

By: Senator(s) Blackwell

To: Medicaid

## SENATE BILL NO. 2867

1 AN ACT TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972,  
2 TO MAKE CERTAIN TECHNICAL AMENDMENTS TO THE PROVISIONS THAT  
3 PROVIDE FOR MEDICAID ELIGIBILITY, TO MODIFY AGE AND INCOME  
4 ELIGIBILITY CRITERIA, AND TO CONFORM WITH FEDERAL LAW TO ALLOW  
5 CHILDREN IN FOSTER CARE TO BE ELIGIBLE UNTIL THEIR 26TH BIRTHDAY;  
6 TO AUTHORIZE THE DIVISION OF MEDICAID TO APPLY FOR A FEDERAL  
7 FAMILY PLANNING WAIVER; TO ELIMINATE THE REQUIREMENT THAT THE  
8 DIVISION MUST APPLY TO THE CENTER FOR MEDICARE AND MEDICAID  
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 AMEND SECTION 43-13-117, MISSISSIPPI CODE  
13 OF 1972, AS AMENDED BY HOUSE BILL NO. 970, 2024 REGULAR SESSION,  
14 TO MAKE CERTAIN TECHNICAL AMENDMENTS TO THE PROVISIONS THAT  
15 PROVIDE FOR MEDICAID SERVICES, TO COMPLY WITH FEDERAL LAW; TO  
16 PROVIDE THAT THE DIVISION SHALL REIMBURSE FOR ONE PAIR OF  
17 EYEGLASSES EVERY TWO YEARS INSTEAD OF EVERY FIVE YEARS FOR CERTAIN  
18 BENEFICIARIES; TO ELIMINATE THE OPTION FOR CERTAIN RURAL HOSPITALS  
19 TO ELECT AGAINST REIMBURSEMENT FOR OUTPATIENT HOSPITAL SERVICES  
20 USING THE AMBULATORY PAYMENT CLASSIFICATION (APC) METHODOLOGY; TO  
21 PROVIDE THAT THE DIVISION SHALL UPDATE THE CASE MIX PAYMENT SYSTEM  
22 AND FAIR RENTAL REIMBURSEMENT SYSTEM AS NECESSARY TO MAINTAIN  
23 COMPLIANCE WITH FEDERAL LAW; TO PROVIDE THAT THE DIVISION OF  
24 MEDICAID MAY IMPLEMENT A QUALITY OR VALUE-BASED COMPONENT TO THE  
25 NURSING FACILITY PAYMENT SYSTEM; TO REQUIRE THE DIVISION TO  
26 REIMBURSE PEDIATRICIANS FOR CERTAIN PRIMARY CARE SERVICES AS  
27 DEFINED BY THE DIVISION AT 100% OF THE RATE ESTABLISHED UNDER  
28 MEDICARE; TO REVISE CERTAIN PROVISIONS RELATED TO FAMILY PLANNING  
29 SERVICES, INCLUDING THAT ORAL CONTRACEPTIVES MAY BE PRESCRIBED AND  
30 DISPENSED IN 12-MONTH SUPPLY INCREMENTS; TO PROVIDE THAT THE  
31 DIVISION MAY REIMBURSE AMBULATORY SURGICAL CARE (ASC) BASED ON  
32 100% OF THE MEDICARE ASC PAYMENT SYSTEM RATE IN EFFECT JULY 1 OF  
33 EACH YEAR AS SET BY CMS; TO AUTHORIZE THE DIVISION TO PROVIDE  
34 REIMBURSEMENT FOR NEUROMUSCULAR TONGUE MUSCLE STIMULATORS AND/OR



FOR ALTERNATIVE METHODS FOR THE REDUCTION OF SNORING AND  
OBSTRUCTIVE SLEEP APNEA; TO INCLUDE ADDITIONAL LICENSED PROVIDERS  
IN THE DIVISION'S UPPER PAYMENT LIMITS PROGRAM; TO AUTHORIZE THAT  
THE DIVISION MAY, IN CONSULTATION WITH THE MISSISSIPPI HOSPITAL  
ASSOCIATION, DEVELOP ALTERNATIVE MODELS FOR DISTRIBUTION OF  
MEDICAL CLAIMS AND SUPPLEMENTAL PAYMENTS FOR INPATIENT AND  
OUTPATIENT HOSPITAL SERVICES; TO PROVIDE THAT 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; TO DELETE TECHNICAL  
PROVISIONS RELATED TO THE MISSISSIPPI HOSPITAL ACCESS PROGRAM  
(MHAP); TO PROVIDE THAT SUPPLEMENTAL PAYMENTS TO A HOSPITAL SHALL  
NOT DECREASE BY MORE THAN 5% WHEN COMPARED TO A HOSPITAL'S PRIOR  
YEAR PAYMENT UNLESS THAT HOSPITAL HAS CLOSED, OR CHANGED SERVICES  
OR PATIENT VOLUME WHICH IMPACTS THAT HOSPITAL'S PAYMENT, AND THE  
DIVISION SHALL NOT SUBSTANTIALLY CHANGE THE METHODOLOGIES USED TO  
CALCULATE A HOSPITAL'S SUPPLEMENTAL PAYMENT; TO PROVIDE THAT THE  
DIVISION SHALL CONTRACT WITH THE STATE DEPARTMENT OF HEALTH TO  
PROVIDE FOR A PERINATAL HIGH RISK MANAGEMENT/INFANT SERVICES  
SYSTEM FOR ANY ELIGIBLE BENEFICIARY THAT CANNOT RECEIVE SUCH  
SERVICES UNDER A DIFFERENT PROGRAM; TO AUTHORIZE THE DIVISION TO  
REIMBURSE FOR SERVICES AT CERTIFIED COMMUNITY BEHAVIORAL HEALTH  
CENTERS; TO EXTEND THE DATE OF REPEAL ON THE PROVISION OF LAW THAT  
PROVIDES THAT THE DIVISION SHALL REIMBURSE FOR OUTPATIENT HOSPITAL  
SERVICES PROVIDED TO ELIGIBLE MEDICAID BENEFICIARIES UNDER THE AGE  
OF 21 BY BORDER CITY UNIVERSITY AFFILIATED PEDIATRIC TEACHING  
HOSPITALS, WHICH WAS REPEALED BY OPERATION OF LAW IN 2024; TO  
REQUIRE THE DIVISION TO DEVELOP AND IMPLEMENT A METHOD FOR  
REIMBURSEMENT OF AUTISM SPECTRUM DISORDER SERVICES BASED ON A  
CONTINUUM OF CARE FOR BEST PRACTICES IN MEDICALLY NECESSARY EARLY  
INTERVENTION TREATMENT; TO REDUCE THE LENGTH OF NOTICE THE  
DIVISION MUST PROVIDE THE MEDICAID COMMITTEE CHAIRMEN FOR PROPOSED  
RATE CHANGES AND TO PROVIDE THAT SUCH LEGISLATIVE NOTICE MAY BE  
EXPEDITED; TO PROVIDE THAT THE DIVISION SHALL REIMBURSE FOR  
PREPARTICIPATION PHYSICAL EVALUATIONS; TO PROVIDE THAT THE  
DIVISION SHALL REIMBURSE FOR UNITED STATES FOOD AND DRUG  
ADMINISTRATION APPROVED GLUCAGON-LIKE PEPTIDE-1 (GLP-1) AGONIST  
MEDICATIONS FOR CHRONIC WEIGHT MANAGEMENT OR FOR ADDITIONAL  
CONDITIONS IN THE DISCRETION OF THE MEDICAL PROVIDER; TO PROHIBIT  
THE DIVISION OF MEDICAID AND CERTAIN MANAGED CARE ENTITIES FROM  
REQUIRING OR IMPOSING ANY STEP THERAPY PROTOCOL WITH RESPECT TO A  
DRUG THAT IS APPROVED BY THE UNITED STATES FDA FOR THE TREATMENT  
OF POSTPARTUM DEPRESSION; TO REQUIRE THE DIVISION TO PROVIDE  
COVERAGE AND REIMBURSEMENT FOR POSTPARTUM DEPRESSION SCREENING; TO  
EXTEND THE DATE OF REPEAL ON SUCH SECTION; TO AMEND SECTION  
43-13-121, MISSISSIPPI CODE OF 1972, TO REDUCE THE LENGTH OF  
NOTICE THE DIVISION MUST PROVIDE THE MEDICAID COMMITTEE CHAIRMEN  
FOR A PROPOSED STATE PLAN AMENDMENT AND TO PROVIDE THAT SUCH  
LEGISLATIVE NOTICE MAY BE EXPEDITED; TO AMEND SECTION 43-13-305,  
MISSISSIPPI CODE OF 1972, TO REVISE CERTAIN PROVISIONS RELATED TO



86 MEDICAID AND THIRD-PARTY BENEFITS TO COMPLY WITH FEDERAL LAW; TO  
87 AMEND SECTION 43-11-1, MISSISSIPPI CODE OF 1972, TO DEFINE ADULT  
88 DAY CARE FACILITY; TO AMEND SECTION 43-11-8, MISSISSIPPI CODE OF  
89 1972, TO PROVIDE FEES FOR ADULT DAY CARE FACILITY LICENSURE AND  
90 LICENSE RENEWAL; TO AMEND SECTION 43-11-13, MISSISSIPPI CODE OF  
91 1972, TO PROVIDE THAT BEGINNING JULY 1, 2026, TO OPERATE AN ADULT  
92 DAY CARE CENTER IN MISSISSIPPI, A FACILITY PROVIDER SHALL BE  
93 LICENSED WITH THE LICENSING DIVISION OF THE STATE DEPARTMENT OF  
94 HEALTH; TO ESTABLISH THAT MISSISSIPPI MEDICAID WAIVER PROVIDERS  
95 ARE REQUIRED TO HAVE A STATE LICENSE AND HAVE A MEDICAID PROVIDER  
96 CONTRACT WITH THE DIVISION OF MEDICAID; TO AMEND SECTION  
97 43-13-117.1, MISSISSIPPI CODE OF 1972, TO REQUIRE THE DIVISION TO  
98 REIMBURSE ADULT DAY CARE CENTERS; TO AMEND SECTION 43-13-117.7,  
99 MISSISSIPPI CODE OF 1972, TO PROVIDE THAT THE DIVISION SHALL NOT  
100 REIMBURSE OR PROVIDE COVERAGE FOR GENDER TRANSITION PROCEDURES FOR  
101 A PERSON OVER 18 YEARS OF AGE; TO AMEND SECTION 37-33-167,  
102 MISSISSIPPI CODE OF 1972, TO MAKE A MINOR, NONSUBSTANTIVE  
103 REVISION; TO AMEND SECTION 43-13-145, MISSISSIPPI CODE OF 1972, TO  
104 PROVIDE THAT A QUARTERLY HOSPITAL ASSESSMENT MAY EXCEED THE  
105 ASSESSMENT IN THE PRIOR QUARTER BY MORE THAN \$3,750,000.00 IF SUCH  
106 INCREASE IS TO MAXIMIZE FEDERAL FUNDS THAT ARE AVAILABLE TO  
107 REIMBURSE HOSPITALS FOR SERVICES PROVIDED UNDER NEW PROGRAMS FOR  
108 HOSPITALS, FOR INCREASED SUPPLEMENTAL PAYMENT PROGRAMS FOR  
109 HOSPITALS OR TO ASSIST WITH STATE MATCHING FUNDS AS AUTHORIZED BY  
110 THE LEGISLATURE; TO AMEND SECTION 43-13-115.1, MISSISSIPPI CODE OF  
111 1972, TO REMOVE THE REQUIREMENT THAT A PREGNANT WOMAN MUST PROVIDE  
112 PROOF OF HER PREGNANCY AND DOCUMENTATION OF HER MONTHLY FAMILY  
113 INCOME WHEN SEEKING A DETERMINATION OF PRESUMPTIVE ELIGIBILITY; TO  
114 AMEND SECTION 41-7-191, MISSISSIPPI CODE OF 1972, TO REVISE  
115 CERTAIN PROVISIONS RELATING TO A HOSPITAL THAT HAS A CERTIFICATE  
116 OF NEED FOR A FORTY BED PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY  
117 IN DESOTO COUNTY; TO PROVIDE THAT THERE SHALL BE NO PROHIBITION OR  
118 RESTRICTIONS ON PARTICIPATION IN THE MEDICAID PROGRAM FOR SUCH  
119 FACILITY THAT WOULD NOT OTHERWISE APPLY TO ANY OTHER SUCH  
120 FACILITY; TO CREATE NEW SECTION 83-9-47, MISSISSIPPI CODE OF 1972,  
121 TO PROHIBIT INSURERS PROVIDING PRESCRIPTION DRUG COVERAGE FROM  
122 REQUIRING OR IMPOSING ANY STEP THERAPY PROTOCOL WITH RESPECT TO  
123 DRUGS APPROVED BY THE UNITED STATES FOOD AND DRUG ADMINISTRATION  
124 (FDA) FOR THE TREATMENT OF POSTPARTUM DEPRESSION; TO CREATE NEW  
125 SECTION 41-140-1, MISSISSIPPI CODE OF 1972, TO DEFINE TERMS; TO  
126 CREATE NEW SECTION 41-140-3, MISSISSIPPI CODE OF 1972, TO REQUIRE  
127 THE STATE DEPARTMENT OF HEALTH TO DEVELOP AND PROMULGATE WRITTEN  
128 EDUCATIONAL MATERIALS AND INFORMATION FOR HEALTH CARE  
129 PROFESSIONALS AND PATIENTS ABOUT MATERNAL MENTAL HEALTH  
130 CONDITIONS; TO REQUIRE HOSPITALS PROVIDING BIRTH SERVICES TO  
131 PROVIDE SUCH EDUCATIONAL MATERIALS TO NEW PARENTS AND, AS  
132 APPROPRIATE, OTHER FAMILY MEMBERS; TO REQUIRE SUCH MATERIALS BE  
133 PROVIDED TO ANY WOMAN WHO PRESENTS WITH SIGNS OF A MATERNAL MENTAL  
134 HEALTH DISORDER; TO CREATE NEW SECTION 41-140-5, MISSISSIPPI CODE  
135 OF 1972, TO REQUIRE ANY HEALTH CARE PROVIDER OR NURSE MIDWIFE WHO  
136 RENDERS POSTNATAL CARE OR PEDIATRIC INFANT CARE TO ENSURE THAT THE



POSTNATAL CARE PATIENT OR BIRTHING MOTHER OF THE PEDIATRIC INFANT  
CARE PATIENT, AS APPLICABLE, IS OFFERED SCREENING FOR POSTPARTUM  
DEPRESSION AND TO PROVIDE APPROPRIATE REFERRALS IF SUCH PATIENT OR  
MOTHER IS DEEMED LIKELY TO BE SUFFERING FROM POSTPARTUM  
DEPRESSION; TO CREATE NEW SECTION 83-9-48, MISSISSIPPI CODE OF  
1972, TO DEFINE "INSURER" AND REQUIRE INSURERS TO PROVIDE COVERAGE  
FOR POSTPARTUM DEPRESSION SCREENING; AND FOR RELATED PURPOSES.

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

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

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

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



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

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

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

(4) [Deleted]

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



189           (6) Children certified by the State Department of Human  
190 Services to the Division of Medicaid of whom the state and county  
191 departments of human services have custody and financial  
192 responsibility, and children who are in adoptions subsidized in  
193 full or part by the Department of Human Services, including  
194 special needs children in non-Title IV-E adoption assistance, who  
195 are approvable under Title XIX of the Medicaid program. The  
196 eligibility of the children covered under this paragraph shall be  
197 determined by the State Department of Human Services.

198           (7) Persons certified by the Division of Medicaid who  
199 are patients in a medical facility (nursing home, hospital,  
200 tuberculosis sanatorium or institution for treatment of mental  
201 diseases), and who, except for the fact that they are patients in  
202 that medical facility, would qualify for grants under Title IV,  
203 Supplementary Security Income (SSI) benefits under Title XVI or  
204 state supplements, and those aged, blind and disabled persons who  
205 would not be eligible for Supplemental Security Income (SSI)  
206 benefits under Title XVI or state supplements if they were not  
207 institutionalized in a medical facility but whose income is below  
208 the maximum standard set by the Division of Medicaid, which  
209 standard shall not exceed that prescribed by federal regulation.

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



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

(9) Individuals who are:

(a) Children born after September 30, 1983, \* \* \*  
between the ages of six (6) and nineteen (19), with family income  
that does not exceed \* \* \* one hundred thirty-three percent (133%)  
of the \* \* \* federal poverty level;

(b) Pregnant women, infants and children \* \* \*  
between the ages of one (1) and six (6), with family income that  
does not exceed \* \* \* one hundred forty-three percent (143%) of  
the federal poverty level; and

(c) Pregnant women and infants who have not  
attained the age of one (1), with family income that does not  
exceed \* \* \* one hundred ninety-four percent (194%) of the federal  
poverty level.

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

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



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

(11) \* \* \* Individuals who are sixty-five (65) years of  
age or older or are disabled as determined under Section  
1614(a)(3) of the federal Social Security Act, as amended, and  
whose income does not exceed one hundred thirty-five percent  
(135%) of the \* \* \* federal poverty level, and whose resources do  
not exceed those established by the Division of Medicaid. The  
eligibility of individuals covered under this paragraph shall be  
determined by the Division of Medicaid. \* \* \* Only those  
individuals covered under the 1115(c) Healthier Mississippi waiver  
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  
paragraph (11) on March 31, 2005, shall be eligible for Medicaid  
coverage under this paragraph (11) from March 31, 2005, through  
December 31, 2005. The division shall give priority in processing  
the applications for those individuals to determine their  
eligibility under this paragraph (11).

(12) Individuals who are qualified Medicare  
beneficiaries (QMB) entitled to Part A Medicare as defined under  
Section 301, Public Law 100-360, known as the Medicare





Catastrophic Coverage Act of 1988, and whose income does not exceed one hundred percent (100%) of the \* \* \* federal poverty level.

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

(13) (a) Individuals who are entitled to Medicare Part A as defined in Section 4501 of the Omnibus Budget Reconciliation Act of 1990, and whose income does not exceed one hundred twenty percent (120%) of the \* \* \* federal poverty level. Eligibility for Medicaid benefits is limited to full payment of Medicare Part B premiums.

(b) Individuals entitled to Part A of Medicare, 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.



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

289           (14)   [Deleted]

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

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

305           (17)   In accordance with the terms of the federal  
306 Personal Responsibility and Work Opportunity Reconciliation Act of  
307 1996 (Public Law 104-193), persons who become ineligible for  
308 assistance under Title IV-A of the federal Social Security Act, as  
309 amended, because of increased income from or hours of employment  
310 of the caretaker relative or because of the expiration of the  
311 applicable earned income disregards, who were eligible for



312 Medicaid for at least three (3) of the six (6) months preceding  
313 the month in which the ineligibility begins, shall be eligible for  
314 Medicaid for up to twelve (12) months. The eligibility of the  
315 individuals covered under this paragraph shall be determined by  
316 the division.

317           (18) Persons who become ineligible for assistance under  
318 Title IV-A of the federal Social Security Act, as amended, as a  
319 result, in whole or in part, of the collection or increased  
320 collection of child or spousal support under Title IV-D of the  
321 federal Social Security Act, as amended, who were eligible for  
322 Medicaid for at least three (3) of the six (6) months immediately  
323 preceding the month in which the ineligibility begins, shall be  
324 eligible for Medicaid for an additional four (4) months beginning  
325 with the month in which the ineligibility begins. The eligibility  
326 of the individuals covered under this paragraph shall be  
327 determined by the division.

328           (19) Disabled workers, whose incomes are above the  
329 Medicaid eligibility limits, but below two hundred fifty percent  
330 (250%) of the federal poverty level, shall be allowed to purchase  
331 Medicaid coverage on a sliding fee scale developed by the Division  
332 of Medicaid.

333           (20) Medicaid eligible children under age eighteen (18)  
334 shall remain eligible for Medicaid benefits until the end of a  
335 period of twelve (12) months following an eligibility



determination, or until such time that the individual exceeds age  
eighteen (18).

(21) Women and men of \* \* \* reproductive age whose  
family income does not exceed \* \* \* one hundred ninety-four  
percent (194%) of the federal poverty level. The eligibility of  
individuals covered under this paragraph (21) shall be determined  
by the Division of Medicaid, and those individuals determined  
eligible shall only receive family planning services covered under  
Section 43-13-117(13) and not any other services covered under  
Medicaid. However, any individual eligible under this paragraph  
(21) who is also eligible under any other provision of this  
section shall receive the benefits to which he or she is entitled  
under that other provision, in addition to family planning  
services covered under Section 43-13-117(13).

The Division of Medicaid \* \* \* may apply to the United States  
Secretary of Health and Human Services for a federal waiver of the  
applicable provisions of Title XIX of the federal Social Security  
Act, as amended, and any other applicable provisions of federal  
law as necessary to allow for the implementation of this paragraph  
(21). \* \* \*

(22) Persons who are workers with a potentially severe  
disability, as determined by the division, shall be allowed to  
purchase Medicaid coverage. The term "worker with a potentially  
severe disability" means a person who is at least sixteen (16)  
years of age but under sixty-five (65) years of age, who has a



physical or mental impairment that is reasonably expected to cause the person to become blind or disabled as defined under Section 1614(a) of the federal Social Security Act, as amended, if the person does not receive items and services provided under Medicaid.

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

(23) Children certified by the Mississippi Department of Human Services for whom the state and county departments of human services have custody and financial responsibility who are in foster care on their eighteenth birthday as reported by the Mississippi Department of Human Services shall be certified Medicaid eligible by the Division of Medicaid until their \* \* \* twenty-sixth birthday. Children who have aged out of foster care while on Medicaid in other states shall qualify until their twenty-sixth birthday.

(24) Individuals who have not attained age sixty-five (65), are not otherwise covered by creditable coverage as defined in the Public Health Services Act, and have been screened for breast and cervical cancer under the Centers for Disease Control



386 and Prevention Breast and Cervical Cancer Early Detection Program  
387 established under Title XV of the Public Health Service Act in  
388 accordance with the requirements of that act and who need  
389 treatment for breast or cervical cancer. Eligibility of  
390 individuals under this paragraph (24) shall be determined by the  
391 Division of Medicaid.

392 (25) The division shall apply to the Centers for  
393 Medicare and Medicaid Services (CMS) for any necessary waivers to  
394 provide services to individuals who are sixty-five (65) years of  
395 age or older or are disabled as determined under Section  
396 1614(a)(3) of the federal Social Security Act, as amended, and  
397 whose income does not exceed one hundred thirty-five percent  
398 (135%) of the \* \* \* federal poverty level, and whose resources do  
399 not exceed those established by the Division of Medicaid, and who  
400 are not otherwise covered by Medicare. Nothing contained in this  
401 paragraph (25) shall entitle an individual to benefits. The  
402 eligibility of individuals covered under this paragraph shall be  
403 determined by the Division of Medicaid.

404 (26) \* \* \* [Deleted]

405 (27) Individuals who are entitled to Medicare Part D  
406 and whose income does not exceed one hundred fifty percent (150%)  
407 of the \* \* \* federal poverty level. Eligibility for payment of  
408 the Medicare Part D subsidy under this paragraph shall be  
409 determined by the division.



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

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

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

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

(1) Inpatient hospital services.

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

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



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

437 (2) Outpatient hospital services.

438 (a) Emergency services.

439 (b) Other outpatient hospital services. The  
440 division shall allow benefits for other medically necessary  
441 outpatient hospital services (such as chemotherapy, radiation,  
442 surgery and therapy), including outpatient services in a clinic or  
443 other facility that is not located inside the hospital, but that  
444 has been designated as an outpatient facility by the hospital, and  
445 that was in operation or under construction on July 1, 2009,  
446 provided that the costs and charges associated with the operation  
447 of the hospital clinic are included in the hospital's cost report.  
448 In addition, the Medicare thirty-five-mile rule will apply to  
449 those hospital clinics not located inside the hospital that are  
450 constructed after July 1, 2009. Where the same services are  
451 reimbursed as clinic services, the division may revise the rate or  
452 methodology of outpatient reimbursement to maintain consistency,  
453 efficiency, economy and quality of care.

454 (c) The division is authorized to implement an  
455 Ambulatory Payment Classification (APC) methodology for outpatient  
456 hospital services. \* \* \*

457 (d) No service benefits or reimbursement  
458 limitations in this subsection (A)(2) shall apply to payments  
459 under an APR-DRG or APC model or a managed care program or similar





model described in subsection (H) of this section unless specifically authorized by the division.

(3) Laboratory and x-ray services.

(4) Nursing facility services.

(a) The division shall make full payment to nursing facilities for each day, not exceeding forty-two (42) days per year, that a patient is absent from the facility on home leave. Payment may be made for the following home leave days in addition to the forty-two-day limitation: Christmas, the day before Christmas, the day after Christmas, Thanksgiving, the day before Thanksgiving and the day after Thanksgiving.

(b) From and after July 1, 1997, the division shall implement the integrated case-mix payment and quality monitoring system, which includes the fair rental system for property costs and in which recapture of depreciation is eliminated. The division may reduce the payment for hospital leave and therapeutic home leave days to the lower of the case-mix category as computed for the resident on leave using the assessment being utilized for payment at that point in time, or a case-mix score of 1.000 for nursing facilities, and shall compute case-mix scores of residents so that only services provided at the nursing facility are considered in calculating a facility's per diem.



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

486 (d) \* \* \* The division shall update the case-mix  
487 payment system \* \* \* and fair rental reimbursement system as  
488 necessary to maintain compliance with federal law. The division  
489 shall develop and implement a payment add-on to reimburse nursing  
490 facilities for ventilator-dependent resident services.

491 (e) The division shall develop and implement, not  
492 later than January 1, 2001, a case-mix payment add-on determined  
493 by time studies and other valid statistical data that will  
494 reimburse a nursing facility for the additional cost of caring for  
495 a resident who has a diagnosis of Alzheimer's or other related  
496 dementia and exhibits symptoms that require special care. Any  
497 such case-mix add-on payment shall be supported by a determination  
498 of additional cost. The division shall also develop and implement  
499 as part of the fair rental reimbursement system for nursing  
500 facility beds, an Alzheimer's resident bed depreciation enhanced  
501 reimbursement system that will provide an incentive to encourage  
502 nursing facilities to convert or construct beds for residents with  
503 Alzheimer's or other related dementia.

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



508                   (g) The division may implement a quality or  
509                   value-based component to the nursing facility payment system.

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

514           (5) Periodic screening and diagnostic services for  
515 individuals under age twenty-one (21) years as are needed to  
516 identify physical and mental defects and to provide health care  
517 treatment and other measures designed to correct or ameliorate  
518 defects and physical and mental illness and conditions discovered  
519 by the screening services, regardless of whether these services  
520 are included in the state plan. The division may include in its  
521 periodic screening and diagnostic program those discretionary  
522 services authorized under the federal regulations adopted to  
523 implement Title XIX of the federal Social Security Act, as  
524 amended. The division, in obtaining physical therapy services,  
525 occupational therapy services, and services for individuals with  
526 speech, hearing and language disorders, may enter into a  
527 cooperative agreement with the State Department of Education for  
528 the provision of those services to handicapped students by public  
529 school districts using state funds that are provided from the  
530 appropriation to the Department of Education to obtain federal  
531 matching funds through the division. The division, in obtaining  
532 medical and mental health assessments, treatment, care and



533 services for children who are in, or at risk of being put in, the  
534 custody of the Mississippi Department of Human Services may enter  
535 into a cooperative agreement with the Mississippi Department of  
536 Human Services for the provision of those services using state  
537 funds that are provided from the appropriation to the Department  
538 of Human Services to obtain federal matching funds through the  
539 division.

540           (6) Physician services. Fees for physician's services  
541 that are covered only by Medicaid shall be reimbursed at ninety  
542 percent (90%) of the rate established on January 1, 2018, and as  
543 may be adjusted each July thereafter, under Medicare. The  
544 division may provide for a reimbursement rate for physician's  
545 services of up to one hundred percent (100%) of the rate  
546 established under Medicare for physician's services that are  
547 provided after the normal working hours of the physician, as  
548 determined in accordance with regulations of the division. The  
549 division may reimburse eligible providers, as determined by the  
550 division, for certain primary care services at one hundred percent  
551 (100%) of the rate established under Medicare. The division shall  
552 reimburse obstetricians \* \* \*, gynecologists and pediatricians for  
553 certain primary care services as defined by the division at one  
554 hundred percent (100%) of the rate established under Medicare.

555           (7) (a) Home health services for eligible persons, not  
556 to exceed in cost the prevailing cost of nursing facility  
557 services. All home health visits must be precertified as required



558 by the division. In addition to physicians, certified registered  
559 nurse practitioners, physician assistants and clinical nurse  
560 specialists are authorized to prescribe or order home health  
561 services and plans of care, sign home health plans of care,  
562 certify and recertify eligibility for home health services and  
563 conduct the required initial face-to-face visit with the recipient  
564 of the services.

565 (b) [Repealed]

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

568 (9) Prescription drugs and other covered drugs and  
569 services as determined by the division.

570 The division shall establish a mandatory preferred drug list.  
571 Drugs not on the mandatory preferred drug list shall be made  
572 available by utilizing prior authorization procedures established  
573 by the division.

574 The division may seek to establish relationships with other  
575 states in order to lower acquisition costs of prescription drugs  
576 to include single-source and innovator multiple-source drugs or  
577 generic drugs. In addition, if allowed by federal law or  
578 regulation, the division may seek to establish relationships with  
579 and negotiate with other countries to facilitate the acquisition  
580 of prescription drugs to include single-source and innovator  
581 multiple-source drugs or generic drugs, if that will lower the  
582 acquisition costs of those prescription drugs.



583           The division may allow for a combination of prescriptions for  
584   single-source and innovator multiple-source drugs and generic  
585   drugs to meet the needs of the beneficiaries.

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

589           Drugs prescribed for a resident of a psychiatric residential  
590   treatment facility must be provided in true unit doses when  
591   available. The division may require that drugs not covered by  
592   Medicare Part D for a resident of a long-term care facility be  
593   provided in true unit doses when available. Those drugs that were  
594   originally billed to the division but are not used by a resident  
595   in any of those facilities shall be returned to the billing  
596   pharmacy for credit to the division, in accordance with the  
597   guidelines of the State Board of Pharmacy and any requirements of  
598   federal law and regulation. Drugs shall be dispensed to a  
599   recipient and only one (1) dispensing fee per month may be  
600   charged. The division shall develop a methodology for reimbursing  
601   for restocked drugs, which shall include a restock fee as  
602   determined by the division not exceeding Seven Dollars and  
603   Eighty-two Cents (\$7.82).

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



608           The division is authorized to develop and implement a program  
609 of payment for additional pharmacist services as determined by the  
610 division.

611           All claims for drugs for dually eligible Medicare/Medicaid  
612 beneficiaries that are paid for by Medicare must be submitted to  
613 Medicare for payment before they may be processed by the  
614 division's online payment system.

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

620           The division shall develop and implement a method or methods  
621 by which the division will provide on a regular basis to Medicaid  
622 providers who are authorized to prescribe drugs, information about  
623 the costs to the Medicaid program of single-source drugs and  
624 innovator multiple-source drugs, and information about other drugs  
625 that may be prescribed as alternatives to those single-source  
626 drugs and innovator multiple-source drugs and the costs to the  
627 Medicaid program of those alternative drugs.

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



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

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

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

644           The division shall allow certain drugs, including  
645 physician-administered drugs, and implantable drug system devices,  
646 and medical supplies, with limited distribution or limited access  
647 for beneficiaries and administered in an appropriate clinical  
648 setting, to be reimbursed as either a medical claim or pharmacy  
649 claim, as determined by the division.

650       \* \* \*

651           The division and any managed care entity described in  
652 subsection (H) of this section shall not require or impose any  
653 step therapy protocol with respect to a drug that is approved by  
654 the United States Food and Drug Administration for the treatment  
655 of postpartum depression.

656           (10) Dental and orthodontic services to be determined  
657 by the division.





658           The division shall increase the amount of the reimbursement  
659 rate for diagnostic and preventative dental services for each of  
660 the fiscal years 2022, 2023 and 2024 by five percent (5%) above  
661 the amount of the reimbursement rate for the previous fiscal year.  
662 The division shall increase the amount of the reimbursement rate  
663 for restorative dental services for each of the fiscal years 2023,  
664 2024 and 2025 by five percent (5%) above the amount of the  
665 reimbursement rate for the previous fiscal year. It is the intent  
666 of the Legislature that the reimbursement rate revision for  
667 preventative dental services will be an incentive to increase the  
668 number of dentists who actively provide Medicaid services. This  
669 dental services reimbursement rate revision shall be known as the  
670 "James Russell Dumas Medicaid Dental Services Incentive Program."

671           The Medical Care Advisory Committee, assisted by the Division  
672 of Medicaid, shall annually determine the effect of this incentive  
673 by evaluating the number of dentists who are Medicaid providers,  
674 the number who and the degree to which they are actively billing  
675 Medicaid, the geographic trends of where dentists are offering  
676 what types of Medicaid services and other statistics pertinent to  
677 the goals of this legislative intent. This data shall annually be  
678 presented to the Chair of the Senate Medicaid Committee and the  
679 Chair of the House Medicaid Committee.

680           The division shall include dental services as a necessary  
681 component of overall health services provided to children who are  
682 eligible for services.



683           (11) Eyeglasses for all Medicaid beneficiaries who have  
684       (a) had surgery on the eyeball or ocular muscle that results in a  
685       vision change for which eyeglasses or a change in eyeglasses is  
686       medically indicated within six (6) months of the surgery and is in  
687       accordance with policies established by the division, or (b) one  
688       (1) pair every \* \* \* two (2) years and in accordance with policies  
689       established by the division. In either instance, the eyeglasses  
690       must be prescribed by a physician skilled in diseases of the eye  
691       or an optometrist, whichever the beneficiary may select.

692           (12) Intermediate care facility services.

693               (a) The division shall make full payment to all  
694       intermediate care facilities for individuals with intellectual  
695       disabilities for each day, not exceeding sixty-three (63) days per  
696       year, that a patient is absent from the facility on home leave.  
697       Payment may be made for the following home leave days in addition  
698       to the sixty-three-day limitation: Christmas, the day before  
699       Christmas, the day after Christmas, Thanksgiving, the day before  
700       Thanksgiving and the day after Thanksgiving.

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

704               (c) Effective January 1, 2015, the division shall  
705       update the fair rental reimbursement system for intermediate care  
706       facilities for individuals with intellectual disabilities.



(13) Family planning services, including drugs, supplies and devices, when those services are under the supervision of a physician or nurse practitioner. Oral contraceptives may be prescribed and dispensed in twelve-month supply increments.

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

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

(b) Dialysis center services.

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.

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

(16) Mental health services. Certain services provided by a psychiatrist shall be reimbursed at up to one hundred percent (100%) of the Medicare rate. Approved therapeutic and case



management services (a) provided by an approved regional mental health/intellectual disability center established under Sections 41-19-31 through 41-19-39, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/intellectual disability center if determined necessary by the Department of Mental Health, using state funds that are provided in the appropriation to the division to match federal funds, or (b) provided by a facility that is certified by the State Department of Mental Health to provide therapeutic and case management services, to be reimbursed on a fee for service basis, or (c) provided in the community by a facility or program operated by the Department of Mental Health. Any such services provided by a facility described in subparagraph (b) must have the prior approval of the division to be reimbursable under this section.

(17) Durable medical equipment services and medical supplies. Precertification of durable medical equipment and medical supplies must be obtained as required by the division. The Division of Medicaid may require durable medical equipment providers to obtain a surety bond in the amount and to the specifications as established by the Balanced Budget Act of 1997. A maximum dollar amount of reimbursement for noninvasive ventilators or ventilation treatments properly ordered and being used in an appropriate care setting shall not be set by any health maintenance organization, coordinated care organization,



757 provider-sponsored health plan, or other organization paid for  
758 services on a capitated basis by the division under any managed  
759 care program or coordinated care program implemented by the  
760 division under this section. Reimbursement by these organizations  
761 to durable medical equipment suppliers for home use of noninvasive  
762 and invasive ventilators shall be on a continuous monthly payment  
763 basis for the duration of medical need throughout a patient's  
764 valid prescription period.

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

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



in Section 1903 of the federal Social Security Act and any applicable regulations.

(b) (i) 1. The division may establish a Medicare Upper Payment Limits Program, as defined in Section 1902(a)(30) of the federal Social Security Act and any applicable federal regulations, or an allowable delivery system or provider payment initiative authorized under 42 CFR 438.6(c), for hospitals, nursing facilities \* \* \*, physicians and other eligible licensed providers as determined by the division employed or contracted by hospitals. The division shall not limit participation in this program to certain hospitals and shall ensure it is available to all hospitals.

2. The division shall establish a Medicaid Supplemental Payment Program, as permitted by the federal Social Security Act and a comparable allowable delivery system or provider payment initiative authorized under 42 CFR 438.6(c), for emergency ambulance transportation providers in accordance with this subsection (A)(18)(b).

(ii) The division shall assess each hospital, nursing facility, and emergency ambulance transportation provider for the sole purpose of financing the state portion of the Medicare Upper Payment Limits Program or other program(s) authorized under this subsection (A)(18)(b). The hospital assessment shall be as provided in Section 43-13-145(4)(a), and the nursing facility and the emergency ambulance transportation



806 assessments, if established, shall be based on Medicaid  
807 utilization or other appropriate method, as determined by the  
808 division, consistent with federal regulations. The assessments  
809 will remain in effect as long as the state participates in the  
810 Medicare Upper Payment Limits Program or other program(s)  
811 authorized under this subsection (A)(18)(b). In addition to the  
812 hospital assessment provided in Section 43-13-145(4)(a), hospitals  
813 with physicians and other eligible licensed providers as  
814 determined by the division participating in the Medicare Upper  
815 Payment Limits Program or other program(s) authorized under this  
816 subsection (A)(18)(b) shall be required to participate in an  
817 intergovernmental transfer or assessment, as determined by the  
818 division, for the purpose of financing the state portion of the  
819 physician UPL payments or other payment(s) authorized under this  
820 subsection (A)(18)(b).

821 (iii) Subject to approval by the Centers for  
822 Medicare and Medicaid Services (CMS) and the provisions of this  
823 subsection (A)(18)(b), the division shall make additional  
824 reimbursement to hospitals, nursing facilities, and emergency  
825 ambulance transportation providers for the Medicare Upper Payment  
826 Limits Program or other program(s) authorized under this  
827 subsection (A)(18)(b), and, if the program is established for  
828 physicians and other eligible licensed providers as determined by  
829 the division, shall make additional reimbursement for physicians  
830 and other eligible licensed providers as determined by the



division, as defined in Section 1902(a)(30) of the federal Social Security Act and any applicable federal regulations, provided the assessment in this subsection (A)(18)(b) is in effect.

(iv) \* \* \* The division is authorized to develop and implement an alternative fee-for-service Upper Payment Limits model in accordance with federal laws and regulations if necessary to preserve supplemental funding. \* \* \* The division, in consultation with the Mississippi Hospital Association, may develop alternative models for distribution of medical claims and supplemental payments for inpatient and outpatient hospital services, and such models may include, but shall not be limited to, the following: increasing rates for inpatient and outpatient services; creating a low-income utilization pool of funds to reimburse hospitals for the costs of uncompensated care, charity care and bad debts as permitted and approved pursuant to federal regulations and the Centers for Medicare and Medicaid Services; supplemental payments based upon Medicaid utilization, quality, service lines and/or costs of providing such services to Medicaid beneficiaries and to uninsured patients. The goals of such payment models shall be to ensure access to inpatient and outpatient care and to maximize any federal funds that are available to reimburse hospitals for services provided. The Chairmen of the Senate and House Medicaid Committees shall be provided copies of the proposed payment model(s) prior to submission.





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

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

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

875 b. In addition to any other funds  
876 paid to ambulance transportation service providers for emergency  
877 medical services provided to Medicaid beneficiaries, each eligible  
878 ambulance transportation service provider shall receive ambulance  
879 service access payments each state fiscal year equal to the  
880 ambulance transportation service provider's upper payment limit



881 gap. Subject to approval by the Centers for Medicare and Medicaid  
882 Services, ambulance service access payments shall be made no less  
883 than on a quarterly basis.

884 c. As used in this paragraph  
885 (18)(b)(v), the term "upper payment limit gap" means the  
886 difference between the total amount that the ambulance  
887 transportation service provider received from Medicaid and the  
888 average amount that the ambulance transportation service provider  
889 would have received from commercial insurers for those services  
890 reimbursed by Medicaid.

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

894 (c) (i) \* \* \* The division shall, subject to  
895 approval by the Centers for Medicare and Medicaid Services (CMS),  
896 establish, implement and operate a Mississippi Hospital Access  
897 Program (MHAP) for the purpose of protecting patient access to  
898 hospital care through hospital inpatient reimbursement programs  
899 provided in this section designed to maintain total hospital  
900 reimbursement for inpatient services rendered by in-state  
901 hospitals and the out-of-state hospital that is authorized by  
902 federal law to submit intergovernmental transfers (IGTs) to the  
903 State of Mississippi and is classified as Level I trauma center  
904 located in a county contiguous to the state line at the maximum



905 levels permissible under applicable federal statutes and  
906 regulations \* \* \*.

907 (ii) Subject to approval by the Centers for  
908 Medicare and Medicaid Services (CMS), the MHAP shall provide  
909 increased inpatient capitation (PMPM) payments to managed care  
910 entities contracting with the division pursuant to subsection (H)  
911 of this section to support availability of hospital services or  
912 such other payments permissible under federal law necessary to  
913 accomplish the intent of this subsection.

914 (iii) The intent of this subparagraph (c) is  
915 that effective for all inpatient hospital Medicaid services during  
916 state fiscal year 2016, and so long as this provision shall remain  
917 in effect hereafter, the division \* \* \* may, to the fullest extent  
918 feasible, replace the additional reimbursement for hospital  
919 inpatient services under the inpatient Medicare Upper Payment  
920 Limits (UPL) Program with additional reimbursement under the MHAP  
921 and other payment programs for inpatient and/or outpatient  
922 payments which may be developed under the authority of this  
923 paragraph.

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



930                   (d) Supplemental payments to a hospital shall not  
931 decrease by more than five percent (5%) when compared to a  
932 hospital's prior year payment unless that hospital has closed, or  
933 changed services or patient volume which impact that hospital's  
934 payment, and the division shall not substantially change the  
935 methodologies used to calculate a hospital's supplemental payment.  
936 Nothing in this paragraph shall be construed to prohibit an  
937 increase in total funding available for hospital supplemental  
938 payment programs. For Mississippi providers described under this  
939 section, the division shall, subject to approval by the Centers  
940 for Medicare and Medicaid Services (CMS), implement and operate  
941 supplemental payment programs at the maximum levels permissible  
942 under applicable federal statutes and regulations.

943                   (19) (a) Perinatal risk-management services. The  
944 division shall promulgate regulations to be effective from and  
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  
948 who are determined to be at risk. Services to be performed  
949 include case management, nutrition assessment/counseling,  
950 psychosocial assessment/counseling and health education. The  
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 program. The State Department of Health shall be reimbursed on a  
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 shall contract with the State Department of Health  
961 for 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  
976 determined by the State Department of Health and the Division of  
977 Medicaid.

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  
984 funds under a cooperative agreement between the division and the  
985 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.



1004                   (22) Ambulatory services delivered in federally  
1005 qualified health centers, rural health centers and clinics of the  
1006 local health departments of the State Department of Health for  
1007 individuals eligible for Medicaid under this article based on  
1008 reasonable costs as determined by the division. Federally  
1009 qualified health centers shall be reimbursed by the Medicaid  
1010 prospective payment system as approved by the Centers for Medicare  
1011 and Medicaid Services. The division shall recognize federally  
1012 qualified health centers (FQHCs), rural health clinics (RHCs) and  
1013 community mental health centers (CMHCs) as both an originating and  
1014 distant site provider for the purposes of telehealth  
1015 reimbursement. The division is further authorized and directed to  
1016 reimburse FQHCs, 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  
1027 twenty-one (21), before the earlier of the date he or she no  
1028 longer requires the services or the date he or she reaches age



1029 twenty-two (22), as provided by federal regulations. From and  
1030 after January 1, 2015, the division shall update the fair rental  
1031 reimbursement system for psychiatric residential treatment  
1032 facilities. Precertification of inpatient days and residential  
1033 treatment days must be obtained as required by the division. From  
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  
1037 reimbursement shall be reimbursed for those services on a full  
1038 reasonable cost basis.

1039 (b) The division may reimburse for services  
1040 provided by a licensed freestanding psychiatric hospital to  
1041 Medicaid recipients over the age of twenty-one (21) in a method  
1042 and manner consistent with the provisions of Section 43-13-117.5.

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. The  
1052 program provides relief of severe pain or other physical symptoms  
1053 and supportive care to meet the special needs arising out of





1054 physical, psychological, spiritual, social and economic stresses  
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           (36) 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  
1106 of the program and the providers of transportation services to  
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  
1111 Committee not later than January 1, 2019, and every two (2) years  
1112 thereafter.

1113 (37) [Deleted]

1114 (38) Chiropractic 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  
1125 the division. From and after July 1, 2009, the division shall  
1126 reimburse crossover claims for inpatient hospital services and  
1127 crossover claims covered under Medicare Part B in the same manner



1128 that was in effect on January 1, 2008, unless specifically  
1129 authorized by the Legislature to change this method.

1130 (40) [Deleted]

1131 (41) 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  
1137 Services from the Spinal Cord and Head Injury Trust Fund  
1138 established under Section 37-33-261 and used to match federal  
1139 funds under a cooperative agreement between the division and the  
1140 department.

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  
1167 regulations of the division.

1168                   (46) The division shall make application to the federal  
1169 Centers for Medicare and Medicaid Services (CMS) for a waiver to  
1170 develop and provide services for children with serious emotional  
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 waived program only if funds for  
1176 these services are specifically appropriated for this purpose by



1177 the Legislature, or if funds are voluntarily provided by affected  
1178 agencies.

1179           (47) (a) The division may develop and implement  
1180 disease management programs for individuals with high-cost chronic  
1181 diseases and conditions, including the use of grants, waivers,  
1182 demonstrations or other projects as necessary.

1183           (b) Participation in any disease management  
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  
1187 elect to discontinue participation in the program at any time.

1188           (48) 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.



1201                   (50)   Services provided by the State Department of  
1202   Rehabilitation Services for the care and rehabilitation of persons  
1203   who are deaf and blind, as allowed under waivers from the United  
1204   States Department of Health and Human Services to provide home-  
1205   and community-based services using state funds that are provided  
1206   from the appropriation to the State Department of Rehabilitation  
1207   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  
1214   physical examination and utilization of these disease management  
1215   tools shall be consistent with current United States Preventive  
1216   Services Task Force or other recognized authority recommendations.

1217               For persons who are determined ineligible for Medicaid, the  
1218   division will provide information and direction for accessing  
1219   medical care and services in the area of their residence.

1220                   (52)   Notwithstanding any provisions of this article,  
1221   the division may pay enhanced reimbursement fees related to trauma  
1222   care, as determined by the division in conjunction with the State  
1223   Department of Health, using funds appropriated to the State  
1224   Department of Health for trauma care and services and used to  
1225   match federal funds under a cooperative agreement between the



1226 division and the State Department of Health. The division, in  
1227 conjunction with the State Department of Health, may use grants,  
1228 waivers, demonstrations, enhanced reimbursements, Upper Payment  
1229 Limits Programs, supplemental payments, or other projects as  
1230 necessary in the development and implementation of this  
1231 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]

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  
1239 six-month period of treatment. The projected period of treatment  
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  
1245 the plan of care. The appeal process for any reduction in therapy  
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  
1261 disease, or any other disease, illness or condition which a  
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                   (a)   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  
1282   under 42 CFR Section 438.6(c) in an amount equal to or greater  
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                   (b)   As used in this paragraph (60), the term  
1288   "border city university-affiliated pediatric teaching hospital"  
1289   means an out-of-state hospital located within a city bordering the  
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,  
1296   maintains at least five (5) different pediatric specialty training  
1297   programs, and maintains at least one hundred (100) operated beds  
1298   dedicated exclusively for the treatment of patients under the age  
1299   of twenty-one (21) years.



1300 (c) The cost of providing services to Mississippi  
1301 Medicaid beneficiaries under the age of twenty-one (21) years who  
1302 are treated by a border city university-affiliated pediatric  
1303 teaching hospital shall not exceed the cost of providing the same  
1304 services to individuals in hospitals in the state.

1305 (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.

1312 (61) Autism spectrum disorder services. The division  
1313 shall develop and implement a method for reimbursement of autism  
1314 spectrum disorder services based on a continuum of care for best  
1315 practices in medically necessary early intervention treatment.  
1316 The division shall work in consultation with the Department of  
1317 Mental Health, healthcare providers, the Autism Advisory  
1318 Committee, and other stakeholders relevant to the autism industry  
1319 to develop these reimbursement rates. The requirements of this  
1320 subsection shall apply to any autism spectrum disorder services  
1321 rendered under the authority of the Medicaid State Plan and any  
1322 Home and Community Based Services Waiver authorized under this  
1323 section through which autism spectrum disorder services are  
1324 provided.



1325           (62) Preparticipation physical evaluations. The  
1326 division shall reimburse for preparticipation physical evaluations  
1327 of beneficiaries in a manner as determined by the division.

1328           (63) Glucagon-like peptide-1 (GLP-1) agonist  
1329 medications that have been approved for chronic weight management  
1330 by the United States Food and Drug Administration (FDA). The  
1331 division shall, in a manner as determined by the division,  
1332 reimburse for FDA-approved GLP-1 agonist medications prescribed  
1333 for chronic weight management and/or for management of additional  
1334 conditions in the discretion of the medical provider.

1335           (64) Coverage and reimbursement for postpartum  
1336 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           (B) Planning and development districts participating in the  
1346 home- and community-based services program for the elderly and  
1347 disabled as case management providers shall be reimbursed for case  
1348 management services at the maximum rate approved by the Centers  
1349 for Medicare and Medicaid Services (CMS).



1350           (C) The division may pay to those providers who participate  
1351 in and accept patient referrals from the division's emergency room  
1352 redirection program a percentage, as determined by the division,  
1353 of savings achieved according to the performance measures and  
1354 reduction of costs required of that program. Federally qualified  
1355 health centers may participate in the emergency room redirection  
1356 program, and the division may pay those centers a percentage of  
1357 any savings to the Medicaid program achieved by the centers'  
1358 accepting patient referrals through the program, as provided in  
1359 this subsection (C).

1360           (D) (1) As used in this subsection (D), the following terms  
1361 shall be defined as provided in this paragraph, except as  
1362 otherwise provided in this subsection:

1363                       (a) "Committees" means the Medicaid Committees of  
1364 the House of Representatives and the Senate, and "committee" means  
1365 either one of those committees.

1366                       (b) "Rate change" means an increase, decrease or  
1367 other change in the payments or rates of reimbursement, or a  
1368 change in any payment methodology that results in an increase,  
1369 decrease or other change in the payments or rates of  
1370 reimbursement, to any Medicaid provider that renders any services  
1371 authorized to be provided to Medicaid recipients under this  
1372 article.

1373           (2) Whenever the Division of Medicaid proposes a rate  
1374 change, the division shall give notice to the chairmen of the



1375 committees at least \* \* \* fifteen (15) calendar days before the  
1376 proposed rate change is scheduled to take effect. The division  
1377 shall furnish the chairmen with a concise summary of each proposed  
1378 rate change along with the notice, and shall furnish the chairmen  
1379 with a copy of any proposed rate change upon request. The  
1380 division also shall provide a summary and copy of any proposed  
1381 rate change to any other member of the Legislature upon request.

1382 (3) If the chairman of either committee or both  
1383 chairmen jointly object to the proposed rate change or any part  
1384 thereof, the chairman or chairmen shall notify the division and  
1385 provide the reasons for their objection in writing not later than  
1386 seven (7) calendar days after receipt of the notice from the  
1387 division. The chairman or chairmen may make written  
1388 recommendations to the division for changes to be made to a  
1389 proposed rate change.

1390 (4) (a) The chairman of either committee or both  
1391 chairmen jointly may hold a committee meeting to review a proposed  
1392 rate change. If either chairman or both chairmen decide to hold a  
1393 meeting, they shall notify the division of their intention in  
1394 writing within seven (7) calendar days after receipt of the notice  
1395 from the division, and shall set the date and time for the meeting  
1396 in their notice to the division, which shall not be later than  
1397 fourteen (14) calendar days after receipt of the notice from the  
1398 division.



1399                   (b) After the committee meeting, the committee or  
1400 committees may object to the proposed rate change or any part  
1401 thereof. The committee or committees shall notify the division  
1402 and the reasons for their objection in writing not later than  
1403 seven (7) calendar days after the meeting. The committee or  
1404 committees may make written recommendations to the division for  
1405 changes to be made to a proposed rate change.

1406                   (5) If both chairmen notify the division in writing  
1407 within seven (7) calendar days after receipt of the notice from  
1408 the division that they do not object to the proposed rate change  
1409 and will not be holding a meeting to review the proposed rate  
1410 change, the proposed rate change will take effect on the original  
1411 date as scheduled by the division or on such other date as  
1412 specified by the division.

1413                   (6) (a) If there are any objections to a proposed rate  
1414 change or any part thereof from either or both of the chairmen or  
1415 the committees, the division may withdraw the proposed rate  
1416 change, make any of the recommended changes to the proposed rate  
1417 change, or not make any changes to the proposed rate change.

1418                   (b) If the division does not make any changes to  
1419 the proposed rate change, it shall notify the chairmen of that  
1420 fact in writing, and the proposed rate change shall take effect on  
1421 the original date as scheduled by the division or on such other  
1422 date as specified by the division.



1423 (c) If the division makes any changes to the  
1424 proposed rate change, the division shall notify the chairmen of  
1425 its actions in writing, and the revised proposed rate change shall  
1426 take effect on the date as specified by the division.

1427 (7) Nothing in this subsection (D) shall be construed  
1428 as giving the chairmen or the committees any authority to veto,  
1429 nullify or revise any rate change proposed by the division. The  
1430 authority of the chairmen or the committees under this subsection  
1431 shall be limited to reviewing, making objections to and making  
1432 recommendations for changes to rate changes proposed by the  
1433 division.

1434 (8) If the division needs to expedite the fifteen-day  
1435 legislative notice set forth in paragraph (2) of this subsection  
1436 (D), the division shall notify both chairmen.

1437 (E) Notwithstanding any provision of this article, no new  
1438 groups or categories of recipients and new types of care and  
1439 services may be added without enabling legislation from the  
1440 Mississippi Legislature, except that the division may authorize  
1441 those changes without enabling legislation when the addition of  
1442 recipients or services is ordered by a court of proper authority.

1443 (F) The executive director shall keep the Governor advised  
1444 on a timely basis of the funds available for expenditure and the  
1445 projected expenditures. Notwithstanding any other provisions of  
1446 this article, if current or projected expenditures of the division  
1447 are reasonably anticipated to exceed the amount of funds





1448 appropriated to the division for any fiscal year, the Governor,  
1449 after consultation with the executive director, shall take all  
1450 appropriate measures to reduce costs, which may include, but are  
1451 not limited to:

1452 (1) Reducing or discontinuing any or all services that  
1453 are deemed to be optional under Title XIX of the Social Security  
1454 Act;

1455 (2) Reducing reimbursement rates for any or all service  
1456 types;

1457 (3) Imposing additional assessments on health care  
1458 providers; or

1459 (4) Any additional cost-containment measures deemed  
1460 appropriate by the Governor.

1461 To the extent allowed under federal law, any reduction to  
1462 services or reimbursement rates under this subsection (F) shall be  
1463 accompanied by a reduction, to the fullest allowable amount, to  
1464 the profit margin and administrative fee portions of capitated  
1465 payments to organizations described in paragraph (1) of subsection  
1466 (H).

1467 Beginning in fiscal year 2010 and in fiscal years thereafter,  
1468 when Medicaid expenditures are projected to exceed funds available  
1469 for the fiscal year, the division shall submit the expected  
1470 shortfall information to the PEER Committee not later than  
1471 December 1 of the year in which the shortfall is projected to  
1472 occur. PEER shall review the computations of the division and



1473 report its findings to the Legislative Budget Office not later  
1474 than January 7 in any year.

1475 (G) Notwithstanding any other provision of this article, it  
1476 shall be the duty of each provider participating in the Medicaid  
1477 program to keep and maintain books, documents and other records as  
1478 prescribed by the Division of Medicaid in accordance with federal  
1479 laws and regulations.

1480 (H) (1) Notwithstanding any other provision of this  
1481 article, the division is authorized to implement (a) a managed  
1482 care program, (b) a coordinated care program, (c) a coordinated  
1483 care organization program, (d) a health maintenance organization  
1484 program, (e) a patient-centered medical home program, (f) an  
1485 accountable care organization program, (g) provider-sponsored  
1486 health plan, or (h) any combination of the above programs. As a  
1487 condition for the approval of any program under this subsection  
1488 (H)(1), the division shall require that no managed care program,  
1489 coordinated care program, coordinated care organization program,  
1490 health maintenance organization program, or provider-sponsored  
1491 health plan may:

1492 (a) Pay providers at a rate that is less than the  
1493 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)  
1494 reimbursement rate;

1495 (b) Override the medical decisions of hospital  
1496 physicians or staff regarding patients admitted to a hospital for  
1497 an emergency medical condition as defined by 42 US Code Section



1498 1395dd. This restriction (b) does not prohibit the retrospective  
1499 review of the appropriateness of the determination that an  
1500 emergency medical condition exists by chart review or coding  
1501 algorithm, nor does it prohibit prior authorization for  
1502 nonemergency hospital admissions;

1503 (c) Pay providers at a rate that is less than the  
1504 normal Medicaid reimbursement rate. It is the intent of the  
1505 Legislature that all managed care entities described in this  
1506 subsection (H), in collaboration with the division, develop and  
1507 implement innovative payment models that incentivize improvements  
1508 in health care quality, outcomes, or value, as determined by the  
1509 division. Participation in the provider network of any managed  
1510 care, coordinated care, provider-sponsored health plan, or similar  
1511 contractor shall not be conditioned on the provider's agreement to  
1512 accept such alternative payment models;

1513 (d) Implement a prior authorization and  
1514 utilization review program for medical services, transportation  
1515 services and prescription drugs that is more stringent than the  
1516 prior authorization processes used by the division in its  
1517 administration of the Medicaid program. Not later than December  
1518 2, 2021, the contractors that are receiving capitated payments  
1519 under a managed care delivery system established under this  
1520 subsection (H) shall submit a report to the Chairmen of the House  
1521 and Senate Medicaid Committees on the status of the prior  
1522 authorization and utilization review program for medical services,



1523 transportation services and prescription drugs that is required to  
1524 be implemented under this subparagraph (d);

1525 (e) [Deleted]

1526 (f) Implement a preferred drug list that is more  
1527 stringent than the mandatory preferred drug list established by  
1528 the division under subsection (A)(9) of this section;

1529 (g) Implement a policy which denies beneficiaries  
1530 with hemophilia access to the federally funded hemophilia  
1531 treatment centers as part of the Medicaid Managed Care network of  
1532 providers.

1533 Each health maintenance organization, coordinated care  
1534 organization, provider-sponsored health plan, or other  
1535 organization paid for services on a capitated basis by the  
1536 division under any managed care program or coordinated care  
1537 program implemented by the division under this section shall use a  
1538 clear set of level of care guidelines in the determination of  
1539 medical necessity and in all utilization management practices,  
1540 including the prior authorization process, concurrent reviews,  
1541 retrospective reviews and payments, that are consistent with  
1542 widely accepted professional standards of care. Organizations  
1543 participating in a managed care program or coordinated care  
1544 program implemented by the division may not use any additional  
1545 criteria that would result in denial of care that would be  
1546 determined appropriate and, therefore, medically necessary under  
1547 those levels of care guidelines.



1548                   (2) Notwithstanding any provision of this section, the  
1549 recipients eligible for enrollment into a Medicaid Managed Care  
1550 Program authorized under this subsection (H) may include only  
1551 those categories of recipients eligible for participation in the  
1552 Medicaid Managed Care Program as of January 1, 2021, the  
1553 Children's Health Insurance Program (CHIP), and the CMS-approved  
1554 Section 1115 demonstration waivers in operation as of January 1,  
1555 2021. No expansion of Medicaid Managed Care Program contracts may  
1556 be implemented by the division without enabling legislation from  
1557 the Mississippi Legislature.

1558                   (3) (a) Any contractors receiving capitated payments  
1559 under a managed care delivery system established in this section  
1560 shall provide to the Legislature and the division statistical data  
1561 to be shared with provider groups in order to improve patient  
1562 access, appropriate utilization, cost savings and health outcomes  
1563 not later than October 1 of each year. Additionally, each  
1564 contractor shall disclose to the Chairmen of the Senate and House  
1565 Medicaid Committees the administrative expenses costs for the  
1566 prior calendar year, and the number of full-equivalent employees  
1567 located in the State of Mississippi dedicated to the Medicaid and  
1568 CHIP lines of business as of June 30 of the current year.

1569                   (b) The division and the contractors participating  
1570 in the managed care program, a coordinated care program or a  
1571 provider-sponsored health plan shall be subject to annual program  
1572 reviews or audits performed by the Office of the State Auditor,



1573 the PEER Committee, the Department of Insurance and/or independent  
1574 third parties.

1575 (c) Those reviews shall include, but not be  
1576 limited to, at least two (2) of the following items:

1577 (i) The financial benefit to the State of  
1578 Mississippi of the managed care program,

1579 (ii) The difference between the premiums paid  
1580 to the managed care contractors and the payments made by those  
1581 contractors to health care providers,

1582 (iii) Compliance with performance measures  
1583 required under the contracts,

1584 (iv) Administrative expense allocation  
1585 methodologies,

1586 (v) Whether nonprovider payments assigned as  
1587 medical expenses are appropriate,

1588 (vi) Capitated arrangements with related  
1589 party subcontractors,

1590 (vii) Reasonableness of corporate  
1591 allocations,

1592 (viii) Value-added benefits and the extent to  
1593 which they are used,

1594 (ix) The effectiveness of subcontractor  
1595 oversight, including subcontractor review,

1596 (x) Whether health care outcomes have been  
1597 improved, and



1598                   (xi) The most common claim denial codes to  
1599 determine the reasons for the denials.

1600           The audit reports shall be considered public documents and  
1601 shall be posted in their entirety on the division's website.

1602           (4) All health maintenance organizations, coordinated  
1603 care organizations, provider-sponsored health plans, or other  
1604 organizations paid for services on a capitated basis by the  
1605 division under any managed care program or coordinated care  
1606 program implemented by the division under this section shall  
1607 reimburse all providers in those organizations at rates no lower  
1608 than those provided under this section for beneficiaries who are  
1609 not participating in those programs.

1610           (5) No health maintenance organization, coordinated  
1611 care organization, provider-sponsored health plan, or other  
1612 organization paid for services on a capitated basis by the  
1613 division under any managed care program or coordinated care  
1614 program implemented by the division under this section shall  
1615 require its providers or beneficiaries to use any pharmacy that  
1616 ships, mails or delivers prescription drugs or legend drugs or  
1617 devices.

1618           (6) (a) Not later than December 1, 2021, the  
1619 contractors who are receiving capitated payments under a managed  
1620 care delivery system established under this subsection (H) shall  
1621 develop and implement a uniform credentialing process for  
1622 providers. Under that uniform credentialing process, a provider



1623 who meets the criteria for credentialing will be credentialed with  
1624 all of those contractors and no such provider will have to be  
1625 separately credentialed by any individual contractor in order to  
1626 receive reimbursement from the contractor. Not later than  
1627 December 2, 2021, those contractors shall submit a report to the  
1628 Chairmen of the House and Senate Medicaid Committees on the status  
1629 of the uniform credentialing process for providers that is  
1630 required under this subparagraph (a).

1631 (b) If those contractors have not implemented a  
1632 uniform credentialing process as described in subparagraph (a) by  
1633 December 1, 2021, the division shall develop and implement, not  
1634 later than July 1, 2022, a single, consolidated credentialing  
1635 process by which all providers will be credentialed. Under the  
1636 division's single, consolidated credentialing process, no such  
1637 contractor shall require its providers to be separately  
1638 credentialed by the contractor in order to receive reimbursement  
1639 from the contractor, but those contractors shall recognize the  
1640 credentialing of the providers by the division's credentialing  
1641 process.

1642 (c) The division shall require a uniform provider  
1643 credentialing application that shall be used in the credentialing  
1644 process that is established under subparagraph (a) or (b). If the  
1645 contractor or division, as applicable, has not approved or denied  
1646 the provider credentialing application within sixty (60) days of  
1647 receipt of the completed application that includes all required





1648 information necessary for credentialing, then the contractor or  
1649 division, upon receipt of a written request from the applicant and  
1650 within five (5) business days of its receipt, shall issue a  
1651 temporary provider credential/enrollment to the applicant if the  
1652 applicant has a valid Mississippi professional or occupational  
1653 license to provide the health care services to which the  
1654 credential/enrollment would apply. The contractor or the division  
1655 shall not issue a temporary credential/enrollment if the applicant  
1656 has reported on the application a history of medical or other  
1657 professional or occupational malpractice claims, a history of  
1658 substance abuse or mental health issues, a criminal record, or a  
1659 history of medical or other licensing board, state or federal  
1660 disciplinary action, including any suspension from participation  
1661 in a federal or state program. The temporary  
1662 credential/enrollment shall be effective upon issuance and shall  
1663 remain in effect until the provider's credentialing/enrollment  
1664 application is approved or denied by the contractor or division.  
1665 The contractor or division shall render a final decision regarding  
1666 credentialing/enrollment of the provider within sixty (60) days  
1667 from the date that the temporary provider credential/enrollment is  
1668 issued to the applicant.

1669 (d) If the contractor or division does not render  
1670 a final decision regarding credentialing/enrollment of the  
1671 provider within the time required in subparagraph (c), the  
1672 provider shall be deemed to be credentialed by and enrolled with



1673 all of the contractors and eligible to receive reimbursement from  
1674 the contractors.

1675           (7) (a) Each contractor that is receiving capitated  
1676 payments under a managed care delivery system established under  
1677 this subsection (H) shall provide to each provider for whom the  
1678 contractor has denied the coverage of a procedure that was ordered  
1679 or requested by the provider for or on behalf of a patient, a  
1680 letter that provides a detailed explanation of the reasons for the  
1681 denial of coverage of the procedure and the name and the  
1682 credentials of the person who denied the coverage. The letter  
1683 shall be sent to the provider in electronic format.

1684           (b) After a contractor that is receiving capitated  
1685 payments under a managed care delivery system established under  
1686 this subsection (H) has denied coverage for a claim submitted by a  
1687 provider, the contractor shall issue to the provider within sixty  
1688 (60) days a final ruling of denial of the claim that allows the  
1689 provider to have a state fair hearing and/or agency appeal with  
1690 the division. If a contractor does not issue a final ruling of  
1691 denial within sixty (60) days as required by this subparagraph  
1692 (b), the provider's claim shall be deemed to be automatically  
1693 approved and the contractor shall pay the amount of the claim to  
1694 the provider.

1695           (c) After a contractor has issued a final ruling  
1696 of denial of a claim submitted by a provider, the division shall  
1697 conduct a state fair hearing and/or agency appeal on the matter of



1698 the disputed claim between the contractor and the provider within  
1699 sixty (60) days, and shall render a decision on the matter within  
1700 thirty (30) days after the date of the hearing and/or appeal.

1701 (8) It is the intention of the Legislature that the  
1702 division evaluate the feasibility of using a single vendor to  
1703 administer pharmacy benefits provided under a managed care  
1704 delivery system established under this subsection (H). Providers  
1705 of pharmacy benefits shall cooperate with the division in any  
1706 transition to a carve-out of pharmacy benefits under managed care.

1707 (9) The division shall evaluate the feasibility of  
1708 using a single vendor to administer dental benefits provided under  
1709 a managed care delivery system established in this subsection (H).  
1710 Providers of dental benefits shall cooperate with the division in  
1711 any transition to a carve-out of dental benefits under managed  
1712 care.

1713 (10) It is the intent of the Legislature that any  
1714 contractor receiving capitated payments under a managed care  
1715 delivery system established in this section shall implement  
1716 innovative programs to improve the health and well-being of  
1717 members diagnosed with prediabetes and diabetes.

1718 (11) It is the intent of the Legislature that any  
1719 contractors receiving capitated payments under a managed care  
1720 delivery system established under this subsection (H) shall work  
1721 with providers of Medicaid services to improve the utilization of  
1722 long-acting reversible contraceptives (LARCs). Not later than



1723 December 1, 2021, any contractors receiving capitated payments  
1724 under a managed care delivery system established under this  
1725 subsection (H) shall provide to the Chairmen of the House and  
1726 Senate Medicaid Committees and House and Senate Public Health  
1727 Committees a report of LARC utilization for State Fiscal Years  
1728 2018 through 2020 as well as any programs, initiatives, or efforts  
1729 made by the contractors and providers to increase LARC  
1730 utilization. This report shall be updated annually to include  
1731 information for subsequent state fiscal years.

1732 (12) The division is authorized to make not more than  
1733 one (1) emergency extension of the contracts that are in effect on  
1734 July 1, 2021, with contractors who are receiving capitated  
1735 payments under a managed care delivery system established under  
1736 this subsection (H), as provided in this paragraph (12). The  
1737 maximum period of any such extension shall be one (1) year, and  
1738 under any such extensions, the contractors shall be subject to all  
1739 of the provisions of this subsection (H). The extended contracts  
1740 shall be revised to incorporate any provisions of this subsection  
1741 (H).

1742 (I) [Deleted]

1743 (J) There shall be no cuts in inpatient and outpatient  
1744 hospital payments, or allowable days or volumes, as long as the  
1745 hospital assessment provided in Section 43-13-145 is in effect.  
1746 This subsection (J) shall not apply to decreases in payments that  
1747 are a result of: reduced hospital admissions, audits or payments



1748 under the APR-DRG or APC models, or a managed care program or  
1749 similar model described in subsection (H) of this section.

1750 (K) In the negotiation and execution of such contracts  
1751 involving services performed by actuarial firms, the Executive  
1752 Director of the Division of Medicaid may negotiate a limitation on  
1753 liability to the state of prospective contractors.

1754 (L) The Division of Medicaid shall reimburse for services  
1755 provided to eligible Medicaid beneficiaries by a licensed birthing  
1756 center in a method and manner to be determined by the division in  
1757 accordance with federal laws and federal regulations. The  
1758 division shall seek any necessary waivers, make any required  
1759 amendments to its State Plan or revise any contracts authorized  
1760 under subsection (H) of this section as necessary to provide the  
1761 services authorized under this subsection. As used in this  
1762 subsection, the term "birthing centers" shall have the meaning as  
1763 defined in Section 41-77-1(a), which is a publicly or privately  
1764 owned facility, place or institution constructed, renovated,  
1765 leased or otherwise established where nonemergency births are  
1766 planned to occur away from the mother's usual residence following  
1767 a documented period of prenatal care for a normal uncomplicated  
1768 pregnancy which has been determined to be low risk through a  
1769 formal risk-scoring examination.

1770 (M) This section shall stand repealed on July 1, \* \* \* 2029.

1771 **SECTION 3.** Section 43-13-121, Mississippi Code of 1972, is  
1772 amended as follows:



1773           43-13-121. (1) The division shall administer the Medicaid  
1774 program under the provisions of this article, and may do the  
1775 following:

1776           (a) Adopt and promulgate reasonable rules, regulations  
1777 and standards, with approval of the Governor, and in accordance  
1778 with the Administrative Procedures Law, Section 25-43-1.101 et  
1779 seq.:

1780                   (i) Establishing methods and procedures as may be  
1781 necessary for the proper and efficient administration of this  
1782 article;

1783                   (ii) Providing Medicaid to all qualified  
1784 recipients under the provisions of this article as the division  
1785 may determine and within the limits of appropriated funds;

1786                   (iii) Establishing reasonable fees, charges and  
1787 rates for medical services and drugs; in doing so, the division  
1788 shall fix all of those fees, charges and rates at the minimum  
1789 levels absolutely necessary to provide the medical assistance  
1790 authorized by this article, and shall not change any of those  
1791 fees, charges or rates except as may be authorized in Section  
1792 43-13-117;

1793                   (iv) Providing for fair and impartial hearings;

1794                   (v) Providing safeguards for preserving the  
1795 confidentiality of records; and

1796                   (vi) For detecting and processing fraudulent  
1797 practices and abuses of the program;



1798                   (b) Receive and expend state, federal and other funds  
1799 in accordance with court judgments or settlements and agreements  
1800 between the State of Mississippi and the federal government, the  
1801 rules and regulations promulgated by the division, with the  
1802 approval of the Governor, and within the limitations and  
1803 restrictions of this article and within the limits of funds  
1804 available for that purpose;

1805                   (c) Subject to the limits imposed by this article and  
1806 subject to the provisions of subsection (8) of this section, to  
1807 submit a Medicaid plan to the United States Department of Health  
1808 and Human Services for approval under the provisions of the  
1809 federal Social Security Act, to act for the state in making  
1810 negotiations relative to the submission and approval of that plan,  
1811 to make such arrangements, not inconsistent with the law, as may  
1812 be required by or under federal law to obtain and retain that  
1813 approval and to secure for the state the benefits of the  
1814 provisions of that law.

1815                   No agreements, specifically including the general plan for  
1816 the operation of the Medicaid program in this state, shall be made  
1817 by and between the division and the United States Department of  
1818 Health and Human Services unless the Attorney General of the State  
1819 of Mississippi has reviewed the agreements, specifically including  
1820 the operational plan, and has certified in writing to the Governor  
1821 and to the executive director of the division that the agreements,



1822 including the plan of operation, have been drawn strictly in  
1823 accordance with the terms and requirements of this article;

1824 (d) In accordance with the purposes and intent of this  
1825 article and in compliance with its provisions, provide for aged  
1826 persons otherwise eligible for the benefits provided under Title  
1827 XVIII of the federal Social Security Act by expenditure of funds  
1828 available for those purposes;

1829 (e) To make reports to the United States Department of  
1830 Health and Human Services as from time to time may be required by  
1831 that federal department and to the Mississippi Legislature as  
1832 provided in this section;

1833 (f) Define and determine the scope, duration and amount  
1834 of Medicaid that may be provided in accordance with this article  
1835 and establish priorities therefor in conformity with this article;

1836 (g) Cooperate and contract with other state agencies  
1837 for the purpose of coordinating Medicaid provided under this  
1838 article and eliminating duplication and inefficiency in the  
1839 Medicaid program;

1840 (h) Adopt and use an official seal of the division;

1841 (i) Sue in its own name on behalf of the State of  
1842 Mississippi and employ legal counsel on a contingency basis with  
1843 the approval of the Attorney General;

1844 (j) To recover any and all payments incorrectly made by  
1845 the division to a recipient or provider from the recipient or  
1846 provider receiving the payments. The division shall be authorized





1847 to collect any overpayments to providers sixty (60) days after the  
1848 conclusion of any administrative appeal unless the matter is  
1849 appealed to a court of proper jurisdiction and bond is posted.  
1850 Any appeal filed after July 1, 2015, shall be to the Chancery  
1851 Court of the First Judicial District of Hinds County, Mississippi,  
1852 within sixty (60) days after the date that the division has  
1853 notified the provider by certified mail sent to the proper address  
1854 of the provider on file with the division and the provider has  
1855 signed for the certified mail notice, or sixty (60) days after the  
1856 date of the final decision if the provider does not sign for the  
1857 certified mail notice. To recover those payments, the division  
1858 may use the following methods, in addition to any other methods  
1859 available to the division:

1860 (i) The division shall report to the Department of  
1861 Revenue the name of any current or former Medicaid recipient who  
1862 has received medical services rendered during a period of  
1863 established Medicaid ineligibility and who has not reimbursed the  
1864 division for the related medical service payment(s). The  
1865 Department of Revenue shall withhold from the state tax refund of  
1866 the individual, and pay to the division, the amount of the  
1867 payment(s) for medical services rendered to the ineligible  
1868 individual that have not been reimbursed to the division for the  
1869 related medical service payment(s).

1870 (ii) The division shall report to the Department  
1871 of Revenue the name of any Medicaid provider to whom payments were



1872 incorrectly made that the division has not been able to recover by  
1873 other methods available to the division. The Department of  
1874 Revenue shall withhold from the state tax refund of the provider,  
1875 and pay to the division, the amount of the payments that were  
1876 incorrectly made to the provider that have not been recovered by  
1877 other available methods;

1878 (k) To recover any and all payments by the division  
1879 fraudulently obtained by a recipient or provider. Additionally,  
1880 if recovery of any payments fraudulently obtained by a recipient  
1881 or provider is made in any court, then, upon motion of the  
1882 Governor, the judge of the court may award twice the payments  
1883 recovered as damages;

1884 (l) Have full, complete and plenary power and authority  
1885 to conduct such investigations as it may deem necessary and  
1886 requisite of alleged or suspected violations or abuses of the  
1887 provisions of this article or of the regulations adopted under  
1888 this article, including, but not limited to, fraudulent or  
1889 unlawful act or deed by applicants for Medicaid or other benefits,  
1890 or payments made to any person, firm or corporation under the  
1891 terms, conditions and authority of this article, to suspend or  
1892 disqualify any provider of services, applicant or recipient for  
1893 gross abuse, fraudulent or unlawful acts for such periods,  
1894 including permanently, and under such conditions as the division  
1895 deems proper and just, including the imposition of a legal rate of  
1896 interest on the amount improperly or incorrectly paid. Recipients



1897 who are found to have misused or abused Medicaid benefits may be  
1898 locked into one (1) physician and/or one (1) pharmacy of the  
1899 recipient's choice for a reasonable amount of time in order to  
1900 educate and promote appropriate use of medical services, in  
1901 accordance with federal regulations. If an administrative hearing  
1902 becomes necessary, the division may, if the provider does not  
1903 succeed in his or her defense, tax the costs of the administrative  
1904 hearing, including the costs of the court reporter or stenographer  
1905 and transcript, to the provider. The convictions of a recipient  
1906 or a provider in a state or federal court for abuse, fraudulent or  
1907 unlawful acts under this chapter shall constitute an automatic  
1908 disqualification of the recipient or automatic disqualification of  
1909 the provider from participation under the Medicaid program.

1910 A conviction, for the purposes of this chapter, shall include  
1911 a judgment entered on a plea of nolo contendere or a  
1912 nonadjudicated guilty plea and shall have the same force as a  
1913 judgment entered pursuant to a guilty plea or a conviction  
1914 following trial. A certified copy of the judgment of the court of  
1915 competent jurisdiction of the conviction shall constitute prima  
1916 facie evidence of the conviction for disqualification purposes;

1917 (m) Establish and provide such methods of  
1918 administration as may be necessary for the proper and efficient  
1919 operation of the Medicaid program, fully utilizing computer  
1920 equipment as may be necessary to oversee and control all current  
1921 expenditures for purposes of this article, and to closely monitor



and supervise all recipient payments and vendors rendering services under this article. Notwithstanding any other provision of state law, the division is authorized to enter into a ten-year contract(s) with a vendor(s) to provide services described in this paragraph (m). Notwithstanding any provision of law to the contrary, the division is authorized to extend its Medicaid Management Information System, including all related components and services, and Decision Support System, including all related components and services, contracts in effect on June 30, 2020, for a period not to exceed two (2) years without complying with state procurement regulations;

(n) To cooperate and contract with the federal government for the purpose of providing Medicaid to Vietnamese and Cambodian refugees, under the provisions of Public Law 94-23 and Public Law 94-24, including any amendments to those laws, only to the extent that the Medicaid assistance and the administrative cost related thereto are one hundred percent (100%) reimbursable by the federal government. For the purposes of Section 43-13-117, persons receiving Medicaid under Public Law 94-23 and Public Law 94-24, including any amendments to those laws, shall not be 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



1947 at the same rate calculated by the United States Department of  
1948 Health and Human Services and/or the Centers for Medicare and  
1949 Medicaid Services (CMS) under federal regulations.

1950 (2) The division also shall exercise such additional powers  
1951 and perform such other duties as may be conferred upon the  
1952 division by act of the Legislature.

1953 (3) The division, and the State Department of Health as the  
1954 agency for licensure of health care facilities and certification  
1955 and inspection for the Medicaid and/or Medicare programs, shall  
1956 contract for or otherwise provide for the consolidation of on-site  
1957 inspections of health care facilities that are necessitated by the  
1958 respective programs and functions of the division and the  
1959 department.

1960 (4) The division and its hearing officers shall have power  
1961 to preserve and enforce order during hearings; to issue subpoenas  
1962 for, to administer oaths to and to compel the attendance and  
1963 testimony of witnesses, or the production of books, papers,  
1964 documents and other evidence, or the taking of depositions before  
1965 any designated individual competent to administer oaths; to  
1966 examine witnesses; and to do all things conformable to law that  
1967 may be necessary to enable them effectively to discharge the  
1968 duties of their office. In compelling the attendance and  
1969 testimony of witnesses, or the production of books, papers,  
1970 documents and other evidence, or the taking of depositions, as  
1971 authorized by this section, the division or its hearing officers



1972 may designate an individual employed by the division or some other  
1973 suitable person to execute and return that process, whose action  
1974 in executing and returning that process shall be as lawful as if  
1975 done by the sheriff or some other proper officer authorized to  
1976 execute and return process in the county where the witness may  
1977 reside. In carrying out the investigatory powers under the  
1978 provisions of this article, the executive director or other  
1979 designated person or persons may examine, obtain, copy or  
1980 reproduce the books, papers, documents, medical charts,  
1981 prescriptions and other records relating to medical care and  
1982 services furnished by the provider to a recipient or designated  
1983 recipients of Medicaid services under investigation. In the  
1984 absence of the voluntary submission of the books, papers,  
1985 documents, medical charts, prescriptions and other records, the  
1986 Governor, the executive director, or other designated person may  
1987 issue and serve subpoenas instantly upon the provider, his or her  
1988 agent, servant or employee for the production of the books,  
1989 papers, documents, medical charts, prescriptions or other records  
1990 during an audit or investigation of the provider. If any provider  
1991 or his or her agent, servant or employee refuses to produce the  
1992 records after being duly subpoenaed, the executive director may  
1993 certify those facts and institute contempt proceedings in the  
1994 manner, time and place as authorized by law for administrative  
1995 proceedings. As an additional remedy, the division may recover  
1996 all amounts paid to the provider covering the period of the audit



or investigation, inclusive of a legal rate of interest and a reasonable attorney's fee and costs of court if suit becomes necessary. Division staff shall have immediate access to the provider's physical location, facilities, records, documents, books, and any other records relating to medical care and services rendered to recipients during regular business hours.

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

(6) In suspending or terminating any provider from participation in the Medicaid program, the division shall preclude the provider from submitting claims for payment, either personally



or through any clinic, group, corporation or other association to the division or its fiscal agents for any services or supplies provided under the Medicaid program except for those services or supplies provided before the suspension or termination. No clinic, group, corporation or other association that is a provider of services shall submit claims for payment to the division or its fiscal agents for any services or supplies provided by a person within that organization who has been suspended or terminated from participation in the Medicaid program except for those services or supplies provided before the suspension or termination. When this provision is violated by a provider of services that is a clinic, group, corporation or other association, the division may suspend or terminate that organization from participation. Suspension may be applied by the division to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure or inadequacy of performance may be imputed to a person with whom the provider is affiliated where that conduct was accomplished within the course of his or her official duty or was effectuated by him or her with 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





2046 employee or any person having an ownership interest equal to five  
2047 percent (5%) or greater in the provider:

2048 (a) Failure to truthfully or fully disclose any and all  
2049 information required, or the concealment of any and all  
2050 information required, on a claim, a provider application or a  
2051 provider agreement, or the making of a false or misleading  
2052 statement to the division relative to the Medicaid program.

2053 (b) Previous or current exclusion, suspension,  
2054 termination from or the involuntary withdrawing from participation  
2055 in the Medicaid program, any other state's Medicaid program,  
2056 Medicare or any other public or private health or health insurance  
2057 program. If the division ascertains that a provider has been  
2058 convicted of a felony under federal or state law for an offense  
2059 that the division determines is detrimental to the best interest  
2060 of the program or of Medicaid beneficiaries, the division may  
2061 refuse to enter into an agreement with that provider, or may  
2062 terminate or refuse to renew an existing agreement.

2063 (c) Conviction under federal or state law of a criminal  
2064 offense relating to the delivery of any goods, services or  
2065 supplies, including the performance of management or  
2066 administrative services relating to the delivery of the goods,  
2067 services or supplies, under the Medicaid program, any other  
2068 state's Medicaid program, Medicare or any other public or private  
2069 health or health insurance program.



2070 (d) Conviction under federal or state law of a criminal  
2071 offense relating to the neglect or abuse of a patient in  
2072 connection with the delivery of any goods, services or supplies.

2073 (e) Conviction under federal or state law of a criminal  
2074 offense relating to the unlawful manufacture, distribution,  
2075 prescription or dispensing of a controlled substance.

2076 (f) Conviction under federal or state law of a criminal  
2077 offense relating to fraud, theft, embezzlement, breach of  
2078 fiduciary responsibility or other financial misconduct.

2079 (g) Conviction under federal or state law of a criminal  
2080 offense punishable by imprisonment of a year or more that involves  
2081 moral turpitude, or acts against the elderly, children or infirm.

2082 (h) Conviction under federal or state law of a criminal  
2083 offense in connection with the interference or obstruction of any  
2084 investigation into any criminal offense listed in paragraphs (c)  
2085 through (i) of this subsection.

2086 (i) Sanction for a violation of federal or state laws  
2087 or rules relative to the Medicaid program, any other state's  
2088 Medicaid program, Medicare or any other public health care or  
2089 health insurance program.

2090 (j) Revocation of license or certification.

2091 (k) Failure to pay recovery properly assessed or  
2092 pursuant to an approved repayment schedule under the Medicaid  
2093 program.

2094 (l) Failure to meet any condition of enrollment.



2095           (8)   (a)   As used in this subsection (8), the following terms  
2096 shall be defined as provided in this paragraph, except as  
2097 otherwise provided in this subsection:

2098                       (i)   "Committees" means the Medicaid Committees of  
2099 the House of Representatives and the Senate, and "committee" means  
2100 either one of those committees.

2101                       (ii)   "State Plan" means the agreement between the  
2102 State of Mississippi and the federal government regarding the  
2103 nature and scope of Mississippi's Medicaid Program.

2104                       (iii)   "State Plan Amendment" means a change to the  
2105 State Plan, which must be approved by the Centers for Medicare and  
2106 Medicaid Services (CMS) before its implementation.

2107           (b)   Whenever the Division of Medicaid proposes a State  
2108 Plan Amendment, the division shall give notice to the chairmen of  
2109 the committees at least \* \* \* fifteen (15) calendar days before  
2110 the proposed State Plan Amendment is filed with CMS. The division  
2111 shall furnish the chairmen with a concise summary of each proposed  
2112 State Plan Amendment along with the notice, and shall furnish the  
2113 chairmen with a copy of any proposed State Plan Amendment upon  
2114 request. The division also shall provide a summary and copy of  
2115 any proposed State Plan Amendment to any other member of the  
2116 Legislature upon request.

2117           (c)   If the chairman of either committee or both  
2118 chairmen jointly object to the proposed State Plan Amendment or  
2119 any part thereof, the chairman or chairmen shall notify the



2120 division and provide the reasons for their objection in writing  
2121 not later than seven (7) calendar days after receipt of the notice  
2122 from the division. The chairman or chairmen may make written  
2123 recommendations to the division for changes to be made to a  
2124 proposed State Plan Amendment.

2125 (d) (i) The chairman of either committee or both  
2126 chairmen jointly may hold a committee meeting to review a proposed  
2127 State Plan Amendment. If either chairman or both chairmen decide  
2128 to hold a meeting, they shall notify the division of their  
2129 intention in writing within seven (7) calendar days after receipt  
2130 of the notice from the division, and shall set the date and time  
2131 for the meeting in their notice to the division, which shall not  
2132 be later than fourteen (14) calendar days after receipt of the  
2133 notice from the division.

2134 (ii) After the committee meeting, the committee or  
2135 committees may object to the proposed State Plan Amendment or any  
2136 part thereof. The committee or committees shall notify the  
2137 division and the reasons for their objection in writing not later  
2138 than seven (7) calendar days after the meeting. The committee or  
2139 committees may make written recommendations to the division for  
2140 changes to be made to a proposed State Plan Amendment.

2141 (e) If both chairmen notify the division in writing  
2142 within seven (7) calendar days after receipt of the notice from  
2143 the division that they do not object to the proposed State Plan  
2144 Amendment and will not be holding a meeting to review the proposed



2145 State Plan Amendment, the division may proceed to file the  
2146 proposed State Plan Amendment with CMS.

2147 (f) (i) If there are any objections to a proposed rate  
2148 change or any part thereof from either or both of the chairmen or  
2149 the committees, the division may withdraw the proposed State Plan  
2150 Amendment, make any of the recommended changes to the proposed  
2151 State Plan Amendment, or not make any changes to the proposed  
2152 State Plan Amendment.

2153 (ii) If the division does not make any changes to  
2154 the proposed State Plan Amendment, it shall notify the chairmen of  
2155 that fact in writing, and may proceed to file the State Plan  
2156 Amendment with CMS.

2157 (iii) If the division makes any changes to the  
2158 proposed State Plan Amendment, the division shall notify the  
2159 chairmen of its actions in writing, and may proceed to file the  
2160 State Plan Amendment with CMS.

2161 (g) Nothing in this subsection (8) shall be construed  
2162 as giving the chairmen or the committees any authority to veto,  
2163 nullify or revise any State Plan Amendment proposed by the  
2164 division. The authority of the chairmen or the committees under  
2165 this subsection shall be limited to reviewing, making objections  
2166 to and making recommendations for changes to State Plan Amendments  
2167 proposed by the division.

2168 (i) If the division does not make any changes to  
2169 the proposed State Plan Amendment, it shall notify the chairmen of



2170 that fact in writing, and may proceed to file the proposed State  
2171 Plan Amendment with CMS.

2172 (ii) If the division makes any changes to the  
2173 proposed State Plan Amendment, the division shall notify the  
2174 chairmen of the changes in writing, and may proceed to file the  
2175 proposed State Plan Amendment with CMS.

2176 (iii) If the division needs to expedite the  
2177 fifteen-day legislative notice set forth in paragraph (b) of this  
2178 subsection (8), the division will notify both chairmen.

2179 (h) Nothing in this subsection (8) shall be construed  
2180 as giving the chairmen of the committees any authority to veto,  
2181 nullify or revise any State Plan Amendment proposed by the  
2182 division. The authority of the chairmen of the committees under  
2183 this subsection shall be limited to reviewing, making objections  
2184 to and making recommendations for suggested changes to State Plan  
2185 Amendments proposed by the division.

2186 **SECTION 4.** Section 43-13-305, Mississippi Code of 1972, is  
2187 amended as follows:

2188 43-13-305. (1) By accepting Medicaid from the Division of  
2189 Medicaid in the Office of the Governor, the recipient shall, to  
2190 the extent of the payment of medical expenses by the Division of  
2191 Medicaid, be deemed to have made an assignment to the Division of  
2192 Medicaid of any and all rights and interests in any third-party  
2193 benefits, hospitalization or indemnity contract or any cause of  
2194 action, past, present or future, against any person, firm or



2195 corporation for Medicaid benefits provided to the recipient by the  
2196 Division of Medicaid for injuries, disease or sickness caused or  
2197 suffered under circumstances creating a cause of action in favor  
2198 of the recipient against any such person, firm or corporation as  
2199 set out in Section 43-13-125. The recipient shall be deemed,  
2200 without the necessity of signing any document, to have appointed  
2201 the Division of Medicaid as his or her true and lawful  
2202 attorney-in-fact in his or her name, place and stead in collecting  
2203 any and all amounts due and owing for medical expenses paid by the  
2204 Division of Medicaid against such person, firm or corporation.

2205 (2) Whenever a provider of medical services or the Division  
2206 of Medicaid submits claims to an insurer on behalf of a Medicaid  
2207 recipient for whom an assignment of rights has been received, or  
2208 whose rights have been assigned by the operation of law, the  
2209 insurer must respond within sixty (60) days of receipt of a claim  
2210 by forwarding payment or issuing a notice of denial directly to  
2211 the submitter of the claim. The failure of the insuring entity to  
2212 comply with the provisions of this section shall subject the  
2213 insuring entity to recourse by the Division of Medicaid in  
2214 accordance with the provision of Section 43-13-315. In the case  
2215 of a responsible insurer, other than the insurers exempted under  
2216 federal law, that requires prior authorization for an item or  
2217 service furnished to a recipient, the insurer shall accept  
2218 authorization provided by the Division of Medicaid that the item  
2219 or service is covered under the state plan (or waiver of such



2220 plan) for such recipient, as if such authorization were the prior  
2221 authorization made by the third party for such item or service.

2222 The Division of Medicaid shall be authorized to endorse any and  
2223 all, including, but not limited to, multi-payee checks, drafts,  
2224 money orders or other negotiable instruments representing Medicaid  
2225 payment recoveries that are received by the Division of Medicaid.

2226 (3) Court orders or agreements for medical support shall  
2227 direct such payments to the Division of Medicaid, which shall be  
2228 authorized to endorse any and all checks, drafts, money orders or  
2229 other negotiable instruments representing medical support payments  
2230 which are received. Any designated medical support funds received  
2231 by the State Department of Human Services or through its local  
2232 county departments shall be paid over to the Division of Medicaid.  
2233 When medical support for a Medicaid recipient is available through  
2234 an absent parent or custodial parent, the insuring entity shall  
2235 direct the medical support payment(s) to the provider of medical  
2236 services or to the Division of Medicaid.

2237 **SECTION 5.** Section 43-11-1, Mississippi Code of 1972, is  
2238 amended as follows:

2239 43-11-1. When used in this chapter, the following words  
2240 shall have the following meaning:

2241 (a) "Institutions for the aged or infirm" means a place  
2242 either governmental or private that provides group living  
2243 arrangements for four (4) or more persons who are unrelated to the  
2244 operator and who are being provided food, shelter and personal





2245 care, whether any such place is organized or operated for profit  
2246 or not. The term "institution for the aged or infirm" includes  
2247 nursing homes, pediatric skilled nursing facilities, psychiatric  
2248 residential treatment facilities, convalescent homes, homes for  
2249 the aged, adult foster care facilities and special care facilities  
2250 for paroled inmates, provided that these institutions fall within  
2251 the scope of the definitions set forth above. The term  
2252 "institution for the aged or infirm" does not include hospitals,  
2253 clinics or mental institutions devoted primarily to providing  
2254 medical service, and does not include any private residence in  
2255 which the owner of the residence is providing personal care  
2256 services to disabled or homeless veterans under an agreement with,  
2257 and in compliance with the standards prescribed by, the United  
2258 States Department of Veterans Affairs, if the owner of the  
2259 residence also provided personal care services to disabled or  
2260 homeless veterans at any time during calendar year 2008.

2261 (b) "Person" means any individual, firm, partnership,  
2262 corporation, company, association or joint-stock association, or  
2263 any licensee herein or the legal successor thereof.

2264 (c) "Personal care" means assistance rendered by  
2265 personnel of the home to aged or infirm residents in performing  
2266 one or more of the activities of daily living, which includes, but  
2267 is not limited to, the bathing, walking, excretory functions,  
2268 feeding, personal grooming and dressing of such residents.



2269 (d) "Psychiatric residential treatment facility" means  
2270 any nonhospital establishment with permanent facilities which  
2271 provides a twenty-four-hour program of care by qualified  
2272 therapists, including, but not limited to, duly licensed mental  
2273 health professionals, psychiatrists, psychologists,  
2274 psychotherapists and licensed certified social workers, for  
2275 emotionally disturbed children and adolescents referred to such  
2276 facility by a court, local school district or by the Department of  
2277 Human Services, who are not in an acute phase of illness requiring  
2278 the services of a psychiatric hospital, and are in need of such  
2279 restorative treatment services. For purposes of this paragraph,  
2280 the term "emotionally disturbed" means a condition exhibiting one  
2281 or more of the following characteristics over a long period of  
2282 time and to a marked degree, which adversely affects educational  
2283 performance:

2284 1. An inability to learn which cannot be explained  
2285 by intellectual, sensory or health factors;

2286 2. An inability to build or maintain satisfactory  
2287 relationships with peers and teachers;

2288 3. Inappropriate types of behavior or feelings  
2289 under normal circumstances;

2290 4. A general pervasive mood of unhappiness or  
2291 depression; or

2292 5. A tendency to develop physical symptoms or  
2293 fears associated with personal or school problems. An



2294 establishment furnishing primarily domiciliary care is not within  
2295 this definition.

2296 (e) "Pediatric skilled nursing facility" means an  
2297 institution or a distinct part of an institution that is primarily  
2298 engaged in providing to inpatients skilled nursing care and  
2299 related services for persons under twenty-one (21) years of age  
2300 who require medical or nursing care or rehabilitation services for  
2301 the rehabilitation of injured, disabled or sick persons.

2302 (f) "Licensing agency" means the State Department of  
2303 Health.

2304 (g) "Medical records" mean, without restriction, those  
2305 medical histories, records, reports, summaries, diagnoses and  
2306 prognoses, records of treatment and medication ordered and given,  
2307 notes, entries, x-rays and other written or graphic data prepared,  
2308 kept, made or maintained in institutions for the aged or infirm  
2309 that pertain to residency in, or services rendered to residents  
2310 of, an institution for the aged or infirm.

2311 (h) "Adult foster care facility" means a home setting  
2312 for vulnerable adults in the community who are unable to live  
2313 independently due to physical, emotional, developmental or mental  
2314 impairments, or in need of emergency and continuing protective  
2315 social services for purposes of preventing further abuse or  
2316 neglect and for safeguarding and enhancing the welfare of the  
2317 abused or neglected vulnerable adult. Adult foster care programs  
2318 shall be designed to meet the needs of vulnerable adults with



2319 impairments through individual plans of care, which provide a  
2320 variety of health, social and related support services in a  
2321 protective setting, enabling participants to live in the  
2322 community. Adult foster care programs may be (i) traditional,  
2323 where the foster care provider lives in the residence and is the  
2324 primary caregiver to clients in the home; (ii) corporate, where  
2325 the foster care home is operated by a corporation with shift staff  
2326 delivering services to clients; or (iii) shelter, where the foster  
2327 care home accepts clients on an emergency short-term basis for up  
2328 to thirty (30) days.

2329           (i) "Special care facilities for paroled inmates" means  
2330 long-term care and skilled nursing facilities licensed as special  
2331 care facilities for medically frail paroled inmates, formed to  
2332 ease the burden of prison overcrowding and provide compassionate  
2333 release and medical parole initiatives while impacting economic  
2334 outcomes for the Mississippi prison system. The facilities shall  
2335 meet all Mississippi Department of Health and federal Center for  
2336 Medicaid Services (CMS) requirements and shall be regulated by  
2337 both agencies; provided, however, such regulations shall not be as  
2338 restrictive as those required for personal care homes and other  
2339 institutions devoted primarily to providing medical services. The  
2340 facilities will offer physical, occupational and speech therapy,  
2341 nursing services, wound care, a dedicated COVID services unit,  
2342 individualized patient centered plans of care, social services,  
2343 spiritual services, physical activities, transportation,



2344 medication, durable medical equipment, personalized meal plans by  
2345 a licensed dietician and security services. There may be up to  
2346 three (3) facilities located in each Supreme Court district, to be  
2347 designated by the Chairman of the State Parole Board or his  
2348 designee.

2349 (j) "Adult day care facility" means a public agency or  
2350 private organization, or a subdivision of such an agency or  
2351 organization, that:

2352 (i) Provides the following items and services:

2353 1. Nursing services;

2354 2. Transportation of the individual to and  
2355 from such adult day care facility in connection with any such item  
2356 or service;

2357 3. Meals;

2358 4. A program of supervised activities that  
2359 meets such criteria as the licensing agency determines and is  
2360 appropriately designed to promote physical and mental health that  
2361 is furnished to the individual by such a facility in a group  
2362 setting for a period not greater than twelve (12) hours per day;

2363 5. The administration of medication by a  
2364 licensed nurse, and a medication management program to minimize  
2365 unnecessary or inappropriate use of prescription drugs and adverse  
2366 events due to unintended prescription drug-to-drug interactions;  
2367 and



2368                   (ii) Meets such standards established by the  
2369 licensing agency to assure quality of care and such other  
2370 requirements as the licensing agency finds necessary in the  
2371 interest of the health and safety of individuals who are furnished  
2372 services in the facility.

2373           **SECTION 6.** Section 43-11-8, Mississippi Code of 1972, is  
2374 amended as follows:

2375           43-11-8. (1) An application for a license for an adult  
2376 foster care facility or for an adult day care facility shall be  
2377 made to the licensing agency upon forms provided by it and shall  
2378 contain such information as the licensing agency reasonably  
2379 requires, which may include affirmative evidence of ability to  
2380 comply with such reasonable standards, rules and regulations as  
2381 are lawfully prescribed hereunder. Each application for a license  
2382 for an adult foster care facility or for an adult day care  
2383 facility shall be accompanied by a license fee of Ten Dollars  
2384 (\$10.00) for each person or bed of licensed capacity, with a  
2385 minimum fee per home or institution of Fifty Dollars (\$50.00),  
2386 which shall be paid to the licensing agency. Any increase in the  
2387 fee charged by the licensing agency under this subsection shall be  
2388 in accordance with the provisions of Section 41-3-65.

2389           (2) A license, unless suspended or revoked, shall be  
2390 renewable annually upon payment by the licensee of an adult foster  
2391 care facility or of an adult day care facility, except for  
2392 personal care homes, of a renewal fee of Ten Dollars (\$10.00) for



2393 each person or bed of licensed capacity in the institution, with a  
2394 minimum renewal fee per institution of Fifty Dollars (\$50.00),  
2395 which shall be paid to the licensing agency, and upon filing by  
2396 the licensee and approval by the licensing agency of an annual  
2397 report upon such uniform dates and containing such information in  
2398 such form as the licensing agency prescribes by regulation. Any  
2399 increase in the fee charged by the licensing agency under this  
2400 subsection shall be in accordance with the provisions of Section  
2401 41-3-65. Each license shall be issued only for the premises and  
2402 person or persons or other legal entity or entities named in the  
2403 application and shall not be transferable or assignable except  
2404 with the written approval of the licensing agency. Licenses shall  
2405 be posted in a conspicuous place on the licensed premises.

2406       **SECTION 7.** Section 43-11-13, Mississippi Code of 1972, is  
2407 amended as follows:

2408       43-11-13. (1) The licensing agency shall adopt, amend,  
2409 promulgate and enforce such rules, regulations and standards,  
2410 including classifications, with respect to all institutions for  
2411 the aged or infirm to be licensed under this chapter as may be  
2412 designed to further the accomplishment of the purpose of this  
2413 chapter in promoting adequate care of individuals in those  
2414 institutions in the interest of public health, safety and welfare.  
2415 Those rules, regulations and standards shall be adopted and  
2416 promulgated by the licensing agency and shall be recorded and  
2417 indexed in a book to be maintained by the licensing agency in its



2418 main office in the State of Mississippi, entitled "Rules,  
2419 Regulations and Minimum Standards for Institutions for the Aged or  
2420 Infirm" and the book shall be open and available to all  
2421 institutions for the aged or infirm and the public generally at  
2422 all reasonable times. Upon the adoption of those rules,  
2423 regulations and standards, the licensing agency shall mail copies  
2424 thereof to all those institutions in the state that have filed  
2425 with the agency their names and addresses for this purpose, but  
2426 the failure to mail the same or the failure of the institutions to  
2427 receive the same shall in no way affect the validity thereof. The  
2428 rules, regulations and standards may be amended by the licensing  
2429 agency, from time to time, as necessary to promote the health,  
2430 safety and welfare of persons living in those institutions.

2431 (2) The licensee shall keep posted in a conspicuous place on  
2432 the licensed premises all current rules, regulations and minimum  
2433 standards applicable to fire protection measures as adopted by the  
2434 licensing agency. The licensee shall furnish to the licensing  
2435 agency at least once each six (6) months a certificate of approval  
2436 and inspection by state or local fire authorities. Failure to  
2437 comply with state laws and/or municipal ordinances and current  
2438 rules, regulations and minimum standards as adopted by the  
2439 licensing agency, relative to fire prevention measures, shall be  
2440 prima facie evidence for revocation of license.

2441 (3) The State Board of Health shall promulgate rules and  
2442 regulations restricting the storage, quantity and classes of drugs





2443 allowed in personal care homes and adult foster care facilities.  
2444 Residents requiring administration of Schedule II Narcotics as  
2445 defined in the Uniform Controlled Substances Law may be admitted  
2446 to a personal care home. Schedule drugs may only be allowed in a  
2447 personal care home if they are administered or stored utilizing  
2448 proper procedures under the direct supervision of a licensed  
2449 physician or nurse.

2450       (4) (a) Notwithstanding any determination by the licensing  
2451 agency that skilled nursing services would be appropriate for a  
2452 resident of a personal care home, that resident, the resident's  
2453 guardian or the legally recognized responsible party for the  
2454 resident may consent in writing for the resident to continue to  
2455 reside in the personal care home, if approved in writing by a  
2456 licensed physician. However, no personal care home shall allow  
2457 more than two (2) residents, or ten percent (10%) of the total  
2458 number of residents in the facility, whichever is greater, to  
2459 remain in the personal care home under the provisions of this  
2460 subsection (4). This consent shall be deemed to be appropriately  
2461 informed consent as described in the regulations promulgated by  
2462 the licensing agency. After that written consent has been  
2463 obtained, the resident shall have the right to continue to reside  
2464 in the personal care home for as long as the resident meets the  
2465 other conditions for residing in the personal care home. A copy  
2466 of the written consent and the physician's approval shall be  
2467 forwarded by the personal care home to the licensing agency.



2468 (b) The State Board of Health shall promulgate rules  
2469 and regulations restricting the handling of a resident's personal  
2470 deposits by the director of a personal care home. Any funds given  
2471 or provided for the purpose of supplying extra comforts,  
2472 conveniences or services to any resident in any personal care  
2473 home, and any funds otherwise received and held from, for or on  
2474 behalf of any such resident, shall be deposited by the director or  
2475 other proper officer of the personal care home to the credit of  
2476 that resident in an account that shall be known as the Resident's  
2477 Personal Deposit Fund. No more than one (1) month's charge for  
2478 the care, support, maintenance and medical attention of the  
2479 resident shall be applied from the account at any one time. After  
2480 the death, discharge or transfer of any resident for whose benefit  
2481 any such fund has been provided, any unexpended balance remaining  
2482 in his personal deposit fund shall be applied for the payment of  
2483 care, cost of support, maintenance and medical attention that is  
2484 accrued. If any unexpended balance remains in that resident's  
2485 personal deposit fund after complete reimbursement has been made  
2486 for payment of care, support, maintenance and medical attention,  
2487 and the director or other proper officer of the personal care home  
2488 has been or shall be unable to locate the person or persons  
2489 entitled to the unexpended balance, the director or other proper  
2490 officer may, after the lapse of one (1) year from the date of that  
2491 death, discharge or transfer, deposit the unexpended balance to  
2492 the credit of the personal care home's operating fund.



2493           (c) The State Board of Health shall promulgate rules  
2494 and regulations requiring personal care homes to maintain records  
2495 relating to health condition, medicine dispensed and administered,  
2496 and any reaction to that medicine. The director of the personal  
2497 care home shall be responsible for explaining the availability of  
2498 those records to the family of the resident at any time upon  
2499 reasonable request.

2500           (5) The State Board of Health and the Mississippi Department  
2501 of Corrections shall jointly issue rules and regulations for the  
2502 operation of the special care facilities for paroled inmates.

2503           (6) (a) For the purposes of this subsection (6):

2504                   (i) "Licensed entity" means a hospital, nursing  
2505 home, personal care home, home health agency, hospice or adult  
2506 foster care facility;

2507                   (ii) "Covered entity" means a licensed entity or a  
2508 health care professional staffing agency;

2509                   (iii) "Employee" means any individual employed by  
2510 a covered entity, and also includes any individual who by contract  
2511 provides to the patients, residents or clients being served by the  
2512 covered entity direct, hands-on, medical patient care in a  
2513 patient's, resident's or client's room or in treatment or recovery  
2514 rooms. The term "employee" does not include health care  
2515 professional/vocational technical students performing clinical  
2516 training in a licensed entity under contracts between their  
2517 schools and the licensed entity, and does not include students at



2518 high schools located in Mississippi who observe the treatment and  
2519 care of patients in a licensed entity as part of the requirements  
2520 of an allied-health course taught in the high school, if:

2521                   1. The student is under the supervision of a  
2522 licensed health care provider; and

2523                   2. The student has signed an affidavit that  
2524 is on file at the student's school stating that he or she has not  
2525 been convicted of or pleaded guilty or nolo contendere to a felony  
2526 listed in paragraph (d) of this subsection (6), or that any such  
2527 conviction or plea was reversed on appeal or a pardon was granted  
2528 for the conviction or plea. Before any student may sign such an  
2529 affidavit, the student's school shall provide information to the  
2530 student explaining what a felony is and the nature of the felonies  
2531 listed in paragraph (d) of this subsection (6).

2532           However, the health care professional/vocational technical  
2533 academic program in which the student is enrolled may require the  
2534 student to obtain criminal history record checks. In such  
2535 incidences, paragraph (a)(iii)1 and 2 of this subsection (6) does  
2536 not preclude the licensing entity from processing submitted  
2537 fingerprints of students from healthcare-related  
2538 professional/vocational technical programs who, as part of their  
2539 program of study, conduct observations and provide clinical care  
2540 and services in a covered entity.

2541           (b) Under regulations promulgated by the State Board of  
2542 Health, the licensing agency shall require to be performed a



2543 criminal history record check on (i) every new employee of a  
2544 covered entity who provides direct patient care or services and  
2545 who is employed on or after July 1, 2003, and (ii) every employee  
2546 of a covered entity employed before July 1, 2003, who has a  
2547 documented disciplinary action by his or her present employer. In  
2548 addition, the licensing agency shall require the covered entity to  
2549 perform a disciplinary check with the professional licensing  
2550 agency of each employee, if any, to determine if any disciplinary  
2551 action has been taken against the employee by that agency.

2552       Except as otherwise provided in paragraph (c) of this  
2553 subsection (6), no such employee hired on or after July 1, 2003,  
2554 shall be permitted to provide direct patient care until the  
2555 results of the criminal history record check have revealed no  
2556 disqualifying record or the employee has been granted a waiver.  
2557 In order to determine the employee applicant's suitability for  
2558 employment, the applicant shall be fingerprinted. Fingerprints  
2559 shall be submitted to the licensing agency from scanning, with the  
2560 results processed through the Department of Public Safety's  
2561 Criminal Information Center. The fingerprints shall then be  
2562 forwarded by the Department of Public Safety to the Federal Bureau  
2563 of Investigation for a national criminal history record check.  
2564 The licensing agency shall notify the covered entity of the  
2565 results of an employee applicant's criminal history record check.  
2566 If the criminal history record check discloses a felony  
2567 conviction, guilty plea or plea of nolo contendere to a felony of



2568 possession or sale of drugs, murder, manslaughter, armed robbery,  
2569 rape, sexual battery, sex offense listed in Section 45-33-23(h),  
2570 child abuse, arson, grand larceny, burglary, gratification of lust  
2571 or aggravated assault, or felonious abuse and/or battery of a  
2572 vulnerable adult that has not been reversed on appeal or for which  
2573 a pardon has not been granted, the employee applicant shall not be  
2574 eligible to be employed by the covered entity.

2575 (c) Any such new employee applicant may, however, be  
2576 employed on a temporary basis pending the results of the criminal  
2577 history record check, but any employment contract with the new  
2578 employee shall be voidable if the new employee receives a  
2579 disqualifying criminal history record check and no waiver is  
2580 granted as provided in this subsection (6).

2581 (d) Under regulations promulgated by the State Board of  
2582 Health, the licensing agency shall require every employee of a  
2583 covered entity employed before July 1, 2003, to sign an affidavit  
2584 stating that he or she has not been convicted of or pleaded guilty  
2585 or nolo contendere to a felony of possession or sale of drugs,  
2586 murder, manslaughter, armed robbery, rape, sexual battery, any sex  
2587 offense listed in Section 45-33-23(h), child abuse, arson, grand  
2588 larceny, burglary, gratification of lust, aggravated assault, or  
2589 felonious abuse and/or battery of a vulnerable adult, or that any  
2590 such conviction or plea was reversed on appeal or a pardon was  
2591 granted for the conviction or plea. No such employee of a covered  
2592 entity hired before July 1, 2003, shall be permitted to provide



2593 direct patient care until the employee has signed the affidavit  
2594 required by this paragraph (d). All such existing employees of  
2595 covered entities must sign the affidavit required by this  
2596 paragraph (d) within six (6) months of the final adoption of the  
2597 regulations promulgated by the State Board of Health. If a person  
2598 signs the affidavit required by this paragraph (d), and it is  
2599 later determined that the person actually had been convicted of or  
2600 pleaded guilty or nolo contendere to any of the offenses listed in  
2601 this paragraph (d) and the conviction or plea has not been  
2602 reversed on appeal or a pardon has not been granted for the  
2603 conviction or plea, the person is guilty of perjury. If the  
2604 offense that the person was convicted of or pleaded guilty or nolo  
2605 contendere to was a violent offense, the person, upon a conviction  
2606 of perjury under this paragraph, shall be punished as provided in  
2607 Section 97-9-61. If the offense that the person was convicted of  
2608 or pleaded guilty or nolo contendere to was a nonviolent offense,  
2609 the person, upon a conviction of perjury under this paragraph,  
2610 shall be punished by a fine of not more than Five Hundred Dollars  
2611 (\$500.00), or by imprisonment in the county jail for not more than  
2612 six (6) months, or by both such fine and imprisonment.

2613 (e) The covered entity may, in its discretion, allow  
2614 any employee who is unable to sign the affidavit required by  
2615 paragraph (d) of this subsection (6) or any employee applicant  
2616 aggrieved by an employment decision under this subsection (6) to  
2617 appear before the covered entity's hiring officer, or his or her



2618 designee, to show mitigating circumstances that may exist and  
2619 allow the employee or employee applicant to be employed by the  
2620 covered entity. The covered entity, upon report and  
2621 recommendation of the hiring officer, may grant waivers for those  
2622 mitigating circumstances, which shall include, but not be limited  
2623 to: (i) age at which the crime was committed; (ii) circumstances  
2624 surrounding the crime; (iii) length of time since the conviction  
2625 and criminal history since the conviction; (iv) work history; (v)  
2626 current employment and character references; and (vi) other  
2627 evidence demonstrating the ability of the individual to perform  
2628 the employment responsibilities competently and that the  
2629 individual does not pose a threat to the health or safety of the  
2630 patients of the covered entity.

2631 (f) The licensing agency may charge the covered entity  
2632 submitting the fingerprints a fee not to exceed Fifty Dollars  
2633 (\$50.00), which covered entity may, in its discretion, charge the  
2634 same fee, or a portion thereof, to the employee applicant. Any  
2635 increase in the fee charged by the licensing agency under this  
2636 paragraph shall be in accordance with the provisions of Section  
2637 41-3-65. Any costs incurred by a covered entity implementing this  
2638 subsection (6) shall be reimbursed as an allowable cost under  
2639 Section 43-13-116.

2640 (g) If the results of an employee applicant's criminal  
2641 history record check reveals no disqualifying event, then the  
2642 covered entity shall, within two (2) weeks of the notification of





2643 no disqualifying event, provide the employee applicant with a  
2644 notarized letter signed by the chief executive officer of the  
2645 covered entity, or his or her authorized designee, confirming the  
2646 employee applicant's suitability for employment based on his or  
2647 her criminal history record check. An employee applicant may use  
2648 that letter for a period of two (2) years from the date of the  
2649 letter to seek employment with any covered entity without the  
2650 necessity of an additional criminal history record check. Any  
2651 covered entity presented with the letter may rely on the letter  
2652 with respect to an employee applicant's criminal background and is  
2653 not required for a period of two (2) years from the date of the  
2654 letter to conduct or have conducted a criminal history record  
2655 check as required in this subsection (6).

2656 (h) The licensing agency, the covered entity, and their  
2657 agents, officers, employees, attorneys and representatives, shall  
2658 be presumed to be acting in good faith for any employment decision  
2659 or action taken under this subsection (6). The presumption of  
2660 good faith may be overcome by a preponderance of the evidence in  
2661 any civil action. No licensing agency, covered entity, nor their  
2662 agents, officers, employees, attorneys and representatives shall  
2663 be held liable in any employment decision or action based in whole  
2664 or in part on compliance with or attempts to comply with the  
2665 requirements of this subsection (6).

2666 (i) The licensing agency shall promulgate regulations  
2667 to implement this subsection (6).



2668                   (j) The provisions of this subsection (6) shall not  
2669 apply to:

2670                   (i) Applicants and employees of the University of  
2671 Mississippi Medical Center for whom criminal history record checks  
2672 and fingerprinting are obtained in accordance with Section  
2673 37-115-41; or

2674                   (ii) Health care professional/vocational technical  
2675 students for whom criminal history record checks and  
2676 fingerprinting are obtained in accordance with Section 37-29-232.

2677           (7) The State Board of Health shall promulgate rules,  
2678 regulations and standards regarding the operation of adult foster  
2679 care facilities and adult day care facilities.

2680           (8) Beginning July 1, 2026, to operate an adult day care  
2681 facility in Mississippi, the facility provider shall be licensed  
2682 with the licensing division of the State Department of Health.  
2683 Mississippi Medicaid waiver providers are required to have a state  
2684 license and have a Medicaid provider contract with the Division of  
2685 Medicaid. The licensure shall consist of one (1) of the following  
2686 two (2) levels of service:

2687                   (a) Basic Level - Level I. Facilities shall be  
2688 licensed to serve clients based on the size and capacity of the  
2689 facility. The facilities shall be required to provide nursing  
2690 services, nutritional services, socialization and therapeutic  
2691 activities. Level I facilities shall maintain, at a minimum, a  
2692 staff-to-client ratio in accordance with the State Department of



Health's standards. Standards governing the quality of care and services rendered shall be developed with input from all stakeholders, including the Division of Medicaid. In addition to providing adult day care services, the licensed provider is required to offer transportation services consistent with State Department of Health regulations.

(b) Enhanced Level - Level II. Enhanced level facilities shall be licensed to serve clients based on the size and capacity of the facility. This type of facility may serve clients with significant impairments and medical needs as determined by the State Department of Health. The facility will be required to provide skilled nursing services in addition to nutritional services, socialization and therapeutic activities. Standards governing the quality of care and services rendered shall be developed with input from all stakeholders, including the Division of Medicaid. Enhanced level facilities shall maintain a staff-to-client ratio in accordance with the State Department of Health's standards. In addition to providing adult day care services, the license provider is required to offer transportation services consistent with State Department of Health regulations.

**SECTION 8.** Section 43-13-117.1, Mississippi Code of 1972, is amended as follows:

43-13-117.1. (1) It is the intent of the Legislature to expand access to Medicaid-funded home- and community-based services for eligible nursing facility residents who choose those



2718 services. The Executive Director of the Division of Medicaid is  
2719 authorized to transfer funds allocated for nursing facility  
2720 services for eligible residents to cover the cost of services  
2721 available through the Independent Living Waiver, the Traumatic  
2722 Brain Injury/Spinal Cord Injury Waiver, the Elderly and Disabled  
2723 Waiver, and the Assisted Living Waiver programs when eligible  
2724 residents choose those community services. The amount of funding  
2725 transferred by the division shall be sufficient to cover the cost  
2726 of home- and community-based waiver services for each eligible  
2727 nursing facility \* \* \* resident who \* \* \* chooses those services.  
2728 The number of nursing facility residents who return to the  
2729 community and home- and community-based waiver services shall not  
2730 count against the total number of waiver slots for which the  
2731 Legislature appropriates funding each year. Any funds remaining  
2732 in the program when a former nursing facility resident ceases to  
2733 participate in a home- and community-based waiver program under  
2734 this provision shall be returned to nursing facility funding.

2735 (2) Beginning July 1, 2026, the Division of Medicaid shall  
2736 reimburse adult day care facilities based on the level of services  
2737 provided by the adult day care facilities, as described in Section  
2738 43-11-13.

2739 **SECTION 9.** Section 43-13-117.7, Mississippi Code of 1972, is  
2740 amended as follows:

2741 43-13-117.7. (1) Notwithstanding any other provisions of  
2742 Section 43-13-117, the division shall not reimburse or provide



2743 coverage for gender transition procedures for a person under  
2744 eighteen (18) years of age. As used in this section, the term  
2745 "gender transition procedures" means the same as defined in  
2746 Section 41-141-3.

2747 (2) The division shall not reimburse or provide coverage for  
2748 gender transition procedures for a person over eighteen (18) years  
2749 of age.

2750 **SECTION 10.** Section 37-33-167, Mississippi Code of 1972, is  
2751 amended as follows:

2752 37-33-167. The State Department of Rehabilitation Services,  
2753 through the Office of Disability Determination Services, may enter  
2754 into agreements with the federal Social Security Administration or  
2755 its successor and other state agencies for the purpose of  
2756 performing eligibility determinations for Medicaid assistance  
2757 payments for those persons who qualify therefor under Section  
2758 43-13-115 \* \* \*, and may adopt such methods of administration as  
2759 may be necessary to secure the full benefits of federal  
2760 appropriations for medical assistance for such persons.

2761 **SECTION 11.** Section 43-13-145, Mississippi Code of 1972, is  
2762 amended as follows:

2763 43-13-145. (1) (a) Upon each nursing facility licensed by  
2764 the State of Mississippi, there is levied an assessment in an  
2765 amount set by the division, equal to the maximum rate allowed by  
2766 federal law or regulation, for each licensed and occupied bed of  
2767 the facility.



2768 (b) A nursing facility is exempt from the assessment  
2769 levied under this subsection if the facility is operated under the  
2770 direction and control of:

2771 (i) The United States Veterans Administration or  
2772 other agency or department of the United States government; or

2773 (ii) The State Veterans Affairs Board.

2774 (2) (a) Upon each intermediate care facility for  
2775 individuals with intellectual disabilities licensed by the State  
2776 of Mississippi, there is levied an assessment in an amount set by  
2777 the division, equal to the maximum rate allowed by federal law or  
2778 regulation, for each licensed and occupied bed of the facility.

2779 (b) An intermediate care facility for individuals with  
2780 intellectual disabilities is exempt from the assessment levied  
2781 under this subsection if the facility is operated under the  
2782 direction and control of:

2783 (i) The United States Veterans Administration or  
2784 other agency or department of the United States government;

2785 (ii) The State Veterans Affairs Board; or

2786 (iii) The University of Mississippi Medical  
2787 Center.

2788 (3) (a) Upon each psychiatric residential treatment  
2789 facility licensed by the State of Mississippi, there is levied an  
2790 assessment in an amount set by the division, equal to the maximum  
2791 rate allowed by federal law or regulation, for each licensed and  
2792 occupied bed of the facility.



2793           (b) A psychiatric residential treatment facility is  
2794 exempt from the assessment levied under this subsection if the  
2795 facility is operated under the direction and control of:  
2796           (i) The United States Veterans Administration or  
2797 other agency or department of the United States government;  
2798           (ii) The University of Mississippi Medical Center;  
2799 or  
2800           (iii) A state agency or a state facility that  
2801 either provides its own state match through intergovernmental  
2802 transfer or certification of funds to the division.  
2803       (4) Hospital assessment.  
2804           (a) (i) Subject to and upon fulfillment of the  
2805 requirements and conditions of paragraph (f) below, and  
2806 notwithstanding any other provisions of this section, an annual  
2807 assessment on each hospital licensed in the state is imposed on  
2808 each non-Medicare hospital inpatient day as defined below at a  
2809 rate that is determined by dividing the sum prescribed in this  
2810 subparagraph (i), plus the nonfederal share necessary to maximize  
2811 the Disproportionate Share Hospital (DSH) and Medicare Upper  
2812 Payment Limits (UPL) Program payments and hospital access payments  
2813 and such other supplemental payments as may be developed pursuant  
2814 to Section 43-13-117(A)(18), by the total number of non-Medicare  
2815 hospital inpatient days as defined below for all licensed  
2816 Mississippi hospitals, except as provided in paragraph (d) below.  
2817 If the state-matching funds percentage for the Mississippi



2818 Medicaid program is sixteen percent (16%) or less, the sum used in  
2819 the formula under this subparagraph (i) shall be Seventy-four  
2820 Million Dollars (\$74,000,000.00). If the state-matching funds  
2821 percentage for the Mississippi Medicaid program is twenty-four  
2822 percent (24%) or higher, the sum used in the formula under this  
2823 subparagraph (i) shall be One Hundred Four Million Dollars  
2824 (\$104,000,000.00). If the state-matching funds percentage for the  
2825 Mississippi Medicaid program is between sixteen percent (16%) and  
2826 twenty-four percent (24%), the sum used in the formula under this  
2827 subparagraph (i) shall be a pro rata amount determined as follows:  
2828 the current state-matching funds percentage rate minus sixteen  
2829 percent (16%) divided by eight percent (8%) multiplied by Thirty  
2830 Million Dollars (\$30,000,000.00) and add that amount to  
2831 Seventy-four Million Dollars (\$74,000,000.00). However, no  
2832 assessment in a quarter under this subparagraph (i) may exceed the  
2833 assessment in the previous quarter by more than Three Million  
2834 Seven Hundred Fifty Thousand Dollars (\$3,750,000.00) (which would  
2835 be Fifteen Million Dollars (\$15,000,000.00) on an annualized  
2836 basis), unless such increase is to maximize federal funds that are  
2837 available to reimburse hospitals for services provided under new  
2838 programs for hospitals, for increased supplemental payment  
2839 programs for hospitals or to assist with state matching funds as  
2840 authorized by the Legislature. The division shall publish the  
2841 state-matching funds percentage rate applicable to the Mississippi  
2842 Medicaid program on the tenth day of the first month of each





2843 quarter and the assessment determined under the formula prescribed  
2844 above shall be applicable in the quarter following any adjustment  
2845 in that state-matching funds percentage rate. The division shall  
2846 notify each hospital licensed in the state as to any projected  
2847 increases or decreases in the assessment determined under this  
2848 subparagraph (i). However, if the Centers for Medicare and  
2849 Medicaid Services (CMS) does not approve the provision in Section  
2850 43-13-117(39) requiring the division to reimburse crossover claims  
2851 for inpatient hospital services and crossover claims covered under  
2852 Medicare Part B for dually eligible beneficiaries in the same  
2853 manner that was in effect on January 1, 2008, the sum that  
2854 otherwise would have been used in the formula under this  
2855 subparagraph (i) shall be reduced by Seven Million Dollars  
2856 (\$7,000,000.00).

2857                   (ii) In addition to the assessment provided under  
2858 subparagraph (i), an additional annual assessment on each hospital  
2859 licensed in the state is imposed on each non-Medicare hospital  
2860 inpatient day as defined below at a rate that is determined by  
2861 dividing twenty-five percent (25%) of any provider reductions in  
2862 the Medicaid program as authorized in Section 43-13-117(F) for  
2863 that fiscal year up to the following maximum amount, plus the  
2864 nonfederal share necessary to maximize the Disproportionate Share  
2865 Hospital (DSH) and inpatient Medicare Upper Payment Limits (UPL)  
2866 Program payments and inpatient hospital access payments, by the  
2867 total number of non-Medicare hospital inpatient days as defined



2868 below for all licensed Mississippi hospitals: in fiscal year  
2869 2010, the maximum amount shall be Twenty-four Million Dollars  
2870 (\$24,000,000.00); in fiscal year 2011, the maximum amount shall be  
2871 Thirty-two Million Dollars (\$32,000,000.00); and in fiscal year  
2872 2012 and thereafter, the maximum amount shall be Forty Million  
2873 Dollars (\$40,000,000.00). Any such deficit in the Medicaid  
2874 program shall be reviewed by the PEER Committee as provided in  
2875 Section 43-13-117(F).

2876 (iii) In addition to the assessments provided in  
2877 subparagraphs (i) and (ii), an additional annual assessment on  
2878 each hospital licensed in the state is imposed pursuant to the  
2879 provisions of Section 43-13-117(F) if the cost-containment  
2880 measures described therein have been implemented and there are  
2881 insufficient funds in the Health Care Trust Fund to reconcile any  
2882 remaining deficit in any fiscal year. If the Governor institutes  
2883 any other additional cost-containment measures on any program or  
2884 programs authorized under the Medicaid program pursuant to Section  
2885 43-13-117(F), hospitals shall be responsible for twenty-five  
2886 percent (25%) of any such additional imposed provider cuts, which  
2887 shall be in the form of an additional assessment not to exceed the  
2888 twenty-five percent (25%) of provider expenditure reductions.  
2889 Such additional assessment shall be imposed on each non-Medicare  
2890 hospital inpatient day in the same manner as assessments are  
2891 imposed under subparagraphs (i) and (ii).

2892 (b) Definitions.



2893 (i) [Deleted]

2894 (ii) For purposes of this subsection (4):

2895 1. "Non-Medicare hospital inpatient day"

2896 means total hospital inpatient days including subcomponent days

2897 less Medicare inpatient days including subcomponent days from the

2898 hospital's most recent Medicare cost report for the second

2899 calendar year preceding the beginning of the state fiscal year, on

2900 file with CMS per the CMS HCRIS database, or cost report submitted

2901 to the Division if the HCRIS database is not available to the

2902 division, as of June 1 of each year.

2903 a. Total hospital inpatient days shall

2904 be the sum of Worksheet S-3, Part 1, column 8 row 14, column 8 row

2905 16, and column 8 row 17, excluding column 8 rows 5 and 6.

2906 b. Hospital Medicare inpatient days

2907 shall be the sum of Worksheet S-3, Part 1, column 6 row 14, column

2908 6 row 16.00, and column 6 row 17, excluding column 6 rows 5 and 6.

2909 c. Inpatient days shall not include

2910 residential treatment or long-term care days.

2911 2. "Subcomponent inpatient day" means the

2912 number of days of care charged to a beneficiary for inpatient

2913 hospital rehabilitation and psychiatric care services in units of

2914 full days. A day begins at midnight and ends twenty-four (24)

2915 hours later. A part of a day, including the day of admission and

2916 day on which a patient returns from leave of absence, counts as a

2917 full day. However, the day of discharge, death, or a day on which



2918 a patient begins a leave of absence is not counted as a day unless  
2919 discharge or death occur on the day of admission. If admission  
2920 and discharge or death occur on the same day, the day is  
2921 considered a day of admission and counts as one (1) subcomponent  
2922 inpatient day.

2923 (c) The assessment provided in this subsection is  
2924 intended to satisfy and not be in addition to the assessment and  
2925 intergovernmental transfers provided in Section 43-13-117(A)(18).  
2926 Nothing in this section shall be construed to authorize any state  
2927 agency, division or department, or county, municipality or other  
2928 local governmental unit to license for revenue, levy or impose any  
2929 other tax, fee or assessment upon hospitals in this state not  
2930 authorized by a specific statute.

2931 (d) Hospitals operated by the United States Department  
2932 of Veterans Affairs and state-operated facilities that provide  
2933 only inpatient and outpatient psychiatric services shall not be  
2934 subject to the hospital assessment provided in this subsection.

2935 (e) Multihospital systems, closure, merger, change of  
2936 ownership and new hospitals.

2937 (i) If a hospital conducts, operates or maintains  
2938 more than one (1) hospital licensed by the State Department of  
2939 Health, the provider shall pay the hospital assessment for each  
2940 hospital separately.

2941 (ii) Notwithstanding any other provision in this  
2942 section, if a hospital subject to this assessment operates or



2943 conducts business only for a portion of a fiscal year, the  
2944 assessment for the state fiscal year shall be adjusted by  
2945 multiplying the assessment by a fraction, the numerator of which  
2946 is the number of days in the year during which the hospital  
2947 operates, and the denominator of which is three hundred sixty-five  
2948 (365). Immediately upon ceasing to operate, the hospital shall  
2949 pay the assessment for the year as so adjusted (to the extent not  
2950 previously paid).

2951 (iii) The division shall determine the tax for new  
2952 hospitals and hospitals that undergo a change of ownership in  
2953 accordance with this section, using the best available  
2954 information, as determined by the division.

2955 (f) Applicability.

2956 The hospital assessment imposed by this subsection shall not  
2957 take effect and/or shall cease to be imposed if:

2958 (i) The assessment is determined to be an  
2959 impermissible tax under Title XIX of the Social Security Act; or

2960 (ii) CMS revokes its approval of the division's  
2961 2009 Medicaid State Plan Amendment for the methodology for DSH  
2962 payments to hospitals under Section 43-13-117(A)(18).

2963 (5) Each health care facility that is subject to the  
2964 provisions of this section shall keep and preserve such suitable  
2965 books and records as may be necessary to determine the amount of  
2966 assessment for which it is liable under this section. The books  
2967 and records shall be kept and preserved for a period of not less



2968 than five (5) years, during which time those books and records  
2969 shall be open for examination during business hours by the  
2970 division, the Department of Revenue, the Office of the Attorney  
2971 General and the State Department of Health.

2972 (6) [Deleted]

2973 (7) All assessments collected under this section shall be  
2974 deposited in the Medical Care Fund created by Section 43-13-143.

2975 (8) The assessment levied under this section shall be in  
2976 addition to any other assessments, taxes or fees levied by law,  
2977 and the assessment shall constitute a debt due the State of  
2978 Mississippi from the time the assessment is due until it is paid.

2979 (9) (a) If a health care facility that is liable for  
2980 payment of an assessment levied by the division does not pay the  
2981 assessment when it is due, the division shall give written notice  
2982 to the health care facility demanding payment of the assessment  
2983 within ten (10) days from the date of delivery of the notice. If  
2984 the health care facility fails or refuses to pay the assessment  
2985 after receiving the notice and demand from the division, the  
2986 division shall withhold from any Medicaid reimbursement payments  
2987 that are due to the health care facility the amount of the unpaid  
2988 assessment and a penalty of ten percent (10%) of the amount of the  
2989 assessment, plus the legal rate of interest until the assessment  
2990 is paid in full. If the health care facility does not participate  
2991 in the Medicaid program, the division shall turn over to the  
2992 Office of the Attorney General the collection of the unpaid



2993 assessment by civil action. In any such civil action, the Office  
2994 of the Attorney General shall collect the amount of the unpaid  
2995 assessment and a penalty of ten percent (10%) of the amount of the  
2996 assessment, plus the legal rate of interest until the assessment  
2997 is paid in full.

2998 (b) As an additional or alternative method for  
2999 collecting unpaid assessments levied by the division, if a health  
3000 care facility fails or refuses to pay the assessment after  
3001 receiving notice and demand from the division, the division may  
3002 file a notice of a tax lien with the chancery clerk of the county  
3003 in which the health care facility is located, for the amount of  
3004 the unpaid assessment and a penalty of ten percent (10%) of the  
3005 amount of the assessment, plus the legal rate of interest until  
3006 the assessment is paid in full. Immediately upon receipt of  
3007 notice of the tax lien for the assessment, the chancery clerk  
3008 shall forward the notice to the circuit clerk who shall enter the  
3009 notice of the tax lien as a judgment upon the judgment roll and  
3010 show in the appropriate columns the name of the health care  
3011 facility as judgment debtor, the name of the division as judgment  
3012 creditor, the amount of the unpaid assessment, and the date and  
3013 time of enrollment. The judgment shall be valid as against  
3014 mortgagees, pledgees, entrusters, purchasers, judgment creditors  
3015 and other persons from the time of filing with the clerk. The  
3016 amount of the judgment shall be a debt due the State of  
3017 Mississippi and remain a lien upon the tangible property of the



3018 health care facility until the judgment is satisfied. The  
3019 judgment shall be the equivalent of any enrolled judgment of a  
3020 court of record and shall serve as authority for the issuance of  
3021 writs of execution, writs of attachment or other remedial writs.

3022 (10) (a) To further the provisions of Section  
3023 43-13-117(A)(18), the Division of Medicaid shall submit to the  
3024 Centers for Medicare and Medicaid Services (CMS) any documents  
3025 regarding the hospital assessment established under subsection (4)  
3026 of this section. In addition to defining the assessment  
3027 established in subsection (4) of this section if necessary, the  
3028 documents shall describe any supplement payment programs and/or  
3029 payment methodologies as authorized in Section 43-13-117(A)(18) if  
3030 necessary.

3031 (b) All hospitals satisfying the minimum federal DSH  
3032 eligibility requirements (Section 1923(d) of the Social Security  
3033 Act) may, subject to OBRA 1993 payment limitations, receive a DSH  
3034 payment. This DSH payment shall expend the balance of the federal  
3035 DSH allotment and associated state share not utilized in DSH  
3036 payments to state-owned institutions for treatment of mental  
3037 diseases. The payment to each hospital shall be calculated by  
3038 applying a uniform percentage to the uninsured costs of each  
3039 eligible hospital, excluding state-owned institutions for  
3040 treatment of mental diseases; however, that percentage for a  
3041 state-owned teaching hospital located in Hinds County shall be  
3042 multiplied by a factor of two (2).





3043           (11) The division shall implement DSH and supplemental  
3044 payment calculation methodologies that result in the maximization  
3045 of available federal funds.

3046           (12) The DSH payments shall be paid on or before December  
3047 31, March 31, and June 30 of each fiscal year, in increments of  
3048 one-third (1/3) of the total calculated DSH amounts. Supplemental  
3049 payments developed pursuant to Section 43-13-117(A)(18) shall be  
3050 paid monthly.

3051           (13) Payment.

3052           (a) The hospital assessment as described in subsection  
3053 (4) for the nonfederal share necessary to maximize the Medicare  
3054 Upper Payments Limits (UPL) Program payments and hospital access  
3055 payments and such other supplemental payments as may be developed  
3056 pursuant to Section 43-3-117(A)(18) shall be assessed and  
3057 collected monthly no later than the fifteenth calendar day of each  
3058 month.

3059           (b) The hospital assessment as described in subsection  
3060 (4) for the nonfederal share necessary to maximize the  
3061 Disproportionate Share Hospital (DSH) payments shall be assessed  
3062 and collected on December 15, March 15 and June 15.

3063           (c) The annual hospital assessment and any additional  
3064 hospital assessment as described in subsection (4) shall be  
3065 assessed and collected on September 15 and on the 15th of each  
3066 month from December through June.



3067           (14) If for any reason any part of the plan for annual DSH  
3068 and supplemental payment programs to hospitals provided under  
3069 subsection (10) of this section and/or developed pursuant to  
3070 Section 43-13-117(A) (18) is not approved by CMS, the remainder of  
3071 the plan shall remain in full force and effect.

3072           (15) Nothing in this section shall prevent the Division of  
3073 Medicaid from facilitating participation in Medicaid supplemental  
3074 hospital payment programs by a hospital located in a county  
3075 contiguous to the State of Mississippi that is also authorized by  
3076 federal law to submit intergovernmental transfers (IGTs) to the  
3077 State of Mississippi to fund the state share of the hospital's  
3078 supplemental and/or MHAP payments.

3079           (16) This section shall stand repealed on July 1, 2028.

3080           **SECTION 12.** Section 43-13-115.1, Mississippi Code of 1972,  
3081 is amended as follows:

3082           43-13-115.1. (1) Ambulatory prenatal care shall be  
3083 available to a pregnant woman under this article during a  
3084 presumptive eligibility period in accordance with the provisions  
3085 of this section.

3086           (2) For purposes of this section, the following terms shall  
3087 be defined as provided in this subsection:

3088           (a) "Presumptive eligibility" means a reasonable  
3089 determination of Medicaid eligibility of a pregnant woman made by  
3090 a qualified provider based only on the countable family income of  
3091 the woman, which allows the woman to receive ambulatory prenatal



3092 care under this article during a presumptive eligibility period  
3093 while the Division of Medicaid makes a determination with respect  
3094 to the eligibility of the woman for Medicaid.

3095 (b) "Presumptive eligibility period" means, with  
3096 respect to a pregnant woman, the period that:

3097 (i) Begins with the date on which a qualified  
3098 provider determines, on the basis of preliminary information, that  
3099 the total countable net family income of the woman does not exceed  
3100 the income limits for eligibility of pregnant women in the  
3101 Medicaid state plan; and

3102 (ii) Ends with, and includes, the earlier of:

3103 1. The day on which a determination is made  
3104 with respect to the eligibility of the woman for Medicaid;

3105 2. In the case of a woman who does not file  
3106 an application by the last day of the month following the month  
3107 during which the provider makes the determination referred to in  
3108 subparagraph (i) of this paragraph, such last day; or

3109 3. Sixty (60) days after the day that the  
3110 provider makes the determination referred to in subparagraph (i)  
3111 of this paragraph.

3112 (c) "Qualified provider" means any provider that meets  
3113 the definition of "qualified provider" under 42 USC Section  
3114 1396r-1. The term includes, but is not limited to, county health  
3115 departments, federally qualified health centers (FQHCs), and other



entities approved and designated by the Division of Medicaid to conduct presumptive eligibility determinations for pregnant women.

(3) A pregnant woman shall be deemed to be presumptively eligible for ambulatory prenatal care under this article if a qualified provider determines, on the basis of preliminary information, that the total countable net family income of the woman does not exceed the income limits for eligibility of pregnant women in the Medicaid state plan. \* \* \* A pregnant woman who is determined to be presumptively eligible may receive no more than one (1) presumptive eligibility period per pregnancy.

(4) A qualified provider that determines that a pregnant woman is presumptively eligible for Medicaid shall:

(a) Notify the Division of Medicaid of the determination within five (5) working days after the date on which determination is made; and

(b) Inform the woman at the time the determination is made that she is required to make application for Medicaid by not later than the last day of the month following the month during which the determination is made.

(5) A pregnant woman who is determined by a qualified provider to be presumptively eligible for Medicaid shall make application for Medicaid by not later than the last day of the 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



3141 make application for Medicaid and information on how to assist  
3142 such women in completing and filing such forms. The division  
3143 shall make those application forms and the application process  
3144 itself as simple as possible.

3145       **SECTION 13.** Section 41-7-191, Mississippi Code of 1972, is  
3146 amended as follows:

3147       41-7-191. (1) No person shall engage in any of the  
3148 following activities without obtaining the required certificate of  
3149 need:

3150               (a) The construction, development or other  
3151 establishment of a new health care facility, which establishment  
3152 shall include the reopening of a health care facility that has  
3153 ceased to operate for a period of sixty (60) months or more;

3154               (b) The relocation of a health care facility or portion  
3155 thereof, or major medical equipment, unless such relocation of a  
3156 health care facility or portion thereof, or major medical  
3157 equipment, which does not involve a capital expenditure by or on  
3158 behalf of a health care facility, is within five thousand two  
3159 hundred eighty (5,280) feet from the main entrance of the health  
3160 care facility;

3161               (c) Any change in the existing bed complement of any  
3162 health care facility through the addition or conversion of any  
3163 beds or the alteration, modernizing or refurbishing of any unit or  
3164 department in which the beds may be located; however, if a health  
3165 care facility has voluntarily delicensed some of its existing bed



3166 complement, it may later relicense some or all of its delicensed  
3167 beds without the necessity of having to acquire a certificate of  
3168 need. The State Department of Health shall maintain a record of  
3169 the delicensing health care facility and its voluntarily  
3170 delicensed beds and continue counting those beds as part of the  
3171 state's total bed count for health care planning purposes. If a  
3172 health care facility that has voluntarily delicensed some of its  
3173 beds later desires to relicense some or all of its voluntarily  
3174 delicensed beds, it shall notify the State Department of Health of  
3175 its intent to increase the number of its licensed beds. The State  
3176 Department of Health shall survey the health care facility within  
3177 thirty (30) days of that notice and, if appropriate, issue the  
3178 health care facility a new license reflecting the new contingent  
3179 of beds. However, in no event may a health care facility that has  
3180 voluntarily delicensed some of its beds be reissued a license to  
3181 operate beds in excess of its bed count before the voluntary  
3182 delicensure of some of its beds without seeking certificate of  
3183 need approval;

3184 (d) Offering of the following health services if those  
3185 services have not been provided on a regular basis by the proposed  
3186 provider of such services within the period of twelve (12) months  
3187 prior to the time such services would be offered:

- 3188 (i) Open-heart surgery services;
- 3189 (ii) Cardiac catheterization services;



3190 (iii) Comprehensive inpatient rehabilitation  
3191 services;  
3192 (iv) Licensed psychiatric services;  
3193 (v) Licensed chemical dependency services;  
3194 (vi) Radiation therapy services;  
3195 (vii) Diagnostic imaging services of an invasive  
3196 nature, i.e. invasive digital angiography;  
3197 (viii) Nursing home care as defined in  
3198 subparagraphs (iv), (vi) and (viii) of Section 41-7-173(h);  
3199 (ix) Home health services;  
3200 (x) Swing-bed services;  
3201 (xi) Ambulatory surgical services;  
3202 (xii) Magnetic resonance imaging services;  
3203 (xiii) [Deleted]  
3204 (xiv) Long-term care hospital services;  
3205 (xv) Positron emission tomography (PET) services;  
3206 (e) The relocation of one or more health services from  
3207 one physical facility or site to another physical facility or  
3208 site, unless such relocation, which does not involve a capital  
3209 expenditure by or on behalf of a health care facility, (i) is to a  
3210 physical facility or site within five thousand two hundred eighty  
3211 (5,280) feet from the main entrance of the health care facility  
3212 where the health care service is located, or (ii) is the result of  
3213 an order of a court of appropriate jurisdiction or a result of  
3214 pending litigation in such court, or by order of the State



3215 Department of Health, or by order of any other agency or legal  
3216 entity of the state, the federal government, or any political  
3217 subdivision of either, whose order is also approved by the State  
3218 Department of Health;

3219 (f) The acquisition or otherwise control of any major  
3220 medical equipment for the provision of medical services; however,  
3221 (i) the acquisition of any major medical equipment used only for  
3222 research purposes, and (ii) the acquisition of major medical  
3223 equipment to replace medical equipment for which a facility is  
3224 already providing medical services and for which the State  
3225 Department of Health has been notified before the date of such  
3226 acquisition shall be exempt from this paragraph; an acquisition  
3227 for less than fair market value must be reviewed, if the  
3228 acquisition at fair market value would be subject to review;

3229 (g) Changes of ownership of existing health care  
3230 facilities in which a notice of intent is not filed with the State  
3231 Department of Health at least thirty (30) days prior to the date  
3232 such change of ownership occurs, or a change in services or bed  
3233 capacity as prescribed in paragraph (c) or (d) of this subsection  
3234 as a result of the change of ownership; an acquisition for less  
3235 than fair market value must be reviewed, if the acquisition at  
3236 fair market value would be subject to review;

3237 (h) The change of ownership of any health care facility  
3238 defined in subparagraphs (iv), (vi) and (viii) of Section  
3239 41-7-173(h), in which a notice of intent as described in paragraph





3240 (g) has not been filed and if the Executive Director, Division of  
3241 Medicaid, Office of the Governor, has not certified in writing  
3242 that there will be no increase in allowable costs to Medicaid from  
3243 revaluation of the assets or from increased interest and  
3244 depreciation as a result of the proposed change of ownership;

3245 (i) Any activity described in paragraphs (a) through  
3246 (h) if undertaken by any person if that same activity would  
3247 require certificate of need approval if undertaken by a health  
3248 care facility;

3249 (j) Any capital expenditure or deferred capital  
3250 expenditure by or on behalf of a health care facility not covered  
3251 by paragraphs (a) through (h);

3252 (k) The contracting of a health care facility as  
3253 defined in subparagraphs (i) through (viii) of Section 41-7-173(h)  
3254 to establish a home office, subunit, or branch office in the space  
3255 operated as a health care facility through a formal arrangement  
3256 with an existing health care facility as defined in subparagraph  
3257 (ix) of Section 41-7-173(h);

3258 (l) The replacement or relocation of a health care  
3259 facility designated as a critical access hospital shall be exempt  
3260 from subsection (1) of this section so long as the critical access  
3261 hospital complies with all applicable federal law and regulations  
3262 regarding such replacement or relocation;

3263 (m) Reopening a health care facility that has ceased to  
3264 operate for a period of sixty (60) months or more, which reopening



3265 requires a certificate of need for the establishment of a new  
3266 health care facility.

3267 (2) The State Department of Health shall not grant approval  
3268 for or issue a certificate of need to any person proposing the new  
3269 construction of, addition to, or expansion of any health care  
3270 facility defined in subparagraphs (iv) (skilled nursing facility)  
3271 and (vi) (intermediate care facility) of Section 41-7-173(h) or  
3272 the conversion of vacant hospital beds to provide skilled or  
3273 intermediate nursing home care, except as hereinafter authorized:

3274 (a) The department may issue a certificate of need to  
3275 any person proposing the new construction of any health care  
3276 facility defined in subparagraphs (iv) and (vi) of Section  
3277 41-7-173(h) as part of a life care retirement facility, in any  
3278 county bordering on the Gulf of Mexico in which is located a  
3279 National Aeronautics and Space Administration facility, not to  
3280 exceed forty (40) beds. From and after July 1, 1999, there shall  
3281 be no prohibition or restrictions on participation in the Medicaid  
3282 program (Section 43-13-101 et seq.) for the beds in the health  
3283 care facility that were authorized under this paragraph (a).

3284 (b) The department may issue certificates of need in  
3285 Harrison County to provide skilled nursing home care for  
3286 Alzheimer's disease patients and other patients, not to exceed one  
3287 hundred fifty (150) beds. From and after July 1, 1999, there  
3288 shall be no prohibition or restrictions on participation in the



3289 Medicaid program (Section 43-13-101 et seq.) for the beds in the  
3290 nursing facilities that were authorized under this paragraph (b).

3291           (c) The department may issue a certificate of need for  
3292 the addition to or expansion of any skilled nursing facility that  
3293 is part of an existing continuing care retirement community  
3294 located in Madison County, provided that the recipient of the  
3295 certificate of need agrees in writing that the skilled nursing  
3296 facility will not at any time participate in the Medicaid program  
3297 (Section 43-13-101 et seq.) or admit or keep any patients in the  
3298 skilled nursing facility who are participating in the Medicaid  
3299 program. This written agreement by the recipient of the  
3300 certificate of need shall be fully binding on any subsequent owner  
3301 of the skilled nursing facility, if the ownership of the facility  
3302 is transferred at any time after the issuance of the certificate  
3303 of need. Agreement that the skilled nursing facility will not  
3304 participate in the Medicaid program shall be a condition of the  
3305 issuance of a certificate of need to any person under this  
3306 paragraph (c), and if such skilled nursing facility at any time  
3307 after the issuance of the certificate of need, regardless of the  
3308 ownership of the facility, participates in the Medicaid program or  
3309 admits or keeps any patients in the facility who are participating  
3310 in the Medicaid program, the State Department of Health shall  
3311 revoke the certificate of need, if it is still outstanding, and  
3312 shall deny or revoke the license of the skilled nursing facility,  
3313 at the time that the department determines, after a hearing



3314 complying with due process, that the facility has failed to comply  
3315 with any of the conditions upon which the certificate of need was  
3316 issued, as provided in this paragraph and in the written agreement  
3317 by the recipient of the certificate of need. The total number of  
3318 beds that may be authorized under the authority of this paragraph  
3319 (c) shall not exceed sixty (60) beds.

3320 (d) The State Department of Health may issue a  
3321 certificate of need to any hospital located in DeSoto County for  
3322 the new construction of a skilled nursing facility, not to exceed  
3323 one hundred twenty (120) beds, in DeSoto County. From and after  
3324 July 1, 1999, there shall be no prohibition or restrictions on  
3325 participation in the Medicaid program (Section 43-13-101 et seq.)  
3326 for the beds in the nursing facility that were authorized under  
3327 this paragraph (d).

3328 (e) The State Department of Health may issue a  
3329 certificate of need for the construction of a nursing facility or  
3330 the conversion of beds to nursing facility beds at a personal care  
3331 facility for the elderly in Lowndes County that is owned and  
3332 operated by a Mississippi nonprofit corporation, not to exceed  
3333 sixty (60) beds. From and after July 1, 1999, there shall be no  
3334 prohibition or restrictions on participation in the Medicaid  
3335 program (Section 43-13-101 et seq.) for the beds in the nursing  
3336 facility that were authorized under this paragraph (e).

3337 (f) The State Department of Health may issue a  
3338 certificate of need for conversion of a county hospital facility



3339 in Itawamba County to a nursing facility, not to exceed sixty (60)  
3340 beds, including any necessary construction, renovation or  
3341 expansion. From and after July 1, 1999, there shall be no  
3342 prohibition or restrictions on participation in the Medicaid  
3343 program (Section 43-13-101 et seq.) for the beds in the nursing  
3344 facility that were authorized under this paragraph (f).

3345 (g) The State Department of Health may issue a  
3346 certificate of need for the construction or expansion of nursing  
3347 facility beds or the conversion of other beds to nursing facility  
3348 beds in either Hinds, Madison or Rankin County, not to exceed  
3349 sixty (60) beds. From and after July 1, 1999, there shall be no  
3350 prohibition or restrictions on participation in the Medicaid  
3351 program (Section 43-13-101 et seq.) for the beds in the nursing  
3352 facility that were authorized under this paragraph (g).

3353 (h) The State Department of Health may issue a  
3354 certificate of need for the construction or expansion of nursing  
3355 facility beds or the conversion of other beds to nursing facility  
3356 beds in either Hancock, Harrison or Jackson County, not to exceed  
3357 sixty (60) beds. From and after July 1, 1999, there shall be no  
3358 prohibition or restrictions on participation in the Medicaid  
3359 program (Section 43-13-101 et seq.) for the beds in the facility  
3360 that were authorized under this paragraph (h).

3361 (i) The department may issue a certificate of need for  
3362 the new construction of a skilled nursing facility in Leake  
3363 County, provided that the recipient of the certificate of need



3364 agrees in writing that the skilled nursing facility will not at  
3365 any time participate in the Medicaid program (Section 43-13-101 et  
3366 seq.) or admit or keep any patients in the skilled nursing  
3367 facility who are participating in the Medicaid program. This  
3368 written agreement by the recipient of the certificate of need  
3369 shall be fully binding on any subsequent owner of the skilled  
3370 nursing facility, if the ownership of the facility is transferred  
3371 at any time after the issuance of the certificate of need.  
3372 Agreement that the skilled nursing facility will not participate  
3373 in the Medicaid program shall be a condition of the issuance of a  
3374 certificate of need to any person under this paragraph (i), and if  
3375 such skilled nursing facility at any time after the issuance of  
3376 the certificate of need, regardless of the ownership of the  
3377 facility, participates in the Medicaid program or admits or keeps  
3378 any patients in the facility who are participating in the Medicaid  
3379 program, the State Department of Health shall revoke the  
3380 certificate of need, if it is still outstanding, and shall deny or  
3381 revoke the license of the skilled nursing facility, at the time  
3382 that the department determines, after a hearing complying with due  
3383 process, that the facility has failed to comply with any of the  
3384 conditions upon which the certificate of need was issued, as  
3385 provided in this paragraph and in the written agreement by the  
3386 recipient of the certificate of need. The provision of Section  
3387 41-7-193(1) regarding substantial compliance of the projection of  
3388 need as reported in the current State Health Plan is waived for



3389 the purposes of this paragraph. The total number of nursing  
3390 facility beds that may be authorized by any certificate of need  
3391 issued under this paragraph (i) shall not exceed sixty (60) beds.  
3392 If the skilled nursing facility authorized by the certificate of  
3393 need issued under this paragraph is not constructed and fully  
3394 operational within eighteen (18) months after July 1, 1994, the  
3395 State Department of Health, after a hearing complying with due  
3396 process, shall revoke the certificate of need, if it is still  
3397 outstanding, and shall not issue a license for the skilled nursing  
3398 facility at any time after the expiration of the eighteen-month  
3399 period.

3400 (j) The department may issue certificates of need to  
3401 allow any existing freestanding long-term care facility in  
3402 Tishomingo County and Hancock County that on July 1, 1995, is  
3403 licensed with fewer than sixty (60) beds. For the purposes of  
3404 this paragraph (j), the provisions of Section 41-7-193(1)  
3405 requiring substantial compliance with the projection of need as  
3406 reported in the current State Health Plan are waived. From and  
3407 after July 1, 1999, there shall be no prohibition or restrictions  
3408 on participation in the Medicaid program (Section 43-13-101 et  
3409 seq.) for the beds in the long-term care facilities that were  
3410 authorized under this paragraph (j).

3411 (k) The department may issue a certificate of need for  
3412 the construction of a nursing facility at a continuing care  
3413 retirement community in Lowndes County. The total number of beds



3414 that may be authorized under the authority of this paragraph (k)  
3415 shall not exceed sixty (60) beds. From and after July 1, 2001,  
3416 the prohibition on the facility participating in the Medicaid  
3417 program (Section 43-13-101 et seq.) that was a condition of  
3418 issuance of the certificate of need under this paragraph (k) shall  
3419 be revised as follows: The nursing facility may participate in  
3420 the Medicaid program from and after July 1, 2001, if the owner of  
3421 the facility on July 1, 2001, agrees in writing that no more than  
3422 thirty (30) of the beds at the facility will be certified for  
3423 participation in the Medicaid program, and that no claim will be  
3424 submitted for Medicaid reimbursement for more than thirty (30)  
3425 patients in the facility in any month or for any patient in the  
3426 facility who is in a bed that is not Medicaid-certified. This  
3427 written agreement by the owner of the facility shall be a  
3428 condition of licensure of the facility, and the agreement shall be  
3429 fully binding on any subsequent owner of the facility if the  
3430 ownership of the facility is transferred at any time after July 1,  
3431 2001. After this written agreement is executed, the Division of  
3432 Medicaid and the State Department of Health shall not certify more  
3433 than thirty (30) of the beds in the facility for participation in  
3434 the Medicaid program. If the facility violates the terms of the  
3435 written agreement by admitting or keeping in the facility on a  
3436 regular or continuing basis more than thirty (30) patients who are  
3437 participating in the Medicaid program, the State Department of  
3438 Health shall revoke the license of the facility, at the time that





the department determines, after a hearing complying with due process, that the facility has violated the written agreement.

(l) Provided that funds are specifically appropriated 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.

(m) The State Department of Health may issue a certificate of need to a county-owned hospital in the Second Judicial District of Panola County for the conversion of not more than seventy-two (72) hospital beds to nursing facility beds, provided that the recipient of the certificate of need agrees in writing that none of the beds at the nursing facility will be certified for participation in the Medicaid program (Section 43-13-101 et seq.), and that no claim will be submitted for Medicaid reimbursement in the nursing facility in any day or for any patient in the nursing facility. This written agreement by the recipient of the certificate of need shall be a condition of the issuance of the certificate of need under this paragraph, and the agreement shall be fully binding on any subsequent owner of



3464 the nursing facility if the ownership of the nursing facility is  
3465 transferred at any time after the issuance of the certificate of  
3466 need. After this written agreement is executed, the Division of  
3467 Medicaid and the State Department of Health shall not certify any  
3468 of the beds in the nursing facility for participation in the  
3469 Medicaid program. If the nursing facility violates the terms of  
3470 the written agreement by admitting or keeping in the nursing  
3471 facility on a regular or continuing basis any patients who are  
3472 participating in the Medicaid program, the State Department of  
3473 Health shall revoke the license of the nursing facility, at the  
3474 time that the department determines, after a hearing complying  
3475 with due process, that the nursing facility has violated the  
3476 condition upon which the certificate of need was issued, as  
3477 provided in this paragraph and in the written agreement. If the  
3478 certificate of need authorized under this paragraph is not issued  
3479 within twelve (12) months after July 1, 2001, the department shall  
3480 deny the application for the certificate of need and shall not  
3481 issue the certificate of need at any time after the twelve-month  
3482 period, unless the issuance is contested. If the certificate of  
3483 need is issued and substantial construction of the nursing  
3484 facility beds has not commenced within eighteen (18) months after  
3485 July 1, 2001, the State Department of Health, after a hearing  
3486 complying with due process, shall revoke the certificate of need  
3487 if it is still outstanding, and the department shall not issue a  
3488 license for the nursing facility at any time after the



3489 eighteen-month period. However, if the issuance of the  
3490 certificate of need is contested, the department shall require  
3491 substantial construction of the nursing facility beds within six  
3492 (6) months after final adjudication on the issuance of the  
3493 certificate of need.

3494           (n) The department may issue a certificate of need for  
3495 the new construction, addition or conversion of skilled nursing  
3496 facility beds in Madison County, provided that the recipient of  
3497 the certificate of need agrees in writing that the skilled nursing  
3498 facility will not at any time participate in the Medicaid program  
3499 (Section 43-13-101 et seq.) or admit or keep any patients in the  
3500 skilled nursing facility who are participating in the Medicaid  
3501 program. This written agreement by the recipient of the  
3502 certificate of need shall be fully binding on any subsequent owner  
3503 of the skilled nursing facility, if the ownership of the facility  
3504 is transferred at any time after the issuance of the certificate  
3505 of need. Agreement that the skilled nursing facility will not  
3506 participate in the Medicaid program shall be a condition of the  
3507 issuance of a certificate of need to any person under this  
3508 paragraph (n), and if such skilled nursing facility at any time  
3509 after the issuance of the certificate of need, regardless of the  
3510 ownership of the facility, participates in the Medicaid program or  
3511 admits or keeps any patients in the facility who are participating  
3512 in the Medicaid program, the State Department of Health shall  
3513 revoke the certificate of need, if it is still outstanding, and



3514 shall deny or revoke the license of the skilled nursing facility,  
3515 at the time that the department determines, after a hearing  
3516 complying with due process, that the facility has failed to comply  
3517 with any of the conditions upon which the certificate of need was  
3518 issued, as provided in this paragraph and in the written agreement  
3519 by the recipient of the certificate of need. The total number of  
3520 nursing facility beds that may be authorized by any certificate of  
3521 need issued under this paragraph (n) shall not exceed sixty (60)  
3522 beds. If the certificate of need authorized under this paragraph  
3523 is not issued within twelve (12) months after July 1, 1998, the  
3524 department shall deny the application for the certificate of need  
3525 and shall not issue the certificate of need at any time after the  
3526 twelve-month period, unless the issuance is contested. If the  
3527 certificate of need is issued and substantial construction of the  
3528 nursing facility beds has not commenced within eighteen (18)  
3529 months after July 1, 1998, the State Department of Health, after a  
3530 hearing complying with due process, shall revoke the certificate  
3531 of need if it is still outstanding, and the department shall not  
3532 issue a license for the nursing facility at any time after the  
3533 eighteen-month period. However, if the issuance of the  
3534 certificate of need is contested, the department shall require  
3535 substantial construction of the nursing facility beds within six  
3536 (6) months after final adjudication on the issuance of the  
3537 certificate of need.



3538           (o) The department may issue a certificate of need for  
3539 the new construction, addition or conversion of skilled nursing  
3540 facility beds in Leake County, provided that the recipient of the  
3541 certificate of need agrees in writing that the skilled nursing  
3542 facility will not at any time participate in the Medicaid program  
3543 (Section 43-13-101 et seq.) or admit or keep any patients in the  
3544 skilled nursing facility who are participating in the Medicaid  
3545 program. This written agreement by the recipient of the  
3546 certificate of need shall be fully binding on any subsequent owner  
3547 of the skilled nursing facility, if the ownership of the facility  
3548 is transferred at any time after the issuance of the certificate  
3549 of need. Agreement that the skilled nursing facility will not  
3550 participate in the Medicaid program shall be a condition of the  
3551 issuance of a certificate of need to any person under this  
3552 paragraph (o), and if such skilled nursing facility at any time  
3553 after the issuance of the certificate of need, regardless of the  
3554 ownership of the facility, participates in the Medicaid program or  
3555 admits or keeps any patients in the facility who are participating  
3556 in the Medicaid program, the State Department of Health shall  
3557 revoke the certificate of need, if it is still outstanding, and  
3558 shall deny or revoke the license of the skilled nursing facility,  
3559 at the time that the department determines, after a hearing  
3560 complying with due process, that the facility has failed to comply  
3561 with any of the conditions upon which the certificate of need was  
3562 issued, as provided in this paragraph and in the written agreement



3563 by the recipient of the certificate of need. The total number of  
3564 nursing facility beds that may be authorized by any certificate of  
3565 need issued under this paragraph (o) shall not exceed sixty (60)  
3566 beds. If the certificate of need authorized under this paragraph  
3567 is not issued within twelve (12) months after July 1, 2001, the  
3568 department shall deny the application for the certificate of need  
3569 and shall not issue the certificate of need at any time after the  
3570 twelve-month period, unless the issuance is contested. If the  
3571 certificate of need is issued and substantial construction of the  
3572 nursing facility beds has not commenced within eighteen (18)  
3573 months after July 1, 2001, the State Department of Health, after a  
3574 hearing complying with due process, shall revoke the certificate  
3575 of need if it is still outstanding, and the department shall not  
3576 issue a license for the nursing facility at any time after the  
3577 eighteen-month period. However, if the issuance of the  
3578 certificate of need is contested, the department shall require  
3579 substantial construction of the nursing facility beds within six  
3580 (6) months after final adjudication on the issuance of the  
3581 certificate of need.

3582 (p) The department may issue a certificate of need for  
3583 the construction of a municipally owned nursing facility within  
3584 the Town of Belmont in Tishomingo County, not to exceed sixty (60)  
3585 beds, provided that the recipient of the certificate of need  
3586 agrees in writing that the skilled nursing facility will not at  
3587 any time participate in the Medicaid program (Section 43-13-101 et



3588 seq.) or admit or keep any patients in the skilled nursing  
3589 facility who are participating in the Medicaid program. This  
3590 written agreement by the recipient of the certificate of need  
3591 shall be fully binding on any subsequent owner of the skilled  
3592 nursing facility, if the ownership of the facility is transferred  
3593 at any time after the issuance of the certificate of need.  
3594 Agreement that the skilled nursing facility will not participate  
3595 in the Medicaid program shall be a condition of the issuance of a  
3596 certificate of need to any person under this paragraph (p), and if  
3597 such skilled nursing facility at any time after the issuance of  
3598 the certificate of need, regardless of the ownership of the  
3599 facility, participates in the Medicaid program or admits or keeps  
3600 any patients in the facility who are participating in the Medicaid  
3601 program, the State Department of Health shall revoke the  
3602 certificate of need, if it is still outstanding, and shall deny or  
3603 revoke the license of the skilled nursing facility, at the time  
3604 that the department determines, after a hearing complying with due  
3605 process, that the facility has failed to comply with any of the  
3606 conditions upon which the certificate of need was issued, as  
3607 provided in this paragraph and in the written agreement by the  
3608 recipient of the certificate of need. The provision of Section  
3609 41-7-193(1) regarding substantial compliance of the projection of  
3610 need as reported in the current State Health Plan is waived for  
3611 the purposes of this paragraph. If the certificate of need  
3612 authorized under this paragraph is not issued within twelve (12)



3613 months after July 1, 1998, the department shall deny the  
3614 application for the certificate of need and shall not issue the  
3615 certificate of need at any time after the twelve-month period,  
3616 unless the issuance is contested. If the certificate of need is  
3617 issued and substantial construction of the nursing facility beds  
3618 has not commenced within eighteen (18) months after July 1, 1998,  
3619 the State Department of Health, after a hearing complying with due  
3620 process, shall revoke the certificate of need if it is still  
3621 outstanding, and the department shall not issue a license for the  
3622 nursing facility at any time after the eighteen-month period.  
3623 However, if the issuance of the certificate of need is contested,  
3624 the department shall require substantial construction of the  
3625 nursing facility beds within six (6) months after final  
3626 adjudication on the issuance of the certificate of need.

3627           (q) (i) Beginning on July 1, 1999, the State  
3628 Department of Health shall issue certificates of need during each  
3629 of the next four (4) fiscal years for the construction or  
3630 expansion of nursing facility beds or the conversion of other beds  
3631 to nursing facility beds in each county in the state having a need  
3632 for fifty (50) or more additional nursing facility beds, as shown  
3633 in the fiscal year 1999 State Health Plan, in the manner provided  
3634 in this paragraph (q). The total number of nursing facility beds  
3635 that may be authorized by any certificate of need authorized under  
3636 this paragraph (q) shall not exceed sixty (60) beds.





3637                   (ii) Subject to the provisions of subparagraph  
3638 (v), during each of the next four (4) fiscal years, the department  
3639 shall issue six (6) certificates of need for new nursing facility  
3640 beds, as follows: During fiscal years 2000, 2001 and 2002, one  
3641 (1) certificate of need shall be issued for new nursing facility  
3642 beds in the county in each of the four (4) Long-Term Care Planning  
3643 Districts designated in the fiscal year 1999 State Health Plan  
3644 that has the highest need in the district for those beds; and two  
3645 (2) certificates of need shall be issued for new nursing facility  
3646 beds in the two (2) counties from the state at large that have the  
3647 highest need in the state for those beds, when considering the  
3648 need on a statewide basis and without regard to the Long-Term Care  
3649 Planning Districts in which the counties are located. During  
3650 fiscal year 2003, one (1) certificate of need shall be issued for  
3651 new nursing facility beds in any county having a need for fifty  
3652 (50) or more additional nursing facility beds, as shown in the  
3653 fiscal year 1999 State Health Plan, that has not received a  
3654 certificate of need under this paragraph (q) during the three (3)  
3655 previous fiscal years. During fiscal year 2000, in addition to  
3656 the six (6) certificates of need authorized in this subparagraph,  
3657 the department also shall issue a certificate of need for new  
3658 nursing facility beds in Amite County and a certificate of need  
3659 for new nursing facility beds in Carroll County.

3660                   (iii) Subject to the provisions of subparagraph  
3661 (v), the certificate of need issued under subparagraph (ii) for



3662 nursing facility beds in each Long-Term Care Planning District  
3663 during each fiscal year shall first be available for nursing  
3664 facility beds in the county in the district having the highest  
3665 need for those beds, as shown in the fiscal year 1999 State Health  
3666 Plan. If there are no applications for a certificate of need for  
3667 nursing facility beds in the county having the highest need for  
3668 those beds by the date specified by the department, then the  
3669 certificate of need shall be available for nursing facility beds  
3670 in other counties in the district in descending order of the need  
3671 for those beds, from the county with the second highest need to  
3672 the county with the lowest need, until an application is received  
3673 for nursing facility beds in an eligible county in the district.

3674 (iv) Subject to the provisions of subparagraph  
3675 (v), the certificate of need issued under subparagraph (ii) for  
3676 nursing facility beds in the two (2) counties from the state at  
3677 large during each fiscal year shall first be available for nursing  
3678 facility beds in the two (2) counties that have the highest need  
3679 in the state for those beds, as shown in the fiscal year 1999  
3680 State Health Plan, when considering the need on a statewide basis  
3681 and without regard to the Long-Term Care Planning Districts in  
3682 which the counties are located. If there are no applications for  
3683 a certificate of need for nursing facility beds in either of the  
3684 two (2) counties having the highest need for those beds on a  
3685 statewide basis by the date specified by the department, then the  
3686 certificate of need shall be available for nursing facility beds



3687 in other counties from the state at large in descending order of  
3688 the need for those beds on a statewide basis, from the county with  
3689 the second highest need to the county with the lowest need, until  
3690 an application is received for nursing facility beds in an  
3691 eligible county from the state at large.

3692 (v) If a certificate of need is authorized to be  
3693 issued under this paragraph (q) for nursing facility beds in a  
3694 county on the basis of the need in the Long-Term Care Planning  
3695 District during any fiscal year of the four-year period, a  
3696 certificate of need shall not also be available under this  
3697 paragraph (q) for additional nursing facility beds in that county  
3698 on the basis of the need in the state at large, and that county  
3699 shall be excluded in determining which counties have the highest  
3700 need for nursing facility beds in the state at large for that  
3701 fiscal year. After a certificate of need has been issued under  
3702 this paragraph (q) for nursing facility beds in a county during  
3703 any fiscal year of the four-year period, a certificate of need  
3704 shall not be available again under this paragraph (q) for  
3705 additional nursing facility beds in that county during the  
3706 four-year period, and that county shall be excluded in determining  
3707 which counties have the highest need for nursing facility beds in  
3708 succeeding fiscal years.

3709 (vi) If more than one (1) application is made for  
3710 a certificate of need for nursing home facility beds available  
3711 under this paragraph (q), in Yalobusha, Newton or Tallahatchie



3712 County, and one (1) of the applicants is a county-owned hospital  
3713 located in the county where the nursing facility beds are  
3714 available, the department shall give priority to the county-owned  
3715 hospital in granting the certificate of need if the following  
3716 conditions are met:

3717                   1. The county-owned hospital fully meets all  
3718 applicable criteria and standards required to obtain a certificate  
3719 of need for the nursing facility beds; and

3720                   2. The county-owned hospital's qualifications  
3721 for the certificate of need, as shown in its application and as  
3722 determined by the department, are at least equal to the  
3723 qualifications of the other applicants for the certificate of  
3724 need.

3725                   (r) (i) Beginning on July 1, 1999, the State  
3726 Department of Health shall issue certificates of need during each  
3727 of the next two (2) fiscal years for the construction or expansion  
3728 of nursing facility beds or the conversion of other beds to  
3729 nursing facility beds in each of the four (4) Long-Term Care  
3730 Planning Districts designated in the fiscal year 1999 State Health  
3731 Plan, to provide care exclusively to patients with Alzheimer's  
3732 disease.

3733                   (ii) Not more than twenty (20) beds may be  
3734 authorized by any certificate of need issued under this paragraph  
3735 (r), and not more than a total of sixty (60) beds may be  
3736 authorized in any Long-Term Care Planning District by all



3737 certificates of need issued under this paragraph (r). However,  
3738 the total number of beds that may be authorized by all  
3739 certificates of need issued under this paragraph (r) during any  
3740 fiscal year shall not exceed one hundred twenty (120) beds, and  
3741 the total number of beds that may be authorized in any Long-Term  
3742 Care Planning District during any fiscal year shall not exceed  
3743 forty (40) beds. Of the certificates of need that are issued for  
3744 each Long-Term Care Planning District during the next two (2)  
3745 fiscal years, at least one (1) shall be issued for beds in the  
3746 northern part of the district, at least one (1) shall be issued  
3747 for beds in the central part of the district, and at least one (1)  
3748 shall be issued for beds in the southern part of the district.

3749 (iii) The State Department of Health, in  
3750 consultation with the Department of Mental Health and the Division  
3751 of Medicaid, shall develop and prescribe the staffing levels,  
3752 space requirements and other standards and requirements that must  
3753 be met with regard to the nursing facility beds authorized under  
3754 this paragraph (r) to provide care exclusively to patients with  
3755 Alzheimer's disease.

3756 (s) The State Department of Health may issue a  
3757 certificate of need to a nonprofit skilled nursing facility using  
3758 the Green House model of skilled nursing care and located in Yazoo  
3759 City, Yazoo County, Mississippi, for the construction, expansion  
3760 or conversion of not more than nineteen (19) nursing facility  
3761 beds. For purposes of this paragraph (s), the provisions of



3762 Section 41-7-193(1) requiring substantial compliance with the  
3763 projection of need as reported in the current State Health Plan  
3764 and the provisions of Section 41-7-197 requiring a formal  
3765 certificate of need hearing process are waived. There shall be no  
3766 prohibition or restrictions on participation in the Medicaid  
3767 program for the person receiving the certificate of need  
3768 authorized under this paragraph (s).

3769 (t) The State Department of Health shall issue  
3770 certificates of need to the owner of a nursing facility in  
3771 operation at the time of Hurricane Katrina in Hancock County that  
3772 was not operational on December 31, 2005, because of damage  
3773 sustained from Hurricane Katrina to authorize the following: (i)  
3774 the construction of a new nursing facility in Harrison County;  
3775 (ii) the relocation of forty-nine (49) nursing facility beds from  
3776 the Hancock County facility to the new Harrison County facility;  
3777 (iii) the establishment of not more than twenty (20) non-Medicaid  
3778 nursing facility beds at the Hancock County facility; and (iv) the  
3779 establishment of not more than twenty (20) non-Medicaid beds at  
3780 the new Harrison County facility. The certificates of need that  
3781 authorize the non-Medicaid nursing facility beds under  
3782 subparagraphs (iii) and (iv) of this paragraph (t) shall be  
3783 subject to the following conditions: The owner of the Hancock  
3784 County facility and the new Harrison County facility must agree in  
3785 writing that no more than fifty (50) of the beds at the Hancock  
3786 County facility and no more than forty-nine (49) of the beds at



3787 the Harrison County facility will be certified for participation  
3788 in the Medicaid program, and that no claim will be submitted for  
3789 Medicaid reimbursement for more than fifty (50) patients in the  
3790 Hancock County facility in any month, or for more than forty-nine  
3791 (49) patients in the Harrison County facility in any month, or for  
3792 any patient in either facility who is in a bed that is not  
3793 Medicaid-certified. This written agreement by the owner of the  
3794 nursing facilities shall be a condition of the issuance of the  
3795 certificates of need under this paragraph (t), and the agreement  
3796 shall be fully binding on any later owner or owners of either  
3797 facility if the ownership of either facility is transferred at any  
3798 time after the certificates of need are issued. After this  
3799 written agreement is executed, the Division of Medicaid and the  
3800 State Department of Health shall not certify more than fifty (50)  
3801 of the beds at the Hancock County facility or more than forty-nine  
3802 (49) of the beds at the Harrison County facility for participation  
3803 in the Medicaid program. If the Hancock County facility violates  
3804 the terms of the written agreement by admitting or keeping in the  
3805 facility on a regular or continuing basis more than fifty (50)  
3806 patients who are participating in the Medicaid program, or if the  
3807 Harrison County facility violates the terms of the written  
3808 agreement by admitting or keeping in the facility on a regular or  
3809 continuing basis more than forty-nine (49) patients who are  
3810 participating in the Medicaid program, the State Department of  
3811 Health shall revoke the license of the facility that is in



3812 violation of the agreement, at the time that the department  
3813 determines, after a hearing complying with due process, that the  
3814 facility has violated the agreement.

3815           (u) The State Department of Health shall issue a  
3816 certificate of need to a nonprofit venture for the establishment,  
3817 construction and operation of a skilled nursing facility of not  
3818 more than sixty (60) beds to provide skilled nursing care for  
3819 ventilator dependent or otherwise medically dependent pediatric  
3820 patients who require medical and nursing care or rehabilitation  
3821 services to be located in a county in which an academic medical  
3822 center and a children's hospital are located, and for any  
3823 construction and for the acquisition of equipment related to those  
3824 beds. The facility shall be authorized to keep such ventilator  
3825 dependent or otherwise medically dependent pediatric patients  
3826 beyond age twenty-one (21) in accordance with regulations of the  
3827 State Board of Health. For purposes of this paragraph (u), the  
3828 provisions of Section 41-7-193(1) requiring substantial compliance  
3829 with the projection of need as reported in the current State  
3830 Health Plan are waived, and the provisions of Section 41-7-197  
3831 requiring a formal certificate of need hearing process are waived.  
3832 The beds authorized by this paragraph shall be counted as  
3833 pediatric skilled nursing facility beds for health planning  
3834 purposes under Section 41-7-171 et seq. There shall be no  
3835 prohibition of or restrictions on participation in the Medicaid





3836 program for the person receiving the certificate of need  
3837 authorized by this paragraph.

3838 (3) The State Department of Health may grant approval for  
3839 and issue certificates of need to any person proposing the new  
3840 construction of, addition to, conversion of beds of or expansion  
3841 of any health care facility defined in subparagraph (x)  
3842 (psychiatric residential treatment facility) of Section  
3843 41-7-173(h). The total number of beds which may be authorized by  
3844 such certificates of need shall not exceed three hundred  
3845 thirty-four (334) beds for the entire state.

3846 (a) Of the total number of beds authorized under this  
3847 subsection, the department shall issue a certificate of need to a  
3848 privately owned psychiatric residential treatment facility in  
3849 Simpson County for the conversion of sixteen (16) intermediate  
3850 care facility for individuals with intellectual disabilities  
3851 (ICF-IID) beds to psychiatric residential treatment facility beds,  
3852 provided that facility agrees in writing that the facility shall  
3853 give priority for the use of those sixteen (16) beds to  
3854 Mississippi residents who are presently being treated in  
3855 out-of-state facilities.

3856 (b) Of the total number of beds authorized under this  
3857 subsection, the department may issue a certificate or certificates  
3858 of need for the construction or expansion of psychiatric  
3859 residential treatment facility beds or the conversion of other  
3860 beds to psychiatric residential treatment facility beds in Warren



3861 County, not to exceed sixty (60) psychiatric residential treatment  
3862 facility beds, provided that the facility agrees in writing that  
3863 no more than thirty (30) of the beds at the psychiatric  
3864 residential treatment facility will be certified for participation  
3865 in the Medicaid program (Section 43-13-101 et seq.) for the use of  
3866 any patients other than those who are participating only in the  
3867 Medicaid program of another state, and that no claim will be  
3868 submitted to the Division of Medicaid for Medicaid reimbursement  
3869 for more than thirty (30) patients in the psychiatric residential  
3870 treatment facility in any day or for any patient in the  
3871 psychiatric residential treatment facility who is in a bed that is  
3872 not Medicaid-certified. This written agreement by the recipient  
3873 of the certificate of need shall be a condition of the issuance of  
3874 the certificate of need under this paragraph, and the agreement  
3875 shall be fully binding on any subsequent owner of the psychiatric  
3876 residential treatment facility if the ownership of the facility is  
3877 transferred at any time after the issuance of the certificate of  
3878 need. After this written agreement is executed, the Division of  
3879 Medicaid and the State Department of Health shall not certify more  
3880 than thirty (30) of the beds in the psychiatric residential  
3881 treatment facility for participation in the Medicaid program for  
3882 the use of any patients other than those who are participating  
3883 only in the Medicaid program of another state. If the psychiatric  
3884 residential treatment facility violates the terms of the written  
3885 agreement by admitting or keeping in the facility on a regular or



3886 continuing basis more than thirty (30) patients who are  
3887 participating in the Mississippi Medicaid program, the State  
3888 Department of Health shall revoke the license of the facility, at  
3889 the time that the department determines, after a hearing complying  
3890 with due process, that the facility has violated the condition  
3891 upon which the certificate of need was issued, as provided in this  
3892 paragraph and in the written agreement.

3893         The State Department of Health, on or before July 1, 2002,  
3894 shall transfer the certificate of need authorized under the  
3895 authority of this paragraph (b), or reissue the certificate of  
3896 need if it has expired, to River Region Health System.

3897         (c) Of the total number of beds authorized under this  
3898 subsection, the department shall issue a certificate of need to a  
3899 hospital currently operating Medicaid-certified acute psychiatric  
3900 beds for adolescents in DeSoto County, for the establishment of a  
3901 forty-bed psychiatric residential treatment facility in DeSoto  
3902 County \* \* \* There shall be no prohibition or restrictions on  
3903 participation in the Medicaid program (Section 43-13-101 et seq.)  
3904 for the person(s) receiving the certificate of need authorized  
3905 under this paragraph (c) or for the beds converted pursuant to the  
3906 authority of that certificate of need that would not apply to any  
3907 other psychiatric residential treatment facility.

3908         (d) Of the total number of beds authorized under this  
3909 subsection, the department may issue a certificate or certificates  
3910 of need for the construction or expansion of psychiatric



3911 residential treatment facility beds or the conversion of other  
3912 beds to psychiatric treatment facility beds, not to exceed thirty  
3913 (30) psychiatric residential treatment facility beds, in either  
3914 Alcorn, Tishomingo, Prentiss, Lee, Itawamba, Monroe, Chickasaw,  
3915 Pontotoc, Calhoun, Lafayette, Union, Benton or Tippah County.

3916 (e) Of the total number of beds authorized under this  
3917 subsection (3) the department shall issue a certificate of need to  
3918 a privately owned, nonprofit psychiatric residential treatment  
3919 facility in Hinds County for an eight-bed expansion of the  
3920 facility, provided that the facility agrees in writing that the  
3921 facility shall give priority for the use of those eight (8) beds  
3922 to Mississippi residents who are presently being treated in  
3923 out-of-state facilities.

3924 (f) The department shall issue a certificate of need to  
3925 a one-hundred-thirty-four-bed specialty hospital located on  
3926 twenty-nine and forty-four one-hundredths (29.44) commercial acres  
3927 at 5900 Highway 39 North in Meridian (Lauderdale County),  
3928 Mississippi, for the addition, construction or expansion of  
3929 child/adolescent psychiatric residential treatment facility beds  
3930 in Lauderdale County. As a condition of issuance of the  
3931 certificate of need under this paragraph, the facility shall give  
3932 priority in admissions to the child/adolescent psychiatric  
3933 residential treatment facility beds authorized under this  
3934 paragraph to patients who otherwise would require out-of-state  
3935 placement. The Division of Medicaid, in conjunction with the



3936 Department of Human Services, shall furnish the facility a list of  
3937 all out-of-state patients on a quarterly basis. Furthermore,  
3938 notice shall also be provided to the parent, custodial parent or  
3939 guardian of each out-of-state patient notifying them of the  
3940 priority status granted by this paragraph. For purposes of this  
3941 paragraph, the provisions of Section 41-7-193(1) requiring  
3942 substantial compliance with the projection of need as reported in  
3943 the current State Health Plan are waived. The total number of  
3944 child/adolescent psychiatric residential treatment facility beds  
3945 that may be authorized under the authority of this paragraph shall  
3946 be sixty (60) beds. There shall be no prohibition or restrictions  
3947 on participation in the Medicaid program (Section 43-13-101 et  
3948 seq.) for the person receiving the certificate of need authorized  
3949 under this paragraph or for the beds converted pursuant to the  
3950 authority of that certificate of need.

3951       (4) (a) From and after March 25, 2021, the department may  
3952 issue a certificate of need to any person for the new construction  
3953 of any hospital, psychiatric hospital or chemical dependency  
3954 hospital that will contain any child/adolescent psychiatric or  
3955 child/adolescent chemical dependency beds, or for the conversion  
3956 of any other health care facility to a hospital, psychiatric  
3957 hospital or chemical dependency hospital that will contain any  
3958 child/adolescent psychiatric or child/adolescent chemical  
3959 dependency beds. There shall be no prohibition or restrictions on  
3960 participation in the Medicaid program (Section 43-13-101 et seq.)



3961 for the person(s) receiving the certificate(s) of need authorized  
3962 under this paragraph (a) or for the beds converted pursuant to the  
3963 authority of that certificate of need. In issuing any new  
3964 certificate of need for any child/adolescent psychiatric or  
3965 child/adolescent chemical dependency beds, either by new  
3966 construction or conversion of beds of another category, the  
3967 department shall give preference to beds which will be located in  
3968 an area of the state which does not have such beds located in it,  
3969 and to a location more than sixty-five (65) miles from existing  
3970 beds. Upon receiving 2020 census data, the department may amend  
3971 the State Health Plan regarding child/adolescent psychiatric and  
3972 child/adolescent chemical dependency beds to reflect the need  
3973 based on new census data.

3974 (i) [Deleted]

3975 (ii) The department may issue a certificate of  
3976 need for the conversion of existing beds in a county hospital in  
3977 Choctaw County from acute care beds to child/adolescent chemical  
3978 dependency beds. For purposes of this subparagraph (ii), the  
3979 provisions of Section 41-7-193(1) requiring substantial compliance  
3980 with the projection of need as reported in the current State  
3981 Health Plan are waived. The total number of beds that may be  
3982 authorized under authority of this subparagraph shall not exceed  
3983 twenty (20) beds. There shall be no prohibition or restrictions  
3984 on participation in the Medicaid program (Section 43-13-101 et  
3985 seq.) for the hospital receiving the certificate of need



authorized under this subparagraph or for the beds converted pursuant to the authority of that certificate of need.

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

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



4011 authorize the construction, expansion or conversion of the beds  
4012 authorized under this subparagraph.

4013                   (iv) The department shall issue a certificate of  
4014 need to the Region 7 Mental Health/Retardation Commission for the  
4015 construction or expansion of child/adolescent psychiatric beds or  
4016 the conversion of other beds to child/adolescent psychiatric beds  
4017 in any of the counties served by the commission. For purposes of  
4018 this subparagraph (iv), the provisions of Section 41-7-193(1)  
4019 requiring substantial compliance with the projection of need as  
4020 reported in the current State Health Plan are waived. The total  
4021 number of beds that may be authorized under the authority of this  
4022 subparagraph shall not exceed twenty (20) beds. There shall be no  
4023 prohibition or restrictions on participation in the Medicaid  
4024 program (Section 43-13-101 et seq.) for the person receiving the  
4025 certificate of need authorized under this subparagraph or for the  
4026 beds converted pursuant to the authority of that certificate of  
4027 need.

4028                   (v) The department may issue a certificate of need  
4029 to any county hospital located in Leflore County for the  
4030 construction or expansion of adult psychiatric beds or the  
4031 conversion of other beds to adult psychiatric beds, not to exceed  
4032 twenty (20) beds, provided that the recipient of the certificate  
4033 of need agrees in writing that the adult psychiatric beds will not  
4034 at any time be certified for participation in the Medicaid program  
4035 and that the hospital will not admit or keep any patients who are





4036 participating in the Medicaid program in any of such adult  
4037 psychiatric beds. This written agreement by the recipient of the  
4038 certificate of need shall be fully binding on any subsequent owner  
4039 of the hospital if the ownership of the hospital is transferred at  
4040 any time after the issuance of the certificate of need. Agreement  
4041 that the adult psychiatric beds will not be certified for  
4042 participation in the Medicaid program shall be a condition of the  
4043 issuance of a certificate of need to any person under this  
4044 subparagraph (v), and if such hospital at any time after the  
4045 issuance of the certificate of need, regardless of the ownership  
4046 of the hospital, has any of such adult psychiatric beds certified  
4047 for participation in the Medicaid program or admits or keeps any  
4048 Medicaid patients in such adult psychiatric beds, the State  
4049 Department of Health shall revoke the certificate of need, if it  
4050 is still outstanding, and shall deny or revoke the license of the  
4051 hospital at the time that the department determines, after a  
4052 hearing complying with due process, that the hospital has failed  
4053 to comply with any of the conditions upon which the certificate of  
4054 need was issued, as provided in this subparagraph and in the  
4055 written agreement by the recipient of the certificate of need.

4056                   (vi) The department may issue a certificate or  
4057 certificates of need for the expansion of child psychiatric beds  
4058 or the conversion of other beds to child psychiatric beds at the  
4059 University of Mississippi Medical Center. For purposes of this  
4060 subparagraph (vi), the provisions of Section 41-7-193(1) requiring



4061 substantial compliance with the projection of need as reported in  
4062 the current State Health Plan are waived. The total number of  
4063 beds that may be authorized under the authority of this  
4064 subparagraph shall not exceed fifteen (15) beds. There shall be  
4065 no prohibition or restrictions on participation in the Medicaid  
4066 program (Section 43-13-101 et seq.) for the hospital receiving the  
4067 certificate of need authorized under this subparagraph or for the  
4068 beds converted pursuant to the authority of that certificate of  
4069 need.

4070 (b) From and after July 1, 1990, no hospital,  
4071 psychiatric hospital or chemical dependency hospital shall be  
4072 authorized to add any child/adolescent psychiatric or  
4073 child/adolescent chemical dependency beds or convert any beds of  
4074 another category to child/adolescent psychiatric or  
4075 child/adolescent chemical dependency beds without a certificate of  
4076 need under the authority of subsection (1)(c) and subsection  
4077 (4)(a) of this section.

4078 (5) The department may issue a certificate of need to a  
4079 county hospital in Winston County for the conversion of fifteen  
4080 (15) acute care beds to geriatric psychiatric care beds.

4081 (6) The State Department of Health shall issue a certificate  
4082 of need to a Mississippi corporation qualified to manage a  
4083 long-term care hospital as defined in Section 41-7-173(h)(xii) in  
4084 Harrison County, not to exceed eighty (80) beds, including any  
4085 necessary renovation or construction required for licensure and



4086 certification, provided that the recipient of the certificate of  
4087 need agrees in writing that the long-term care hospital will not  
4088 at any time participate in the Medicaid program (Section 43-13-101  
4089 et seq.) or admit or keep any patients in the long-term care  
4090 hospital who are participating in the Medicaid program. This  
4091 written agreement by the recipient of the certificate of need  
4092 shall be fully binding on any subsequent owner of the long-term  
4093 care hospital, if the ownership of the facility is transferred at  
4094 any time after the issuance of the certificate of need. Agreement  
4095 that the long-term care hospital will not participate in the  
4096 Medicaid program shall be a condition of the issuance of a  
4097 certificate of need to any person under this subsection (6), and  
4098 if such long-term care hospital at any time after the issuance of  
4099 the certificate of need, regardless of the ownership of the  
4100 facility, participates in the Medicaid program or admits or keeps  
4101 any patients in the facility who are participating in the Medicaid  
4102 program, the State Department of Health shall revoke the  
4103 certificate of need, if it is still outstanding, and shall deny or  
4104 revoke the license of the long-term care hospital, at the time  
4105 that the department determines, after a hearing complying with due  
4106 process, that the facility has failed to comply with any of the  
4107 conditions upon which the certificate of need was issued, as  
4108 provided in this subsection and in the written agreement by the  
4109 recipient of the certificate of need. For purposes of this  
4110 subsection, the provisions of Section 41-7-193(1) requiring



4111 substantial compliance with the projection of need as reported in  
4112 the current State Health Plan are waived.

4113       (7) The State Department of Health may issue a certificate  
4114 of need to any hospital in the state to utilize a portion of its  
4115 beds for the "swing-bed" concept. Any such hospital must be in  
4116 conformance with the federal regulations regarding such swing-bed  
4117 concept at the time it submits its application for a certificate  
4118 of need to the State Department of Health, except that such  
4119 hospital may have more licensed beds or a higher average daily  
4120 census (ADC) than the maximum number specified in federal  
4121 regulations for participation in the swing-bed program. Any  
4122 hospital meeting all federal requirements for participation in the  
4123 swing-bed program which receives such certificate of need shall  
4124 render services provided under the swing-bed concept to any  
4125 patient eligible for Medicare (Title XVIII of the Social Security  
4126 Act) who is certified by a physician to be in need of such  
4127 services, and no such hospital shall permit any patient who is  
4128 eligible for both Medicaid and Medicare or eligible only for  
4129 Medicaid to stay in the swing beds of the hospital for more than  
4130 thirty (30) days per admission unless the hospital receives prior  
4131 approval for such patient from the Division of Medicaid, Office of  
4132 the Governor. Any hospital having more licensed beds or a higher  
4133 average daily census (ADC) than the maximum number specified in  
4134 federal regulations for participation in the swing-bed program  
4135 which receives such certificate of need shall develop a procedure



4136 to ensure that before a patient is allowed to stay in the swing  
4137 beds of the hospital, there are no vacant nursing home beds  
4138 available for that patient located within a fifty-mile radius of  
4139 the hospital. When any such hospital has a patient staying in the  
4140 swing beds of the hospital and the hospital receives notice from a  
4141 nursing home located within such radius that there is a vacant bed  
4142 available for that patient, the hospital shall transfer the  
4143 patient to the nursing home within a reasonable time after receipt  
4144 of the notice. Any hospital which is subject to the requirements  
4145 of the two (2) preceding sentences of this subsection may be  
4146 suspended from participation in the swing-bed program for a  
4147 reasonable period of time by the State Department of Health if the  
4148 department, after a hearing complying with due process, determines  
4149 that the hospital has failed to comply with any of those  
4150 requirements.

4151 (8) The Department of Health shall not grant approval for or  
4152 issue a certificate of need to any person proposing the new  
4153 construction of, addition to or expansion of a health care  
4154 facility as defined in subparagraph (viii) of Section 41-7-173(h),  
4155 except as hereinafter provided: The department may issue a  
4156 certificate of need to a nonprofit corporation located in Madison  
4157 County, Mississippi, for the construction, expansion or conversion  
4158 of not more than twenty (20) beds in a community living program  
4159 for developmentally disabled adults in a facility as defined in  
4160 subparagraph (viii) of Section 41-7-173(h). For purposes of this



4161 subsection (8), the provisions of Section 41-7-193(1) requiring  
4162 substantial compliance with the projection of need as reported in  
4163 the current State Health Plan and the provisions of Section  
4164 41-7-197 requiring a formal certificate of need hearing process  
4165 are waived. There shall be no prohibition or restrictions on  
4166 participation in the Medicaid program for the person receiving the  
4167 certificate of need authorized under this subsection (8).

4168 (9) The Department of Health shall not grant approval for or  
4169 issue a certificate of need to any person proposing the  
4170 establishment of, or expansion of the currently approved territory  
4171 of, or the contracting to establish a home office, subunit or  
4172 branch office within the space operated as a health care facility  
4173 as defined in Section 41-7-173(h)(i) through (viii) by a health  
4174 care facility as defined in subparagraph (ix) of Section  
4175 41-7-173(h).

4176 (10) Health care facilities owned and/or operated by the  
4177 state or its agencies are exempt from the restraints in this  
4178 section against issuance of a certificate of need if such addition  
4179 or expansion consists of repairing or renovation necessary to  
4180 comply with the state licensure law. This exception shall not  
4181 apply to the new construction of any building by such state  
4182 facility. This exception shall not apply to any health care  
4183 facilities owned and/or operated by counties, municipalities,  
4184 districts, unincorporated areas, other defined persons, or any  
4185 combination thereof.



4186           (11) The new construction, renovation or expansion of or  
4187 addition to any health care facility defined in subparagraph (ii)  
4188 (psychiatric hospital), subparagraph (iv) (skilled nursing  
4189 facility), subparagraph (vi) (intermediate care facility),  
4190 subparagraph (viii) (intermediate care facility for individuals  
4191 with intellectual disabilities) and subparagraph (x) (psychiatric  
4192 residential treatment facility) of Section 41-7-173(h) which is  
4193 owned by the State of Mississippi and under the direction and  
4194 control of the State Department of Mental Health, and the addition  
4195 of new beds or the conversion of beds from one category to another  
4196 in any such defined health care facility which is owned by the  
4197 State of Mississippi and under the direction and control of the  
4198 State Department of Mental Health, shall not require the issuance  
4199 of a certificate of need under Section 41-7-171 et seq.,  
4200 notwithstanding any provision in Section 41-7-171 et seq. to the  
4201 contrary.

4202           (12) The new construction, renovation or expansion of or  
4203 addition to any veterans homes or domiciliaries for eligible  
4204 veterans of the State of Mississippi as authorized under Section  
4205 35-1-19 shall not require the issuance of a certificate of need,  
4206 notwithstanding any provision in Section 41-7-171 et seq. to the  
4207 contrary.

4208           (13) The repair or the rebuilding of an existing, operating  
4209 health care facility that sustained significant damage from a  
4210 natural disaster that occurred after April 15, 2014, in an area



4211 that is proclaimed a disaster area or subject to a state of  
4212 emergency by the Governor or by the President of the United States  
4213 shall be exempt from all of the requirements of the Mississippi  
4214 Certificate of Need Law (Section 41-7-171 et seq.) and any and all  
4215 rules and regulations promulgated under that law, subject to the  
4216 following conditions:

4217 (a) The repair or the rebuilding of any such damaged  
4218 health care facility must be within one (1) mile of the  
4219 pre-disaster location of the campus of the damaged health care  
4220 facility, except that any temporary post-disaster health care  
4221 facility operating location may be within five (5) miles of the  
4222 pre-disaster location of the damaged health care facility;

4223 (b) The repair or the rebuilding of the damaged health  
4224 care facility (i) does not increase or change the complement of  
4225 its bed capacity that it had before the Governor's or the  
4226 President's proclamation, (ii) does not increase or change its  
4227 levels and types of health care services that it provided before  
4228 the Governor's or the President's proclamation, and (iii) does not  
4229 rebuild in a different county; however, this paragraph does not  
4230 restrict or prevent a health care facility from decreasing its bed  
4231 capacity that it had before the Governor's or the President's  
4232 proclamation, or from decreasing the levels of or decreasing or  
4233 eliminating the types of health care services that it provided  
4234 before the Governor's or the President's proclamation, when the  
4235 damaged health care facility is repaired or rebuilt;





4236 (c) The exemption from Certificate of Need Law provided  
4237 under this subsection (13) is valid for only five (5) years from  
4238 the date of the Governor's or the President's proclamation. If  
4239 actual construction has not begun within that five-year period,  
4240 the exemption provided under this subsection is inapplicable; and

4241 (d) The Division of Health Facilities Licensure and  
4242 Certification of the State Department of Health shall provide the  
4243 same oversight for the repair or the rebuilding of the damaged  
4244 health care facility that it provides to all health care facility  
4245 construction projects in the state.

4246 For the purposes of this subsection (13), "significant  
4247 damage" to a health care facility means damage to the health care  
4248 facility requiring an expenditure of at least One Million Dollars  
4249 (\$1,000,000.00).

4250 (14) The State Department of Health shall issue a  
4251 certificate of need to any hospital which is currently licensed  
4252 for two hundred fifty (250) or more acute care beds and is located  
4253 in any general hospital service area not having a comprehensive  
4254 cancer center, for the establishment and equipping of such a  
4255 center which provides facilities and services for outpatient  
4256 radiation oncology therapy, outpatient medical oncology therapy,  
4257 and appropriate support services including the provision of  
4258 radiation therapy services. The provisions of Section 41-7-193(1)  
4259 regarding substantial compliance with the projection of need as



4260 reported in the current State Health Plan are waived for the  
4261 purpose of this subsection.

4262 (15) The State Department of Health may authorize the  
4263 transfer of hospital beds, not to exceed sixty (60) beds, from the  
4264 North Panola Community Hospital to the South Panola Community  
4265 Hospital. The authorization for the transfer of those beds shall  
4266 be exempt from the certificate of need review process.

4267 (16) The State Department of Health shall issue any  
4268 certificates of need necessary for Mississippi State University  
4269 and a public or private health care provider to jointly acquire  
4270 and operate a linear accelerator and a magnetic resonance imaging  
4271 unit. Those certificates of need shall cover all capital  
4272 expenditures related to the project between Mississippi State  
4273 University and the health care provider, including, but not  
4274 limited to, the acquisition of the linear accelerator, the  
4275 magnetic resonance imaging unit and other radiological modalities;  
4276 the offering of linear accelerator and magnetic resonance imaging  
4277 services; and the cost of construction of facilities in which to  
4278 locate these services. The linear accelerator and the magnetic  
4279 resonance imaging unit shall be (a) located in the City of  
4280 Starkville, Oktibbeha County, Mississippi; (b) operated jointly by  
4281 Mississippi State University and the public or private health care  
4282 provider selected by Mississippi State University through a  
4283 request for proposals (RFP) process in which Mississippi State  
4284 University selects, and the Board of Trustees of State



4285 Institutions of Higher Learning approves, the health care provider  
4286 that makes the best overall proposal; (c) available to Mississippi  
4287 State University for research purposes two-thirds (2/3) of the  
4288 time that the linear accelerator and magnetic resonance imaging  
4289 unit are operational; and (d) available to the public or private  
4290 health care provider selected by Mississippi State University and  
4291 approved by the Board of Trustees of State Institutions of Higher  
4292 Learning one-third (1/3) of the time for clinical, diagnostic and  
4293 treatment purposes. For purposes of this subsection, the  
4294 provisions of Section 41-7-193(1) requiring substantial compliance  
4295 with the projection of need as reported in the current State  
4296 Health Plan are waived.

4297       (17) The State Department of Health shall issue a  
4298 certificate of need for the construction of an acute care hospital  
4299 in Kemper County, not to exceed twenty-five (25) beds, which shall  
4300 be named the "John C. Stennis Memorial Hospital." In issuing the  
4301 certificate of need under this subsection, the department shall  
4302 give priority to a hospital located in Lauderdale County that has  
4303 two hundred fifteen (215) beds. For purposes of this subsection,  
4304 the provisions of Section 41-7-193(1) requiring substantial  
4305 compliance with the projection of need as reported in the current  
4306 State Health Plan and the provisions of Section 41-7-197 requiring  
4307 a formal certificate of need hearing process are waived. There  
4308 shall be no prohibition or restrictions on participation in the  
4309 Medicaid program (Section 43-13-101 et seq.) for the person or



4310 entity receiving the certificate of need authorized under this  
4311 subsection or for the beds constructed under the authority of that  
4312 certificate of need.

4313 (18) The planning, design, construction, renovation,  
4314 addition, furnishing and equipping of a clinical research unit at  
4315 any health care facility defined in Section 41-7-173(h) that is  
4316 under the direction and control of the University of Mississippi  
4317 Medical Center and located in Jackson, Mississippi, and the  
4318 addition of new beds or the conversion of beds from one (1)  
4319 category to another in any such clinical research unit, shall not  
4320 require the issuance of a certificate of need under Section  
4321 41-7-171 et seq., notwithstanding any provision in Section  
4322 41-7-171 et seq. to the contrary.

4323 (19) [Repealed]

4324 (20) Nothing in this section or in any other provision of  
4325 Section 41-7-171 et seq. shall prevent any nursing facility from  
4326 designating an appropriate number of existing beds in the facility  
4327 as beds for providing care exclusively to patients with  
4328 Alzheimer's disease.

4329 (21) Nothing in this section or any other provision of  
4330 Section 41-7-171 et seq. shall prevent any health care facility  
4331 from the new construction, renovation, conversion or expansion of  
4332 new beds in the facility designated as intensive care units,  
4333 negative pressure rooms, or isolation rooms pursuant to the  
4334 provisions of Sections 41-14-1 through 41-14-11, or Section



41-14-31. For purposes of this subsection, the provisions of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in the current State Health Plan and the provisions of Section 41-7-197 requiring a formal certificate of need hearing process are waived.

**SECTION 14.** The following shall be codified as Section 83-9-47, Mississippi Code of 1972:

83-9-47. (1) An insurer providing coverage for prescription 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.

(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 15.** The following shall be codified as Section 41-140-1, Mississippi Code of 1972:

41-140-1. **Definitions.** (1) "Maternal health care facility" means any facility that provides prenatal or perinatal care,



4360 including, but not limited to, hospitals, clinics and other  
4361 physician facilities.

4362 (2) "Maternal health care provider" means any physician,  
4363 nurse or other authorized practitioner that attends to pregnant  
4364 women and mothers of infants.

4365 **SECTION 16.** The following shall be codified as Section  
4366 41-140-3, Mississippi Code of 1972:

4367 41-140-3. **Education and awareness.** (1) The State  
4368 Department of Health shall develop written educational materials  
4369 and information for health care professionals and patients about  
4370 maternal mental health conditions, including postpartum  
4371 depression.

4372 (a) The materials shall include information on the  
4373 symptoms and methods of coping with postpartum depression, as well  
4374 treatment options and resources;

4375 (b) The State Department of Health shall periodically  
4376 review the materials and information to determine their  
4377 effectiveness and ensure they reflect the most up-to-date and  
4378 accurate information;

4379 (c) The State Department of Health shall post on its  
4380 website the materials and information; and

4381 (d) The State Department of Health shall make available  
4382 or distribute the materials and information in physical form upon  
4383 request.



(2) Hospitals that provide birth services shall provide departing new parents and other family members, as appropriate, with written materials and information developed under subsection (1) of this section, upon discharge from such institution.

(3) Any facility, physician, health care provider or nurse midwife who renders prenatal care, postnatal care, or pediatric infant care, shall provide the materials and information developed under subsection (1)(a) of this section, to any woman who presents with signs of a maternal mental health disorder.

**SECTION 17.** The following shall be codified as Section 41-140-5, Mississippi Code of 1972:

41-140-5. **Screening and linkage to care.** (1) Any physician, health care provider, or nurse midwife who renders postnatal care or who provides pediatric infant care shall ensure that the postnatal care patient or birthing mother of the pediatric infant care patient, as applicable, is offered screening for postpartum depression, and, if such patient or birthing mother does not object to such screening, shall ensure that such patient or birthing mother is appropriately screened for postpartum depression in line with evidence-based guidelines, such as the Bright Futures Toolkit developed by the American Academy of Pediatrics.

(2) If a health care provider administering screening in accordance with this section determines, based on the screening methodology administered, that the postnatal care patient or



4409 birthing mother of the pediatric infant care patient is likely to  
4410 be suffering from postpartum depression, such health care provider  
4411 shall provide appropriate referrals, including discussion of  
4412 available treatments for postpartum depression, including  
4413 pharmacological treatments.

4414       **SECTION 18.** The following shall be codified as Section  
4415 83-9-48, Mississippi Code of 1972:

4416       83-9-48.   **Coverage of screening for postpartum depression.**

4417       (1) An insurer shall provide coverage for postpartum depression  
4418 screening required pursuant to Section 41-140-3. Such coverage  
4419 shall provide for additional reimbursement for the administration  
4420 of postpartum depression screening adequate to compensate the  
4421 health care provider for the provision of such screening and  
4422 consistent with ensuring broad access to postpartum depression  
4423 screening in line with evidence-based guidelines.

4424       (2) As used in this section, "insurer" means any hospital,  
4425 health or medical expense insurance policy, hospital or medical  
4426 service contract, employee welfare benefit plan, contract or  
4427 agreement with a health maintenance organization or a preferred  
4428 provider organization, health and accident insurance policy, or  
4429 any other insurance contract of this type, including a group  
4430 insurance plan. However, the term "insurer" does not include a  
4431 preferred provider organization that is only a network of  
4432 providers and does not define health care benefits for the purpose  
4433 of coverage under a health care benefits plan.





4434           **SECTION 19.** This act shall take effect and be in force from  
4435 and after its passage.

