider received from Medicaid and the

average amount that the ambulance transportation service provider

would have received from commercial insurers for those services

reimbursed by Medicaid.

4. An ambulance service access payment shall not be used to offset any other payment by the division for emergency or nonemergency services to Medicaid beneficiaries.

approval by the Centers for Medicare and Medicaid Services (CMS), establish, implement and operate a Mississippi Hospital Access Program (MHAP) for the purpose of protecting patient access to hospital care through hospital inpatient reimbursement programs provided in this section designed to maintain total hospital reimbursement for inpatient services rendered by in-state hospitals and the out-of-state hospital that is authorized by federal law to submit intergovernmental transfers (IGTs) to the State of Mississippi and is classified as Level I trauma center

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920 (ii) Subject to approval by the Centers for 921 Medicare and Medicaid Services (CMS), the MHAP shall provide 922 increased inpatient capitation (PMPM) payments to managed care 923 entities contracting with the division pursuant to subsection (H) 924 of this section to support availability of hospital services or 925 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 * * * may, to the fullest extent feasible, replace the additional reimbursement for hospital inpatient services under the inpatient Medicare Upper Payment Limits (UPL) Program with additional reimbursement under the MHAP and other payment programs for inpatient and/or outpatient payments which may be developed under the authority of this paragraph.

937 (iv) The division shall assess each hospital 938 as provided in Section 43-13-145(4)(a) for the purpose of 939 financing the state portion of the MHAP, supplemental payments and 940 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.

943 (19)(a) Perinatal risk-management services. division shall promulgate regulations to be effective from and 944 945 after October 1, 1988, to establish a comprehensive perinatal 946 system for risk assessment of all pregnant and infant Medicaid 947 recipients and for management, education and follow-up for those who are determined to be at risk. Services to be performed 948 949 include case management, nutrition assessment/counseling, 950 psychosocial assessment/counseling and health education. 951 division * * * may contract with the State Department of Health to 952 provide services within this paragraph (Perinatal High Risk 953 Management/Infant Services System (PHRM/ISS)) for any eligible 954 beneficiary who cannot receive these services under a different 955 The State Department of Health shall be reimbursed on a program. 956 full reasonable cost basis for services provided under this 957 subparagraph (a). Any program authorized under subsection H of 958 this section shall develop a perinatal risk-management services 959 program in consultation with the division and the State Department 960 of Health or may contract with the State Department of Health for 961 these services, and the programs shall begin providing these 962 services no later than January 1, 2026.

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

966 statewide system of delivery of early intervention services, under

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

968 The State Department of Health shall certify annually in writing

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

970 state early intervention funds available that will be utilized as

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

972 shall be used to provide expanded targeted case management

973 services for Medicaid eligible children with special needs who are

974 eligible for the state's early intervention system.

975 Qualifications for persons providing service coordination shall be

determined by the State Department of Health and the Division of

977 Medicaid.

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

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

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

981 community-based services for physically disabled people using

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

983 Department of Rehabilitation Services and used to match federal

funds under a cooperative agreement between the division and the

department, provided that funds for these services are

986 specifically appropriated to the Department of Rehabilitation

987 Services.

988 (21) Nurse practitioner services. Services furnished

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

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

991 but not limited to, nurse anesthetists, nurse midwives, family 992 nurse practitioners, family planning nurse practitioners, 993 pediatric nurse practitioners, obstetrics-gynecology nurse 994 practitioners and neonatal nurse practitioners, under regulations 995 adopted by the division. Reimbursement for those services shall 996 not exceed ninety percent (90%) of the reimbursement rate for 997 comparable services rendered by a physician. The division may 998 provide for a reimbursement rate for nurse practitioner services 999 of up to one hundred percent (100%) of the reimbursement rate for 1000 comparable services rendered by a physician for nurse practitioner 1001 services that are provided after the normal working hours of the 1002 nurse practitioner, as determined in accordance with regulations 1003 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

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1016 reimburse FOHCs, RHCs and CMHCs for both distant site and 1017 originating site services when such services are appropriately 1018 provided by the same organization.

1019 (23)Inpatient psychiatric services.

1020 (a) Inpatient psychiatric services to be 1021 determined by the division for recipients under age twenty-one 1022 (21) that are provided under the direction of a physician in an 1023 inpatient program in a licensed acute care psychiatric facility or 1024 in a licensed psychiatric residential treatment facility, before 1025 the recipient reaches age twenty-one (21) or, if the recipient was 1026 receiving the services immediately before he or she reached age twenty-one (21), before the earlier of the date he or she no 1027 1028 longer requires the services or the date he or she reaches age twenty-two (22), as provided by federal regulations. From and 1029 after January 1, 2015, the division shall update the fair rental 1030 1031 reimbursement system for psychiatric residential treatment 1032 facilities. Precertification of inpatient days and residential treatment days must be obtained as required by the division. 1033 1034 and after July 1, 2009, all state-owned and state-operated 1035 facilities that provide inpatient psychiatric services to persons 1036 under age twenty-one (21) who are eligible for Medicaid reimbursement shall be reimbursed for those services on a full 1037 reasonable cost basis. 1038

provided by a licensed freestanding psychiatric hospital to

The division may reimburse for services

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L041	Medicaid :	recipients	over	the ag	ge of	twenty	y−on	e (21)	in a	method	1
L042	and manne:	r consisten	t wit	h the	provi	isions	of	Section	43-1	L3-117.	5.

- 1043 (24) * * * Certified Community Behavioral Health

 1044 Centers (CCBHCs). The division may reimburse CCBHCs in a manner
- 1045 as determined by the division.
- 1046 (25) [Deleted]
- 1047 (26)Hospice care. As used in this paragraph, the term 1048 "hospice care" means a coordinated program of active professional 1049 medical attention within the home and outpatient and inpatient 1050 care that treats the terminally ill patient and family as a unit, 1051 employing a medically directed interdisciplinary team. 1052 program provides relief of severe pain or other physical symptoms 1053 and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses 1054 1055 that are experienced during the final stages of illness and during 1056 dying and bereavement and meets the Medicare requirements for 1057 participation as a hospice as provided in federal regulations.
- 1058 (27) Group health plan premiums and cost-sharing if it
 1059 is cost-effective as defined by the United States Secretary of
 1060 Health and Human Services.
- 1061 (28) Other health insurance premiums that are
 1062 cost-effective as defined by the United States Secretary of Health
 1063 and Human Services. Medicare eligible must have Medicare Part B
 1064 before other insurance premiums can be paid.

1065	(29) The Division of Medicaid may apply for a waiver
1066	from the United States Department of Health and Human Services for
1067	home- and community-based services for developmentally disabled
1068	people using state funds that are provided from the appropriation
1069	to the State Department of Mental Health and/or funds transferred
1070	to the department by a political subdivision or instrumentality of
1071	the state and used to match federal funds under a cooperative
1072	agreement between the division and the department, provided that
1073	funds for these services are specifically appropriated to the
1074	Department of Mental Health and/or transferred to the department
1075	by a political subdivision or instrumentality of the state.

- 1076 (30) Pediatric skilled nursing services as determined 1077 by the division and in a manner consistent with regulations 1078 promulgated by the Mississippi State Department of Health.
- 1079 (31) Targeted case management services for children
 1080 with special needs, under waivers from the United States
 1081 Department of Health and Human Services, using state funds that
 1082 are provided from the appropriation to the Mississippi Department
 1083 of Human Services and used to match federal funds under a
 1084 cooperative agreement between the division and the department.
- 1085 (32) Care and services provided in Christian Science
 1086 Sanatoria listed and certified by the Commission for Accreditation
 1087 of Christian Science Nursing Organizations/Facilities, Inc.,
 1088 rendered in connection with treatment by prayer or spiritual means

1089 to the extent that those services are subject to reimbursement 1090 under Section 1903 of the federal Social Security Act.

- 1091 (33) Podiatrist services.
- 1092 (34) Assisted living services as provided through
 1093 home- and community-based services under Title XIX of the federal
 1094 Social Security Act, as amended, subject to the availability of
 1095 funds specifically appropriated for that purpose by the
 1096 Legislature.
- 1097 (35) Services and activities authorized in Sections
 1098 43-27-101 and 43-27-103, using state funds that are provided from
 1099 the appropriation to the Mississippi Department of Human Services
 1100 and used to match federal funds under a cooperative agreement
 1101 between the division and the department.
- 1102 Nonemergency transportation services for 1103 Medicaid-eligible persons as determined by the division. The PEER 1104 Committee shall conduct a performance evaluation of the 1105 nonemergency transportation program to evaluate the administration of the program and the providers of transportation services to 1106 1107 determine the most cost-effective ways of providing nonemergency 1108 transportation services to the patients served under the program. 1109 The performance evaluation shall be completed and provided to the 1110 members of the Senate Medicaid Committee and the House Medicaid Committee not later than January 1, 2019, and every two (2) years 1111 1112 thereafter.
- 1113 (37) [Deleted]

1114	(38) Uniropractic services. A chiropractor's manual
1115	manipulation of the spine to correct a subluxation, if x-ray
1116	demonstrates that a subluxation exists and if the subluxation has
1117	resulted in a neuromusculoskeletal condition for which
1118	manipulation is appropriate treatment, and related spinal x-rays
1119	performed to document these conditions. Reimbursement for
1120	chiropractic services shall not exceed Seven Hundred Dollars
1121	(\$700.00) per year per beneficiary.

- 1122 (39) Dually eligible Medicare/Medicaid beneficiaries. 1123 The division shall pay the Medicare deductible and coinsurance 1124 amounts for services available under Medicare, as determined by the division. From and after July 1, 2009, the division shall 1125 1126 reimburse crossover claims for inpatient hospital services and 1127 crossover claims covered under Medicare Part B in the same manner that was in effect on January 1, 2008, unless specifically 1128 1129 authorized by the Legislature to change this method.
- 1130 (40) [Deleted]
- 1131 Services provided by the State Department of 1132 Rehabilitation Services for the care and rehabilitation of persons 1133 with spinal cord injuries or traumatic brain injuries, as allowed 1134 under waivers from the United States Department of Health and 1135 Human Services, using up to seventy-five percent (75%) of the 1136 funds that are appropriated to the Department of Rehabilitation Services from the Spinal Cord and Head Injury Trust Fund 1137 established under Section 37-33-261 and used to match federal 1138

1139	funds	under	a	cooperative	agreement	between	the	division	and	the
1140	depar	tment.								

- 1141 (42) [Deleted]
- 1142 (43) The division shall provide reimbursement,

 1143 according to a payment schedule developed by the division, for

 1144 smoking cessation medications for pregnant women during their
- 1145 pregnancy and other Medicaid-eligible women who are of
- 1146 child-bearing age.
- 1147 (44) Nursing facility services for the severely
- 1148 disabled.
- 1149 (a) Severe disabilities include, but are not
- 1150 limited to, spinal cord injuries, closed-head injuries and
- 1151 ventilator-dependent patients.
- 1152 (b) Those services must be provided in a long-term
- 1153 care nursing facility dedicated to the care and treatment of
- 1154 persons with severe disabilities.
- 1155 (45) Physician assistant services. Services furnished
- 1156 by a physician assistant who is licensed by the State Board of
- 1157 Medical Licensure and is practicing with physician supervision
- 1158 under regulations adopted by the board, under regulations adopted
- 1159 by the division. Reimbursement for those services shall not
- 1160 exceed ninety percent (90%) of the reimbursement rate for
- 1161 comparable services rendered by a physician. The division may
- 1162 provide for a reimbursement rate for physician assistant services
- 1163 of up to one hundred percent (100%) or the reimbursement rate for

1164 comparable services rendered by a physician for physician 1165 assistant services that are provided after the normal working 1166 hours of the physician assistant, as determined in accordance with regulations of the division. 1167

1168 The division shall make application to the federal 1169 Centers for Medicare and Medicaid Services (CMS) for a waiver to develop and provide services for children with serious emotional 1170 1171 disturbances as defined in Section 43-14-1(1), which may include 1172 home- and community-based services, case management services or 1173 managed care services through mental health providers certified by 1174 the Department of Mental Health. The division may implement and 1175 provide services under this waivered program only if funds for 1176 these services are specifically appropriated for this purpose by the Legislature, or if funds are voluntarily provided by affected 1177 1178 agencies.

1179 The division may develop and implement 1180 disease management programs for individuals with high-cost chronic diseases and conditions, including the use of grants, waivers, 1181 1182 demonstrations or other projects as necessary.

1183 Participation in any disease management (b) 1184 program implemented under this paragraph (47) is optional with the 1185 individual. An individual must affirmatively elect to participate 1186 in the disease management program in order to participate, and may elect to discontinue participation in the program at any time. 1187

Pediatric long-term acute care hospital services.

1189	(a) Pediatric long-term acute care hospital
1190	services means services provided to eligible persons under
1191	twenty-one (21) years of age by a freestanding Medicare-certified
1192	hospital that has an average length of inpatient stay greater than
1193	twenty-five (25) days and that is primarily engaged in providing
1194	chronic or long-term medical care to persons under twenty-one (21)
1195	years of age.

- 1196 (b) The services under this paragraph (48) shall 1197 be reimbursed as a separate category of hospital services.
- 1198 (49) The division may establish copayments and/or 1199 coinsurance for any Medicaid services for which copayments and/or 1200 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.
- 1208 (51) Upon determination of Medicaid eligibility and in 1209 association with annual redetermination of Medicaid eligibility, 1210 beneficiaries shall be encouraged to undertake a physical 1211 examination that will establish a base-line level of health and 1212 identification of a usual and customary source of care (a medical 1213 home) to aid utilization of disease management tools. This

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L214	physical examination and utilization of these disease management
L215	tools shall be consistent with current United States Preventive
1216	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.

the division may pay enhanced reimbursement fees related to trauma care, as determined by the division in conjunction with the State Department of Health, using funds appropriated to the State Department of Health for trauma care and services and used to match federal funds under a cooperative agreement between the division and the State Department of Health. The division, in conjunction with the State Department of Health, may use grants, waivers, demonstrations, enhanced reimbursements, Upper Payment Limits Programs, supplemental payments, or other projects as necessary in the development and implementation of this reimbursement program.

1232 (53) Targeted case management services for high-cost 1233 beneficiaries may be developed by the division for all services 1234 under this section.

1235 (54) [Deleted]

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1236 (55) Therapy services. The plan of care for therapy
1237 services may be developed to cover a period of treatment for up to
1238 six (6) months, but in no event shall the plan of care exceed a

six-month period of treatment. The projected period of treatment 1239 1240 must be indicated on the initial plan of care and must be updated 1241 with each subsequent revised plan of care. Based on medical 1242 necessity, the division shall approve certification periods for 1243 less than or up to six (6) months, but in no event shall the 1244 certification period exceed the period of treatment indicated on the plan of care. The appeal process for any reduction in therapy 1245 1246 services shall be consistent with the appeal process in federal 1247 regulations.

1248 (56) Prescribed pediatric extended care centers

1249 services for medically dependent or technologically dependent

1250 children with complex medical conditions that require continual

1251 care as prescribed by the child's attending physician, as

1252 determined by the division.

1253 (57) No Medicaid benefit shall restrict coverage for 1254 medically appropriate treatment prescribed by a physician and 1255 agreed to by a fully informed individual, or if the individual 1256 lacks legal capacity to consent by a person who has legal 1257 authority to consent on his or her behalf, based on an 1258 individual's diagnosis with a terminal condition. As used in this 1259 paragraph (57), "terminal condition" means any aggressive 1260 malignancy, chronic end-stage cardiovascular or cerebral vascular disease, or any other disease, illness or condition which a 1261 1262 physician diagnoses as terminal.

1263	(58) Treatment services for persons with opioid
1264	dependency or other highly addictive substance use disorders. The
1265	division is authorized to reimburse eligible providers for
1266	treatment of opioid dependency and other highly addictive
1267	substance use disorders, as determined by the division. Treatment
1268	related to these conditions shall not count against any physician
1269	visit limit imposed under this section.

- 1270 (59) The division shall allow beneficiaries between the
 1271 ages of ten (10) and eighteen (18) years to receive vaccines
 1272 through a pharmacy venue. The division and the State Department
 1273 of Health shall coordinate and notify OB-GYN providers that the
 1274 Vaccines for Children program is available to providers free of
 1275 charge.
- 1276 (60) Border city university-affiliated pediatric 1277 teaching hospital.
- 1278 Payments may only be made to a border city 1279 university-affiliated pediatric teaching hospital if the Centers 1280 for Medicare and Medicaid Services (CMS) approve an increase in 1281 the annual request for the provider payment initiative authorized under 42 CFR Section 438.6(c) in an amount equal to or greater 1282 1283 than the estimated annual payment to be made to the border city 1284 university-affiliated pediatric teaching hospital. The estimate 1285 shall be based on the hospital's prior year Mississippi managed 1286 care utilization.

1287 As used in this paragraph (60), the term 1288 "border city university-affiliated pediatric teaching hospital" means an out-of-state hospital located within a city bordering the 1289 1290 eastern bank of the Mississippi River and the State of Mississippi 1291 that submits to the division a copy of a current and effective 1292 affiliation agreement with an accredited university and other 1293 documentation establishing that the hospital is 1294 university-affiliated, is licensed and designated as a pediatric 1295 hospital or pediatric primary hospital within its home state, maintains at least five (5) different pediatric specialty training 1296 1297 programs, and maintains at least one hundred (100) operated beds 1298 dedicated exclusively for the treatment of patients under the age

- (c) The cost of providing services to Mississippi
 Medicaid beneficiaries under the age of twenty-one (21) years who
 are treated by a border city university-affiliated pediatric
 teaching hospital shall not exceed the cost of providing the same
 services to individuals in hospitals in the state.
- (d) It is the intent of the Legislature that

 1306 payments shall not result in any in-state hospital receiving

 1307 payments lower than they would otherwise receive if not for the

 1308 payments made to any border city university-affiliated pediatric

 1309 teaching hospital.
- 1310 (e) This paragraph (60) shall stand repealed on 1311 July 1, * * * 2029.

of twenty-one (21) years.

L312	(61) Autism spectrum disorder services. The division
L313	shall develop and implement a method for reimbursement of autism
L314	spectrum disorder services based on a continuum of care for best
L315	practices in medically necessary early intervention treatment.
L316	The division shall work in consultation with the Department of
L317	Mental Health, healthcare providers, the Autism Advisory
L318	Committee, and other stakeholders relevant to the autism industry
L319	to develop these reimbursement rates. The requirements of this
L320	subsection shall apply to any autism spectrum disorder services
L321	rendered under the authority of the Medicaid State Plan and any
L322	Home and Community Based Services Waiver authorized under this
L323	section through which autism spectrum disorder services are
L324	provided.
L325	(62) Preparticipation physical evaluations. The
L326	division shall reimburse for preparticipation physical evaluations
L327	of beneficiaries in a manner as determined by the division.
L328	(63) Glucagon-like peptide-1 (GLP-1) agonist
L329	medications that have been approved for chronic weight management
L330	by the United States Food and Drug Administration (FDA). The
L331	division shall, in a manner as determined by the division,
L332	reimburse for FDA-approved GLP-1 agonist medications prescribed
L333	for chronic weight management and/or for management of additional
L334	conditions in the discretion of the medical provider.
L335	(64) Coverage and reimbursement for postpartum
L336	depression screening. The division and any managed care entity

1337	described in subsection (H) of this section shall provide coverage
1338	for postpartum depression screening required pursuant to Section
1339	41-140-5. Such coverage shall provide for additional
1340	reimbursement for the administration of postpartum depression
1341	screening adequate to compensate the health care provider for the
1342	provision of such screening and consistent with ensuring broad
1343	access to postpartum depression screening in line with
1344	evidence-based guidelines.
1345	(65) Nonstatin medications. The division shall provide
1346	coverage and reimbursement, in a manner as determined by the
1347	division, for any nonstatin medication that has a unique
1348	indication to reduce the risk of a major cardiovascular event in
1349	primary prevention and secondary prevention patients.
1350	(B) Planning and development districts participating in the
1351	home- and community-based services program for the elderly and
1352	disabled as case management providers shall be reimbursed for case
1353	management services at the maximum rate approved by the Centers
1354	for Medicare and Medicaid Services (CMS).
1355	(C) The division may pay to those providers who participate
1356	in and accept patient referrals from the division's emergency room

redirection program a percentage, as determined by the division,

reduction of costs required of that program. Federally qualified

health centers may participate in the emergency room redirection

program, and the division may pay those centers a percentage of

of savings achieved according to the performance measures and

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any savings to the Medicaid program achieved by the centers'
accepting patient referrals through the program, as provided in
this subsection (C).

- 1365 (D) (1) As used in this subsection (D), the following terms
 1366 shall be defined as provided in this paragraph, except as
 1367 otherwise provided in this subsection:
- 1368 (a) "Committees" means the Medicaid Committees of
 1369 the House of Representatives and the Senate, and "committee" means
 1370 either one of those committees.
- 1371 (b) "Rate change" means an increase, decrease or
 1372 other change in the payments or rates of reimbursement, or a
 1373 change in any payment methodology that results in an increase,
 1374 decrease or other change in the payments or rates of
 1375 reimbursement, to any Medicaid provider that renders any services
 1376 authorized to be provided to Medicaid recipients under this
 1377 article.
- 1378 Whenever the Division of Medicaid proposes a rate (2) change, the division shall give notice to the chairmen of the 1379 1380 committees at least * * * fifteen (15) calendar days before the 1381 proposed rate change is scheduled to take effect. The division 1382 shall furnish the chairmen with a concise summary of each proposed 1383 rate change along with the notice, and shall furnish the chairmen 1384 with a copy of any proposed rate change upon request. 1385 division also shall provide a summary and copy of any proposed 1386 rate change to any other member of the Legislature upon request.

1387	(3) If the chairman of either committee or both
1388	chairmen jointly object to the proposed rate change or any part
1389	thereof, the chairman or chairmen shall notify the division and
1390	provide the reasons for their objection in writing not later than
1391	seven (7) calendar days after receipt of the notice from the
1392	division. The chairman or chairmen may make written
1393	recommendations to the division for changes to be made to a
1394	proposed rate change.

- 1395 (a) The chairman of either committee or both (4) 1396 chairmen jointly may hold a committee meeting to review a proposed 1397 rate change. If either chairman or both chairmen decide to hold a 1398 meeting, they shall notify the division of their intention in 1399 writing within seven (7) calendar days after receipt of the notice 1400 from the division, and shall set the date and time for the meeting in their notice to the division, which shall not be later than 1401 1402 fourteen (14) calendar days after receipt of the notice from the 1403 division.
- After the committee meeting, the committee or 1404 (b) 1405 committees may object to the proposed rate change or any part 1406 The committee or committees shall notify the division thereof. 1407 and the reasons for their objection in writing not later than 1408 seven (7) calendar days after the meeting. The committee or 1409 committees may make written recommendations to the division for changes to be made to a proposed rate change. 1410

1411	(5) If both chairmen notify the division in writing
1412	within seven (7) calendar days after receipt of the notice from
1413	the division that they do not object to the proposed rate change
1414	and will not be holding a meeting to review the proposed rate
1415	change, the proposed rate change will take effect on the original
1416	date as scheduled by the division or on such other date as
1417	specified by the division.

- 1418 (6) (a) If there are any objections to a proposed rate
 1419 change or any part thereof from either or both of the chairmen or
 1420 the committees, the division may withdraw the proposed rate
 1421 change, make any of the recommended changes to the proposed rate
 1422 change, or not make any changes to the proposed rate change.
- (b) If the division does not make any changes to
 the proposed rate change, it shall notify the chairmen of that
 fact in writing, and the proposed rate change shall take effect on
 the original date as scheduled by the division or on such other
 date as specified by the division.
- 1428 (c) If the division makes any changes to the 1429 proposed rate change, the division shall notify the chairmen of 1430 its actions in writing, and the revised proposed rate change shall 1431 take effect on the date as specified by the division.
- 1432 (7) Nothing in this subsection (D) shall be construed 1433 as giving the chairmen or the committees any authority to veto, 1434 nullify or revise any rate change proposed by the division. The 1435 authority of the chairmen or the committees under this subsection

1436	shall be limited to revi	ewing, making	g objections to	and making
1437	recommendations for chan	ges to rate o	changes propose	d by the
1438	division			

- 1439 (8) If the division needs to expedite the fifteen-day

 1440 legislative notice set forth in paragraph (2) of this subsection

 1441 (D), the division shall notify both chairmen.
- 1442 (E) Notwithstanding any provision of this article, no new
 1443 groups or categories of recipients and new types of care and
 1444 services may be added without enabling legislation from the
 1445 Mississippi Legislature, except that the division may authorize
 1446 those changes without enabling legislation when the addition of
 1447 recipients or services is ordered by a court of proper authority.
- 1448 The executive director shall keep the Governor advised on a timely basis of the funds available for expenditure and the 1449 1450 projected expenditures. Notwithstanding any other provisions of 1451 this article, if current or projected expenditures of the division 1452 are reasonably anticipated to exceed the amount of funds appropriated to the division for any fiscal year, the Governor, 1453 1454 after consultation with the executive director, shall take all 1455 appropriate measures to reduce costs, which may include, but are 1456 not limited to:
- 1457 (1) Reducing or discontinuing any or all services that 1458 are deemed to be optional under Title XIX of the Social Security 1459 Act;

1460	(2) Reducing reimbursement rates for any or all service
1461	types;
1462	(3) Imposing additional assessments on health care
1463	providers; or
1464	(4) Any additional cost-containment measures deemed
1465	appropriate by the Governor.
1466	To the extent allowed under federal law, any reduction to
1467	services or reimbursement rates under this subsection (F) shall be
1468	accompanied by a reduction, to the fullest allowable amount, to
1469	the profit margin and administrative fee portions of capitated
1470	payments to organizations described in paragraph (1) of subsection
1471	(H).

1472 Beginning in fiscal year 2010 and in fiscal years thereafter, when Medicaid expenditures are projected to exceed funds available 1473 for the fiscal year, the division shall submit the expected 1474 shortfall information to the PEER Committee not later than 1475 1476 December 1 of the year in which the shortfall is projected to 1477 occur. PEER shall review the computations of the division and 1478 report its findings to the Legislative Budget Office not later than January 7 in any year. 1479

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

1485	(H) (1) Notwithstanding any other provision of this
1486	article, the division is authorized to implement (a) a managed
1487	care program, (b) a coordinated care program, (c) a coordinated
1488	care organization program, (d) a health maintenance organization
1489	program, (e) a patient-centered medical home program, (f) an
1490	accountable care organization program, (g) provider-sponsored
1491	health plan, or (h) any combination of the above programs. As a
1492	condition for the approval of any program under this subsection
1493	(H)(1), the division shall require that no managed care program,
1494	coordinated care program, coordinated care organization program,
1495	health maintenance organization program, or provider-sponsored
1496	health plan may:

- 1497 (a) Pay providers at a rate that is less than the
 1498 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
 1499 reimbursement rate;
- 1500 (b) Override the medical decisions of hospital 1501 physicians or staff regarding patients admitted to a hospital for 1502 an emergency medical condition as defined by 42 US Code Section 1503 1395dd. This restriction (b) does not prohibit the retrospective 1504 review of the appropriateness of the determination that an 1505 emergency medical condition exists by chart review or coding 1506 algorithm, nor does it prohibit prior authorization for nonemergency hospital admissions; 1507
- 1508 (c) Pay providers at a rate that is less than the 1509 normal Medicaid reimbursement rate. It is the intent of the

1510	Legislature that all managed care entities described in this
1511	subsection (H), in collaboration with the division, develop and
1512	implement innovative payment models that incentivize improvements
1513	in health care quality, outcomes, or value, as determined by the
1514	division. Participation in the provider network of any managed
1515	care, coordinated care, provider-sponsored health plan, or similar
1516	contractor shall not be conditioned on the provider's agreement to
1517	accept such alternative payment models;

1518 (d) Implement a prior authorization and 1519 utilization review program for medical services, transportation 1520 services and prescription drugs that is more stringent than the prior authorization processes used by the division in its 1521 1522 administration of the Medicaid program. Not later than December 2, 2021, the contractors that are receiving capitated payments 1523 under a managed care delivery system established under this 1524 1525 subsection (H) shall submit a report to the Chairmen of the House 1526 and Senate Medicaid Committees on the status of the prior 1527 authorization and utilization review program for medical services, 1528 transportation services and prescription drugs that is required to 1529 be implemented under this subparagraph (d);

1530 (e) [Deleted]

1531 (f) Implement a preferred drug list that is more 1532 stringent than the mandatory preferred drug list established by 1533 the division under subsection (A)(9) of this section;

1534	(g) Implement a policy which denies beneficiaries
1535	with hemophilia access to the federally funded hemophilia
1536	treatment centers as part of the Medicaid Managed Care network of
1537	providers.

Each health maintenance organization, coordinated care organization, provider-sponsored health plan, or other organization paid for services on a capitated basis by the division under any managed care program or coordinated care program implemented by the division under this section shall use a clear set of level of care guidelines in the determination of medical necessity and in all utilization management practices, including the prior authorization process, concurrent reviews, retrospective reviews and payments, that are consistent with widely accepted professional standards of care. Organizations participating in a managed care program or coordinated care program implemented by the division may not use any additional criteria that would result in denial of care that would be determined appropriate and, therefore, medically necessary under those levels of care guidelines.

(2) Notwithstanding any provision of this section, the recipients eligible for enrollment into a Medicaid Managed Care Program authorized under this subsection (H) may include only those categories of recipients eligible for participation in the Medicaid Managed Care Program as of January 1, 2021, the Children's Health Insurance Program (CHIP), and the CMS-approved

1559 Section 1115 demonstration waivers in operation as of January 1,

1560 2021. No expansion of Medicaid Managed Care Program contracts may

1561 be implemented by the division without enabling legislation from

1562 the Mississippi Legislature.

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1563 (3) (a) Any contractors receiving capitated payments

1564 under a managed care delivery system established in this section

shall provide to the Legislature and the division statistical data

1566 to be shared with provider groups in order to improve patient

1567 access, appropriate utilization, cost savings and health outcomes

1568 not later than October 1 of each year. Additionally, each

1569 contractor shall disclose to the Chairmen of the Senate and House

1570 Medicaid Committees the administrative expenses costs for the

1571 prior calendar year, and the number of full-equivalent employees

1572 located in the State of Mississippi dedicated to the Medicaid and

1573 CHIP lines of business as of June 30 of the current year.

1574 (b) The division and the contractors participating

1575 in the managed care program, a coordinated care program or a

1576 provider-sponsored health plan shall be subject to annual program

1577 reviews or audits performed by the Office of the State Auditor,

1578 the PEER Committee, the Department of Insurance and/or independent

1579 third parties.

1580 (c) Those reviews shall include, but not be

1581 limited to, at least two (2) of the following items:

1582 (i) The financial benefit to the State of

1583 Mississippi of the managed care program,

1584	(ii) The difference between the premiums paid
1585	to the managed care contractors and the payments made by those
1586	contractors to health care providers,
1587	(iii) Compliance with performance measures
1588	required under the contracts,
1589	(iv) Administrative expense allocation
1590	methodologies,
1591	(v) Whether nonprovider payments assigned as
1592	medical expenses are appropriate,
1593	(vi) Capitated arrangements with related
1594	party subcontractors,
1595	(vii) Reasonableness of corporate
1596	allocations,
1597	(viii) Value-added benefits and the extent to
1598	which they are used,
1599	(ix) The effectiveness of subcontractor
1600	oversight, including subcontractor review,
1601	(x) Whether health care outcomes have been
1602	improved, and
1603	(xi) The most common claim denial codes to
1604	determine the reasons for the denials.
1605	The audit reports shall be considered public documents and
1606	shall be posted in their entirety on the division's website.
1607	(4) All health maintenance organizations, coordinated
1608	care organizations, provider-sponsored health plans, or other

organizations paid for services on a capitated basis by the
division under any managed care program or coordinated care
program implemented by the division under this section shall
reimburse all providers in those organizations at rates no lower
than those provided under this section for beneficiaries who are
not participating in those programs.

- (5) No health maintenance organization, coordinated care organization, provider-sponsored health plan, or other organization paid for services on a capitated basis by the division under any managed care program or coordinated care program implemented by the division under this section shall require its providers or beneficiaries to use any pharmacy that ships, mails or delivers prescription drugs or legend drugs or devices.
- 1623 Not later than December 1, 2021, the (a) 1624 contractors who are receiving capitated payments under a managed 1625 care delivery system established under this subsection (H) shall 1626 develop and implement a uniform credentialing process for 1627 providers. Under that uniform credentialing process, a provider 1628 who meets the criteria for credentialing will be credentialed with 1629 all of those contractors and no such provider will have to be 1630 separately credentialed by any individual contractor in order to receive reimbursement from the contractor. Not later than 1631 1632 December 2, 2021, those contractors shall submit a report to the Chairmen of the House and Senate Medicaid Committees on the status 1633

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of the uniform credentialing process for providers that is required under this subparagraph (a).

1636 If those contractors have not implemented a (b) 1637 uniform credentialing process as described in subparagraph (a) by 1638 December 1, 2021, the division shall develop and implement, not 1639 later than July 1, 2022, a single, consolidated credentialing process by which all providers will be credentialed. Under the 1640 1641 division's single, consolidated credentialing process, no such 1642 contractor shall require its providers to be separately credentialed by the contractor in order to receive reimbursement 1643 1644 from the contractor, but those contractors shall recognize the 1645 credentialing of the providers by the division's credentialing 1646 process.

credentialing application that shall be used in the credentialing process that is established under subparagraph (a) or (b). If the contractor or division, as applicable, has not approved or denied the provider credentialing application within sixty (60) days of receipt of the completed application that includes all required information necessary for credentialing, then the contractor or division, upon receipt of a written request from the applicant and within five (5) business days of its receipt, shall issue a temporary provider credential/enrollment to the applicant if the applicant has a valid Mississippi professional or occupational license to provide the health care services to which the

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1659 credential/enrollment would apply. The contractor or the division 1660 shall not issue a temporary credential/enrollment if the applicant has reported on the application a history of medical or other 1661 1662 professional or occupational malpractice claims, a history of 1663 substance abuse or mental health issues, a criminal record, or a 1664 history of medical or other licensing board, state or federal 1665 disciplinary action, including any suspension from participation 1666 in a federal or state program. The temporary 1667 credential/enrollment shall be effective upon issuance and shall remain in effect until the provider's credentialing/enrollment 1668 1669 application is approved or denied by the contractor or division. 1670 The contractor or division shall render a final decision regarding 1671 credentialing/enrollment of the provider within sixty (60) days from the date that the temporary provider credential/enrollment is 1672 1673 issued to the applicant. 1674

(d) If the contractor or division does not render a final decision regarding credentialing/enrollment of the provider within the time required in subparagraph (c), the provider shall be deemed to be credentialed by and enrolled with all of the contractors and eligible to receive reimbursement from the contractors.

1680 (7) (a) Each contractor that is receiving capitated
1681 payments under a managed care delivery system established under
1682 this subsection (H) shall provide to each provider for whom the
1683 contractor has denied the coverage of a procedure that was ordered

or requested by the provider for or on behalf of a patient, a

letter that provides a detailed explanation of the reasons for the

denial of coverage of the procedure and the name and the

credentials of the person who denied the coverage. The letter

shall be sent to the provider in electronic format.

(b) After a contractor that is receiving capitated payments under a managed care delivery system established under this subsection (H) has denied coverage for a claim submitted by a provider, the contractor shall issue to the provider within sixty (60) days a final ruling of denial of the claim that allows the provider to have a state fair hearing and/or agency appeal with the division. If a contractor does not issue a final ruling of denial within sixty (60) days as required by this subparagraph (b), the provider's claim shall be deemed to be automatically approved and the contractor shall pay the amount of the claim to the provider.

(c) After a contractor has issued a final ruling of denial of a claim submitted by a provider, the division shall conduct a state fair hearing and/or agency appeal on the matter of the disputed claim between the contractor and the provider within sixty (60) days, and shall render a decision on the matter within thirty (30) days after the date of the hearing and/or appeal.

1706 (8) It is the intention of the Legislature that the
1707 division evaluate the feasibility of using a single vendor to
1708 administer pharmacy benefits provided under a managed care

1709 delivery system established under this subsection (H). Providers 1710 of pharmacy benefits shall cooperate with the division in any transition to a carve-out of pharmacy benefits under managed care. 1711

- 1712 (9)The division shall evaluate the feasibility of 1713 using a single vendor to administer dental benefits provided under 1714 a managed care delivery system established in this subsection (H). Providers of dental benefits shall cooperate with the division in 1715 1716 any transition to a carve-out of dental benefits under managed 1717 care.
- 1718 (10)It is the intent of the Legislature that any 1719 contractor receiving capitated payments under a managed care 1720 delivery system established in this section shall implement 1721 innovative programs to improve the health and well-being of 1722 members diagnosed with prediabetes and diabetes.
- 1723 (11)It is the intent of the Legislature that any 1724 contractors receiving capitated payments under a managed care 1725 delivery system established under this subsection (H) shall work with providers of Medicaid services to improve the utilization of 1726 1727 long-acting reversible contraceptives (LARCs). Not later than 1728 December 1, 2021, any contractors receiving capitated payments 1729 under a managed care delivery system established under this 1730 subsection (H) shall provide to the Chairmen of the House and Senate Medicaid Committees and House and Senate Public Health 1731 1732 Committees a report of LARC utilization for State Fiscal Years 1733 2018 through 2020 as well as any programs, initiatives, or efforts

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1734 made by the contractors and providers to increase LARC

1735 utilization. This report shall be updated annually to include

1736 information for subsequent state fiscal years.

1737 (12) The division is authorized to make not more than

1738 one (1) emergency extension of the contracts that are in effect on

1739 July 1, 2021, with contractors who are receiving capitated

1740 payments under a managed care delivery system established under

1741 this subsection (H), as provided in this paragraph (12). The

1742 maximum period of any such extension shall be one (1) year, and

1743 under any such extensions, the contractors shall be subject to all

1744 of the provisions of this subsection (H). The extended contracts

1745 shall be revised to incorporate any provisions of this subsection

1746 (H).

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1747 (I) [Deleted]

1748 (J) There shall be no cuts in inpatient and outpatient

1749 hospital payments, or allowable days or volumes, as long as the

1750 hospital assessment provided in Section 43-13-145 is in effect.

1751 This subsection (J) shall not apply to decreases in payments that

are a result of: reduced hospital admissions, audits or payments

1753 under the APR-DRG or APC models, or a managed care program or

1754 similar model described in subsection (H) of this section.

1755 (K) In the negotiation and execution of such contracts

1756 involving services performed by actuarial firms, the Executive

1757 Director of the Division of Medicaid may negotiate a limitation on

1758 liability to the state of prospective contractors.

1759	(L) The Division of Medicaid shall reimburse for services
1760	provided to eligible Medicaid beneficiaries by a licensed birthing
1761	center in a method and manner to be determined by the division in
1762	accordance with federal laws and federal regulations. The
1763	division shall seek any necessary waivers, make any required
1764	amendments to its State Plan or revise any contracts authorized
1765	under subsection (H) of this section as necessary to provide the
1766	services authorized under this subsection. As used in this
1767	subsection, the term "birthing centers" shall have the meaning as
1768	defined in Section $41-77-1(a)$, which is a publicly or privately
1769	owned facility, place or institution constructed, renovated,
1770	leased or otherwise established where nonemergency births are
1771	planned to occur away from the mother's usual residence following
1772	a documented period of prenatal care for a normal uncomplicated
1773	pregnancy which has been determined to be low risk through a
1774	formal risk-scoring examination.

1775 The Division of Medicaid shall reimburse ambulance (M) 1776 service providers that provide an assessment, triage or treatment 1777 for eligible Medicaid beneficiaries. The reimbursement rate for 1778 an ambulance service provider whose operators provide an 1779 assessment, triage or treatment shall be reimbursed at a rate or 1780 methodology as determined by the division. The division shall 1781 consult with the Mississippi Ambulance Alliance in determining the 1782 initial rate or methodology, and the division shall give due

1783 $$ consideration of the inclusion in the Transforming Reimburse
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- 1784 for Emergency Ambulance Transportation program.
- 1785 (***N) This section shall stand repealed on July 1, ***
- 1786 2029.
- 1787 **SECTION 3.** Section 43-13-121, Mississippi Code of 1972, is
- 1788 amended as follows:
- 1789 43-13-121. (1) The division shall administer the Medicaid
- 1790 program under the provisions of this article, and may do the
- 1791 following:
- 1792 (a) Adopt and promulgate reasonable rules, regulations
- 1793 and standards, with approval of the Governor, and in accordance
- 1794 with the Administrative Procedures Law, Section 25-43-1.101 et
- 1795 seq.:
- 1796 (i) Establishing methods and procedures as may be
- 1797 necessary for the proper and efficient administration of this
- 1798 article;
- 1799 (ii) Providing Medicaid to all qualified
- 1800 recipients under the provisions of this article as the division
- 1801 may determine and within the limits of appropriated funds;
- 1802 (iii) Establishing reasonable fees, charges and
- 1803 rates for medical services and drugs; in doing so, the division
- 1804 shall fix all of those fees, charges and rates at the minimum
- 1805 levels absolutely necessary to provide the medical assistance
- 1806 authorized by this article, and shall not change any of those

1808	43-13-117;
1809	(iv) Providing for fair and impartial hearings;
1810	(v) Providing safeguards for preserving the
1811	confidentiality of records; and
1812	(vi) For detecting and processing fraudulent
1813	practices and abuses of the program;
1814	(b) Receive and expend state, federal and other funds
1815	in accordance with court judgments or settlements and agreements
1816	between the State of Mississippi and the federal government, the
1817	rules and regulations promulgated by the division, with the
1818	approval of the Governor, and within the limitations and
1819	restrictions of this article and within the limits of funds
1820	available for that purpose;
1821	(c) Subject to the limits imposed by this article and
1822	subject to the provisions of subsection (8) of this section, to
1823	submit a Medicaid plan to the United States Department of Health
1824	and Human Services for approval under the provisions of the
1825	federal Social Security Act, to act for the state in making
1826	negotiations relative to the submission and approval of that plan
1827	to make such arrangements, not inconsistent with the law, as may
1828	be required by or under federal law to obtain and retain that
1829	approval and to secure for the state the benefits of the
1830	provisions of that law.

fees, charges or rates except as may be authorized in Section

1831	No agreements, specifically including the general plan for
1832	the operation of the Medicaid program in this state, shall be made
1833	by and between the division and the United States Department of
1834	Health and Human Services unless the Attorney General of the State
1835	of Mississippi has reviewed the agreements, specifically including
1836	the operational plan, and has certified in writing to the Governor
1837	and to the executive director of the division that the agreements,
1838	including the plan of operation, have been drawn strictly in
1839	accordance with the terms and requirements of this article;

- (d) In accordance with the purposes and intent of this article and in compliance with its provisions, provide for aged persons otherwise eligible for the benefits provided under Title XVIII of the federal Social Security Act by expenditure of funds available for those purposes;
- 1845 (e) To make reports to the United States Department of
 1846 Health and Human Services as from time to time may be required by
 1847 that federal department and to the Mississippi Legislature as
 1848 provided in this section;
- 1849 (f) Define and determine the scope, duration and amount
 1850 of Medicaid that may be provided in accordance with this article
 1851 and establish priorities therefor in conformity with this article;
- 1852 (g) Cooperate and contract with other state agencies
 1853 for the purpose of coordinating Medicaid provided under this
 1854 article and eliminating duplication and inefficiency in the
 1855 Medicaid program;

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1856	/1_ \	7\ _1	1				7		⊥ 1	division;
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- 1857 (i) Sue in its own name on behalf of the State of
 1858 Mississippi and employ legal counsel on a contingency basis with
 1859 the approval of the Attorney General;
- 1860 To recover any and all payments incorrectly made by 1861 the division to a recipient or provider from the recipient or provider receiving the payments. The division shall be authorized 1862 1863 to collect any overpayments to providers sixty (60) days after the 1864 conclusion of any administrative appeal unless the matter is 1865 appealed to a court of proper jurisdiction and bond is posted. 1866 Any appeal filed after July 1, 2015, shall be to the Chancery 1867 Court of the First Judicial District of Hinds County, Mississippi, 1868 within sixty (60) days after the date that the division has notified the provider by certified mail sent to the proper address 1869 1870 of the provider on file with the division and the provider has 1871 signed for the certified mail notice, or sixty (60) days after the 1872 date of the final decision if the provider does not sign for the 1873 certified mail notice. To recover those payments, the division 1874 may use the following methods, in addition to any other methods 1875 available to the division:
- (i) The division shall report to the Department of
 Revenue the name of any current or former Medicaid recipient who
 has received medical services rendered during a period of
 established Medicaid ineligibility and who has not reimbursed the
 division for the related medical service payment(s). The

Department of Revenue shall withhold from the state tax refund of the individual, and pay to the division, the amount of the payment(s) for medical services rendered to the ineligible individual that have not been reimbursed to the division for the related medical service payment(s).

1886 (ii) The division shall report to the Department of Revenue the name of any Medicaid provider to whom payments were 1887 1888 incorrectly made that the division has not been able to recover by 1889 other methods available to the division. The Department of 1890 Revenue shall withhold from the state tax refund of the provider, 1891 and pay to the division, the amount of the payments that were 1892 incorrectly made to the provider that have not been recovered by 1893 other available methods;

(k) To recover any and all payments by the division fraudulently obtained by a recipient or provider. Additionally, if recovery of any payments fraudulently obtained by a recipient or provider is made in any court, then, upon motion of the Governor, the judge of the court may award twice the payments recovered as damages;

(1) Have full, complete and plenary power and authority
1901 to conduct such investigations as it may deem necessary and
1902 requisite of alleged or suspected violations or abuses of the
1903 provisions of this article or of the regulations adopted under
1904 this article, including, but not limited to, fraudulent or
1905 unlawful act or deed by applicants for Medicaid or other benefits,

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1906	or payments made to any person, firm or corporation under the
1907	terms, conditions and authority of this article, to suspend or
1908	disqualify any provider of services, applicant or recipient for
1909	gross abuse, fraudulent or unlawful acts for such periods,
1910	including permanently, and under such conditions as the division
1911	deems proper and just, including the imposition of a legal rate of
1912	interest on the amount improperly or incorrectly paid. Recipients
1913	who are found to have misused or abused Medicaid benefits may be
1914	locked into one (1) physician and/or one (1) pharmacy of the
1915	recipient's choice for a reasonable amount of time in order to
1916	educate and promote appropriate use of medical services, in
1917	accordance with federal regulations. If an administrative hearing
1918	becomes necessary, the division may, if the provider does not
1919	succeed in his or her defense, tax the costs of the administrative
1920	hearing, including the costs of the court reporter or stenographer
1921	and transcript, to the provider. The convictions of a recipient
1922	or a provider in a state or federal court for abuse, fraudulent or
1923	unlawful acts under this chapter shall constitute an automatic
1924	disqualification of the recipient or automatic disqualification of
1925	the provider from participation under the Medicaid program.
1926	A conviction, for the purposes of this chapter, shall include
1927	a judgment entered on a plea of nolo contendere or a
1928	nonadjudicated guilty plea and shall have the same force as a
1929	judgment entered pursuant to a guilty plea or a conviction
1930	following trial. A certified copy of the judgment of the court of

1931	competent jurisdiction of the conviction shall constitute prima
1932	facie evidence of the conviction for disqualification purposes;
1933	(m) Establish and provide such methods of
1934	administration as may be necessary for the proper and efficient
1935	operation of the Medicaid program, fully utilizing computer
1936	equipment as may be necessary to oversee and control all current
1937	expenditures for purposes of this article, and to closely monitor
1938	and supervise all recipient payments and vendors rendering
1939	services under this article. Notwithstanding any other provision
1940	of state law, the division is authorized to enter into a ten-year
1941	contract(s) with a vendor(s) to provide services described in this
1942	paragraph (m). Notwithstanding any provision of law to the
1943	contrary, the division is authorized to extend its Medicaid * * *
1944	<pre>Enterprise System * * * and fiscal agent services, including all</pre>
1945	related components and services, contracts in effect on June
1946	30, * * * <u>2025</u> , for * * * <u>additional five-year periods if the</u>
1947	system continues to meet the needs of the state, the annual cost
1948	continues to be a fair market value, and the rate of increase is
1949	no more than five percent (5%) or the current Consumer Price
1950	Index, whichever is less. Notwithstanding any other provision of
1951	state law, the division is authorized to enter into a two-year
1952	contract ending no later than June 30, 2027, with a vendor to
1953	provide support of the division's eligibility system;
1954	(n) To cooperate and contract with the federal
1955	government for the purpose of providing Medicaid to Vietnamese and

1956 Cambodian refugees, under the provisions of Public Law 94-23 and Public Law 94-24, including any amendments to those laws, only to 1957 1958 the extent that the Medicaid assistance and the administrative 1959 cost related thereto are one hundred percent (100%) reimbursable 1960 by the federal government. For the purposes of Section 43-13-117, 1961 persons receiving Medicaid under Public Law 94-23 and Public Law 1962 94-24, including any amendments to those laws, shall not be 1963 considered a new group or category of recipient; and

- (o) The division shall impose penalties upon Medicaid only, Title XIX participating long-term care facilities found to be in noncompliance with division and certification standards in accordance with federal and state regulations, including interest at the same rate calculated by the United States Department of Health and Human Services and/or the Centers for Medicare and Medicaid Services (CMS) under federal regulations.
- 1971 (2) The division also shall exercise such additional powers
 1972 and perform such other duties as may be conferred upon the
 1973 division by act of the Legislature.
- 1974 (3) The division, and the State Department of Health as the
 1975 agency for licensure of health care facilities and certification
 1976 and inspection for the Medicaid and/or Medicare programs, shall
 1977 contract for or otherwise provide for the consolidation of on-site
 1978 inspections of health care facilities that are necessitated by the
 1979 respective programs and functions of the division and the
 1980 department.

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1981	(4) The division and its hearing officers shall have power
1982	to preserve and enforce order during hearings; to issue subpoenas
1983	for, to administer oaths to and to compel the attendance and
1984	testimony of witnesses, or the production of books, papers,
1985	documents and other evidence, or the taking of depositions before
1986	any designated individual competent to administer oaths; to
1987	examine witnesses; and to do all things conformable to law that
1988	may be necessary to enable them effectively to discharge the
1989	duties of their office. In compelling the attendance and
1990	testimony of witnesses, or the production of books, papers,
1991	documents and other evidence, or the taking of depositions, as
1992	authorized by this section, the division or its hearing officers
1993	may designate an individual employed by the division or some other
1994	suitable person to execute and return that process, whose action
1995	in executing and returning that process shall be as lawful as if
1996	done by the sheriff or some other proper officer authorized to
1997	execute and return process in the county where the witness may
1998	reside. In carrying out the investigatory powers under the
1999	provisions of this article, the executive director or other
2000	designated person or persons may examine, obtain, copy or
2001	reproduce the books, papers, documents, medical charts,
2002	prescriptions and other records relating to medical care and
2003	services furnished by the provider to a recipient or designated
2004	recipients of Medicaid services under investigation. In the
2005	absence of the voluntary submission of the books, papers,

2006 documents, medical charts, prescriptions and other records, the Governor, the executive director, or other designated person may 2007 issue and serve subpoenas instantly upon the provider, his or her 2008 2009 agent, servant or employee for the production of the books, 2010 papers, documents, medical charts, prescriptions or other records 2011 during an audit or investigation of the provider. If any provider 2012 or his or her agent, servant or employee refuses to produce the 2013 records after being duly subpoenaed, the executive director may 2014 certify those facts and institute contempt proceedings in the manner, time and place as authorized by law for administrative 2015 2016 proceedings. As an additional remedy, the division may recover 2017 all amounts paid to the provider covering the period of the audit 2018 or investigation, inclusive of a legal rate of interest and a 2019 reasonable attorney's fee and costs of court if suit becomes necessary. Division staff shall have immediate access to the 2020 provider's physical location, facilities, records, documents, 2021 2022 books, and any other records relating to medical care and services rendered to recipients during regular business hours. 2023

(5) If any person in proceedings before the division disobeys or resists any lawful order or process, or misbehaves during a hearing or so near the place thereof as to obstruct the hearing, or neglects to produce, after having been ordered to do so, any pertinent book, paper or document, or refuses to appear after having been subpoenaed, or upon appearing refuses to take the oath as a witness, or after having taken the oath refuses to

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2031 be examined according to law, the executive director shall certify 2032 the facts to any court having jurisdiction in the place in which it is sitting, and the court shall thereupon, in a summary manner, 2033 2034 hear the evidence as to the acts complained of, and if the 2035 evidence so warrants, punish that person in the same manner and to 2036 the same extent as for a contempt committed before the court, or 2037 commit that person upon the same condition as if the doing of the 2038 forbidden act had occurred with reference to the process of, or in 2039 the presence of, the court.

2040 In suspending or terminating any provider from 2041 participation in the Medicaid program, the division shall preclude 2042 the provider from submitting claims for payment, either personally 2043 or through any clinic, group, corporation or other association to the division or its fiscal agents for any services or supplies 2044 2045 provided under the Medicaid program except for those services or 2046 supplies provided before the suspension or termination. 2047 clinic, group, corporation or other association that is a provider of services shall submit claims for payment to the division or its 2048 2049 fiscal agents for any services or supplies provided by a person 2050 within that organization who has been suspended or terminated from 2051 participation in the Medicaid program except for those services or 2052 supplies provided before the suspension or termination. provision is violated by a provider of services that is a clinic, 2053 2054 group, corporation or other association, the division may suspend 2055 or terminate that organization from participation. Suspension may 2056 be applied by the division to all known affiliates of a provider, 2057 provided that each decision to include an affiliate is made on a 2058 case-by-case basis after giving due regard to all relevant facts 2059 and circumstances. The violation, failure or inadequacy of 2060 performance may be imputed to a person with whom the provider is 2061 affiliated where that conduct was accomplished within the course 2062 of his or her official duty or was effectuated by him or her with 2063 the knowledge or approval of that person.

- (7) The division may deny or revoke enrollment in the Medicaid program to a provider if any of the following are found to be applicable to the provider, his or her agent, a managing employee or any person having an ownership interest equal to five percent (5%) or greater in the provider:
- 2069 (a) Failure to truthfully or fully disclose any and all
 2070 information required, or the concealment of any and all
 2071 information required, on a claim, a provider application or a
 2072 provider agreement, or the making of a false or misleading
 2073 statement to the division relative to the Medicaid program.
- 2074 (b) Previous or current exclusion, suspension,
 2075 termination from or the involuntary withdrawing from participation
 2076 in the Medicaid program, any other state's Medicaid program,
 2077 Medicare or any other public or private health or health insurance
 2078 program. If the division ascertains that a provider has been
 2079 convicted of a felony under federal or state law for an offense
 2080 that the division determines is detrimental to the best interest

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2081	of the program or of Medicaid beneficiaries, the division may
2082	refuse to enter into an agreement with that provider, or may
2083	terminate or refuse to renew an existing agreement.

- 2084 (c) Conviction under federal or state law of a criminal
 2085 offense relating to the delivery of any goods, services or
 2086 supplies, including the performance of management or
 2087 administrative services relating to the delivery of the goods,
 2088 services or supplies, under the Medicaid program, any other
 2089 state's Medicaid program, Medicare or any other public or private
 2090 health or health insurance program.
- 2091 (d) Conviction under federal or state law of a criminal 2092 offense relating to the neglect or abuse of a patient in 2093 connection with the delivery of any goods, services or supplies.
- 2094 (e) Conviction under federal or state law of a criminal 2095 offense relating to the unlawful manufacture, distribution, 2096 prescription or dispensing of a controlled substance.
- 2097 (f) Conviction under federal or state law of a criminal 2098 offense relating to fraud, theft, embezzlement, breach of 2099 fiduciary responsibility or other financial misconduct.
- 2100 (g) Conviction under federal or state law of a criminal 2101 offense punishable by imprisonment of a year or more that involves 2102 moral turpitude, or acts against the elderly, children or infirm.
- 2103 (h) Conviction under federal or state law of a criminal 2104 offense in connection with the interference or obstruction of any

2105	investigation	into	any	criminal	offense	listed	in	paragraphs	(C)
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- 2106 through (i) of this subsection.
- 2107 (i) Sanction for a violation of federal or state laws
- 2108 or rules relative to the Medicaid program, any other state's
- 2109 Medicaid program, Medicare or any other public health care or
- 2110 health insurance program.
- 2111 (j) Revocation of license or certification.
- 2112 (k) Failure to pay recovery properly assessed or
- 2113 pursuant to an approved repayment schedule under the Medicaid
- 2114 program.
- 2115 (1) Failure to meet any condition of enrollment.
- 2116 (8) (a) As used in this subsection (8), the following terms
- 2117 shall be defined as provided in this paragraph, except as
- 2118 otherwise provided in this subsection:
- 2119 (i) "Committees" means the Medicaid Committees of
- 2120 the House of Representatives and the Senate, and "committee" means
- 2121 either one of those committees.
- 2122 (ii) "State Plan" means the agreement between the
- 2123 State of Mississippi and the federal government regarding the
- 2124 nature and scope of Mississippi's Medicaid Program.
- 2125 (iii) "State Plan Amendment" means a change to the
- 2126 State Plan, which must be approved by the Centers for Medicare and
- 2127 Medicaid Services (CMS) before its implementation.
- 2128 (b) Whenever the Division of Medicaid proposes a State
- 2129 Plan Amendment, the division shall give notice to the chairmen of

2130 the committees at least * * * fifteen (15) calendar days before 2131 the proposed State Plan Amendment is filed with CMS. The division 2132 shall furnish the chairmen with a concise summary of each proposed 2133 State Plan Amendment along with the notice, and shall furnish the 2134 chairmen with a copy of any proposed State Plan Amendment upon 2135 request. The division also shall provide a summary and copy of 2136 any proposed State Plan Amendment to any other member of the 2137 Legislature upon request.

2138 If the chairman of either committee or both (c) 2139 chairmen jointly object to the proposed State Plan Amendment or 2140 any part thereof, the chairman or chairmen shall notify the division and provide the reasons for their objection in writing 2141 2142 not later than seven (7) calendar days after receipt of the notice from the division. The chairman or chairmen may make written 2143 2144 recommendations to the division for changes to be made to a 2145 proposed State Plan Amendment.

2146 The chairman of either committee or both (d) (i) chairmen jointly may hold a committee meeting to review a proposed 2147 2148 State Plan Amendment. If either chairman or both chairmen decide 2149 to hold a meeting, they shall notify the division of their 2150 intention in writing within seven (7) calendar days after receipt of the notice from the division, and shall set the date and time 2151 for the meeting in their notice to the division, which shall not 2152 2153 be later than fourteen (14) calendar days after receipt of the notice from the division. 2154

2155	(ii) After the committee meeting, the committee or
2156	committees may object to the proposed State Plan Amendment or any
2157	part thereof. The committee or committees shall notify the
2158	division and the reasons for their objection in writing not later
2159	than seven (7) calendar days after the meeting. The committee or
2160	committees may make written recommendations to the division for
2161	changes to be made to a proposed State Plan Amendment.

- (e) If both chairmen notify the division in writing
 within seven (7) calendar days after receipt of the notice from
 the division that they do not object to the proposed State Plan
 Amendment and will not be holding a meeting to review the proposed
 State Plan Amendment, the division may proceed to file the
 proposed State Plan Amendment with CMS.
- (f) (i) If there are any objections to a proposed rate change or any part thereof from either or both of the chairmen or the committees, the division may withdraw the proposed State Plan Amendment, make any of the recommended changes to the proposed State Plan Amendment, or not make any changes to the proposed State Plan Amendment.
- 2174 (ii) If the division does not make any changes to
 2175 the proposed State Plan Amendment, it shall notify the chairmen of
 2176 that fact in writing, and may proceed to file the State Plan
 2177 Amendment with CMS.
- 2178 (iii) If the division makes any changes to the 2179 proposed State Plan Amendment, the division shall notify the

2180	chairmen	of	its	actions	in	writing,	and	may	proceed	to	file	the
2181	State Pla	an A	Amena	dment wit	-h (~MS						

- 2182 (g) Nothing in this subsection (8) shall be construed
 2183 as giving the chairmen or the committees any authority to veto,
 2184 nullify or revise any State Plan Amendment proposed by the
 2185 division. The authority of the chairmen or the committees under
 2186 this subsection shall be limited to reviewing, making objections
 2187 to and making recommendations for changes to State Plan Amendments
 2188 proposed by the division.
- 2189 (i) If the division does not make any changes to
 2190 the proposed State Plan Amendment, it shall notify the chairmen of
 2191 that fact in writing, and may proceed to file the proposed State
 2192 Plan Amendment with CMS.
- 2193 (ii) If the division makes any changes to the 2194 proposed State Plan Amendment, the division shall notify the 2195 chairmen of the changes in writing, and may proceed to file the 2196 proposed State Plan Amendment with CMS.
- 2197 (iii) If the division needs to expedite the
 2198 fifteen-day legislative notice set forth in paragraph (b) of this
 2199 subsection (8), the division will notify both chairmen.
- (h) Nothing in this subsection (8) shall be construed as giving the chairmen of the committees any authority to veto, nullify or revise any State Plan Amendment proposed by the division. The authority of the chairmen of the committees under this subsection shall be limited to reviewing, making objections

to and making recommendations for suggested changes to State Plan
Amendments proposed by the division.

2207 **SECTION 4.** Section 43-13-305, Mississippi Code of 1972, is 2208 amended as follows:

2209 43-13-305. By accepting Medicaid from the Division of (1) 2210 Medicaid in the Office of the Governor, the recipient shall, to 2211 the extent of the payment of medical expenses by the Division of 2212 Medicaid, be deemed to have made an assignment to the Division of 2213 Medicaid of any and all rights and interests in any third-party 2214 benefits, hospitalization or indemnity contract or any cause of 2215 action, past, present or future, against any person, firm or 2216 corporation for Medicaid benefits provided to the recipient by the 2217 Division of Medicaid for injuries, disease or sickness caused or suffered under circumstances creating a cause of action in favor 2218 2219 of the recipient against any such person, firm or corporation as 2220 set out in Section 43-13-125. The recipient shall be deemed, 2221 without the necessity of signing any document, to have appointed 2222 the Division of Medicaid as his or her true and lawful 2223 attorney-in-fact in his or her name, place and stead in collecting 2224 any and all amounts due and owing for medical expenses paid by the 2225 Division of Medicaid against such person, firm or corporation.

(2) Whenever a provider of medical services or the Division of Medicaid submits claims to an insurer on behalf of a Medicaid recipient for whom an assignment of rights has been received, or whose rights have been assigned by the operation of law, the

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2230 insurer must respond within sixty (60) days of receipt of a claim 2231 by forwarding payment or issuing a notice of denial directly to 2232 the submitter of the claim. The failure of the insuring entity to 2233 comply with the provisions of this section shall subject the 2234 insuring entity to recourse by the Division of Medicaid in 2235 accordance with the provision of Section 43-13-315. In the case 2236 of a responsible insurer, other than the insurers exempted under 2237 federal law, that requires prior authorization for an item or 2238 service furnished to a recipient, the insurer shall accept 2239 authorization provided by the Division of Medicaid that the item 2240 or service is covered under the state plan (or waiver of such 2241 plan) for such recipient, as if such authorization were the prior 2242 authorization made by the third party for such item or service. 2243 The Division of Medicaid shall be authorized to endorse any and all, including, but not limited to, multi-payee checks, drafts, 2244 2245 money orders or other negotiable instruments representing Medicaid 2246 payment recoveries that are received by the Division of Medicaid.

(3) Court orders or agreements for medical support shall direct such payments to the Division of Medicaid, which shall be authorized to endorse any and all checks, drafts, money orders or other negotiable instruments representing medical support payments which are received. Any designated medical support funds received by the State Department of Human Services or through its local county departments shall be paid over to the Division of Medicaid. When medical support for a Medicaid recipient is available through

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an absent parent or custodial parent, the insuring entity shall direct the medical support payment(s) to the provider of medical services or to the Division of Medicaid.

2258 **SECTION 5.** Section 43-11-1, Mississippi Code of 1972, is 2259 amended as follows:

2260 43-11-1. When used in this chapter, the following words 2261 shall have the following meaning:

2262 "Institutions for the aged or infirm" means a place (a) 2263 either governmental or private that provides group living 2264 arrangements for four (4) or more persons who are unrelated to the 2265 operator and who are being provided food, shelter and personal 2266 care, whether any such place is organized or operated for profit 2267 The term "institution for the aged or infirm" includes nursing homes, pediatric skilled nursing facilities, psychiatric 2268 residential treatment facilities, convalescent homes, homes for 2269 2270 the aged, adult foster care facilities and special care facilities 2271 for paroled inmates, provided that these institutions fall within 2272 the scope of the definitions set forth above. The term 2273 "institution for the aged or infirm" does not include hospitals, 2274 clinics or mental institutions devoted primarily to providing 2275 medical service, and does not include any private residence in 2276 which the owner of the residence is providing personal care 2277 services to disabled or homeless veterans under an agreement with, 2278 and in compliance with the standards prescribed by, the United 2279 States Department of Veterans Affairs, if the owner of the

residence also provided personal care services to disabled or homeless veterans at any time during calendar year 2008.

- 2282 (b) "Person" means any individual, firm, partnership,
 2283 corporation, company, association or joint-stock association, or
 2284 any licensee herein or the legal successor thereof.
- (c) "Personal care" means assistance rendered by

 personnel of the home to aged or infirm residents in performing

 one or more of the activities of daily living, which includes, but

 is not limited to, the bathing, walking, excretory functions,

 feeding, personal grooming and dressing of such residents.
- 2290 (d) "Psychiatric residential treatment facility" means 2291 any nonhospital establishment with permanent facilities which 2292 provides a twenty-four-hour program of care by qualified 2293 therapists, including, but not limited to, duly licensed mental 2294 health professionals, psychiatrists, psychologists, 2295 psychotherapists and licensed certified social workers, for 2296 emotionally disturbed children and adolescents referred to such 2297 facility by a court, local school district or by the Department of 2298 Human Services, who are not in an acute phase of illness requiring 2299 the services of a psychiatric hospital, and are in need of such 2300 restorative treatment services. For purposes of this paragraph, 2301 the term "emotionally disturbed" means a condition exhibiting one 2302 or more of the following characteristics over a long period of 2303 time and to a marked degree, which adversely affects educational

performance:

2305	1	. An	inabi	lity to	learn	which	cannot	be	explained
2306	by intellectual,	sens	ory or	health	facto:	rs;			

- 2307 2. An inability to build or maintain satisfactory 2308 relationships with peers and teachers;
- 2309 3. Inappropriate types of behavior or feelings 2310 under normal circumstances;
- 2311 4. A general pervasive mood of unhappiness or 2312 depression; or
- 5. A tendency to develop physical symptoms or
 2314 fears associated with personal or school problems. An
 2315 establishment furnishing primarily domiciliary care is not within
 2316 this definition.
- (e) "Pediatric skilled nursing facility" means an institution or a distinct part of an institution that is primarily engaged in providing to inpatients skilled nursing care and related services for persons under twenty-one (21) years of age who require medical or nursing care or rehabilitation services for the rehabilitation of injured, disabled or sick persons.
- 2323 (f) "Licensing agency" means the State Department of 2324 Health.
- 2325 (g) "Medical records" mean, without restriction, those
 2326 medical histories, records, reports, summaries, diagnoses and
 2327 prognoses, records of treatment and medication ordered and given,
 2328 notes, entries, x-rays and other written or graphic data prepared,
 2329 kept, made or maintained in institutions for the aged or infirm

that pertain to residency in, or services rendered to residents of, an institution for the aged or infirm.

- "Adult foster care facility" means a home setting 2332 (h) 2333 for vulnerable adults in the community who are unable to live 2334 independently due to physical, emotional, developmental or mental 2335 impairments, or in need of emergency and continuing protective 2336 social services for purposes of preventing further abuse or 2337 neglect and for safeguarding and enhancing the welfare of the 2338 abused or neglected vulnerable adult. Adult foster care programs 2339 shall be designed to meet the needs of vulnerable adults with 2340 impairments through individual plans of care, which provide a variety of health, social and related support services in a 2341 2342 protective setting, enabling participants to live in the 2343 community. Adult foster care programs may be (i) traditional, 2344 where the foster care provider lives in the residence and is the 2345 primary caregiver to clients in the home; (ii) corporate, where 2346 the foster care home is operated by a corporation with shift staff delivering services to clients; or (iii) shelter, where the foster 2347 2348 care home accepts clients on an emergency short-term basis for up 2349 to thirty (30) days.
- 2350 (i) "Special care facilities for paroled inmates" means
 2351 long-term care and skilled nursing facilities licensed as special
 2352 care facilities for medically frail paroled inmates, formed to
 2353 ease the burden of prison overcrowding and provide compassionate
 2354 release and medical parole initiatives while impacting economic

2355	outcomes for the Mississippi prison system. The facilities shall
2356	meet all Mississippi Department of Health and federal Center for
2357	Medicaid Services (CMS) requirements and shall be regulated by
2358	both agencies; provided, however, such regulations shall not be as
2359	restrictive as those required for personal care homes and other
2360	institutions devoted primarily to providing medical services. The
2361	facilities will offer physical, occupational and speech therapy,
2362	nursing services, wound care, a dedicated COVID services unit,
2363	individualized patient centered plans of care, social services,
2364	spiritual services, physical activities, transportation,
2365	medication, durable medical equipment, personalized meal plans by
2366	a licensed dietician and security services. There may be up to
2367	three (3) facilities located in each Supreme Court district, to be
2368	designated by the Chairman of the State Parole Board or his
2369	designee.
2370	(j) "Adult day care facility" means a public agency or
2371	private organization, or a subdivision of such an agency or
2372	organization, that:
2373	(i) Provides the following items and services:
2374	1. Nursing services;
2375	2. Transportation of the individual to and
2376	from such adult day care facility in connection with any such item
2377	or service;
2378	3. Meals;

2379	4. A program of supervised activities that
2380	meets such criteria as the licensing agency determines and is
2381	appropriately designed to promote physical and mental health that
2382	is furnished to the individual by such a facility in a group
2383	setting for a period not greater than twelve (12) hours per day;
2384	5. The administration of medication by a
2385	licensed nurse, and a medication management program to minimize
2386	unnecessary or inappropriate use of prescription drugs and adverse
2387	events due to unintended prescription drug-to-drug interactions;
2388	<u>and</u>
2389	(ii) Meets such standards established by the
2390	licensing agency to assure quality of care and such other
2391	requirements as the licensing agency finds necessary in the
2392	interest of the health and safety of individuals who are furnished
2393	services in the facility.
2394	SECTION 6. Section 43-11-8, Mississippi Code of 1972, is
2395	amended as follows:
2396	43-11-8. (1) An application for a license for an adult
2397	foster care facility or for an adult day care facility shall be
2398	made to the licensing agency upon forms provided by it and shall
2399	contain such information as the licensing agency reasonably
2400	requires, which may include affirmative evidence of ability to
2401	comply with such reasonable standards, rules and regulations as
2402	are lawfully prescribed hereunder. Each application for a license
2403	for an adult foster care facility or for an adult day care

facility shall be accompanied by a license fee of Ten Dollars

(\$10.00) for each person or bed of licensed capacity, with a

minimum fee per home or institution of Fifty Dollars (\$50.00),

which shall be paid to the licensing agency. Any increase in the

fee charged by the licensing agency under this subsection shall be

in accordance with the provisions of Section 41-3-65.

A license, unless suspended or revoked, shall be renewable annually upon payment by the licensee of an adult foster care facility or of an adult day care facility, except for personal care homes, of a renewal fee of Ten Dollars (\$10.00) for each person or bed of licensed capacity in the institution, with a minimum renewal fee per institution of Fifty Dollars (\$50.00), which shall be paid to the licensing agency, and upon filing by the licensee and approval by the licensing agency of an annual report upon such uniform dates and containing such information in such form as the licensing agency prescribes by regulation. increase in the fee charged by the licensing agency under this subsection shall be in accordance with the provisions of Section 41-3-65. Each license shall be issued only for the premises and person or persons or other legal entity or entities named in the application and shall not be transferable or assignable except with the written approval of the licensing agency. Licenses shall be posted in a conspicuous place on the licensed premises.

2427 **SECTION 7.** Section 43-11-13, Mississippi Code of 1972, is 2428 amended as follows:

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2429	43-11-13. (1) The licensing agency shall adopt, amend,
2430	promulgate and enforce such rules, regulations and standards,
2431	including classifications, with respect to all institutions for
2432	the aged or infirm to be licensed under this chapter as may be
2433	designed to further the accomplishment of the purpose of this
2434	chapter in promoting adequate care of individuals in those
2435	institutions in the interest of public health, safety and welfare.
2436	Those rules, regulations and standards shall be adopted and
2437	promulgated by the licensing agency and shall be recorded and
2438	indexed in a book to be maintained by the licensing agency in its
2439	main office in the State of Mississippi, entitled "Rules,
2440	Regulations and Minimum Standards for Institutions for the Aged or
2441	Infirm" and the book shall be open and available to all
2442	institutions for the aged or infirm and the public generally at
2443	all reasonable times. Upon the adoption of those rules,
2444	regulations and standards, the licensing agency shall mail copies
2445	thereof to all those institutions in the state that have filed
2446	with the agency their names and addresses for this purpose, but
2447	the failure to mail the same or the failure of the institutions to
2448	receive the same shall in no way affect the validity thereof. The
2449	rules, regulations and standards may be amended by the licensing
2450	agency, from time to time, as necessary to promote the health,
2451	safety and welfare of persons living in those institutions.
2452	(2) The licensee shall keep posted in a conspicuous place on

the licensed premises all current rules, regulations and minimum

2454 standards applicable to fire protection measures as adopted by the 2455 licensing agency. The licensee shall furnish to the licensing 2456 agency at least once each six (6) months a certificate of approval 2457 and inspection by state or local fire authorities. Failure to 2458 comply with state laws and/or municipal ordinances and current 2459 rules, regulations and minimum standards as adopted by the 2460 licensing agency, relative to fire prevention measures, shall be 2461 prima facie evidence for revocation of license.

- regulations restricting the storage, quantity and classes of drugs allowed in personal care homes and adult foster care facilities.

 Residents requiring administration of Schedule II Narcotics as defined in the Uniform Controlled Substances Law may be admitted to a personal care home. Schedule drugs may only be allowed in a personal care home if they are administered or stored utilizing proper procedures under the direct supervision of a licensed physician or nurse.
- 2471 Notwithstanding any determination by the licensing (4)2472 agency that skilled nursing services would be appropriate for a 2473 resident of a personal care home, that resident, the resident's 2474 quardian or the legally recognized responsible party for the 2475 resident may consent in writing for the resident to continue to 2476 reside in the personal care home, if approved in writing by a 2477 licensed physician. However, no personal care home shall allow more than two (2) residents, or ten percent (10%) of the total 2478

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2479 number of residents in the facility, whichever is greater, to 2480 remain in the personal care home under the provisions of this 2481 subsection (4). This consent shall be deemed to be appropriately 2482 informed consent as described in the regulations promulgated by 2483 the licensing agency. After that written consent has been 2484 obtained, the resident shall have the right to continue to reside 2485 in the personal care home for as long as the resident meets the 2486 other conditions for residing in the personal care home. 2487 of the written consent and the physician's approval shall be 2488 forwarded by the personal care home to the licensing agency. 2489 (b) The State Board of Health shall promulgate rules 2490

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

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2504 care, cost of support, maintenance and medical attention that is 2505 If any unexpended balance remains in that resident's 2506 personal deposit fund after complete reimbursement has been made 2507 for payment of care, support, maintenance and medical attention, 2508 and the director or other proper officer of the personal care home 2509 has been or shall be unable to locate the person or persons entitled to the unexpended balance, the director or other proper 2510 2511 officer may, after the lapse of one (1) year from the date of that 2512 death, discharge or transfer, deposit the unexpended balance to 2513 the credit of the personal care home's operating fund.

- 2514 (c) The State Board of Health shall promulgate rules
 2515 and regulations requiring personal care homes to maintain records
 2516 relating to health condition, medicine dispensed and administered,
 2517 and any reaction to that medicine. The director of the personal
 2518 care home shall be responsible for explaining the availability of
 2519 those records to the family of the resident at any time upon
 2520 reasonable request.
- 2521 (5) The State Board of Health and the Mississippi Department 2522 of Corrections shall jointly issue rules and regulations for the 2523 operation of the special care facilities for paroled inmates.
 - (6) (a) For the purposes of this subsection (6):
- (i) "Licensed entity" means a hospital, nursing home, personal care home, home health agency, hospice or adult foster care facility;

2529	health care professional staffing agency;
2530	(iii) "Employee" means any individual employed by
2531	a covered entity, and also includes any individual who by contract
2532	provides to the patients, residents or clients being served by the
2533	covered entity direct, hands-on, medical patient care in a
2534	patient's, resident's or client's room or in treatment or recovery
2535	rooms. The term "employee" does not include health care
2536	professional/vocational technical students performing clinical
2537	training in a licensed entity under contracts between their
2538	schools and the licensed entity, and does not include students at
2539	high schools located in Mississippi who observe the treatment and
2540	care of patients in a licensed entity as part of the requirements
2541	of an allied-health course taught in the high school, if:
2542	1. The student is under the supervision of a
2543	licensed health care provider; and
2544	2. The student has signed an affidavit that
2545	is on file at the student's school stating that he or she has not

(ii) "Covered entity" means a licensed entity or a

been convicted of or pleaded guilty or nolo contendere to a felony

listed in paragraph (d) of this subsection (6), or that any such

conviction or plea was reversed on appeal or a pardon was granted

for the conviction or plea. Before any student may sign such an

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2553 However, the health care professional/vocational technical 2554 academic program in which the student is enrolled may require the 2555 student to obtain criminal history record checks. 2556 incidences, paragraph (a) (iii) 1 and 2 of this subsection (6) does 2557 not preclude the licensing entity from processing submitted 2558 fingerprints of students from healthcare-related 2559 professional/vocational technical programs who, as part of their 2560 program of study, conduct observations and provide clinical care 2561 and services in a covered entity.

(b) Under regulations promulgated by the State Board of Health, the licensing agency shall require to be performed a criminal history record check on (i) every new employee of a covered entity who provides direct patient care or services and who is employed on or after July 1, 2003, and (ii) every employee of a covered entity employed before July 1, 2003, who has a documented disciplinary action by his or her present employer. In addition, the licensing agency shall require the covered entity to perform a disciplinary check with the professional licensing agency of each employee, if any, to determine if any disciplinary action has been taken against the employee by that agency.

Except as otherwise provided in paragraph (c) of this
subsection (6), no such employee hired on or after July 1, 2003,
shall be permitted to provide direct patient care until the
results of the criminal history record check have revealed no
disqualifying record or the employee has been granted a waiver.

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2578 In order to determine the employee applicant's suitability for 2579 employment, the applicant shall be fingerprinted. Fingerprints 2580 shall be submitted to the licensing agency from scanning, with the 2581 results processed through the Department of Public Safety's 2582 Criminal Information Center. The fingerprints shall then be 2583 forwarded by the Department of Public Safety to the Federal Bureau 2584 of Investigation for a national criminal history record check. 2585 The licensing agency shall notify the covered entity of the 2586 results of an employee applicant's criminal history record check. If the criminal history record check discloses a felony 2587 2588 conviction, quilty plea or plea of nolo contendere to a felony of 2589 possession or sale of drugs, murder, manslaughter, armed robbery, 2590 rape, sexual battery, sex offense listed in Section 45-33-23(h), 2591 child abuse, arson, grand larceny, burglary, gratification of lust 2592 or aggravated assault, or felonious abuse and/or battery of a 2593 vulnerable adult that has not been reversed on appeal or for which 2594 a pardon has not been granted, the employee applicant shall not be eligible to be employed by the covered entity. 2595

2596 (c) Any such new employee applicant may, however, be
2597 employed on a temporary basis pending the results of the criminal
2598 history record check, but any employment contract with the new
2599 employee shall be voidable if the new employee receives a
2600 disqualifying criminal history record check and no waiver is
2601 granted as provided in this subsection (6).

602	(d) Under regulations promulgated by the State Board of
2603	Health, the licensing agency shall require every employee of a
2604	covered entity employed before July 1, 2003, to sign an affidavit
2605	stating that he or she has not been convicted of or pleaded guilty
2606	or nolo contendere to a felony of possession or sale of drugs,
2607	murder, manslaughter, armed robbery, rape, sexual battery, any sex
2608	offense listed in Section 45-33-23(h), child abuse, arson, grand
2609	larceny, burglary, gratification of lust, aggravated assault, or
2610	felonious abuse and/or battery of a vulnerable adult, or that any
2611	such conviction or plea was reversed on appeal or a pardon was
2612	granted for the conviction or plea. No such employee of a covered
2613	entity hired before July 1, 2003, shall be permitted to provide
2614	direct patient care until the employee has signed the affidavit
2615	required by this paragraph (d). All such existing employees of
2616	covered entities must sign the affidavit required by this
2617	paragraph (d) within six (6) months of the final adoption of the
2618	regulations promulgated by the State Board of Health. If a person
2619	signs the affidavit required by this paragraph (d), and it is
2620	later determined that the person actually had been convicted of or
2621	pleaded guilty or nolo contendere to any of the offenses listed in
2622	this paragraph (d) and the conviction or plea has not been
2623	reversed on appeal or a pardon has not been granted for the
2624	conviction or plea, the person is guilty of perjury. If the
2625	offense that the person was convicted of or pleaded guilty or nolo
2626	contendere to was a violent offense, the person, upon a conviction

of perjury under this paragraph, shall be punished as provided in Section 97-9-61. If the offense that the person was convicted of or pleaded guilty or nolo contendere to was a nonviolent offense, the person, upon a conviction of perjury under this paragraph, shall be punished by a fine of not more than Five Hundred Dollars (\$500.00), or by imprisonment in the county jail for not more than six (6) months, or by both such fine and imprisonment.

2634 The covered entity may, in its discretion, allow 2635 any employee who is unable to sign the affidavit required by 2636 paragraph (d) of this subsection (6) or any employee applicant 2637 aggrieved by an employment decision under this subsection (6) to 2638 appear before the covered entity's hiring officer, or his or her 2639 designee, to show mitigating circumstances that may exist and 2640 allow the employee or employee applicant to be employed by the 2641 covered entity. The covered entity, upon report and 2642 recommendation of the hiring officer, may grant waivers for those 2643 mitigating circumstances, which shall include, but not be limited 2644 (i) age at which the crime was committed; (ii) circumstances 2645 surrounding the crime; (iii) length of time since the conviction 2646 and criminal history since the conviction; (iv) work history; (v) 2647 current employment and character references; and (vi) other 2648 evidence demonstrating the ability of the individual to perform 2649 the employment responsibilities competently and that the 2650 individual does not pose a threat to the health or safety of the 2651 patients of the covered entity.

2652 The licensing agency may charge the covered entity 2653 submitting the fingerprints a fee not to exceed Fifty Dollars (\$50.00), which covered entity may, in its discretion, charge the 2654 2655 same fee, or a portion thereof, to the employee applicant. Any 2656 increase in the fee charged by the licensing agency under this 2657 paragraph shall be in accordance with the provisions of Section 2658 41-3-65. Any costs incurred by a covered entity implementing this 2659 subsection (6) shall be reimbursed as an allowable cost under 2660 Section 43-13-116.

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

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2677	(h) The licensing agency, the covered entity, and their
2678	agents, officers, employees, attorneys and representatives, shall
2679	be presumed to be acting in good faith for any employment decision
2680	or action taken under this subsection (6). The presumption of
2681	good faith may be overcome by a preponderance of the evidence in
2682	any civil action. No licensing agency, covered entity, nor their
2683	agents, officers, employees, attorneys and representatives shall
2684	be held liable in any employment decision or action based in whole
2685	or in part on compliance with or attempts to comply with the
2686	requirements of this subsection (6).

- 2687 (i) The licensing agency shall promulgate regulations 2688 to implement this subsection (6).
- 2689 (j) The provisions of this subsection (6) shall not 2690 apply to:
- 2691 (i) Applicants and employees of the University of
 2692 Mississippi Medical Center for whom criminal history record checks
 2693 and fingerprinting are obtained in accordance with Section
 2694 37-115-41; or
- 2695 (ii) Health care professional/vocational technical 2696 students for whom criminal history record checks and 2697 fingerprinting are obtained in accordance with Section 37-29-232.
- 2698 (7) The State Board of Health shall promulgate rules,
 2699 regulations and standards regarding the operation of adult foster
 2700 care facilities and adult day care facilities.

2701	(8) Beginning July 1, 2026, to operate an adult day care
2702	facility in Mississippi, the facility provider shall be licensed
2703	with the licensing division of the State Department of Health.
2704	Mississippi Medicaid waiver providers are required to have a state
2705	license and have a Medicaid provider contract with the Division of
2706	Medicaid.
2707	Facilities shall be licensed to serve clients based on the
2708	size and capacity of the facility. The facilities shall be
2709	required to provide nursing services, nutritional services,
2710	socialization and therapeutic activities. The facilities shall
2711	maintain, at a minimum, a staff-to-client ratio in accordance with
2712	the State Department of Health's standards. Standards governing
2713	the quality of care and services rendered shall be developed with
2714	input from all stakeholders, including the Division of Medicaid.
2715	In addition to providing adult day care services, the licensed
2716	provider is required to offer transportation services consistent
2717	with State Department of Health regulations.
2718	SECTION 8. Section 43-13-117.1, Mississippi Code of 1972, is
2719	amended as follows:
2720	43-13-117.1. It is the intent of the Legislature to expand
2721	access to Medicaid-funded home- and community-based services for
2722	eligible nursing facility residents who choose those services.
2723	The Executive Director of the Division of Medicaid is authorized
2724	to transfer funds allocated for nursing facility services for
2725	eligible residents to cover the cost of services available through

- 2726 the Independent Living Waiver, the Traumatic Brain Injury/Spinal
- 2727 Cord Injury Waiver, the Elderly and Disabled Waiver, and the
- 2728 Assisted Living Waiver programs when eligible residents choose
- 2729 those community services. The amount of funding transferred by
- 2730 the division shall be sufficient to cover the cost of home- and
- 2731 community-based waiver services for each eligible nursing
- 2732 facility * * * resident who * * * chooses those services. The
- 2733 number of nursing facility residents who return to the community
- 2734 and home- and community-based waiver services shall not count
- 2735 against the total number of waiver slots for which the Legislature
- 2736 appropriates funding each year. Any funds remaining in the
- 2737 program when a former nursing facility resident ceases to
- 2738 participate in a home- and community-based waiver program under
- 2739 this provision shall be returned to nursing facility funding.
- 2740 **SECTION 9.** Section 43-13-117.7, Mississippi Code of 1972, is
- 2741 amended as follows:
- 2742 43-13-117.7. Notwithstanding any other provisions of Section
- 2743 43-13-117, the division shall not reimburse or provide coverage
- 2744 for gender transition procedures for * * * any person * * *.
- 2745 **SECTION 10.** Section 37-33-167, Mississippi Code of 1972, is
- 2746 amended as follows:
- 2747 37-33-167. The State Department of Rehabilitation Services,
- 2748 through the Office of Disability Determination Services, may enter
- 2749 into agreements with the federal Social Security Administration or
- 2750 its successor and other state agencies for the purpose of

- 2751 performing eligibility determinations for Medicaid assistance
- 2752 payments for those persons who qualify therefor under Section
- 2753 43-13-115 * * * *, and may adopt such methods of administration as
- 2754 may be necessary to secure the full benefits of federal
- 2755 appropriations for medical assistance for such persons.
- 2756 **SECTION 11.** Section 43-13-145, Mississippi Code of 1972, is
- 2757 amended as follows:
- 2758 43-13-145. (1) (a) Upon each nursing facility licensed by
- 2759 the State of Mississippi, there is levied an assessment in an
- 2760 amount set by the division, equal to the maximum rate allowed by
- 2761 federal law or regulation, for each licensed and occupied bed of
- 2762 the facility.
- (b) A nursing facility is exempt from the assessment
- 2764 levied under this subsection if the facility is operated under the
- 2765 direction and control of:
- 2766 (i) The United States Veterans Administration or
- 2767 other agency or department of the United States government; or
- 2768 (ii) The State Veterans Affairs Board.
- 2769 (2) (a) Upon each intermediate care facility for
- 2770 individuals with intellectual disabilities licensed by the State
- 2771 of Mississippi, there is levied an assessment in an amount set by
- 2772 the division, equal to the maximum rate allowed by federal law or
- 2773 regulation, for each licensed and occupied bed of the facility.
- 2774 (b) An intermediate care facility for individuals with
- 2775 intellectual disabilities is exempt from the assessment levied

2776	under	this	subsection	if	the	facility	is	operated	under	the
2777	direct	cion a	and control	of:	:					

- 2778 (i) The United States Veterans Administration or 2779 other agency or department of the United States government;
- 2780 (ii) The State Veterans Affairs Board; or
- 2781 (iii) The University of Mississippi Medical
- 2782 Center.
- 2783 (3) (a) Upon each psychiatric residential treatment
 2784 facility licensed by the State of Mississippi, there is levied an
 2785 assessment in an amount set by the division, equal to the maximum
 2786 rate allowed by federal law or regulation, for each licensed and
 2787 occupied bed of the facility.
- (b) A psychiatric residential treatment facility is 2789 exempt from the assessment levied under this subsection if the 2790 facility is operated under the direction and control of:
- 2791 (i) The United States Veterans Administration or 2792 other agency or department of the United States government;
- 2793 (ii) The University of Mississippi Medical Center;
- 2794 or
- 2795 (iii) A state agency or a state facility that
 2796 either provides its own state match through intergovernmental
 2797 transfer or certification of funds to the division.
- 2798 (4) Hospital assessment.
- 2799 (a) (i) Subject to and upon fulfillment of the 2800 requirements and conditions of paragraph (f) below, and

2801	notwithstanding any other provisions of this section, an annual
2802	assessment on each hospital licensed in the state is imposed on
2803	each non-Medicare hospital inpatient day as defined below at a
2804	rate that is determined by dividing the sum prescribed in this
2805	subparagraph (i), plus the nonfederal share necessary to maximize
2806	the Disproportionate Share Hospital (DSH) and Medicare Upper
2807	Payment Limits (UPL) Program payments and hospital access payments
2808	and such other supplemental payments as may be developed pursuant
2809	to Section 43-13-117(A)(18), by the total number of non-Medicare
2810	hospital inpatient days as defined below for all licensed
2811	Mississippi hospitals, except as provided in paragraph (d) below.
2812	If the state-matching funds percentage for the Mississippi
2813	Medicaid program is sixteen percent (16%) or less, the sum used in
2814	the formula under this subparagraph (i) shall be Seventy-four
2815	Million Dollars (\$74,000,000.00). If the state-matching funds
2816	percentage for the Mississippi Medicaid program is twenty-four
2817	percent (24%) or higher, the sum used in the formula under this
2818	subparagraph (i) shall be One Hundred Four Million Dollars
2819	(\$104,000,000.00). If the state-matching funds percentage for the
2820	Mississippi Medicaid program is between sixteen percent (16%) and
2821	twenty-four percent (24%), the sum used in the formula under this
2822	subparagraph (i) shall be a pro rata amount determined as follows:
2823	the current state-matching funds percentage rate minus sixteen
2824	percent (16%) divided by eight percent (8%) multiplied by Thirty
2825	Million Dollars (\$30,000,000.00) and add that amount to

2826	Seventy-four Million Dollars (\$74,000,000.00). However, no
2827	assessment in a quarter under this subparagraph (i) may exceed the
2828	assessment in the previous quarter by more than Three Million
2829	Seven Hundred Fifty Thousand Dollars (\$3,750,000.00) (which would
2830	be Fifteen Million Dollars (\$15,000,000.00) on an annualized
2831	basis), unless such increase is to maximize federal funds that are
2832	available to reimburse hospitals for services provided under new
2833	programs for hospitals, for increased supplemental payment
2834	programs for hospitals or to assist with state matching funds as
2835	authorized by the Legislature. The division shall publish the
2836	state-matching funds percentage rate applicable to the Mississippi
2837	Medicaid program on the tenth day of the first month of each
2838	quarter and the assessment determined under the formula prescribed
2839	above shall be applicable in the quarter following any adjustment
2840	in that state-matching funds percentage rate. The division shall
2841	notify each hospital licensed in the state as to any projected
2842	increases or decreases in the assessment determined under this
2843	subparagraph (i). However, if the Centers for Medicare and
2844	Medicaid Services (CMS) does not approve the provision in Section
2845	43-13-117(39) requiring the division to reimburse crossover claims
2846	for inpatient hospital services and crossover claims covered under
2847	Medicare Part B for dually eligible beneficiaries in the same
2848	manner that was in effect on January 1, 2008, the sum that
849	otherwise would have been used in the formula under this

2850 subparagraph (i) shall be reduced by Seven Million Dollars 2851 (\$7,000,000.00).

2852 In addition to the assessment provided under 2853 subparagraph (i), an additional annual assessment on each hospital 2854 licensed in the state is imposed on each non-Medicare hospital 2855 inpatient day as defined below at a rate that is determined by 2856 dividing twenty-five percent (25%) of any provider reductions in 2857 the Medicaid program as authorized in Section 43-13-117(F) for 2858 that fiscal year up to the following maximum amount, plus the 2859 nonfederal share necessary to maximize the Disproportionate Share 2860 Hospital (DSH) and inpatient Medicare Upper Payment Limits (UPL) 2861 Program payments and inpatient hospital access payments, by the 2862 total number of non-Medicare hospital inpatient days as defined 2863 below for all licensed Mississippi hospitals: in fiscal year 2864 2010, the maximum amount shall be Twenty-four Million Dollars 2865 (\$24,000,000.00); in fiscal year 2011, the maximum amount shall be 2866 Thirty-two Million Dollars (\$32,000,000.00); and in fiscal year 2867 2012 and thereafter, the maximum amount shall be Forty Million 2868 Dollars (\$40,000,000.00). Any such deficit in the Medicaid 2869 program shall be reviewed by the PEER Committee as provided in 2870 Section 43-13-117(F).

2871 In addition to the assessments provided in (iii) 2872 subparagraphs (i) and (ii), an additional annual assessment on 2873 each hospital licensed in the state is imposed pursuant to the provisions of Section 43-13-117(F) if the cost-containment 2874

2875 measures described therein have been implemented and there are 2876 insufficient funds in the Health Care Trust Fund to reconcile any 2877 remaining deficit in any fiscal year. If the Governor institutes 2878 any other additional cost-containment measures on any program or 2879 programs authorized under the Medicaid program pursuant to Section 2880 43-13-117(F), hospitals shall be responsible for twenty-five 2881 percent (25%) of any such additional imposed provider cuts, which 2882 shall be in the form of an additional assessment not to exceed the 2883 twenty-five percent (25%) of provider expenditure reductions. 2884 Such additional assessment shall be imposed on each non-Medicare 2885 hospital inpatient day in the same manner as assessments are 2886 imposed under subparagraphs (i) and (ii).

- 2887 (b) Definitions.
- 2888 (i) [Deleted]

- 2889 (ii) For purposes of this subsection (4):
- "Non-Medicare hospital inpatient day" 2891 means total hospital inpatient days including subcomponent days 2892 less Medicare inpatient days including subcomponent days from the 2893 hospital's most recent Medicare cost report for the second 2894 calendar year preceding the beginning of the state fiscal year, on 2895 file with CMS per the CMS HCRIS database, or cost report submitted 2896 to the Division if the HCRIS database is not available to the
- 2897 division, as of June 1 of each year.

2898 Total hospital inpatient days shall 2899 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. 2900 2901 Hospital Medicare inpatient days 2902 shall be the sum of Worksheet S-3, Part 1, column 6 row 14, column 2903 6 row 16.00, and column 6 row 17, excluding column 6 rows 5 and 6. 2904 c. Inpatient days shall not include 2905 residential treatment or long-term care days. 2906 2. "Subcomponent inpatient day" means the number of days of care charged to a beneficiary for inpatient 2907 2908 hospital rehabilitation and psychiatric care services in units of 2909 full days. A day begins at midnight and ends twenty-four (24) 2910 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 2911 2912 full day. However, the day of discharge, death, or a day on which 2913 a patient begins a leave of absence is not counted as a day unless 2914 discharge or death occur on the day of admission. If admission and discharge or death occur on the same day, the day is 2915 2916 considered a day of admission and counts as one (1) subcomponent 2917 inpatient day. 2918 The assessment provided in this subsection is 2919 intended to satisfy and not be in addition to the assessment and 2920 intergovernmental transfers provided in Section 43-13-117(A)(18).

Nothing in this section shall be construed to authorize any state

agency, division or department, or county, municipality or other

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- local governmental unit to license for revenue, levy or impose any other tax, fee or assessment upon hospitals in this state not authorized by a specific statute.
- 2926 (d) Hospitals operated by the United States Department
 2927 of Veterans Affairs and state-operated facilities that provide
 2928 only inpatient and outpatient psychiatric services shall not be
 2929 subject to the hospital assessment provided in this subsection.
- 2930 (e) Multihospital systems, closure, merger, change of 2931 ownership and new hospitals.
- 2932 (i) If a hospital conducts, operates or maintains
 2933 more than one (1) hospital licensed by the State Department of
 2934 Health, the provider shall pay the hospital assessment for each
 2935 hospital separately.
- 2936 (ii) Notwithstanding any other provision in this 2937 section, if a hospital subject to this assessment operates or 2938 conducts business only for a portion of a fiscal year, the 2939 assessment for the state fiscal year shall be adjusted by multiplying the assessment by a fraction, the numerator of which 2940 2941 is the number of days in the year during which the hospital 2942 operates, and the denominator of which is three hundred sixty-five 2943 Immediately upon ceasing to operate, the hospital shall 2944 pay the assessment for the year as so adjusted (to the extent not 2945 previously paid).
- 2946 (iii) The division shall determine the tax for new 2947 hospitals and hospitals that undergo a change of ownership in

2948	accordance	with	this	sectio	n,	using	the	best	available
2949	information	, as	deter	cmined	bv	the di	lvisi	ion.	

- 2950 (f) Applicability.
- The hospital assessment imposed by this subsection shall not take effect and/or shall cease to be imposed if:
- 2953 (i) The assessment is determined to be an
 2954 impermissible tax under Title XIX of the Social Security Act; or
 2955 (ii) CMS revokes its approval of the division's
 2956 2009 Medicaid State Plan Amendment for the methodology for DSH
- 2957 payments to hospitals under Section 43-13-117(A)(18).
- 2958 Each health care facility that is subject to the provisions of this section shall keep and preserve such suitable 2959 2960 books and records as may be necessary to determine the amount of 2961 assessment for which it is liable under this section. 2962 and records shall be kept and preserved for a period of not less 2963 than five (5) years, during which time those books and records 2964 shall be open for examination during business hours by the 2965 division, the Department of Revenue, the Office of the Attorney 2966 General and the State Department of Health.
- 2967 (6) [Deleted]
- 2968 (7) All assessments collected under this section shall be 2969 deposited in the Medical Care Fund created by Section 43-13-143.
- 2970 (8) The assessment levied under this section shall be in 2971 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.

- 2974 If a health care facility that is liable for (a) 2975 payment of an assessment levied by the division does not pay the 2976 assessment when it is due, the division shall give written notice 2977 to the health care facility demanding payment of the assessment within ten (10) days from the date of delivery of the notice. If 2978 2979 the health care facility fails or refuses to pay the assessment 2980 after receiving the notice and demand from the division, the 2981 division shall withhold from any Medicaid reimbursement payments 2982 that are due to the health care facility the amount of the unpaid 2983 assessment and a penalty of ten percent (10%) of the amount of the 2984 assessment, plus the legal rate of interest until the assessment 2985 If the health care facility does not participate is paid in full. 2986 in the Medicaid program, the division shall turn over to the 2987 Office of the Attorney General the collection of the unpaid 2988 assessment by civil action. In any such civil action, the Office of the Attorney General shall collect the amount of the unpaid 2989 2990 assessment and a penalty of ten percent (10%) of the amount of the 2991 assessment, plus the legal rate of interest until the assessment 2992 is paid in full.
- 2993 (b) As an additional or alternative method for
 2994 collecting unpaid assessments levied by the division, if a health
 2995 care facility fails or refuses to pay the assessment after
 2996 receiving notice and demand from the division, the division may

2997 file a notice of a tax lien with the chancery clerk of the county 2998 in which the health care facility is located, for the amount of the unpaid assessment and a penalty of ten percent (10%) of the 2999 3000 amount of the assessment, plus the legal rate of interest until 3001 the assessment is paid in full. Immediately upon receipt of 3002 notice of the tax lien for the assessment, the chancery clerk 3003 shall forward the notice to the circuit clerk who shall enter the 3004 notice of the tax lien as a judgment upon the judgment roll and 3005 show in the appropriate columns the name of the health care 3006 facility as judgment debtor, the name of the division as judgment 3007 creditor, the amount of the unpaid assessment, and the date and 3008 time of enrollment. The judgment shall be valid as against 3009 mortgagees, pledgees, entrusters, purchasers, judgment creditors 3010 and other persons from the time of filing with the clerk. 3011 amount of the judgment shall be a debt due the State of 3012 Mississippi and remain a lien upon the tangible property of the 3013 health care facility until the judgment is satisfied. judgment shall be the equivalent of any enrolled judgment of a 3014 3015 court of record and shall serve as authority for the issuance of 3016 writs of execution, writs of attachment or other remedial writs. 3017 (10)(a) To further the provisions of Section 3018 43-13-117(A)(18), the Division of Medicaid shall submit to the Centers for Medicare and Medicaid Services (CMS) any documents 3019 3020 regarding the hospital assessment established under subsection (4) of this section. In addition to defining the assessment 3021

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.

- 3026 All hospitals satisfying the minimum federal DSH (b) 3027 eligibility requirements (Section 1923(d) of the Social Security 3028 Act) may, subject to OBRA 1993 payment limitations, receive a DSH 3029 This DSH payment shall expend the balance of the federal 3030 DSH allotment and associated state share not utilized in DSH payments to state-owned institutions for treatment of mental 3031 3032 diseases. The payment to each hospital shall be calculated by 3033 applying a uniform percentage to the uninsured costs of each 3034 eligible hospital, excluding state-owned institutions for 3035 treatment of mental diseases; however, that percentage for a 3036 state-owned teaching hospital located in Hinds County shall be 3037 multiplied by a factor of two (2).
- 3038 (11) The division shall implement DSH and supplemental 3039 payment calculation methodologies that result in the maximization 3040 of available federal funds.
- 3041 (12) The DSH payments shall be paid on or before December 3042 31, March 31, and June 30 of each fiscal year, in increments of one-third (1/3) of the total calculated DSH amounts. Supplemental payments developed pursuant to Section 43-13-117(A)(18) shall be 3045 paid monthly.
- 3046 (13) Payment.

3047	(a) The hospital assessment as described in subsection
3048	(4) for the nonfederal share necessary to maximize the Medicare
3049	Upper Payments Limits (UPL) Program payments and hospital access
3050	payments and such other supplemental payments as may be developed
3051	pursuant to Section 43-3-117(A)(18) shall be assessed and
3052	collected monthly no later than the fifteenth calendar day of each
3053	month.

- 3054 (b) The hospital assessment as described in subsection 3055 (4) for the nonfederal share necessary to maximize the 3056 Disproportionate Share Hospital (DSH) payments shall be assessed 3057 and collected on December 15, March 15 and June 15.
- 3058 (c) The annual hospital assessment and any additional 3059 hospital assessment as described in subsection (4) shall be 3060 assessed and collected on September 15 and on the 15th of each 3061 month from December through June.
- 3062 (14) If for any reason any part of the plan for annual DSH
 3063 and supplemental payment programs to hospitals provided under
 3064 subsection (10) of this section and/or developed pursuant to
 3065 Section 43-13-117(A)(18) is not approved by CMS, the remainder of
 3066 the plan shall remain in full force and effect.
- 3067 (15) Nothing in this section shall prevent the Division of
 3068 Medicaid from facilitating participation in Medicaid supplemental
 3069 hospital payment programs by a hospital located in a county
 3070 contiguous to the State of Mississippi that is also authorized by
 3071 federal law to submit intergovernmental transfers (IGTs) to the

- 3072 State of Mississippi to fund the state share of the hospital's supplemental and/or MHAP payments.
- 3074 (16) This section shall stand repealed on July 1, 2028.
- 3075 **SECTION 12.** Section 43-13-115.1, Mississippi Code of 1972,
- 3076 is amended as follows:
- 3077 43-13-115.1. (1) Ambulatory prenatal care shall be
- 3078 available to a pregnant woman under this article during a
- 3079 presumptive eligibility period in accordance with the provisions
- 3080 of this section.
- 3081 (2) For purposes of this section, the following terms shall
- 3082 be defined as provided in this subsection:
- 3083 (a) "Presumptive eligibility" means a reasonable
- 3084 determination of Medicaid eligibility of a pregnant woman made by
- 3085 a qualified provider based only on the countable family income of
- 3086 the woman, which allows the woman to receive ambulatory prenatal
- 3087 care under this article during a presumptive eligibility period
- 3088 while the Division of Medicaid makes a determination with respect
- 3089 to the eligibility of the woman for Medicaid.
- 3090 (b) "Presumptive eligibility period" means, with
- 3091 respect to a pregnant woman, the period that:
- 3092 (i) Begins with the date on which a qualified
- 3093 provider determines, on the basis of preliminary information, that
- 3094 the total countable net family income of the woman does not exceed
- 3095 the income limits for eligibility of pregnant women in the
- 3096 Medicaid state plan; and

3097	(ii) Ends with, and includes, the earlier of:
3098	1. The day on which a determination is made
3099	with respect to the eligibility of the woman for Medicaid;
3100	2. In the case of a woman who does not file
3101	an application by the last day of the month following the month
3102	during which the provider makes the determination referred to in
3103	subparagraph (i) of this paragraph, such last day; or
3104	3. Sixty (60) days after the day that the
3105	provider makes the determination referred to in subparagraph (i)
3106	of this paragraph.
3107	(c) "Qualified provider" means any provider that meets
3108	the definition of "qualified provider" under 42 USC Section
3109	1396r-1. The term includes, but is not limited to, county health
3110	departments, federally qualified health centers (FQHCs), and other
3111	entities approved and designated by the Division of Medicaid to
3112	conduct presumptive eligibility determinations for pregnant women.
3113	(3) A pregnant woman shall be deemed to be presumptively
3114	eligible for ambulatory prenatal care under this article if a
3115	qualified provider determines, on the basis of preliminary
3116	information, that the total countable net family income of the
3117	woman does not exceed the income limits for eligibility of
3118	pregnant women in the Medicaid state plan. * * * A pregnant woman
3119	who is determined to be presumptively eligible may receive no more

3120 than one (1) presumptive eligibility period per pregnancy.

3121	(4)	A	qualified	provider	that	determine	s that	a	pregnant
3122	woman	is	pre	sumptively	, eligible	e for	Medicaid	shall:		

- 3123 (a) Notify the Division of Medicaid of the
 3124 determination within five (5) working days after the date on which
 3125 determination is made; and
- 3126 (b) Inform the woman at the time the determination is 3127 made that she is required to make application for Medicaid by not 3128 later than the last day of the month following the month during 3129 which the determination is made.
- 3130 (5) A pregnant woman who is determined by a qualified 3131 provider to be presumptively eligible for Medicaid shall make 3132 application for Medicaid by not later than the last day of the 3133 month following the month during which the determination is made.
 - (6) The Division of Medicaid shall provide qualified providers with such forms as are necessary for a pregnant woman to make application for Medicaid and information on how to assist such women in completing and filing such forms. The division shall make those application forms and the application process itself as simple as possible.
- 3140 **SECTION 13.** Section 41-7-191, Mississippi Code of 1972, is 3141 amended as follows:
- 3142 41-7-191. (1) No person shall engage in any of the 3143 following activities without obtaining the required certificate of 3144 need:

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3145	(a) The construction, development or other
3146	establishment of a new health care facility, which establishment
3147	shall include the reopening of a health care facility that has
3148	ceased to operate for a period of sixty (60) months or more;

- 3149 (b) The relocation of a health care facility or portion
 3150 thereof, or major medical equipment, unless such relocation of a
 3151 health care facility or portion thereof, or major medical
 3152 equipment, which does not involve a capital expenditure by or on
 3153 behalf of a health care facility, is within five thousand two
 3154 hundred eighty (5,280) feet from the main entrance of the health
 3155 care facility;
- 3156 Any change in the existing bed complement of any health care facility through the addition or conversion of any 3157 beds or the alteration, modernizing or refurbishing of any unit or 3158 3159 department in which the beds may be located; however, if a health 3160 care facility has voluntarily delicensed some of its existing bed 3161 complement, it may later relicense some or all of its delicensed beds without the necessity of having to acquire a certificate of 3162 3163 The State Department of Health shall maintain a record of need. 3164 the delicensing health care facility and its voluntarily 3165 delicensed beds and continue counting those beds as part of the 3166 state's total bed count for health care planning purposes. health care facility that has voluntarily delicensed some of its 3167 3168 beds later desires to relicense some or all of its voluntarily delicensed beds, it shall notify the State Department of Health of 3169

3170	its intent to increase the number of its licensed beds. The State
3171	Department of Health shall survey the health care facility within
3172	thirty (30) days of that notice and, if appropriate, issue the
3173	health care facility a new license reflecting the new contingent
3174	of beds. However, in no event may a health care facility that has
3175	voluntarily delicensed some of its beds be reissued a license to
3176	operate beds in excess of its bed count before the voluntary
3177	delicensure of some of its beds without seeking certificate of
3178	need approval;
3179	(d) Offering of the following health services if those
3180	services have not been provided on a regular basis by the proposed
3181	provider of such services within the period of twelve (12) months
3182	prior to the time such services would be offered:
3183	(i) Open-heart surgery services;
3184	(ii) Cardiac catheterization services;
3185	(iii) Comprehensive inpatient rehabilitation
3186	services;
3187	(iv) Licensed psychiatric services;
3188	(v) Licensed chemical dependency services;
3189	(vi) Radiation therapy services;
3190	(vii) Diagnostic imaging services of an invasive
3191	nature, i.e. invasive digital angiography;
3192	(viii) Nursing home care as defined in
3193	subparagraphs (iv), (vi) and (viii) of Section 41-7-173(h);
3194	(ix) Home health services;

3195	(x) Swing-bed services;
3196	(xi) Ambulatory surgical services;
3197	(xii) Magnetic resonance imaging services;
3198	(xiii) [Deleted]
3199	(xiv) Long-term care hospital services;
3200	(xv) Positron emission tomography (PET) services;
3201	(e) The relocation of one or more health services from
3202	one physical facility or site to another physical facility or
3203	site, unless such relocation, which does not involve a capital
3204	expenditure by or on behalf of a health care facility, (i) is to a
3205	physical facility or site within five thousand two hundred eighty
3206	(5,280) feet from the main entrance of the health care facility
3207	where the health care service is located, or (ii) is the result of
3208	an order of a court of appropriate jurisdiction or a result of
3209	pending litigation in such court, or by order of the State
3210	Department of Health, or by order of any other agency or legal
3211	entity of the state, the federal government, or any political
3212	subdivision of either, whose order is also approved by the State
3213	Department of Health;
3214	(f) The acquisition or otherwise control of any major
3215	medical equipment for the provision of medical services; however,
3216	(i) the acquisition of any major medical equipment used only for
3217	research purposes, and (ii) the acquisition of major medical
3218	equipment to replace medical equipment for which a facility is
3219	already providing medical services and for which the State

3221	acquisition shall be exempt from this paragraph; an acquisition
3222	for less than fair market value must be reviewed, if the
3223	acquisition at fair market value would be subject to review;
3224	(g) Changes of ownership of existing health care
3225	facilities in which a notice of intent is not filed with the State
3226	Department of Health at least thirty (30) days prior to the date
3227	such change of ownership occurs, or a change in services or bed
3228	capacity as prescribed in paragraph (c) or (d) of this subsection
3229	as a result of the change of ownership; an acquisition for less
3230	than fair market value must be reviewed, if the acquisition at
3231	fair market value would be subject to review;
3232	(h) The change of ownership of any health care facility
3233	defined in subparagraphs (iv), (vi) and (viii) of Section
3234	41-7-173(h), in which a notice of intent as described in paragraph
3235	(g) has not been filed and if the Executive Director, Division of
3236	Medicaid, Office of the Governor, has not certified in writing
3237	that there will be no increase in allowable costs to Medicaid from
3238	revaluation of the assets or from increased interest and
3239	depreciation as a result of the proposed change of ownership;
3240	(i) Any activity described in paragraphs (a) through
3241	(h) if undertaken by any person if that same activity would
3242	require certificate of need approval if undertaken by a health
3243	care facility;

Department of Health has been notified before the date of such

3244	(j)	Any	capital	expen	diture d	or def	ferred cap	pital	L
3245	expenditure by	or o	n behalf	ofa	health	care	facility	not	covered
3246	by paragraphs	(a) t	hrough ((h);					

- 3247 (k) The contracting of a health care facility as
 3248 defined in subparagraphs (i) through (viii) of Section 41-7-173(h)
 3249 to establish a home office, subunit, or branch office in the space
 3250 operated as a health care facility through a formal arrangement
 3251 with an existing health care facility as defined in subparagraph
 3252 (ix) of Section 41-7-173(h);
- 3253 (1) The replacement or relocation of a health care
 3254 facility designated as a critical access hospital shall be exempt
 3255 from subsection (1) of this section so long as the critical access
 3256 hospital complies with all applicable federal law and regulations
 3257 regarding such replacement or relocation;
- 3258 (m) Reopening a health care facility that has ceased to 3259 operate for a period of sixty (60) months or more, which reopening 3260 requires a certificate of need for the establishment of a new 3261 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:

3269	(a) The department may issue a certificate of need to
3270	any person proposing the new construction of any health care
3271	facility defined in subparagraphs (iv) and (vi) of Section
3272	41-7-173(h) as part of a life care retirement facility, in any
3273	county bordering on the Gulf of Mexico in which is located a
3274	National Aeronautics and Space Administration facility, not to
3275	exceed forty (40) beds. From and after July 1, 1999, there shall
3276	be no prohibition or restrictions on participation in the Medicaid
3277	program (Section 43-13-101 et seq.) for the beds in the health
3278	care facility that were authorized under this paragraph (a).

- (b) The department may issue certificates of need in Harrison County to provide skilled nursing home care for Alzheimer's disease patients and other patients, not to exceed one hundred fifty (150) 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 nursing facilities that were authorized under this paragraph (b).
- 3286 The department may issue a certificate of need for (C) 3287 the addition to or expansion of any skilled nursing facility that 3288 is part of an existing continuing care retirement community 3289 located in Madison County, provided that the recipient of the 3290 certificate of need agrees in writing that the skilled nursing 3291 facility will not at any time participate in the Medicaid program 3292 (Section 43-13-101 et seq.) or admit or keep any patients in the skilled nursing facility who are participating in the Medicaid 3293

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3294 This written agreement by the recipient of the 3295 certificate of need shall be fully binding on any subsequent owner 3296 of the skilled nursing facility, if the ownership of the facility 3297 is transferred at any time after the issuance of the certificate 3298 of need. Agreement that the skilled nursing facility will not 3299 participate in the Medicaid program shall be a condition of the 3300 issuance of a certificate of need to any person under this 3301 paragraph (c), and if such skilled nursing facility at any time 3302 after the issuance of the certificate of need, regardless of the 3303 ownership of the facility, participates in the Medicaid program or 3304 admits or keeps any patients in the facility who are participating 3305 in the Medicaid program, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and 3306 3307 shall deny or revoke the license of the skilled nursing facility, 3308 at the time that the department determines, after a hearing 3309 complying with due process, that the facility has failed to comply with any of the conditions upon which the certificate of need was 3310 issued, as provided in this paragraph and in the written agreement 3311 3312 by the recipient of the certificate of need. The total number of 3313 beds that may be authorized under the authority of this paragraph 3314 (c) shall not exceed sixty (60) beds.

3315 (d) The State Department of Health may issue a
3316 certificate of need to any hospital located in DeSoto County for
3317 the new construction of a skilled nursing facility, not to exceed
3318 one hundred twenty (120) beds, in DeSoto County. 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 nursing facility that were authorized under this paragraph (d).

3323 The State Department of Health may issue a 3324 certificate of need for the construction of a nursing facility or 3325 the conversion of beds to nursing facility beds at a personal care 3326 facility for the elderly in Lowndes County that is owned and 3327 operated by a Mississippi nonprofit corporation, not to exceed sixty (60) beds. From and after July 1, 1999, there shall be no 3328 3329 prohibition or restrictions on participation in the Medicaid 3330 program (Section 43-13-101 et seq.) for the beds in the nursing 3331 facility that were authorized under this paragraph (e).

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

(g) 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 Hinds, Madison or Rankin County, not to exceed

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sixty (60) 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 nursing facility that were authorized under this paragraph (g).

3348 The State Department of Health may issue a (h) 3349 certificate of need for the construction or expansion of nursing 3350 facility beds or the conversion of other beds to nursing facility 3351 beds in either Hancock, Harrison or Jackson County, not to exceed 3352 sixty (60) beds. From and after July 1, 1999, there shall be no 3353 prohibition or restrictions on participation in the Medicaid 3354 program (Section 43-13-101 et seq.) for the beds in the facility 3355 that were authorized under this paragraph (h).

3356 The department may issue a certificate of need for 3357 the new construction of a skilled nursing facility in Leake 3358 County, provided that the recipient of the certificate of need 3359 agrees in writing that the skilled nursing facility will not at 3360 any time participate in the Medicaid program (Section 43-13-101 et seq.) or admit or keep any patients in the skilled nursing 3361 3362 facility who are participating in the Medicaid program. 3363 written agreement by the recipient of the certificate of need 3364 shall be fully binding on any subsequent owner of the skilled 3365 nursing facility, if the ownership of the facility is transferred at any time after the issuance of the certificate of need. 3366 3367 Agreement that the skilled nursing facility will not participate in the Medicaid program shall be a condition of the issuance of a 3368

3369	certificate of need to any person under this paragraph (i), and if
3370	such skilled nursing facility at any time after the issuance of
3371	the certificate of need, regardless of the ownership of the
3372	facility, participates in the Medicaid program or admits or keeps
3373	any patients in the facility who are participating in the Medicaid
3374	program, the State Department of Health shall revoke the
3375	certificate of need, if it is still outstanding, and shall deny or
3376	revoke the license of the skilled nursing facility, at the time
3377	that the department determines, after a hearing complying with due
3378	process, that the facility has failed to comply with any of the
3379	conditions upon which the certificate of need was issued, as
3380	provided in this paragraph and in the written agreement by the
3381	recipient of the certificate of need. The provision of Section
3382	41-7-193(1) regarding substantial compliance of the projection of
3383	need as reported in the current State Health Plan is waived for
3384	the purposes of this paragraph. The total number of nursing
3385	facility beds that may be authorized by any certificate of need
3386	issued under this paragraph (i) shall not exceed sixty (60) beds.
3387	If the skilled nursing facility authorized by the certificate of
3388	need issued under this paragraph is not constructed and fully
3389	operational within eighteen (18) months after July 1, 1994, the
3390	State Department of Health, after a hearing complying with due
3391	process, shall revoke the certificate of need, if it is still
3392	outstanding, and shall not issue a license for the skilled nursing

facility at any time after the expiration of the eighteen-month period.

- 3395 The department may issue certificates of need to (i) 3396 allow any existing freestanding long-term care facility in 3397 Tishomingo County and Hancock County that on July 1, 1995, is 3398 licensed with fewer than sixty (60) beds. For the purposes of 3399 this paragraph (j), the provisions of Section 41-7-193(1) 3400 requiring substantial compliance with the projection of need as 3401 reported in the current State Health Plan are waived. From and 3402 after July 1, 1999, there shall be no prohibition or restrictions 3403 on participation in the Medicaid program (Section 43-13-101 et 3404 seq.) for the beds in the long-term care facilities that were 3405 authorized under this paragraph (j).
- 3406 The department may issue a certificate of need for 3407 the construction of a nursing facility at a continuing care 3408 retirement community in Lowndes County. The total number of beds 3409 that may be authorized under the authority of this paragraph (k) shall not exceed sixty (60) beds. From and after July 1, 2001, 3410 3411 the prohibition on the facility participating in the Medicaid 3412 program (Section 43-13-101 et seq.) that was a condition of 3413 issuance of the certificate of need under this paragraph (k) shall 3414 be revised as follows: The nursing facility may participate in the Medicaid program from and after July 1, 2001, if the owner of 3415 3416 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 3417

3418 participation in the Medicaid program, and that no claim will be 3419 submitted for Medicaid reimbursement for more than thirty (30) patients in the facility in any month or for any patient in the 3420 facility who is in a bed that is not Medicaid-certified. 3421 3422 written agreement by the owner of the facility shall be a 3423 condition of licensure of the facility, and the agreement shall be 3424 fully binding on any subsequent owner of the facility if the 3425 ownership of the facility is transferred at any time after July 1, 3426 After this written agreement is executed, the Division of Medicaid and the State Department of Health shall not certify more 3427 3428 than thirty (30) of the beds in the facility for participation in 3429 the Medicaid program. If the facility violates the terms of the 3430 written agreement by admitting or keeping in the facility on a regular or continuing basis more than thirty (30) patients who are 3431 participating in the Medicaid program, the State Department of 3432 3433 Health shall revoke the license of the facility, at the time that 3434 the department determines, after a hearing complying with due process, that the facility has violated the written agreement. 3435 3436 (1)Provided that funds are specifically appropriated 3437 therefor by the Legislature, the department may issue a 3438 certificate of need to a rehabilitation hospital in Hinds County

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.

3446 (m) The State Department of Health may issue a 3447 certificate of need to a county-owned hospital in the Second 3448 Judicial District of Panola County for the conversion of not more than seventy-two (72) hospital beds to nursing facility beds, 3449 3450 provided that the recipient of the certificate of need agrees in 3451 writing that none of the beds at the nursing facility will be 3452 certified for participation in the Medicaid program (Section 3453 43-13-101 et seq.), and that no claim will be submitted for 3454 Medicaid reimbursement in the nursing facility in any day or for 3455 any patient in the nursing facility. This written agreement by 3456 the recipient of the certificate of need shall be a condition of 3457 the issuance of the certificate of need under this paragraph, and 3458 the agreement shall be fully binding on any subsequent owner of 3459 the nursing facility if the ownership of the nursing facility is transferred at any time after the issuance of the certificate of 3460 3461 After this written agreement is executed, the Division of need. 3462 Medicaid and the State Department of Health shall not certify any 3463 of the beds in the nursing facility for participation in the 3464 Medicaid program. If the nursing facility violates the terms of the written agreement by admitting or keeping in the nursing 3465 3466 facility on a regular or continuing basis any patients who are participating in the Medicaid program, the State Department of 3467

3468 Health shall revoke the license of the nursing facility, at the time that the department determines, after a hearing complying 3469 with due process, that the nursing facility has violated the 3470 condition upon which the certificate of need was issued, as 3471 3472 provided in this paragraph and in the written agreement. If the 3473 certificate of need authorized under this paragraph is not issued 3474 within twelve (12) months after July 1, 2001, the department shall 3475 deny the application for the certificate of need and shall not 3476 issue the certificate of need at any time after the twelve-month period, unless the issuance is contested. If the certificate of 3477 3478 need is issued and substantial construction of the nursing facility beds has not commenced within eighteen (18) months after 3479 3480 July 1, 2001, the State Department of Health, after a hearing 3481 complying with due process, shall revoke the certificate of need if it is still outstanding, and the department shall not issue a 3482 3483 license for the nursing facility at any time after the 3484 eighteen-month period. However, if the issuance of the 3485 certificate of need is contested, the department shall require 3486 substantial construction of the nursing facility beds within six 3487 (6) months after final adjudication on the issuance of the 3488 certificate of need.

3489 (n) The department may issue a certificate of need for 3490 the new construction, addition or conversion of skilled nursing 3491 facility beds in Madison County, provided that the recipient of 3492 the certificate of need agrees in writing that the skilled nursing 3493 facility will not at any time participate in the Medicaid program 3494 (Section 43-13-101 et seq.) or admit or keep any patients in the skilled nursing facility who are participating in the Medicaid 3495 3496 This written agreement by the recipient of the program. 3497 certificate of need shall be fully binding on any subsequent owner 3498 of the skilled nursing facility, if the ownership of the facility is transferred at any time after the issuance of the certificate 3499 3500 of need. Agreement that the skilled nursing facility will not 3501 participate in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this 3502 3503 paragraph (n), and if such skilled nursing facility at any time 3504 after the issuance of the certificate of need, regardless of the 3505 ownership of the facility, participates in the Medicaid program or 3506 admits or keeps any patients in the facility who are participating 3507 in the Medicaid program, the State Department of Health shall 3508 revoke the certificate of need, if it is still outstanding, and 3509 shall deny or revoke the license of the skilled nursing facility, at the time that the department determines, after a hearing 3510 3511 complying with due process, that the facility has failed to comply 3512 with any of the conditions upon which the certificate of need was 3513 issued, as provided in this paragraph and in the written agreement 3514 by the recipient of the certificate of need. The total number of nursing facility beds that may be authorized by any certificate of 3515 3516 need issued under this paragraph (n) shall not exceed sixty (60) beds. If the certificate of need authorized under this paragraph 3517

3518 is not issued within twelve (12) months after July 1, 1998, the 3519 department shall deny the application for the certificate of need 3520 and shall not issue the certificate of need at any time after the 3521 twelve-month period, unless the issuance is contested. 3522 certificate of need is issued and substantial construction of the 3523 nursing facility beds has not commenced within eighteen (18) 3524 months after July 1, 1998, the State Department of Health, after a 3525 hearing complying with due process, shall revoke the certificate 3526 of need if it is still outstanding, and the department shall not 3527 issue a license for the nursing facility at any time after the 3528 eighteen-month period. However, if the issuance of the 3529 certificate of need is contested, the department shall require 3530 substantial construction of the nursing facility beds within six (6) months after final adjudication on the issuance of the 3531 3532 certificate of need.

3533 The department may issue a certificate of need for 3534 the new construction, addition or conversion of skilled nursing facility beds in Leake County, provided that the recipient of the 3535 3536 certificate of need agrees in writing that the skilled nursing 3537 facility will not at any time participate in the Medicaid program 3538 (Section 43-13-101 et seq.) or admit or keep any patients in the 3539 skilled nursing facility who are participating in the Medicaid This written agreement by the recipient of the 3540 3541 certificate of need shall be fully binding on any subsequent owner of the skilled nursing facility, if the ownership of the facility 3542

3543 is transferred at any time after the issuance of the certificate 3544 Agreement that the skilled nursing facility will not participate in the Medicaid program shall be a condition of the 3545 3546 issuance of a certificate of need to any person under this 3547 paragraph (o), and if such skilled nursing facility at any time 3548 after the issuance of the certificate of need, regardless of the ownership of the facility, participates in the Medicaid program or 3549 3550 admits or keeps any patients in the facility who are participating 3551 in the Medicaid program, the State Department of Health shall 3552 revoke the certificate of need, if it is still outstanding, and 3553 shall deny or revoke the license of the skilled nursing facility, 3554 at the time that the department determines, after a hearing 3555 complying with due process, that the facility has failed to comply 3556 with any of the conditions upon which the certificate of need was 3557 issued, as provided in this paragraph and in the written agreement 3558 by the recipient of the certificate of need. The total number of 3559 nursing facility beds that may be authorized by any certificate of need issued under this paragraph (o) shall not exceed sixty (60) 3560 3561 If the certificate of need authorized under this paragraph beds. 3562 is not issued within twelve (12) months after July 1, 2001, the 3563 department shall deny the application for the certificate of need 3564 and shall not issue the certificate of need at any time after the 3565 twelve-month period, unless the issuance is contested. 3566 certificate of need is issued and substantial construction of the nursing facility beds has not commenced within eighteen (18) 3567

3568 months after July 1, 2001, the State Department of Health, after a hearing complying with due process, shall revoke the certificate 3569 3570 of need if it is still outstanding, and the department shall not 3571 issue a license for the nursing facility at any time after the 3572 eighteen-month period. However, if the issuance of the 3573 certificate of need is contested, the department shall require 3574 substantial construction of the nursing facility beds within six 3575 (6) months after final adjudication on the issuance of the 3576 certificate of need.

3577 (g) The department may issue a certificate of need for 3578 the construction of a municipally owned nursing facility within the Town of Belmont in Tishomingo County, not to exceed sixty (60) 3579 3580 beds, provided that the recipient of the certificate of need agrees in writing that the skilled nursing facility will not at 3581 any time participate in the Medicaid program (Section 43-13-101 et 3582 3583 seq.) or admit or keep any patients in the skilled nursing 3584 facility who are participating in the Medicaid program. written agreement by the recipient of the certificate of need 3585 3586 shall be fully binding on any subsequent owner of the skilled 3587 nursing facility, if the ownership of the facility is transferred 3588 at any time after the issuance of the certificate of need. 3589 Agreement that the skilled nursing facility will not participate 3590 in the Medicaid program shall be a condition of the issuance of a 3591 certificate of need to any person under this paragraph (p), and if such skilled nursing facility at any time after the issuance of 3592

3593	the certificate of need, regardless of the ownership of the
3594	facility, participates in the Medicaid program or admits or keeps
3595	any patients in the facility who are participating in the Medicaid
3596	program, the State Department of Health shall revoke the
3597	certificate of need, if it is still outstanding, and shall deny or
3598	revoke the license of the skilled nursing facility, at the time
3599	that the department determines, after a hearing complying with due
3600	process, that the facility has failed to comply with any of the
3601	conditions upon which the certificate of need was issued, as
3602	provided in this paragraph and in the written agreement by the
3603	recipient of the certificate of need. The provision of Section
3604	41-7-193(1) regarding substantial compliance of the projection of
3605	need as reported in the current State Health Plan is waived for
3606	the purposes of this paragraph. If the certificate of need
3607	authorized under this paragraph is not issued within twelve (12)
3608	months after July 1, 1998, the department shall deny the
3609	application for the certificate of need and shall not issue the
3610	certificate of need at any time after the twelve-month period,
3611	unless the issuance is contested. If the certificate of need is
3612	issued and substantial construction of the nursing facility beds
3613	has not commenced within eighteen (18) months after July 1, 1998,
3614	the State Department of Health, after a hearing complying with due
3615	process, shall revoke the certificate of need if it is still
3616	outstanding, and the department shall not issue a license for the
3617	nursing facility at any time after the eighteen-month period.

3619 the department shall require substantial construction of the nursing facility beds within six (6) months after final 3620 3621 adjudication on the issuance of the certificate of need. Beginning on July 1, 1999, the State 3622 (q) (i) 3623 Department of Health shall issue certificates of need during each 3624 of the next four (4) fiscal years for the construction or 3625 expansion of nursing facility beds or the conversion of other beds 3626 to nursing facility beds in each county in the state having a need for fifty (50) or more additional nursing facility beds, as shown 3627 3628 in the fiscal year 1999 State Health Plan, in the manner provided 3629 in this paragraph (q). The total number of nursing facility beds 3630 that may be authorized by any certificate of need authorized under this paragraph (q) shall not exceed sixty (60) beds. 3631 3632 Subject to the provisions of subparagraph 3633 (v), during each of the next four (4) fiscal years, the department 3634 shall issue six (6) certificates of need for new nursing facility beds, as follows: During fiscal years 2000, 2001 and 2002, one 3635 3636 (1) certificate of need shall be issued for new nursing facility 3637 beds in the county in each of the four (4) Long-Term Care Planning 3638 Districts designated in the fiscal year 1999 State Health Plan 3639 that has the highest need in the district for those beds; and two 3640 (2) certificates of need shall be issued for new nursing facility 3641 beds in the two (2) counties from the state at large that have the highest need in the state for those beds, when considering the 3642

However, if the issuance of the certificate of need is contested,

3643 need on a statewide basis and without regard to the Long-Term Care 3644 Planning Districts in which the counties are located. fiscal year 2003, one (1) certificate of need shall be issued for 3645 new nursing facility beds in any county having a need for fifty 3646 3647 (50) or more additional nursing facility beds, as shown in the 3648 fiscal year 1999 State Health Plan, that has not received a certificate of need under this paragraph (q) during the three (3) 3649 3650 previous fiscal years. During fiscal year 2000, in addition to 3651 the six (6) certificates of need authorized in this subparagraph, the department also shall issue a certificate of need for new 3652 3653 nursing facility beds in Amite County and a certificate of need 3654 for new nursing facility beds in Carroll County. 3655 Subject to the provisions of subparagraph (iii) 3656 (v), the certificate of need issued under subparagraph (ii) for 3657 nursing facility beds in each Long-Term Care Planning District 3658 during each fiscal year shall first be available for nursing 3659 facility beds in the county in the district having the highest 3660 need for those beds, as shown in the fiscal year 1999 State Health 3661 Plan. If there are no applications for a certificate of need for 3662 nursing facility beds in the county having the highest need for 3663 those beds by the date specified by the department, then the 3664 certificate of need shall be available for nursing facility beds in other counties in the district in descending order of the need 3665

for those beds, 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 in the district.

Subject to the provisions of subparagraph (v), the certificate of need issued under subparagraph (ii) for nursing facility beds in the two (2) counties from the state at large during each fiscal year shall first be available for nursing 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 State Health Plan, when considering the need on a statewide basis and without regard to the Long-Term Care Planning Districts in which the counties are located. If there are no applications for a certificate of need for nursing facility beds in either of the two (2) counties having the highest need for those beds on a statewide basis by the date specified by the department, then the certificate of need shall be available for nursing facility beds 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.

(v) If a certificate of need is authorized to be issued under this paragraph (q) for nursing facility beds in a county on the basis of the need in the Long-Term Care Planning District during any fiscal year of the four-year period, a certificate of need shall not also be available under this

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3692 paragraph (q) for additional nursing facility beds in that county 3693 on the basis of the need in the state at large, and that county shall be excluded in determining which counties have the highest 3694 need for nursing facility beds in the state at large for that 3695 fiscal year. After a certificate of need has been issued under 3696 3697 this paragraph (q) for nursing facility beds in a county during any fiscal year of the four-year period, a certificate of need 3698 3699 shall not be available again under this paragraph (q) for 3700 additional nursing facility beds in that county during the four-year period, and that county shall be excluded in determining 3701 3702 which counties have the highest need for nursing facility beds in succeeding fiscal years. 3703

3704 If more than one (1) application is made for 3705 a certificate of need for nursing home facility beds available 3706 under this paragraph (q), in Yalobusha, Newton or Tallahatchie 3707 County, and one (1) of the applicants is a county-owned hospital 3708 located in the county where the nursing facility beds are available, the department shall give priority to the county-owned 3709 3710 hospital in granting the certificate of need if the following 3711 conditions are met:

- 3712 1. The county-owned hospital fully meets all applicable criteria and standards required to obtain a certificate of need for the nursing facility beds; and
- 3715 2. The county-owned hospital's qualifications 3716 for the certificate of need, as shown in its application and as

3717 determined by the department, are at least equal to the 3718 qualifications of the other applicants for the certificate of 3719 need.

3720 Beginning on July 1, 1999, the State (r)(i) 3721 Department of Health shall issue certificates of need during each 3722 of the next two (2) fiscal years for the construction or expansion of nursing facility beds or the conversion of other beds to 3723 3724 nursing facility beds in each of the four (4) Long-Term Care 3725 Planning Districts designated in the fiscal year 1999 State Health 3726 Plan, to provide care exclusively to patients with Alzheimer's 3727 disease.

3728 Not more than twenty (20) beds may be 3729 authorized by any certificate of need issued under this paragraph 3730 (r), and not more than a total of sixty (60) beds may be 3731 authorized in any Long-Term Care Planning District by all 3732 certificates of need issued under this paragraph (r). However, 3733 the total number of beds that may be authorized by all 3734 certificates of need issued under this paragraph (r) during any 3735 fiscal year shall not exceed one hundred twenty (120) beds, and 3736 the total number of beds that may be authorized in any Long-Term 3737 Care Planning District during any fiscal year shall not exceed 3738 forty (40) beds. Of the certificates of need that are issued for each Long-Term Care Planning District during the next two (2) 3739 3740 fiscal years, at least one (1) shall be issued for beds in the northern part of the district, at least one (1) shall be issued 3741

for beds in the central part of the district, and at least one (1) shall be issued for beds in the southern part of the district.

(iii) The State Department of Health, in

3745 consultation with the Department of Mental Health and the Division

3746 of Medicaid, shall develop and prescribe the staffing levels,

3747 space requirements and other standards and requirements that must

3748 be met with regard to the nursing facility beds authorized under

3749 this paragraph (r) to provide care exclusively to patients with

3750 Alzheimer's disease.

3751 (s) The State Department of Health may issue a 3752 certificate of need to a nonprofit skilled nursing facility using 3753 the Green House model of skilled nursing care and located in Yazoo 3754 City, Yazoo County, Mississippi, for the construction, expansion 3755 or conversion of not more than nineteen (19) nursing facility 3756 beds. For purposes of this paragraph (s), the provisions of 3757 Section 41-7-193(1) requiring substantial compliance with the 3758 projection of need as reported in the current State Health Plan and the provisions of Section 41-7-197 requiring a formal 3759 3760 certificate of need hearing process are waived. There shall be no 3761 prohibition or restrictions on participation in the Medicaid 3762 program for the person receiving the certificate of need 3763 authorized under this paragraph (s).

3764 (t) The State Department of Health shall issue
3765 certificates of need to the owner of a nursing facility in
3766 operation at the time of Hurricane Katrina in Hancock County that

3767 was not operational on December 31, 2005, because of damage 3768 sustained from Hurricane Katrina to authorize the following: 3769 the construction of a new nursing facility in Harrison County; 3770 (ii) the relocation of forty-nine (49) nursing facility beds from 3771 the Hancock County facility to the new Harrison County facility; 3772 (iii) the establishment of not more than twenty (20) non-Medicaid 3773 nursing facility beds at the Hancock County facility; and (iv) the 3774 establishment of not more than twenty (20) non-Medicaid beds at 3775 the new Harrison County facility. The certificates of need that authorize the non-Medicaid nursing facility beds under 3776 3777 subparagraphs (iii) and (iv) of this paragraph (t) shall be 3778 subject to the following conditions: The owner of the Hancock 3779 County facility and the new Harrison County facility must agree in 3780 writing that no more than fifty (50) of the beds at the Hancock 3781 County facility and no more than forty-nine (49) of the beds at 3782 the Harrison County facility will be certified for participation 3783 in the Medicaid program, and that no claim will be submitted for Medicaid reimbursement for more than fifty (50) patients in the 3784 3785 Hancock County facility in any month, or for more than forty-nine 3786 (49) patients in the Harrison County facility in any month, or for 3787 any patient in either facility who is in a bed that is not 3788 Medicaid-certified. This written agreement by the owner of the nursing facilities shall be a condition of the issuance of the 3789 3790 certificates of need under this paragraph (t), and the agreement shall be fully binding on any later owner or owners of either 3791

3792 facility if the ownership of either facility is transferred at any 3793 time after the certificates of need are issued. After this written agreement is executed, the Division of Medicaid and the 3794 3795 State Department of Health shall not certify more than fifty (50) 3796 of the beds at the Hancock County facility or more than forty-nine 3797 (49) of the beds at the Harrison County facility for participation in the Medicaid program. If the Hancock County facility violates 3798 3799 the terms of the written agreement by admitting or keeping in the 3800 facility on a regular or continuing basis more than fifty (50) 3801 patients who are participating in the Medicaid program, or if the 3802 Harrison County facility violates the terms of the written 3803 agreement by admitting or keeping in the facility on a regular or 3804 continuing basis more than forty-nine (49) patients who are 3805 participating in the Medicaid program, the State Department of 3806 Health shall revoke the license of the facility that is in violation of the agreement, at the time that the department 3807 3808 determines, after a hearing complying with due process, that the 3809 facility has violated the agreement.

(u) The State Department of Health shall issue a certificate of need to a nonprofit venture for the establishment, construction and operation of a skilled nursing facility of not more than sixty (60) beds to provide skilled nursing care for ventilator dependent or otherwise medically dependent pediatric patients who require medical and nursing care or rehabilitation services to be located in a county in which an academic medical

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3817 center and a children's hospital are located, and for any 3818 construction and for the acquisition of equipment related to those The facility shall be authorized to keep such ventilator 3819 dependent or otherwise medically dependent pediatric patients 3820 3821 beyond age twenty-one (21) in accordance with regulations of the 3822 State Board of Health. For purposes of this paragraph (u), the 3823 provisions of Section 41-7-193(1) requiring substantial compliance 3824 with the projection of need as reported in the current State 3825 Health Plan are waived, and the provisions of Section 41-7-197 3826 requiring a formal certificate of need hearing process are waived. 3827 The beds authorized by this paragraph shall be counted as 3828 pediatric skilled nursing facility beds for health planning 3829 purposes under Section 41-7-171 et seq. There shall be no 3830 prohibition of or restrictions on participation in the Medicaid 3831 program for the person receiving the certificate of need 3832 authorized by this paragraph.

3833 The State Department of Health may grant approval for (3) and issue certificates of need to any person proposing the new 3834 3835 construction of, addition to, conversion of beds of or expansion 3836 of any health care facility defined in subparagraph (x) 3837 (psychiatric residential treatment facility) of Section 3838 41-7-173(h). The total number of beds which may be authorized by such certificates of need shall not exceed three hundred 3839 thirty-four (334) beds for the entire state. 3840

3841	(a) Of the total number of beds authorized under this
3842	subsection, the department shall issue a certificate of need to a
3843	privately owned psychiatric residential treatment facility in
3844	Simpson County for the conversion of sixteen (16) intermediate
3845	care facility for individuals with intellectual disabilities
3846	(ICF-IID) beds to psychiatric residential treatment facility beds,
3847	provided that facility agrees in writing that the facility shall
3848	give priority for the use of those sixteen (16) beds to
3849	Mississippi residents who are presently being treated in
3850	out-of-state facilities.

(b) Of the total number of beds authorized under this subsection, the department may issue a certificate or certificates of need for the construction or expansion of psychiatric residential treatment facility beds or the conversion of other beds to psychiatric residential treatment facility beds in Warren County, not to exceed sixty (60) psychiatric residential treatment facility beds, provided that the facility agrees in writing that no more than thirty (30) of the beds at the psychiatric residential treatment facility will be certified for participation in the Medicaid program (Section 43-13-101 et seq.) for the use of any patients other than those who are participating only in the Medicaid program of another state, and that no claim will be submitted to the Division of Medicaid for Medicaid reimbursement for more than thirty (30) patients in the psychiatric residential treatment facility in any day or for any patient in the

3866	psychiatric residential treatment facility who is in a bed that is
3867	not Medicaid-certified. This written agreement by the recipient
3868	of the certificate of need shall be a condition of the issuance of
3869	the certificate of need under this paragraph, and the agreement
3870	shall be fully binding on any subsequent owner of the psychiatric
3871	residential treatment facility if the ownership of the facility is
3872	transferred at any time after the issuance of the certificate of
3873	need. After this written agreement is executed, the Division of
3874	Medicaid and the State Department of Health shall not certify more
3875	than thirty (30) of the beds in the psychiatric residential
3876	treatment facility for participation in the Medicaid program for
3877	the use of any patients other than those who are participating
3878	only in the Medicaid program of another state. If the psychiatric
3879	residential treatment facility violates the terms of the written
3880	agreement by admitting or keeping in the facility on a regular or
3881	continuing basis more than thirty (30) patients who are
3882	participating in the Mississippi Medicaid program, the State
3883	Department of Health shall revoke the license of the facility, at
3884	the time that the department determines, after a hearing complying
3885	with due process, that the facility has violated the condition
3886	upon which the certificate of need was issued, as provided in this
3887	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

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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 3892 subsection, the department shall issue a certificate of need to a 3893 3894 hospital currently operating Medicaid-certified acute psychiatric 3895 beds for adolescents in DeSoto County, for the establishment of a 3896 forty-bed psychiatric residential treatment facility in DeSoto 3897 County * * *. There shall be no prohibition or restrictions on 3898 participation in the Medicaid program (Section 43-13-101 et seq.) 3899 for the person(s) receiving the certificate of need authorized 3900 under this paragraph (c) or for the beds converted pursuant to the 3901 authority of that certificate of need that would not apply to any other psychiatric residential treatment facility. 3902
 - (d) Of the total number of beds authorized under this subsection, the department may issue a certificate or certificates of need for the construction or expansion of psychiatric residential treatment facility beds or the conversion of other beds to psychiatric treatment facility beds, not to exceed thirty (30) psychiatric residential treatment facility beds, in either Alcorn, Tishomingo, Prentiss, Lee, Itawamba, Monroe, Chickasaw, Pontotoc, Calhoun, Lafayette, Union, Benton or Tippah County.
- 3911 (e) Of the total number of beds authorized under this 3912 subsection (3) the department shall issue a certificate of need to 3913 a privately owned, nonprofit psychiatric residential treatment 3914 facility in Hinds County for an eight-bed expansion of the

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facility, provided that the facility agrees in writing that the facility shall give priority for the use of those eight (8) beds to Mississippi residents who are presently being treated in out-of-state facilities.

3919 The department shall issue a certificate of need to (f) 3920 a one-hundred-thirty-four-bed specialty hospital located on twenty-nine and forty-four one-hundredths (29.44) commercial acres 3921 3922 at 5900 Highway 39 North in Meridian (Lauderdale County), 3923 Mississippi, for the addition, construction or expansion of 3924 child/adolescent psychiatric residential treatment facility beds 3925 in Lauderdale County. As a condition of issuance of the 3926 certificate of need under this paragraph, the facility shall give 3927 priority in admissions to the child/adolescent psychiatric 3928 residential treatment facility beds authorized under this 3929 paragraph to patients who otherwise would require out-of-state 3930 placement. The Division of Medicaid, in conjunction with the 3931 Department of Human Services, shall furnish the facility a list of 3932 all out-of-state patients on a quarterly basis. Furthermore, 3933 notice shall also be provided to the parent, custodial parent or 3934 quardian of each out-of-state patient notifying them of the 3935 priority status granted by this paragraph. For purposes of this 3936 paragraph, the provisions of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in 3937 3938 the current State Health Plan are waived. The total number of child/adolescent psychiatric residential treatment facility beds 3939

that may be authorized under the authority of this paragraph shall be sixty (60) 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 paragraph or for the beds converted pursuant to the authority of that certificate of need.

(a) From and after March 25, 2021, the department may 3946 3947 issue a certificate of need to any person for the new construction 3948 of any hospital, psychiatric hospital or chemical dependency 3949 hospital that will contain any child/adolescent psychiatric or 3950 child/adolescent chemical dependency beds, or for the conversion 3951 of any other health care facility to a hospital, psychiatric 3952 hospital or chemical dependency hospital that will contain any 3953 child/adolescent psychiatric or child/adolescent chemical 3954 dependency beds. There shall be no prohibition or restrictions on 3955 participation in the Medicaid program (Section 43-13-101 et seq.) 3956 for the person(s) receiving the certificate(s) of need authorized 3957 under this paragraph (a) or for the beds converted pursuant to the 3958 authority of that certificate of need. In issuing any new 3959 certificate of need for any child/adolescent psychiatric or 3960 child/adolescent chemical dependency beds, either by new 3961 construction or conversion of beds of another category, the 3962 department shall give preference to beds which will be located in 3963 an area of the state which does not have such beds located in it, and to a location more than sixty-five (65) miles from existing 3964

3965 beds. Upon receiving 2020 census data, the department may amend 3966 the State Health Plan regarding child/adolescent psychiatric and 3967 child/adolescent chemical dependency beds to reflect the need 3968 based on new census data.

3969 (i) [Deleted]

3970 (ii) The department may issue a certificate of need for the conversion of existing beds in a county hospital in 3971 3972 Choctaw County from acute care beds to child/adolescent chemical 3973 dependency beds. For purposes of this subparagraph (ii), the provisions of Section 41-7-193(1) requiring substantial compliance 3974 3975 with the projection of need as reported in the current State 3976 Health Plan are waived. The total number of beds that may be 3977 authorized under authority of this subparagraph shall not exceed There shall be no prohibition or restrictions 3978 twenty (20) beds. 3979 on participation in the Medicaid program (Section 43-13-101 et 3980 seq.) for the hospital receiving the certificate of need 3981 authorized under this subparagraph or for the beds converted pursuant to the authority of that certificate of need. 3982

(iii) The department may issue a certificate or certificates of need for the construction or expansion of child/adolescent psychiatric beds or the conversion of other beds to child/adolescent psychiatric beds in Warren County. For 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.

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3990 The total number of beds that may be authorized under the
3991 authority of this subparagraph shall not exceed twenty (20) beds.
3992 There shall be no prohibition or restrictions on participation in
3993 the Medicaid program (Section 43-13-101 et seq.) for the person
3994 receiving the certificate of need authorized under this
3995 subparagraph or for the beds converted pursuant to the authority
3996 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

4015 reported in the current State Health Plan are waived. The total 4016 number of beds that may be authorized under the authority of this subparagraph shall not exceed twenty (20) beds. 4017 There shall be no 4018 prohibition or restrictions on participation in the Medicaid 4019 program (Section 43-13-101 et seq.) for the person receiving the 4020 certificate of need authorized under this subparagraph or for the 4021 beds converted pursuant to the authority of that certificate of 4022 need.

4023 The department may issue a certificate of need (∇) 4024 to any county hospital located in Leflore County for the 4025 construction or expansion of adult psychiatric beds or the 4026 conversion of other beds to adult psychiatric beds, not to exceed 4027 twenty (20) beds, provided that the recipient of the certificate 4028 of need agrees in writing that the adult psychiatric beds will not 4029 at any time be certified for participation in the Medicaid program 4030 and that the hospital will not admit or keep any patients who are 4031 participating in the Medicaid program in any of such adult psychiatric beds. This written agreement by the recipient of the 4032 4033 certificate of need shall be fully binding on any subsequent owner 4034 of the hospital if the ownership of the hospital is transferred at 4035 any time after the issuance of the certificate of need. Agreement 4036 that the adult psychiatric beds will not be certified for participation in the Medicaid program shall be a condition of the 4037 4038 issuance of a certificate of need to any person under this subparagraph (v), and if such hospital at any time after the 4039

4040 issuance of the certificate of need, regardless of the ownership 4041 of the hospital, has any of such adult psychiatric beds certified for participation in the Medicaid program or admits or keeps any 4042 Medicaid patients in such adult psychiatric beds, the State 4043 4044 Department of Health shall revoke the certificate of need, if it 4045 is still outstanding, and shall deny or revoke the license of the 4046 hospital at the time that the department determines, after a 4047 hearing complying with due process, that the hospital has failed 4048 to comply with any of the conditions upon which the certificate of 4049 need was issued, as provided in this subparagraph and in the 4050 written agreement by the recipient of the certificate of need. 4051 The department may issue a certificate or 4052 certificates of need for the expansion of child psychiatric beds 4053 or the conversion of other beds to child psychiatric beds at the 4054 University of Mississippi Medical Center. For purposes of this 4055 subparagraph (vi), the provisions of Section 41-7-193(1) requiring 4056 substantial compliance with the projection of need as reported in 4057 the current State Health Plan are waived. The total number of 4058 beds that may be authorized under the authority of this 4059 subparagraph shall not exceed fifteen (15) beds. There shall be 4060 no prohibition or restrictions on participation in the Medicaid 4061 program (Section 43-13-101 et seq.) for the hospital receiving the certificate of need authorized under this subparagraph or for the 4062 4063 beds converted pursuant to the authority of that certificate of 4064 need.

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- 4065 From and after July 1, 1990, no hospital, 4066 psychiatric hospital or chemical dependency hospital shall be 4067 authorized to add any child/adolescent psychiatric or 4068 child/adolescent chemical dependency beds or convert any beds of 4069 another category to child/adolescent psychiatric or 4070 child/adolescent chemical dependency beds without a certificate of 4071 need under the authority of subsection (1)(c) and subsection 4072 (4)(a) of this section.
- 4073 (5) The department may issue a certificate of need to a
 4074 county hospital in Winston County for the conversion of fifteen
 4075 (15) acute care beds to geriatric psychiatric care beds.
- 4076 The State Department of Health shall issue a certificate (6) 4077 of need to a Mississippi corporation qualified to manage a 4078 long-term care hospital as defined in Section 41-7-173(h)(xii) in 4079 Harrison County, not to exceed eighty (80) beds, including any 4080 necessary renovation or construction required for licensure and 4081 certification, provided that the recipient of the certificate of 4082 need agrees in writing that the long-term care hospital will not 4083 at any time participate in the Medicaid program (Section 43-13-101 et seq.) * * * except as a crossover enrolled provider. 4084 4085 written agreement by the recipient of the certificate of need 4086 shall be fully binding on any subsequent owner of the long-term care hospital, if the ownership of the facility is transferred at 4087 4088 any time after the issuance of the certificate of need. Agreement that the long-term care hospital will not participate in the 4089

4090 Medicaid program except as a crossover enrolled provider shall be 4091 a condition of the issuance of a certificate of need to any person 4092 under this subsection (6), and if such long-term care hospital at 4093 any time after the issuance of the certificate of need, regardless 4094 of the ownership of the facility, participates in the Medicaid 4095 program * * * except as a crossover enrolled provider, the State 4096 Department of Health shall revoke the certificate of need, if it 4097 is still outstanding, and shall deny or revoke the license of the 4098 long-term care hospital, at the time that the department 4099 determines, after a hearing complying with due process, that the 4100 facility has failed to comply with any of the conditions upon 4101 which the certificate of need was issued, as provided in this 4102 subsection and in the written agreement by the recipient of the 4103 certificate of need. For purposes of this subsection, the provisions of Section 41-7-193(1) requiring substantial compliance 4104 4105 with the projection of need as reported in the current State 4106 Health Plan are waived. This subsection (6) shall be retroactive 4107 to July 1, 2023.

4108 (7) The State Department of Health may issue a certificate
4109 of need to any hospital in the state to utilize a portion of its
4110 beds for the "swing-bed" concept. Any such hospital must be in
4111 conformance with the federal regulations regarding such swing-bed
4112 concept at the time it submits its application for a certificate
4113 of need to the State Department of Health, except that such
4114 hospital may have more licensed beds or a higher average daily

1115	census (ADC) than the maximum number specified in federal
1116	regulations for participation in the swing-bed program. Any
1117	hospital meeting all federal requirements for participation in the
1118	swing-bed program which receives such certificate of need shall
1119	render services provided under the swing-bed concept to any
1120	patient eligible for Medicare (Title XVIII of the Social Security
1121	Act) who is certified by a physician to be in need of such
1122	services, and no such hospital shall permit any patient who is
1123	eligible for both Medicaid and Medicare or eligible only for
1124	Medicaid to stay in the swing beds of the hospital for more than
1125	thirty (30) days per admission unless the hospital receives prior
1126	approval for such patient from the Division of Medicaid, Office of
1127	the Governor. Any hospital having more licensed beds or a higher
1128	average daily census (ADC) than the maximum number specified in
1129	federal regulations for participation in the swing-bed program
1130	which receives such certificate of need shall develop a procedure
1131	to ensure that before a patient is allowed to stay in the swing
1132	beds of the hospital, there are no vacant nursing home beds
1133	available for that patient located within a fifty-mile radius of
1134	the hospital. When any such hospital has a patient staying in the
1135	swing beds of the hospital and the hospital receives notice from a
1136	nursing home located within such radius that there is a vacant bed
1137	available for that patient, the hospital shall transfer the
1138	patient to the nursing home within a reasonable time after receipt
1139	of the notice. Any hospital which is subject to the requirements

of the two (2) preceding sentences of this subsection may be suspended from participation in the swing-bed program for a reasonable period of time by the State Department of Health if the department, after a hearing complying with due process, determines that the hospital has failed to comply with any of those requirements.

4146 The Department of Health shall not grant approval for or (8) 4147 issue a certificate of need to any person proposing the new 4148 construction of, addition to or expansion of a health care 4149 facility as defined in subparagraph (viii) of Section 41-7-173(h), 4150 except as hereinafter provided: The department may issue a certificate of need to a nonprofit corporation located in Madison 4151 4152 County, Mississippi, for the construction, expansion or conversion of not more than twenty (20) beds in a community living program 4153 4154 for developmentally disabled adults in a facility as defined in 4155 subparagraph (viii) of Section 41-7-173(h). For purposes of this 4156 subsection (8), the provisions of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in 4157 4158 the current State Health Plan and the provisions of Section 4159 41-7-197 requiring a formal certificate of need hearing process 4160 are waived. There shall be no prohibition or restrictions on 4161 participation in the Medicaid program for the person receiving the certificate of need authorized under this subsection (8). 4162

4163 (9) The Department of Health shall not grant approval for or 4164 issue a certificate of need to any person proposing the establishment of, or expansion of the currently approved territory
of, or the contracting to establish a home office, subunit or
branch office within the space operated as a health care facility
as defined in Section 41-7-173(h)(i) through (viii) by a health
care facility as defined in subparagraph (ix) of Section

(10) Health care facilities owned and/or operated by the 4171 4172 state or its agencies are exempt from the restraints in this 4173 section against issuance of a certificate of need if such addition 4174 or expansion consists of repairing or renovation necessary to 4175 comply with the state licensure law. This exception shall not 4176 apply to the new construction of any building by such state 4177 facility. This exception shall not apply to any health care facilities owned and/or operated by counties, municipalities, 4178 4179 districts, unincorporated areas, other defined persons, or any 4180 combination thereof.

(11) The new construction, renovation or expansion of or addition to any health care facility defined in subparagraph (ii) (psychiatric hospital), subparagraph (iv) (skilled nursing facility), subparagraph (vi) (intermediate care facility), subparagraph (viii) (intermediate care facility for individuals with intellectual disabilities) and subparagraph (x) (psychiatric residential treatment facility) of Section 41-7-173(h) which is owned by the State of Mississippi and under the direction and control of the State Department of Mental Health, and the addition

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41-7-173(h).

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

- 4197 (12) The new construction, renovation or expansion of or
 4198 addition to any veterans homes or domiciliaries for eligible
 4199 veterans of the State of Mississippi as authorized under Section
 4200 35-1-19 shall not require the issuance of a certificate of need,
 4201 notwithstanding any provision in Section 41-7-171 et seq. to the
 4202 contrary.
- 4203 The repair or the rebuilding of an existing, operating 4204 health care facility that sustained significant damage from a 4205 natural disaster that occurred after April 15, 2014, in an area 4206 that is proclaimed a disaster area or subject to a state of 4207 emergency by the Governor or by the President of the United States 4208 shall be exempt from all of the requirements of the Mississippi 4209 Certificate of Need Law (Section 41-7-171 et seq.) and any and all 4210 rules and regulations promulgated under that law, subject to the 4211 following conditions:
- 4212 (a) The repair or the rebuilding of any such damaged 4213 health care facility must be within one (1) mile of the 4214 pre-disaster location of the campus of the damaged health care

4215	facility, except that any temporary post-disaster health care
4216	facility operating location may be within five (5) miles of the
4217	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;
- The exemption from Certificate of Need Law provided (C) under this subsection (13) is valid for only five (5) years from the date of the Governor's or the President's proclamation. Ιf actual construction has not begun within that five-year period, the exemption provided under this subsection is inapplicable; and
- 4236 The Division of Health Facilities Licensure and (d) 4237 Certification of the State Department of Health shall provide the same oversight for the repair or the rebuilding of the damaged 4238

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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).

- 4245 The State Department of Health shall issue a 4246 certificate of need to any hospital which is currently licensed 4247 for two hundred fifty (250) or more acute care beds and is located 4248 in any general hospital service area not having a comprehensive 4249 cancer center, for the establishment and equipping of such a 4250 center which provides facilities and services for outpatient 4251 radiation oncology therapy, outpatient medical oncology therapy, 4252 and appropriate support services including the provision of 4253 radiation therapy services. The provisions of Section 41-7-193(1) 4254 regarding substantial compliance with the projection of need as 4255 reported in the current State Health Plan are waived for the 4256 purpose of this subsection.
- 4257 (15) The State Department of Health may authorize the
 4258 transfer of hospital beds, not to exceed sixty (60) beds, from the
 4259 North Panola Community Hospital to the South Panola Community
 4260 Hospital. The authorization for the transfer of those beds shall
 4261 be exempt from the certificate of need review process.
- 4262 (16) The State Department of Health shall issue any
 4263 certificates of need necessary for Mississippi State University

4264	and a public or private health care provider to jointly acquire
4265	and operate a linear accelerator and a magnetic resonance imaging
4266	unit. Those certificates of need shall cover all capital
4267	expenditures related to the project between Mississippi State
4268	University and the health care provider, including, but not
4269	limited to, the acquisition of the linear accelerator, the
4270	magnetic resonance imaging unit and other radiological modalities;
4271	the offering of linear accelerator and magnetic resonance imaging
4272	services; and the cost of construction of facilities in which to
4273	locate these services. The linear accelerator and the magnetic
4274	resonance imaging unit shall be (a) located in the City of
4275	Starkville, Oktibbeha County, Mississippi; (b) operated jointly by
4276	Mississippi State University and the public or private health care
4277	provider selected by Mississippi State University through a
4278	request for proposals (RFP) process in which Mississippi State
4279	University selects, and the Board of Trustees of State
4280	Institutions of Higher Learning approves, the health care provider
4281	that makes the best overall proposal; (c) available to Mississippi
4282	State University for research purposes two-thirds (2/3) of the
4283	time that the linear accelerator and magnetic resonance imaging
4284	unit are operational; and (d) available to the public or private
4285	health care provider selected by Mississippi State University and
4286	approved by the Board of Trustees of State Institutions of Higher
4287	Learning one-third $(1/3)$ of the time for clinical, diagnostic and
4288	treatment purposes. 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 are waived.

- 4292 The State Department of Health shall issue a 4293 certificate of need for the construction of an acute care hospital 4294 in Kemper County, not to exceed twenty-five (25) beds, which shall 4295 be named the "John C. Stennis Memorial Hospital." In issuing the 4296 certificate of need under this subsection, the department shall 4297 give priority to a hospital located in Lauderdale County that has 4298 two hundred fifteen (215) beds. For purposes of this subsection, 4299 the provisions of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in the current 4300 4301 State Health Plan and the provisions of Section 41-7-197 requiring 4302 a formal certificate of need hearing process are waived. 4303 shall be no prohibition or restrictions on participation in the 4304 Medicaid program (Section 43-13-101 et seq.) for the person or 4305 entity receiving the certificate of need authorized under this 4306 subsection or for the beds constructed under the authority of that 4307 certificate of need.
- 4308 (18) The planning, design, construction, renovation,
 4309 addition, furnishing and equipping of a clinical research unit at
 4310 any health care facility defined in Section 41-7-173(h) that is
 4311 under the direction and control of the University of Mississippi
 4312 Medical Center and located in Jackson, Mississippi, and the
 4313 addition of new beds or the conversion of beds from one (1)

- 4314 category to another in any such clinical research unit, shall not
- 4315 require the issuance of a certificate of need under Section
- 4316 41-7-171 et seq., notwithstanding any provision in Section
- 4317 41-7-171 et seq. to the contrary.
- 4318 (19) [Repealed]
- 4319 (20) Nothing in this section or in any other provision of
- 4320 Section 41-7-171 et seq. shall prevent any nursing facility from
- 4321 designating an appropriate number of existing beds in the facility
- 4322 as beds for providing care exclusively to patients with
- 4323 Alzheimer's disease.
- 4324 (21) Nothing in this section or any other provision of
- 4325 Section 41-7-171 et seq. shall prevent any health care facility
- 4326 from the new construction, renovation, conversion or expansion of
- 4327 new beds in the facility designated as intensive care units,
- 4328 negative pressure rooms, or isolation rooms pursuant to the
- 4329 provisions of Sections 41-14-1 through 41-14-11, or Section
- 4330 41-14-31. For purposes of this subsection, the provisions of
- 4331 Section 41-7-193(1) requiring substantial compliance with the
- 4332 projection of need as reported in the current State Health Plan
- 4333 and the provisions of Section 41-7-197 requiring a formal
- 4334 certificate of need hearing process are waived.
- 4335 **SECTION 14.** The following shall be codified as Section

- 4336 83-9-47, Mississippi Code of 1972:
- 4337 83-9-47. (1) An insurer providing coverage for prescription
- 4338 drugs shall not require or impose any step therapy protocol with

- respect to a drug that is approved by the United States Food and Drug Administration for the treatment of postpartum depression.
- 4341 (2) As used in this section, "insurer" means any hospital,
- 4342 health or medical expense insurance policy, hospital or medical
- 4343 service contract, employee welfare benefit plan, contract or
- 4344 agreement with a health maintenance organization or a preferred
- 4345 provider organization, health and accident insurance policy, or
- 4346 any other insurance contract of this type, including a group
- 4347 insurance plan. However, the term "insurer" does not include a
- 4348 preferred provider organization that is only a network of
- 4349 providers and does not define health care benefits for the purpose
- 4350 of coverage under a health care benefits plan.
- 4351 **SECTION 15.** The following shall be codified as Section
- 4352 41-140-1, Mississippi Code of 1972:
- 4353 41-140-1. **Definitions**. (1) "Maternal health care facility"
- 4354 means any facility that provides prenatal or perinatal care,
- 4355 including, but not limited to, hospitals, clinics and other
- 4356 physician facilities.
- 4357 (2) "Maternal health care provider" means any physician,
- 4358 nurse or other authorized practitioner that attends to pregnant
- 4359 women and mothers of infants.
- 4360 **SECTION 16.** The following shall be codified as Section
- 4361 41-140-3, Mississippi Code of 1972:
- 4362 41-140-3. Education and awareness. (1) The State
- 4363 Department of Health shall develop written educational materials

1364	and	information	for	health	care	professionals	and	patients	about
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- 4365 maternal mental health conditions, including postpartum
- 4366 depression.
- 4367 (a) The materials shall include information on the
- 4368 symptoms and methods of coping with postpartum depression, as well
- 4369 treatment options and resources;
- 4370 (b) The State Department of Health shall periodically
- 4371 review the materials and information to determine their
- 4372 effectiveness and ensure they reflect the most up-to-date and
- 4373 accurate information;
- 4374 (c) The State Department of Health shall post on its
- 4375 website the materials and information; and
- 4376 (d) The State Department of Health shall make available
- 4377 or distribute the materials and information in physical form upon
- 4378 request.
- 4379 (2) Hospitals that provide birth services shall provide
- 4380 departing new parents and other family members, as appropriate,
- 4381 with written materials and information developed under subsection
- 4382 (1) of this section, upon discharge from such institution.
- 4383 (3) Any facility, physician, health care provider or nurse
- 4384 midwife who renders prenatal care, postnatal care, or pediatric
- 4385 infant care, shall provide the materials and information developed
- 4386 under subsection (1)(a) of this section, to any woman who presents
- 4387 with signs of a maternal mental health disorder.



4388 SECTION 17. The following shall be codified as Section

- 4389 41-140-5, Mississippi Code of 1972:
- 41-140-5. Screening and linkage to care. (1) 4390
- physician, health care provider, or nurse midwife who renders 4391
- 4392 postnatal care or who provides pediatric infant care shall ensure
- 4393 that the postnatal care patient or birthing mother of the
- 4394 pediatric infant care patient, as applicable, is offered screening
- 4395 for postpartum depression, and, if such patient or birthing mother
- 4396 does not object to such screening, shall ensure that such patient
- 4397 or birthing mother is appropriately screened for postpartum
- 4398 depression in line with evidence-based guidelines, such as the
- 4399 Bright Futures Toolkit developed by the American Academy of
- 4400 Pediatrics.
- 4401 If a health care provider administering screening in
- 4402 accordance with this section determines, based on the screening
- 4403 methodology administered, that the postnatal care patient or
- 4404 birthing mother of the pediatric infant care patient is likely to
- 4405 be suffering from postpartum depression, such health care provider
- 4406 shall provide appropriate referrals, including discussion of
- 4407 available treatments for postpartum depression, including
- 4408 pharmacological treatments.
- 4409 The following shall be codified as Section SECTION 18.
- 4410 83-9-48, Mississippi Code of 1972:
- 83-9-48. Coverage of screening for postpartum depression. 4411
- An insurer shall provide coverage for postpartum depression 4412

4413	screening required pursuant to Section 41-140-3. Such coverage
4414	shall provide for additional reimbursement for the administration
4415	of postpartum depression screening adequate to compensate the
4416	health care provider for the provision of such screening and
4417	consistent with ensuring broad access to postpartum depression
4418	screening in line with evidence-based guidelines.

- (2) As used in this section, "insurer" means any hospital, health or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, contract or agreement with a health maintenance organization or a preferred provider organization, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan. However, the term "insurer" does not include a preferred provider organization that is only a network of providers and does not define health care benefits for the purpose of coverage under a health care benefits plan.
- SECTION 19. This act shall take effect and be in force from and after its passage.

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