By: Senator(s) Blackwell, Simmons (13th) To: Medicaid

SENATE BILL NO. 2867 (As Passed the Senate)

AN ACT TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972, TO MAKE CERTAIN TECHNICAL AMENDMENTS TO THE PROVISIONS THAT PROVIDE FOR MEDICAID ELIGIBILITY, TO MODIFY AGE AND INCOME ELIGIBILITY CRITERIA, AND TO CONFORM WITH FEDERAL LAW TO ALLOW 5 CHILDREN IN FOSTER CARE TO BE ELIGIBLE UNTIL THEIR 26TH BIRTHDAY; TO AUTHORIZE THE DIVISION OF MEDICAID TO APPLY FOR A FEDERAL 7 FAMILY PLANNING WAIVER; TO ELIMINATE THE REQUIREMENT THAT THE DIVISION MUST APPLY TO THE CENTER FOR MEDICARE AND MEDICAID 8 9 SERVICES (CMS) FOR WAIVERS TO PROVIDE SERVICES FOR CERTAIN 10 INDIVIDUALS WHO ARE END STAGE RENAL DISEASE PATIENTS ON DIALYSIS, 11 CANCER PATIENTS ON CHEMOTHERAPY OR ORGAN TRANSPLANT RECIPIENTS ON 12 ANTIREJECTION DRUGS; TO REQUIRE THE DIVISION TO SUBMIT A WAIVER BY JULY 1, 2025, TO CMS TO AUTHORIZE THE DIVISION TO CONDUCT LESS FREQUENT MEDICAL REDETERMINATIONS FOR ELIGIBLE CHILDREN WHO HAVE 14 1.5 CERTAIN LONG-TERM OR CHRONIC CONDITIONS THAT DO NOT NEED TO BE 16 REIDENTIFIED EVERY YEAR; TO AMEND SECTION 43-13-117, MISSISSIPPI 17 CODE OF 1972, AS AMENDED BY HOUSE BILL NO. 970, 2024 REGULAR 18 SESSION, TO MAKE CERTAIN TECHNICAL AMENDMENTS TO THE PROVISIONS 19 THAT PROVIDE FOR MEDICAID SERVICES, TO COMPLY WITH FEDERAL LAW; TO 20 PROVIDE THAT THE DIVISION SHALL REIMBURSE FOR ONE PAIR OF 21 EYEGLASSES EVERY TWO YEARS INSTEAD OF EVERY FIVE YEARS FOR CERTAIN 22 BENEFICIARIES; TO ELIMINATE THE OPTION FOR CERTAIN RURAL HOSPITALS 23 TO ELECT AGAINST REIMBURSEMENT FOR OUTPATIENT HOSPITAL SERVICES 24 USING THE AMBULATORY PAYMENT CLASSIFICATION (APC) METHODOLOGY; TO 25 PROVIDE THAT THE DIVISION SHALL UPDATE THE CASE MIX PAYMENT SYSTEM 26 AND FAIR RENTAL REIMBURSEMENT SYSTEM AS NECESSARY TO MAINTAIN 27 COMPLIANCE WITH FEDERAL LAW; TO PROVIDE THAT THE DIVISION OF 28 MEDICAID MAY IMPLEMENT A QUALITY OR VALUE-BASED COMPONENT TO THE 29 NURSING FACILITY PAYMENT SYSTEM; TO REQUIRE THE DIVISION TO 30 REIMBURSE PEDIATRICIANS FOR CERTAIN PRIMARY CARE SERVICES AS 31 DEFINED BY THE DIVISION AT 100% OF THE RATE ESTABLISHED UNDER 32 MEDICARE; TO PROVIDE THAT THE DIVISION MAY REIMBURSE AMBULATORY SURGICAL CARE (ASC) BASED ON 100% OF THE MEDICARE ASC PAYMENT 33 34 SYSTEM RATE IN EFFECT JULY 1 OF EACH YEAR AS SET BY CMS; TO

AUTHORIZE THE DIVISION TO PROVIDE REIMBURSEMENT FOR NEUROMUSCULAR 35 36 TONGUE MUSCLE STIMULATORS AND/OR FOR ALTERNATIVE METHODS FOR THE 37 REDUCTION OF SNORING AND OBSTRUCTIVE SLEEP APNEA; TO INCLUDE 38 ADDITIONAL LICENSED PROVIDERS IN THE DIVISION'S UPPER PAYMENT 39 LIMITS PROGRAM; TO AUTHORIZE THAT THE DIVISION MAY, IN CONSULTATION WITH THE MISSISSIPPI HOSPITAL ASSOCIATION, DEVELOP 40 41 ALTERNATIVE MODELS FOR DISTRIBUTION OF MEDICAL CLAIMS AND 42 SUPPLEMENTAL PAYMENTS FOR INPATIENT AND OUTPATIENT HOSPITAL 43 SERVICES; TO PROVIDE THAT THE DIVISION MAY, TO THE FULLEST EXTENT FEASIBLE, REPLACE THE ADDITIONAL REIMBURSEMENT FOR HOSPITAL 44 45 INPATIENT SERVICES UNDER THE INPATIENT MEDICARE UPPER PAYMENT LIMITS (UPL) PROGRAM WITH ADDITIONAL REIMBURSEMENT UNDER THE MHAP 46 47 AND OTHER PAYMENT PROGRAMS; TO DELETE TECHNICAL PROVISIONS RELATED 48 TO THE MISSISSIPPI HOSPITAL ACCESS PROGRAM (MHAP); TO PROVIDE THAT THE DIVISION SHALL CONTRACT WITH THE STATE DEPARTMENT OF HEALTH TO 49 50 PROVIDE FOR A PERINATAL HIGH RISK MANAGEMENT/INFANT SERVICES 51 SYSTEM FOR ANY ELIGIBLE BENEFICIARY THAT CANNOT RECEIVE SUCH 52 SERVICES UNDER A DIFFERENT PROGRAM; TO AUTHORIZE THE DIVISION TO 53 REIMBURSE FOR SERVICES AT CERTIFIED COMMUNITY BEHAVIORAL HEALTH 54 CENTERS; TO EXTEND THE DATE OF REPEAL ON THE PROVISION OF LAW THAT 5.5 PROVIDES THAT THE DIVISION SHALL REIMBURSE FOR OUTPATIENT HOSPITAL 56 SERVICES PROVIDED TO ELIGIBLE MEDICAID BENEFICIARIES UNDER THE AGE 57 OF 21 BY BORDER CITY UNIVERSITY AFFILIATED PEDIATRIC TEACHING 58 HOSPITALS, WHICH WAS REPEALED BY OPERATION OF LAW IN 2024; TO 59 REQUIRE THE DIVISION TO DEVELOP AND IMPLEMENT A METHOD FOR 60 REIMBURSEMENT OF AUTISM SPECTRUM DISORDER SERVICES BASED ON A 61 CONTINUUM OF CARE FOR BEST PRACTICES IN MEDICALLY NECESSARY EARLY 62 INTERVENTION TREATMENT; TO REDUCE THE LENGTH OF NOTICE THE 63 DIVISION MUST PROVIDE THE MEDICAID COMMITTEE CHAIRMEN FOR PROPOSED 64 RATE CHANGES AND TO PROVIDE THAT SUCH LEGISLATIVE NOTICE MAY BE EXPEDITED; TO PROVIDE THAT THE DIVISION SHALL REIMBURSE FOR 65 66 PREPARTICIPATION PHYSICAL EVALUATIONS; TO PROVIDE THAT THE 67 DIVISION SHALL REIMBURSE FOR UNITED STATES FOOD AND DRUG 68 ADMINISTRATION APPROVED GLUCAGON-LIKE PEPTIDE-1 (GLP-1) AGONIST 69 MEDICATIONS FOR CHRONIC WEIGHT MANAGEMENT OR FOR ADDITIONAL 70 CONDITIONS IN THE DISCRETION OF THE MEDICAL PROVIDER; TO PROHIBIT 71 THE DIVISION OF MEDICAID AND CERTAIN MANAGED CARE ENTITIES FROM 72 REQUIRING OR IMPOSING ANY STEP THERAPY PROTOCOL WITH RESPECT TO A 73 DRUG THAT IS APPROVED BY THE UNITED STATES FDA FOR THE TREATMENT OF POSTPARTUM DEPRESSION; TO REQUIRE THE DIVISION TO PROVIDE 74 75 COVERAGE AND REIMBURSEMENT FOR POSTPARTUM DEPRESSION SCREENING; TO 76 REQUIRE THE DIVISION TO PROVIDE COVERAGE AND TO REIMBURSE FOR ANY 77 NONSTATIN MEDICATION THAT HAS A UNIQUE INDICATION TO REDUCE THE 78 RISK OF A MAJOR CARDIOVASCULAR EVENT IN PRIMARY PREVENTION AND 79 SECONDARY PREVENTION PATIENTS; TO REMOVE THE OPTION FOR CERTAIN 80 HEARINGS AND TO MODIFY PROCEDURE REGARDING APPEALS; TO REQUIRE THE 81 DIVISION TO REIMBURSE AMBULANCE TRANSPORTATION SERVICE PROVIDERS 82 THAT PROVIDE AN ASSESSMENT, TRIAGE OR TREATMENT FOR ELIGIBLE 83 MEDICAID BENEFICIARIES; TO SET CERTAIN REIMBURSEMENT LEVELS FOR 84 SUCH PROVIDERS; TO PROVIDE THAT THE DIVISION IS AUTHORIZED TO 85 EXTEND ITS MEDICAID ENTERPRISE SYSTEM AND FISCAL AGENT SERVICES,

86 INCLUDING ALL RELATED COMPONENTS AND SERVICES, CONTRACTS IN EFFECT ON JUNE 30, 2025, FOR ADDITIONAL FIVE-YEAR PERIODS IF THE SYSTEM 87 88 CONTINUES TO MEET THE NEEDS OF THE STATE, THE ANNUAL COST 89 CONTINUES TO BE A FAIR MARKET VALUE, AND THE RATE OF INCREASE IS 90 NO MORE THAN FIVE PERCENT OR THE CURRENT CONSUMER PRICE INDEX, 91 WHICHEVER IS LESS; TO EXTEND THE DATE OF REPEAL ON SUCH SECTION; 92 TO AMEND SECTION 43-13-121, MISSISSIPPI CODE OF 1972, TO ELIMINATE 93 APPEALS TO THE CHANCERY COURT OF THE FIRST JUDICIAL DISTRICT OF HINDS COUNTY, MISSISSIPPI, FOLLOWING THE CONCLUSION OF AN 94 95 ADMINISTRATIVE APPEAL; TO DELETE LANGUAGE AUTHORIZING THE DIVISION TO TAX THE COSTS OF CERTAIN ADMINISTRATIVE HEARINGS TO A PROVIDER 96 97 IF SUCH PROVIDER DOES NOT SUCCEED IN HIS OR HER DEFENSE; TO REDUCE 98 THE LENGTH OF NOTICE THE DIVISION MUST PROVIDE THE MEDICAID 99 COMMITTEE CHAIRMEN FOR A PROPOSED STATE PLAN AMENDMENT AND TO 100 PROVIDE THAT SUCH LEGISLATIVE NOTICE MAY BE EXPEDITED; TO 101 AUTHORIZE THE DIVISION TO ENTER INTO A TWO-YEAR CONTRACT WITH A 102 VENDOR TO PROVIDE SUPPORT OF THE DIVISION'S ELIGIBILITY SYSTEM; TO AMEND SECTION 43-13-305, MISSISSIPPI CODE OF 1972, TO REVISE 103 104 CERTAIN PROVISIONS RELATED TO MEDICAID AND THIRD-PARTY BENEFITS TO COMPLY WITH FEDERAL LAW; TO AMEND SECTION 43-11-1, MISSISSIPPI 105 106 CODE OF 1972, TO DEFINE ADULT DAY CARE FACILITY; TO AMEND SECTION 107 43-11-8, MISSISSIPPI CODE OF 1972, TO PROVIDE FEES FOR ADULT DAY 108 CARE FACILITY LICENSURE AND LICENSE RENEWAL; TO AMEND SECTION 109 43-11-13, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT BEGINNING JULY 110 1, 2026, TO OPERATE AN ADULT DAY CARE CENTER IN MISSISSIPPI, A 111 FACILITY PROVIDER SHALL BE LICENSED WITH THE LICENSING DIVISION OF 112 THE STATE DEPARTMENT OF HEALTH; TO ESTABLISH THAT MISSISSIPPI 113 MEDICAID WAIVER PROVIDERS ARE REQUIRED TO HAVE A STATE LICENSE AND 114 HAVE A MEDICAID PROVIDER CONTRACT WITH THE DIVISION OF MEDICAID; 115 TO AMEND SECTION 43-13-117.1, MISSISSIPPI CODE OF 1972, TO MAKE 116 MINOR, NONSUBSTANTIVE REVISIONS; TO AMEND SECTION 43-13-117.7, 117 MISSISSIPPI CODE OF 1972, TO PROVIDE THAT THE DIVISION SHALL NOT 118 REIMBURSE OR PROVIDE COVERAGE FOR GENDER TRANSITION PROCEDURES FOR 119 ANY PERSON; TO AMEND SECTION 37-33-167, MISSISSIPPI CODE OF 1972, 120 TO MAKE A MINOR, NONSUBSTANTIVE REVISION; TO AMEND SECTION 121 43-13-145, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT A QUARTERLY 122 HOSPITAL ASSESSMENT MAY EXCEED THE ASSESSMENT IN THE PRIOR QUARTER BY MORE THAN \$3,750,000.00 IF SUCH INCREASE IS TO MAXIMIZE FEDERAL 123 124 FUNDS THAT ARE AVAILABLE TO REIMBURSE HOSPITALS FOR SERVICES 125 PROVIDED UNDER NEW PROGRAMS FOR HOSPITALS, FOR INCREASED 126 SUPPLEMENTAL PAYMENT PROGRAMS FOR HOSPITALS OR TO ASSIST WITH 127 STATE MATCHING FUNDS AS AUTHORIZED BY THE LEGISLATURE; TO AMEND 128 SECTION 43-13-115.1, MISSISSIPPI CODE OF 1972, TO REMOVE THE 129 REQUIREMENT THAT A PREGNANT WOMAN MUST PROVIDE PROOF OF HER 130 PREGNANCY AND DOCUMENTATION OF HER MONTHLY FAMILY INCOME WHEN 131 SEEKING A DETERMINATION OF PRESUMPTIVE ELIGIBILITY; TO AMEND 132 SECTION 41-7-191, MISSISSIPPI CODE OF 1972, TO REVISE CERTAIN PROVISIONS RELATING TO A HOSPITAL THAT HAS A CERTIFICATE OF NEED 133 134 FOR A FORTY-BED PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY IN 135 DESOTO COUNTY; TO PROVIDE THAT THERE SHALL BE NO PROHIBITION OR 136 RESTRICTIONS ON PARTICIPATION IN THE MEDICAID PROGRAM FOR SUCH

138 FACILITY; TO PROVIDE THAT A CERTAIN LONG-TERM CARE HOSPITAL IN 139 HARRISON COUNTY MAY NOT PARTICIPATE IN THE MEDICAID PROGRAM EXCEPT 140 AS A CROSSOVER ENROLLED PROVIDER; TO REQUIRE THE ISSUANCE OF A 141 HEALTH CARE CERTIFICATE OF NEED FOR ADDITIONAL BEDS IN A COMMUNITY LIVING PROGRAM FOR DEVELOPMENTALLY DISABLED ADULTS LOCATED IN 142 143 MADISON COUNTY; TO CREATE NEW SECTION 83-9-47, MISSISSIPPI CODE OF 144 1972, TO PROHIBIT INSURERS PROVIDING PRESCRIPTION DRUG COVERAGE 145 FROM REQUIRING OR IMPOSING ANY STEP THERAPY PROTOCOL WITH RESPECT

FACILITY THAT WOULD NOT OTHERWISE APPLY TO ANY OTHER SUCH

- 146 TO DRUGS APPROVED BY THE UNITED STATES FOOD AND DRUG 147 ADMINISTRATION (FDA) FOR THE TREATMENT OF POSTPARTUM DEPRESSION;
- 148 TO CREATE NEW SECTION 41-140-1, MISSISSIPPI CODE OF 1972, TO
- DEFINE TERMS; TO CREATE NEW SECTION 41-140-3, MISSISSIPPI CODE OF 149 150
- 1972, TO REQUIRE THE STATE DEPARTMENT OF HEALTH TO DEVELOP AND PROMULGATE WRITTEN EDUCATIONAL MATERIALS AND INFORMATION FOR 151
- 152 HEALTH CARE PROFESSIONALS AND PATIENTS ABOUT MATERNAL MENTAL
- 153 HEALTH CONDITIONS; TO REQUIRE HOSPITALS PROVIDING BIRTH SERVICES
- 154 TO PROVIDE SUCH EDUCATIONAL MATERIALS TO NEW PARENTS AND, AS
- 155 APPROPRIATE, OTHER FAMILY MEMBERS; TO REQUIRE SUCH MATERIALS BE
- 156 PROVIDED TO ANY WOMAN WHO PRESENTS WITH SIGNS OF A MATERNAL MENTAL
- 157 HEALTH DISORDER; TO CREATE NEW SECTION 41-140-5, MISSISSIPPI CODE
- 158 OF 1972, TO REQUIRE ANY HEALTH CARE PROVIDER OR NURSE MIDWIFE WHO
- 159 RENDERS POSTNATAL CARE OR PEDIATRIC INFANT CARE TO ENSURE THAT THE
- 160 POSTNATAL CARE PATIENT OR BIRTHING MOTHER OF THE PEDIATRIC INFANT
- 161 CARE PATIENT, AS APPLICABLE, IS OFFERED SCREENING FOR POSTPARTUM
- 162 DEPRESSION AND TO PROVIDE APPROPRIATE REFERRALS IF SUCH PATIENT OR
- 163 MOTHER IS DEEMED LIKELY TO BE SUFFERING FROM POSTPARTUM
- 164 DEPRESSION; TO CREATE NEW SECTION 83-9-48, MISSISSIPPI CODE OF
- 165 1972, TO DEFINE "INSURER" AND REQUIRE INSURERS TO PROVIDE COVERAGE
- 166 FOR POSTPARTUM DEPRESSION SCREENING; TO AMEND SECTION 43-13-107,
- 167
- MISSISSIPPI CODE OF 1972, TO ESTABLISH A MEDICAID ADVISORY
  COMMITTEE AND BENEFICIARY ADVISORY COMMITTEE AS REQUIRED PURSUANT 168
- 169 TO FEDERAL REGULATIONS; TO PROVIDE THAT ALL MEMBERS OF THE MEDICAL
- 170 CARE ADVISORY COMMITTEE SERVING ON JANUARY 1, 2025, SHALL BE
- 171 SELECTED TO SERVE ON THE MEDICAID ADVISORY COMMITTEE AND SUCH
- 172 MEMBERS SHALL SERVE UNTIL JULY 1, 2028; AND FOR RELATED PURPOSES.
- 173 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:
- 174 Section 43-13-115, Mississippi Code of 1972, is SECTION 1.
- 175 amended as follows:
- 176 43-13-115. Recipients of Medicaid shall be the following
- 177 persons only:

PAGE 4

- 178 Those who are qualified for public assistance
- 179 grants under provisions of Title IV-A and E of the federal Social

181 IV-A and low income families and children under Section 1931 of 182 the federal Social Security Act. For the purposes of this paragraph (1) and paragraphs (8), (17) and (18) of this section, 183 any reference to Title IV-A or to Part A of Title IV of the 184 185 federal Social Security Act, as amended, or the state plan under 186 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 187 188 amended, and the state plan under Title IV-A, including the income and resource standards and methodologies under Title IV-A and the 189 state plan, as they existed on July 16, 1996. The Department of 190 191 Human Services shall determine Medicaid eligibility for children 192 receiving public assistance grants under Title IV-E. The division 193 shall determine eligibility for low income families under Section 1931 of the federal Social Security Act and shall redetermine 194 195 eligibility for those continuing under Title IV-A grants.

Security Act, as amended, including those statutorily deemed to be

- (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.
- 202 (3) Qualified pregnant women who would be eligible for 203 Medicaid as a low income family member under Section 1931 of the 204 federal Social Security Act if her child were born. The

180

196

197

198

199

200

205	eligibility	of	the	individuals	covered	under	this	paragraph	shall
206	be determine	ed k	y th	ne division.					

- 207 (4) [Deleted]
- 208 (5) A child born on or after October 1, 1984, to a 209 woman eligible for and receiving Medicaid under the state plan on 210 the date of the child's birth shall be deemed to have applied for 211 Medicaid and to have been found eligible for Medicaid under the 212 plan on the date of that birth, and will remain eligible for 213 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 214 215 Medicaid or would be eligible for Medicaid if pregnant. 216 eligibility of individuals covered in this paragraph shall be 217 determined by the Division of Medicaid.
- 218 Children certified by the State Department of Human 219 Services to the Division of Medicaid of whom the state and county 220 departments of human services have custody and financial 221 responsibility, and children who are in adoptions subsidized in 222 full or part by the Department of Human Services, including 223 special needs children in non-Title IV-E adoption assistance, who 224 are approvable under Title XIX of the Medicaid program. eligibility of the children covered under this paragraph shall be 225 226 determined by the State Department of Human Services.
- 227 (7) Persons certified by the Division of Medicaid who
  228 are patients in a medical facility (nursing home, hospital,
  229 tuberculosis sanatorium or institution for treatment of mental

- 230 diseases), and who, except for the fact that they are patients in
- 231 that medical facility, would qualify for grants under Title IV,
- 232 Supplementary Security Income (SSI) benefits under Title XVI or
- 233 state supplements, and those aged, blind and disabled persons who
- 234 would not be eligible for Supplemental Security Income (SSI)
- 235 benefits under Title XVI or state supplements if they were not
- 236 institutionalized in a medical facility but whose income is below
- 237 the maximum standard set by the Division of Medicaid, which
- 238 standard shall not exceed that prescribed by federal regulation.
- 239 (8) Children under eighteen (18) years of age and
- 240 pregnant women (including those in intact families) who meet the
- 241 financial standards of the state plan approved under Title IV-A of
- 242 the federal Social Security Act, as amended. The eligibility of
- 243 children covered under this paragraph shall be determined by the
- 244 Division of Medicaid.
- 245 (9) Individuals who are:
- 246 (a) Children born after September 30, 1983, \* \* \*
- 247 between the ages of six (6) and nineteen (19), with family income
- 248 that does not exceed \* \* \* one hundred thirty-three percent (133%)
- 249 of the \* \* \* federal poverty level;
- 250 (b) Pregnant women, infants and children \* \* \*
- 251 between the ages of one (1) and six (6), with family income that
- 252 does not exceed \* \* \* one hundred forty-three percent (143%) of
- 253 the federal poverty level; and

254	(c) Pregnant women and infants who have not
255	attained the age of one (1), with family income that does not
256	exceed * * * one hundred ninety-four percent (194%) of the federal
257	poverty level.
258	The eligibility of individuals covered in (a), (b) and (c) of
259	this paragraph shall be determined by the division.
260	(10) Certain disabled children age eighteen (18) or
261	under who are living at home, who would be eligible, if in a
262	medical institution, for SSI or a state supplemental payment under
263	Title XVI of the federal Social Security Act, as amended, and
264	therefore for Medicaid under the plan, and for whom the state has
265	made a determination as required under Section 1902(e)(3)(b) of
266	the federal Social Security Act, as amended. The eligibility of
267	individuals under this paragraph shall be determined by the
268	Division of Medicaid. The division shall submit a waiver by July
269	1, 2025, to the Centers for Medicare and Medicaid Services to
270	<u>require</u> less frequent medical redeterminations for children
271	eligible under this subsection who have certain long-term or
272	chronic conditions that do not need to be reidentified every year.
273	(11) * * * Individuals who are sixty-five (65) years of
274	age or older or are disabled as determined under Section
275	1614(a)(3) of the federal Social Security Act, as amended, and
276	whose income does not exceed one hundred thirty-five percent
277	(135%) of the * * * $\frac{1}{2}$ federal poverty level, and whose resources do
72	not exceed those established by the Division of Medicaid. The

- 279 eligibility of individuals covered under this paragraph shall be
- 280 determined by the Division of Medicaid. \* \* \* Only those
- 281 individuals covered under the 1115(c) Healthier Mississippi waiver
- 282 will be covered under this category.
- 283 Any individual who applied for Medicaid during the period
- 284 from July 1, 2004, through March 31, 2005, who otherwise would
- 285 have been eligible for coverage under this paragraph (11) if it
- 286 had been in effect at the time the individual submitted his or her
- 287 application and is still eligible for coverage under this
- 288 paragraph (11) on March 31, 2005, shall be eligible for Medicaid
- 289 coverage under this paragraph (11) from March 31, 2005, through
- 290 December 31, 2005. The division shall give priority in processing
- 291 the applications for those individuals to determine their
- 292 eligibility under this paragraph (11).
- 293 (12) Individuals who are qualified Medicare
- 294 beneficiaries (QMB) entitled to Part A Medicare as defined under
- 295 Section 301, Public Law 100-360, known as the Medicare
- 296 Catastrophic Coverage Act of 1988, and whose income does not
- 297 exceed one hundred percent (100%) of the \* \* \* federal poverty
- 298 level.
- The eligibility of individuals covered under this paragraph
- 300 shall be determined by the Division of Medicaid, and those
- 301 individuals determined eligible shall receive Medicare
- 302 cost-sharing expenses only as more fully defined by the Medicare

- 303 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of 304 1997.
- 305 (13) (a) Individuals who are entitled to Medicare Part
- 306 A as defined in Section 4501 of the Omnibus Budget Reconciliation
- 307 Act of 1990, and whose income does not exceed one hundred twenty
- 308 percent (120%) of the \* \* \* federal poverty level. Eligibility
- 309 for Medicaid benefits is limited to full payment of Medicare Part
- 310 B premiums.
- 311 (b) Individuals entitled to Part A of Medicare,
- 312 with income above one hundred twenty percent (120%), but less than
- 313 one hundred thirty-five percent (135%) of the federal poverty
- 314 level, and not otherwise eligible for Medicaid. Eligibility for
- 315 Medicaid benefits is limited to full payment of Medicare Part B
- 316 premiums. The number of eligible individuals is limited by the
- 317 availability of the federal capped allocation at one hundred
- 318 percent (100%) of federal matching funds, as more fully defined in
- 319 the Balanced Budget Act of 1997.
- The eligibility of individuals covered under this paragraph
- 321 shall be determined by the Division of Medicaid.
- 322 (14) [Deleted]
- 323 (15) Disabled workers who are eligible to enroll in
- 324 Part A Medicare as required by Public Law 101-239, known as the
- 325 Omnibus Budget Reconciliation Act of 1989, and whose income does
- 326 not exceed two hundred percent (200%) of the federal poverty level
- 327 as determined in accordance with the Supplemental Security Income

328	(SSI) program. The eligibility of individuals covered under this
329	paragraph shall be determined by the Division of Medicaid and
330	those individuals shall be entitled to buy-in coverage of Medicare
331	Part A premiums only under the provisions of this paragraph (15).

- 332 (16) In accordance with the terms and conditions of
  333 approved Title XIX waiver from the United States Department of
  334 Health and Human Services, persons provided home- and
  335 community-based services who are physically disabled and certified
  336 by the Division of Medicaid as eligible due to applying the income
  337 and deeming requirements as if they were institutionalized.
  - Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193), persons who become ineligible for assistance under Title IV-A of the federal Social Security Act, as amended, because of increased income from or hours of employment of the caretaker relative or because of the expiration of the applicable earned income disregards, who were eligible for Medicaid for at least three (3) of the six (6) months preceding the month in which the ineligibility begins, shall be eligible for Medicaid for up to twelve (12) months. The eligibility of the individuals covered under this paragraph shall be determined by the division.
- 350 (18) Persons who become ineligible for assistance under 351 Title IV-A of the federal Social Security Act, as amended, as a 352 result, in whole or in part, of the collection or increased

339

340

341

342

343

344

345

346

347

348

- 353 collection of child or spousal support under Title IV-D of the federal Social Security Act, as amended, who were eligible for 354 355 Medicaid for at least three (3) of the six (6) months immediately 356 preceding the month in which the ineligibility begins, shall be 357 eligible for Medicaid for an additional four (4) months beginning 358 with the month in which the ineligibility begins. The eligibility 359 of the individuals covered under this paragraph shall be 360 determined by the division.
- 361 (19) Disabled workers, whose incomes are above the
  362 Medicaid eligibility limits, but below two hundred fifty percent
  363 (250%) of the federal poverty level, shall be allowed to purchase
  364 Medicaid coverage on a sliding fee scale developed by the Division
  365 of Medicaid.
- 366 (20) Medicaid eligible children under age eighteen (18)
  367 shall remain eligible for Medicaid benefits until the end of a
  368 period of twelve (12) months following an eligibility
  369 determination, or until such time that the individual exceeds age
  370 eighteen (18).
- 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). \* \* \*

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

403	as specified by the division. The eligibility of individuals
404	covered under this paragraph (22) shall be determined by the
405	Division of Medicaid.

- 406 (23) Children certified by the Mississippi Department 407 of Human Services for whom the state and county departments of 408 human services have custody and financial responsibility who are 409 in foster care on their eighteenth birthday as reported by the 410 Mississippi Department of Human Services shall be certified 411 Medicaid eligible by the Division of Medicaid until their \* \* \* 412 twenty-sixth birthday. Children who have aged out of foster care 413 while on Medicaid in other states shall qualify until their 414 twenty-sixth birthday.
- 415 Individuals who have not attained age sixty-five 416 (65), are not otherwise covered by creditable coverage as defined 417 in the Public Health Services Act, and have been screened for 418 breast and cervical cancer under the Centers for Disease Control 419 and Prevention Breast and Cervical Cancer Early Detection Program 420 established under Title XV of the Public Health Service Act in 421 accordance with the requirements of that act and who need 422 treatment for breast or cervical cancer. Eligibility of 423 individuals under this paragraph (24) shall be determined by the 424 Division of Medicaid.
- 425 (25) The division shall apply to the Centers for 426 Medicare and Medicaid Services (CMS) for any necessary waivers to 427 provide services to individuals who are sixty-five (65) years of

-	25 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
429	1614(a)(3) of the federal Social Security Act, as amended, and
430	whose income does not exceed one hundred thirty-five percent
431	(135%) of the * * * $\frac{\text{federal poverty level}}{\text{federal poverty level}}$ , and whose resources do
432	not exceed those established by the Division of Medicaid, and who
433	are not otherwise covered by Medicare. Nothing contained in this

age or older or are disabled as determined under Section

- 434 paragraph (25) shall entitle an individual to benefits. The
- 435 eligibility of individuals covered under this paragraph shall be
- 436 determined by the Division of Medicaid.
- 437 (26) \* \* \* [Deleted]

- 438 (27) Individuals who are entitled to Medicare Part D
- and whose income does not exceed one hundred fifty percent (150%)
- 440 of the \* \* \* federal poverty level. Eligibility for payment of
- 441 the Medicare Part D subsidy under this paragraph shall be
- 442 determined by the division.
- 443 (28) The division is authorized and directed to provide
- 444 up to twelve (12) months of continuous coverage postpartum for any
- 445 individual who qualifies for Medicaid coverage under this section
- 446 as a pregnant woman, to the extent allowable under federal law and
- 447 as determined by the division.
- The division shall redetermine eligibility for all categories
- 449 of recipients described in each paragraph of this section not less
- 450 frequently than required by federal law.
- 451 **SECTION 2.** Section 43-13-117, Mississippi Code of 1972, is
- 452 amended as follows:

- 453 43-13-117. (A) Medicaid as authorized by this article shall 454 include payment of part or all of the costs, at the discretion of 455 the division, with approval of the Governor and the Centers for 456 Medicare and Medicaid Services, of the following types of care and 457 services rendered to eligible applicants who have been determined 458 to be eligible for that care and services, within the limits of 459 state appropriations and federal matching funds:
- 460 (1)Inpatient hospital services.
- 461 The division is authorized to implement an All (a) Patient Refined Diagnosis Related Groups (APR-DRG) reimbursement 462 463 methodology for inpatient hospital services.
- 464 No service benefits or reimbursement (b) 465 limitations in this subsection (A)(1) shall apply to payments 466 under an APR-DRG or Ambulatory Payment Classification (APC) model 467 or a managed care program or similar model described in subsection 468 (H) of this section unless specifically authorized by the 469 division.
- 470 Outpatient hospital services. (2)
- 471 Emergency services. (a)
- 472 Other outpatient hospital services. (b) 473 division shall allow benefits for other medically necessary 474 outpatient hospital services (such as chemotherapy, radiation, 475 surgery and therapy), including outpatient services in a clinic or 476 other facility that is not located inside the hospital, but that

has been designated as an outpatient facility by the hospital, and

- 478 that was in operation or under construction on July 1, 2009,
- 479 provided that the costs and charges associated with the operation
- 480 of the hospital clinic are included in the hospital's cost report.
- 481 In addition, the Medicare thirty-five-mile rule will apply to
- 482 those hospital clinics not located inside the hospital that are
- 483 constructed after July 1, 2009. Where the same services are
- 484 reimbursed as clinic services, the division may revise the rate or
- 485 methodology of outpatient reimbursement to maintain consistency,
- 486 efficiency, economy and quality of care.
- 487 (c) The division is authorized to implement an
- 488 Ambulatory Payment Classification (APC) methodology for outpatient
- 489 hospital services. \* \* \*
- 490 (d) No service benefits or reimbursement
- 491 limitations in this subsection (A)(2) shall apply to payments
- 492 under an APR-DRG or APC model or a managed care program or similar
- 493 model described in subsection (H) of this section unless
- 494 specifically authorized by the division.
- 495 (3) Laboratory and x-ray services.
- 496 (4) Nursing facility services.
- 497 (a) The division shall make full payment to
- 498 nursing facilities for each day, not exceeding forty-two (42) days
- 499 per year, that a patient is absent from the facility on home
- 500 leave. Payment may be made for the following home leave days in
- 501 addition to the forty-two-day limitation: Christmas, the day

- 502 before Christmas, the day after Christmas, Thanksgiving, the day 503 before Thanksgiving and the day after Thanksgiving.
- 504 From and after July 1, 1997, the division 505 shall implement the integrated case-mix payment and quality 506 monitoring system, which includes the fair rental system for 507 property costs and in which recapture of depreciation is 508 eliminated. The division may reduce the payment for hospital 509 leave and therapeutic home leave days to the lower of the case-mix 510 category as computed for the resident on leave using the 511 assessment being utilized for payment at that point in time, or a 512 case-mix score of 1.000 for nursing facilities, and shall compute 513 case-mix scores of residents so that only services provided at the 514 nursing facility are considered in calculating a facility's per 515 diem.
- 516 (c) From and after July 1, 1997, all state-owned 517 nursing facilities shall be reimbursed on a full reasonable cost 518 basis.
- (d) \* \* \* The division shall update the case-mix

  payment system \* \* and fair rental reimbursement system as

  necessary to maintain compliance with federal law. The division

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

  facilities for ventilator-dependent resident services.
- (e) The division shall develop and implement, not later than January 1, 2001, a case-mix payment add-on determined by time studies and other valid statistical data that will

527	reimburse a nursing facility for the additional cost of caring for
528	a resident who has a diagnosis of Alzheimer's or other related
529	dementia and exhibits symptoms that require special care. Any
530	such case-mix add-on payment shall be supported by a determination
531	of additional cost. The division shall also develop and implement
532	as part of the fair rental reimbursement system for nursing
533	facility beds, an Alzheimer's resident bed depreciation enhanced
534	reimbursement system that will provide an incentive to encourage
535	nursing facilities to convert or construct beds for residents with
536	Alzheimer's or other related dementia.

- (f)The division shall develop and implement an assessment process for long-term care services. The division may provide the assessment and related functions directly or through contract with the area agencies on aging.
- (g) The division may implement a quality or value-based component to the nursing facility payment system.
- 543 The division shall apply for necessary federal waivers to 544 assure that additional services providing alternatives to nursing 545 facility care are made available to applicants for nursing 546 facility care.
- 547 (5) Periodic screening and diagnostic services for 548 individuals under age twenty-one (21) years as are needed to 549 identify physical and mental defects and to provide health care 550 treatment and other measures designed to correct or ameliorate 551 defects and physical and mental illness and conditions discovered

537

538

539

540

541

552 by the screening services, regardless of whether these services are included in the state plan. The division may include in its 553 554 periodic screening and diagnostic program those discretionary 555 services authorized under the federal regulations adopted to implement Title XIX of the federal Social Security Act, as 556 557 amended. The division, in obtaining physical therapy services, 558 occupational therapy services, and services for individuals with 559 speech, hearing and language disorders, may enter into a 560 cooperative agreement with the State Department of Education for the provision of those services to handicapped students by public 561 562 school districts using state funds that are provided from the 563 appropriation to the Department of Education to obtain federal 564 matching funds through the division. The division, in obtaining 565 medical and mental health assessments, treatment, care and 566 services for children who are in, or at risk of being put in, the 567 custody of the Mississippi Department of Human Services may enter 568 into a cooperative agreement with the Mississippi Department of 569 Human Services for the provision of those services using state 570 funds that are provided from the appropriation to the Department 571 of Human Services to obtain federal matching funds through the 572 division.

(6) Physician services. Fees for physician's services that are covered only by Medicaid shall be reimbursed at ninety percent (90%) of the rate established on January 1, 2018, and as may be adjusted each July thereafter, under Medicare. The

573

574

575

577	division may provide for a reimbursement rate for physician's
578	services of up to one hundred percent (100%) of the rate
579	established under Medicare for physician's services that are
580	provided after the normal working hours of the physician, as
581	determined in accordance with regulations of the division. The
582	division may reimburse eligible providers, as determined by the
583	division, for certain primary care services at one hundred percent
584	(100%) of the rate established under Medicare. The division shall
585	reimburse obstetricians * * $\star$ , gynecologists and pediatricians for
586	certain primary care services as defined by the division at one
587	hundred percent (100%) of the rate established under Medicare.

- (7) (a) Home health services for eligible persons, not to exceed in cost the prevailing cost of nursing facility services. All home health visits must be precertified as required by the division. In addition to physicians, certified registered nurse practitioners, physician assistants and clinical nurse specialists are authorized to prescribe or order home health services and plans of care, sign home health plans of care, certify and recertify eligibility for home health services and conduct the required initial face-to-face visit with the recipient of the services.
- 598 (b) [Repealed]
- 599 (8) Emergency medical transportation services as 600 determined by the division.

589

590

591

592

593

594

595

596

601		( 5	9) Prescri	ption	drugs	and	other	covered	drugs	and
602	services	as	determined	by th	ne divi	isior	1.			

The division shall establish a mandatory preferred drug list.

Drugs not on the mandatory preferred drug list shall be made

available by utilizing prior authorization procedures established

by the division.

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

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

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

Drugs prescribed for a resident of a psychiatric residential treatment facility must be provided in true unit doses when available. The division may require that drugs not covered by Medicare Part D for a resident of a long-term care facility be

626	provided in true unit doses when available. Those drugs that were
627	originally billed to the division but are not used by a resident
628	in any of those facilities shall be returned to the billing
629	pharmacy for credit to the division, in accordance with the
630	guidelines of the State Board of Pharmacy and any requirements of
631	federal law and regulation. Drugs shall be dispensed to a
632	recipient and only one (1) dispensing fee per month may be
633	charged. The division shall develop a methodology for reimbursing
634	for restocked drugs, which shall include a restock fee as
635	determined by the division not exceeding Seven Dollars and

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

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

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

The division shall develop a pharmacy policy in which drugs in tamper-resistant packaging that are prescribed for a resident of a nursing facility but are not dispensed to the resident shall

636

Eighty-two Cents (\$7.82).

651	be returned	d to	the pharmac	y and	not	billed	to	Medicaid,	in
652	accordance	with	quidelines	of t	he S	tate Bo	ard	of Pharma	.су.

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

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

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

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

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

The division shall allow certain drugs, including

physician-administered drugs, and implantable drug system devices,

and medical supplies, with limited distribution or limited access

for beneficiaries and administered in an appropriate clinical

setting, to be reimbursed as either a medical claim or pharmacy

claim, as determined by the division.

683 \* \* \*

684

685

686

687

688

The division and any managed care entity described in subsection (H) of this section 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.

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

691 The division shall increase the amount of the reimbursement 692 rate for diagnostic and preventative dental services for each of 693 the fiscal years 2022, 2023 and 2024 by five percent (5%) above 694 the amount of the reimbursement rate for the previous fiscal year. 695 The division shall increase the amount of the reimbursement rate 696 for restorative dental services for each of the fiscal years 2023, 697 2024 and 2025 by five percent (5%) above the amount of the reimbursement rate for the previous fiscal year. It is the intent 698

699 of the Legislature that the reimbursement rate revision for 700 preventative dental services will be an incentive to increase the 701 number of dentists who actively provide Medicaid services. 702 dental services reimbursement rate revision shall be known as the 703 "James Russell Dumas Medicaid Dental Services Incentive Program." 704 The Medical Care Advisory Committee, assisted by the Division 705 of Medicaid, shall annually determine the effect of this incentive 706 by evaluating the number of dentists who are Medicaid providers, 707 the number who and the degree to which they are actively billing

708 Medicaid, the geographic trends of where dentists are offering 709 what types of Medicaid services and other statistics pertinent to 710 the goals of this legislative intent. This data shall annually be 711 presented to the Chair of the Senate Medicaid Committee and the 712 Chair of the House Medicaid Committee.

The division shall include dental services as a necessary 713 component of overall health services provided to children who are 715 eligible for services.

Eyeglasses for all Medicaid beneficiaries who have (a) had surgery on the eyeball or ocular muscle that results in a vision change for which eyeglasses or a change in eyeglasses is medically indicated within six (6) months of the surgery and is in accordance with policies established by the division, or (b) one (1) pair every \* \* \* two (2) years and in accordance with policies established by the division. In either instance, the eyeglasses

714

716

717

718

719

720

721

723	must	be	prescribed	bу	a	physi	lciar	n skilled	in	dise	eases	of	the	eye
724	or an	or	otometrist,	whi	Lcl	never	the	beneficia	arv	mav	selec	ct.		

- 725 (12) Intermediate care facility services.
- 726 (a) The division shall make full payment to all
- 727 intermediate care facilities for individuals with intellectual
- 728 disabilities for each day, not exceeding sixty-three (63) days per
- 729 year, that a patient is absent from the facility on home leave.
- 730 Payment may be made for the following home leave days in addition
- 731 to the sixty-three-day limitation: Christmas, the day before
- 732 Christmas, the day after Christmas, Thanksgiving, the day before
- 733 Thanksgiving and the day after Thanksgiving.
- 734 (b) All state-owned intermediate care facilities
- 735 for individuals with intellectual disabilities shall be reimbursed
- 736 on a full reasonable cost basis.
- 737 (c) Effective January 1, 2015, the division shall
- 738 update the fair rental reimbursement system for intermediate care
- 739 facilities for individuals with intellectual disabilities.
- 740 (13) Family planning services, including drugs,
- 741 supplies and devices, when those services are under the
- 742 supervision of a physician or nurse practitioner.
- 743 (14) Clinic services. Preventive, diagnostic,
- 744 therapeutic, rehabilitative or palliative services that are
- 745 furnished by a facility that is not part of a hospital but is
- 746 organized and operated to provide medical care to outpatients.
- 747 Clinic services include, but are not limited to:

748	(a) Services provided by ambulatory surgical
749	centers (ACSs) as defined in Section 41-75-1(a); and
750	(b) Dialysis center services.
751	Ambulatory Surgical Care (ASCs) may be reimbursed by the
752	division based on one hundred percent (100%) of the Medicare ASC
753	Payment System rate in effect July 1 of each year as set by the
754	Center for Medicare and Medicaid Services.
755	(15) Home- and community-based services for the elderly
756	and disabled, as provided under Title XIX of the federal Social
757	Security Act, as amended, under waivers, subject to the
758	availability of funds specifically appropriated for that purpose
759	by the Legislature.
760	(16) Mental health services. Certain services provided
761	by a psychiatrist shall be reimbursed at up to one hundred percent
762	(100%) of the Medicare rate. Approved therapeutic and case
763	management services (a) provided by an approved regional mental
764	health/intellectual disability center established under Sections
765	41-19-31 through 41-19-39, or by another community mental health
766	service provider meeting the requirements of the Department of
767	Mental Health to be an approved mental health/intellectual
768	disability center if determined necessary by the Department of
769	Mental Health, using state funds that are provided in the
770	appropriation to the division to match federal funds, or (b)
771	provided by a facility that is certified by the State Department

of Mental Health to provide therapeutic and case management

///3	services, to be reimbursed on a fee for service basis, or (c)
774	provided in the community by a facility or program operated by the
775	Department of Mental Health. Any such services provided by a
776	facility described in subparagraph (b) must have the prior
777	approval of the division to be reimbursable under this section.
778	(17) Durable medical equipment services and medical
779	supplies. Precertification of durable medical equipment and
780	medical supplies must be obtained as required by the division.
781	The Division of Medicaid may require durable medical equipment
782	providers to obtain a surety bond in the amount and to the
783	specifications as established by the Balanced Budget Act of 1997.
784	A maximum dollar amount of reimbursement for noninvasive
785	ventilators or ventilation treatments properly ordered and being
786	used in an appropriate care setting shall not be set by any health
787	maintenance organization, coordinated care organization,
788	provider-sponsored health plan, or other organization paid for
789	services on a capitated basis by the division under any managed
790	care program or coordinated care program implemented by the
791	division under this section. Reimbursement by these organizations
792	to durable medical equipment suppliers for home use of noninvasive
793	and invasive ventilators shall be on a continuous monthly payment
794	basis for the duration of medical need throughout a patient's
795	valid prescription period.

796	The division may provide reimbursement for neuromuscular	
797	tongue muscle stimulators and/or for alternative methods for the	1e
798	reduction of snoring and obstructive sleep apnea.	

- 799 (a) Notwithstanding any other provision of this (18)800 section to the contrary, as provided in the Medicaid state plan 801 amendment or amendments as defined in Section 43-13-145(10), the 802 division shall make additional reimbursement to hospitals that 803 serve a disproportionate share of low-income patients and that 804 meet the federal requirements for those payments as provided in Section 1923 of the federal Social Security Act and any applicable 805 806 regulations. It is the intent of the Legislature that the 807 division shall draw down all available federal funds allotted to 808 the state for disproportionate share hospitals. However, from and 809 after January 1, 1999, public hospitals participating in the 810 Medicaid disproportionate share program may be required to 811 participate in an intergovernmental transfer program as provided 812 in Section 1903 of the federal Social Security Act and any 813 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

820	providers	as	determined	bу	the	di	vision	employed	dor	contra	acted	bу
821	hospitals.											
822				2	. Tì	he	divisio	n shall	esta	ablish	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).

828 (ii) The division shall assess each hospital, 829 nursing facility, and emergency ambulance transportation provider 830 for the sole purpose of financing the state portion of the 831 Medicare Upper Payment Limits Program or other program(s) 832 authorized under this subsection (A) (18) (b). The hospital 833 assessment shall be as provided in Section 43-13-145(4)(a), and 834 the nursing facility and the emergency ambulance transportation 835 assessments, if established, shall be based on Medicaid 836 utilization or other appropriate method, as determined by the 837 division, consistent with federal regulations. The assessments 838 will remain in effect as long as the state participates in the 839 Medicare Upper Payment Limits Program or other program(s) 840 authorized under this subsection (A) (18) (b). In addition to the

hospital assessment provided in Section 43-13-145(4)(a), hospitals

with physicians and other eligible licensed providers as

determined by the division participating in the Medicare Upper

Payment Limits Program or other program(s) authorized under this

841

842

843

845	subsection (A)(18)(b) shall be required to participate in an
846	intergovernmental transfer or assessment, as determined by the
847	division, for the purpose of financing the state portion of the
848	physician UPL payments or other payment(s) authorized under this
849	subsection (A)(18)(b).
850	(iii) Subject to approval by the Centers for
851	Medicare and Medicaid Services (CMS) and the provisions of this
852	subsection (A)(18)(b), the division shall make additional
853	reimbursement to hospitals, nursing facilities, and emergency
854	ambulance transportation providers for the Medicare Upper Payment
855	Limits Program or other program(s) authorized under this
856	subsection (A)(18)(b), and, if the program is established for
857	physicians and other eligible licensed providers as determined by
858	the division, shall make additional reimbursement for physicians
859	and other eligible licensed providers as determined by the
860	division, as defined in Section 1902(a)(30) of the federal Social
861	Security Act and any applicable federal regulations, provided the
862	assessment in this subsection (A)(18)(b) is in effect.
863	(iv) * * * The division is authorized to
864	develop and implement an alternative fee-for-service Upper Payment
865	Limits model in accordance with federal laws and regulations if
866	necessary to preserve supplemental funding. * * * The division,
867	in consultation with the Mississippi Hospital Association, may
868	develop alternative models for distribution of medical claims and
869	supplemental payments for inpatient and outpatient hospital

871	to, the following: increasing rates for inpatient and outpatient
872	services; creating a low-income utilization pool of funds to
873	reimburse hospitals for the costs of uncompensated care, charity
874	care and bad debts as permitted and approved pursuant to federal
875	regulations and the Centers for Medicare and Medicaid Services;
876	supplemental payments based upon Medicaid utilization, quality,
877	service lines and/or costs of providing such services to Medicaid
878	beneficiaries and to uninsured patients. The goals of such
879	payment models shall be to ensure access to inpatient and
880	outpatient care and to maximize any federal funds that are
881	available to reimburse hospitals for services provided. The
882	Chairmen of the Senate and House Medicaid Committees shall be
883	provided copies of the proposed payment model(s) prior to
884	submission.
885	(v) 1. To preserve and improve access to
886	ambulance transportation provider services, the division shall
887	seek CMS approval to make ambulance service access payments as set
888	forth in this subsection (A)(18)(b) for all covered emergency
889	ambulance services rendered on or after July 1, 2022, and shall
890	make such ambulance service access payments for all covered
891	services rendered on or after the effective date of CMS approval.
892	2. The division shall calculate the
893	ambulance service access payment amount as the balance of the
894	portion of the Medical Care Fund related to ambulance

services, and such models may include, but shall not be limited

895	transportation service provider assessments plus any federal
896	matching funds earned on the balance, up to, but not to exceed,
897	the upper payment limit gap for all emergency ambulance service
898	providers.

3. a. Except for ambulance services

900 exempt from the assessment provided in this paragraph (18)(b), all

901 ambulance transportation service providers shall be eligible for

902 ambulance service access payments each state fiscal year as set

903 forth in this paragraph (18)(b).

b. In addition to any other funds paid to ambulance transportation service providers for emergency medical services provided to Medicaid beneficiaries, each eligible ambulance transportation service provider shall receive ambulance service access payments each state fiscal year equal to the ambulance transportation service provider's upper payment limit gap. Subject to approval by the Centers for Medicare and Medicaid Services, ambulance service access payments shall be made no less than on a quarterly basis.

c. As used in this paragraph

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

difference between the total amount that the ambulance

transportation service provider received from Medicaid and the

average amount that the ambulance transportation service provider

would have received from commercial insurers for those services

reimbursed by Medicaid.

904

905

906

907

908

909

910

911

921	shall not be used to offset any other payment by the division for
922	emergency or nonemergency services to Medicaid beneficiaries.
923	(c) (i) * * * The division shall, subject to
924	approval by the Centers for Medicare and Medicaid Services (CMS),
925	establish, implement and operate a Mississippi Hospital Access
926	Program (MHAP) for the purpose of protecting patient access to
927	hospital care through hospital inpatient reimbursement programs
928	provided in this section designed to maintain total hospital
929	reimbursement for inpatient services rendered by in-state
930	hospitals and the out-of-state hospital that is authorized by
931	federal law to submit intergovernmental transfers (IGTs) to the
932	State of Mississippi and is classified as Level I trauma center
933	located in a county contiguous to the state line at the maximum
934	levels permissible under applicable federal statutes and
935	regulations * * *.
936	(ii) Subject to approval by the Centers for
937	Medicare and Medicaid Services (CMS), the MHAP shall provide
938	increased inpatient capitation (PMPM) payments to managed care
939	entities contracting with the division pursuant to subsection (H)
940	of this section to support availability of hospital services or
941	such other payments permissible under federal law necessary to
942	accomplish the intent of this subsection.
943	(iii) The intent of this subparagraph (c) is
944	that effective for all inpatient hospital Medicaid services during

4. An ambulance service access payment

945 state fiscal year 2016, and so long as this provision shall remain 946 in effect hereafter, the division  $\star$   $\star$  may, to the fullest extent feasible, replace the additional reimbursement for hospital 947 948 inpatient services under the inpatient Medicare Upper Payment Limits (UPL) Program with additional reimbursement under the MHAP 949 950 and other payment programs for inpatient and/or outpatient 951 payments which may be developed under the authority of this 952 paragraph.

953 (iv) The division shall assess each hospital 954 as provided in Section 43-13-145(4)(a) for the purpose of 955 financing the state portion of the MHAP, supplemental payments and 956 such other purposes as specified in Section 43-13-145. The 957 assessment will remain in effect as long as the MHAP and 958 supplemental payments are in effect.

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

959

960

961

962

963

964

965

966

967

968

970	beneficiary who cannot receive these services under a different
971	program. The State Department of Health shall be reimbursed on a
972	full reasonable cost basis for services provided under this
973	subparagraph (a). Any program authorized under subsection H of
974	this section shall develop a perinatal risk-management services
975	program in consultation with the division and the State Department
976	of Health or may contract with the State Department of Health for
977	these services, and the programs shall begin providing these
978	services no later than January 1, 2026.
979	(b) Early intervention system services. The
086	division shall cooperate with the State Department of Health,
981	acting as lead agency, in the development and implementation of a
982	statewide system of delivery of early intervention services, under
983	Part C of the Individuals with Disabilities Education Act (IDEA).
984	The State Department of Health shall certify annually in writing
985	to the executive director of the division the dollar amount of
986	state early intervention funds available that will be utilized as
987	a certified match for Medicaid matching funds. Those funds then
88	shall be used to provide expanded targeted case management
989	services for Medicaid eligible children with special needs who are
990	eligible for the state's early intervention system.
991	Qualifications for persons providing service coordination shall be
992	determined by the State Department of Health and the Division of

Medicaid.

993

994	(20) Home- and community-based services for physically
995	disabled approved services as allowed by a waiver from the United
996	States Department of Health and Human Services for home- and
997	community-based services for physically disabled people using
998	state funds that are provided from the appropriation to the State
999	Department of Rehabilitation Services and used to match federal
1000	funds under a cooperative agreement between the division and the
1001	department, provided that funds for these services are
1002	specifically appropriated to the Department of Rehabilitation
1003	Services.

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

PAGE 38

1018 nurse practitioner, as determined in accordance with regulations
1019 of the division.

- 1020 Ambulatory services delivered in federally 1021 qualified health centers, rural health centers and clinics of the 1022 local health departments of the State Department of Health for 1023 individuals eligible for Medicaid under this article based on 1024 reasonable costs as determined by the division. Federally 1025 qualified health centers shall be reimbursed by the Medicaid 1026 prospective payment system as approved by the Centers for Medicare and Medicaid Services. The division shall recognize federally 1027 qualified health centers (FQHCs), rural health clinics (RHCs) and 1028 1029 community mental health centers (CMHCs) as both an originating and 1030 distant site provider for the purposes of telehealth 1031 reimbursement. The division is further authorized and directed to reimburse FQHCs, RHCs and CMHCs for both distant site and 1032 1033 originating site services when such services are appropriately 1034 provided by the same organization.
  - (23) Inpatient psychiatric services.
- (a) Inpatient psychiatric services to be

  1037 determined by the division for recipients under age twenty-one

  1038 (21) that are provided under the direction of a physician in an

  1039 inpatient program in a licensed acute care psychiatric facility or

  1040 in a licensed psychiatric residential treatment facility, before

  1041 the recipient reaches age twenty-one (21) or, if the recipient was

  1042 receiving the services immediately before he or she reached age

1043	twenty-one (21), before the earlier of the date he of she ho
1044	longer requires the services or the date he or she reaches age
1045	twenty-two (22), as provided by federal regulations. From and
1046	after January 1, 2015, the division shall update the fair rental
1047	reimbursement system for psychiatric residential treatment
1048	facilities. Precertification of inpatient days and residential
1049	treatment days must be obtained as required by the division. From
1050	and after July 1, 2009, all state-owned and state-operated
1051	facilities that provide inpatient psychiatric services to persons
1052	under age twenty-one (21) who are eligible for Medicaid
1053	reimbursement shall be reimbursed for those services on a full
1054	reasonable cost basis.

- 1055 (b) The division may reimburse for services
  1056 provided by a licensed freestanding psychiatric hospital to
  1057 Medicaid recipients over the age of twenty-one (21) in a method
  1058 and manner consistent with the provisions of Section 43-13-117.5.
- 1059 (24) \* \* \* Certified Community Behavioral Health

  1060 Centers (CCBHCs). The division may reimburse CCBHCs in a manner

  1061 as determined by the division.
- 1062 (25) [Deleted]
- 1063 (26) Hospice care. As used in this paragraph, the term
  1064 "hospice care" means a coordinated program of active professional
  1065 medical attention within the home and outpatient and inpatient
  1066 care that treats the terminally ill patient and family as a unit,
  1067 employing a medically directed interdisciplinary team. The

1068	program provides relief of severe pain or other physical symptoms
1069	and supportive care to meet the special needs arising out of
1070	physical, psychological, spiritual, social and economic stresses
1071	that are experienced during the final stages of illness and during
1072	dying and bereavement and meets the Medicare requirements for
1073	participation as a hospice as provided in federal regulations.

- 1074 (27) Group health plan premiums and cost-sharing if it
  1075 is cost-effective as defined by the United States Secretary of
  1076 Health and Human Services.
- 1077 (28) Other health insurance premiums that are
  1078 cost-effective as defined by the United States Secretary of Health
  1079 and Human Services. Medicare eligible must have Medicare Part B
  1080 before other insurance premiums can be paid.
  - from the United States Department of Health and Human Services for home- and community-based services for developmentally disabled people using state funds that are provided from the appropriation to the State Department of Mental Health and/or funds transferred to the department by a political subdivision or instrumentality of the state and used to match federal funds under a cooperative agreement between the division and the department, provided that funds for these services are specifically appropriated to the Department of Mental Health and/or transferred to the department by a political subdivision or instrumentality of the state.

1092	(30)	Pediatric skilled nursing services as determine	èd
1093	by the division	and in a manner consistent with regulations	
1094	promulgated by	the Mississippi State Department of Health.	

- 1095 (31) Targeted case management services for children
  1096 with special needs, under waivers from the United States
  1097 Department of Health and Human Services, using state funds that
  1098 are provided from the appropriation to the Mississippi Department
  1099 of Human Services and used to match federal funds under a
  1100 cooperative agreement between the division and the department.
- 1101 (32) Care and services provided in Christian Science
  1102 Sanatoria listed and certified by the Commission for Accreditation
  1103 of Christian Science Nursing Organizations/Facilities, Inc.,
  1104 rendered in connection with treatment by prayer or spiritual means
  1105 to the extent that those services are subject to reimbursement
  1106 under Section 1903 of the federal Social Security Act.
- 1107 (33) Podiatrist services.
- 1108 (34) Assisted living services as provided through
  1109 home- and community-based services under Title XIX of the federal
  1110 Social Security Act, as amended, subject to the availability of
  1111 funds specifically appropriated for that purpose by the
  1112 Legislature.
- 1113 (35) Services and activities authorized in Sections
  1114 43-27-101 and 43-27-103, using state funds that are provided from
  1115 the appropriation to the Mississippi Department of Human Services

1116	and	used	to	match	federal	funds	under	а	cooperative	agreement

- 1117 between the division and the department.
- 1118 (36) Nonemergency transportation services for
- 1119 Medicaid-eligible persons as determined by the division. The PEER
- 1120 Committee shall conduct a performance evaluation of the
- 1121 nonemergency transportation program to evaluate the administration
- 1122 of the program and the providers of transportation services to
- 1123 determine the most cost-effective ways of providing nonemergency
- 1124 transportation services to the patients served under the program.
- 1125 The performance evaluation shall be completed and provided to the
- 1126 members of the Senate Medicaid Committee and the House Medicaid
- 1127 Committee not later than January 1, 2019, and every two (2) years
- 1128 thereafter.
- 1129 (37) [Deleted]
- 1130 (38) Chiropractic services. A chiropractor's manual
- 1131 manipulation of the spine to correct a subluxation, if x-ray
- 1132 demonstrates that a subluxation exists and if the subluxation has
- 1133 resulted in a neuromusculoskeletal condition for which
- 1134 manipulation is appropriate treatment, and related spinal x-rays
- 1135 performed to document these conditions. Reimbursement for
- 1136 chiropractic services shall not exceed Seven Hundred Dollars
- 1137 (\$700.00) per year per beneficiary.
- 1138 (39) Dually eligible Medicare/Medicaid beneficiaries.
- 1139 The division shall pay the Medicare deductible and coinsurance
- 1140 amounts for services available under Medicare, as determined by

the division. From and after July 1, 2009, the division shall reimburse crossover claims for inpatient hospital services and crossover claims covered under Medicare Part B in the same manner that was in effect on January 1, 2008, unless specifically

authorized by the Legislature to change this method.

1146 (40) [Deleted]

1145

1147 Services provided by the State Department of (41)1148 Rehabilitation Services for the care and rehabilitation of persons 1149 with spinal cord injuries or traumatic brain injuries, as allowed 1150 under waivers from the United States Department of Health and 1151 Human Services, using up to seventy-five percent (75%) of the 1152 funds that are appropriated to the Department of Rehabilitation 1153 Services from the Spinal Cord and Head Injury Trust Fund established under Section 37-33-261 and used to match federal 1154 1155 funds under a cooperative agreement between the division and the 1156 department.

1157 (42) [Deleted]

1158 (43) The division shall provide reimbursement,
1159 according to a payment schedule developed by the division, for
1160 smoking cessation medications for pregnant women during their
1161 pregnancy and other Medicaid-eligible women who are of
1162 child-bearing age.

1163 (44) Nursing facility services for the severely 1164 disabled.

1165	(a)	Severe disabi	lities include	e, but are not
1166	limited to, spinal	cord injuries,	closed-head i	injuries and
1167	ventilator-dependen	nt patients.		

- 1168 (b) Those services must be provided in a long-term
  1169 care nursing facility dedicated to the care and treatment of
  1170 persons with severe disabilities.
- Physician assistant services. Services furnished 1171 (45)1172 by a physician assistant who is licensed by the State Board of 1173 Medical Licensure and is practicing with physician supervision 1174 under regulations adopted by the board, under regulations adopted 1175 by the division. Reimbursement for those services shall not exceed ninety percent (90%) of the reimbursement rate for 1176 1177 comparable services rendered by a physician. The division may provide for a reimbursement rate for physician assistant services 1178 1179 of up to one hundred percent (100%) or the reimbursement rate for 1180 comparable services rendered by a physician for physician 1181 assistant services that are provided after the normal working 1182 hours of the physician assistant, as determined in accordance with 1183 regulations of the division.
- (46) The division shall make application to the federal Centers for Medicare and Medicaid Services (CMS) for a waiver to develop and provide services for children with serious emotional disturbances as defined in Section 43-14-1(1), which may include home- and community-based services, case management services or managed care services through mental health providers certified by

L190	the Department of Mental Health. The division may implement and
L191	provide services under this waivered program only if funds for
L192	these services are specifically appropriated for this purpose by
L193	the Legislature, or if funds are voluntarily provided by affected
L194	agencies.

- 1195 (47) (a) The division may develop and implement
  1196 disease management programs for individuals with high-cost chronic
  1197 diseases and conditions, including the use of grants, waivers,
  1198 demonstrations or other projects as necessary.
- 1199 (b) Participation in any disease management
  1200 program implemented under this paragraph (47) is optional with the
  1201 individual. An individual must affirmatively elect to participate
  1202 in the disease management program in order to participate, and may
  1203 elect to discontinue participation in the program at any time.
- 1204 (48) Pediatric long-term acute care hospital services.
- (a) Pediatric long-term acute care hospital services means services provided to eligible persons under twenty-one (21) years of age by a freestanding Medicare-certified hospital that has an average length of inpatient stay greater than twenty-five (25) days and that is primarily engaged in providing chronic or long-term medical care to persons under twenty-one (21) years of age.
- 1212 (b) The services under this paragraph (48) shall
  1213 be reimbursed as a separate category of hospital services.

L214	(49	9)	The	division	may	estab	olish	copay	ments a	and/o	r
L215	coinsurance f	for	any	Medicaid	serv	rices	for	which	copayme	ents	and/or
1216	coinsurance a	are	allo	owable und	der f	edera	al la	worr	regulati	ion.	

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

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

1236 (52) Notwithstanding any provisions of this article,
1237 the division may pay enhanced reimbursement fees related to trauma
1238 care, as determined by the division in conjunction with the State

1239	Department of Health, using funds appropriated to the State
1240	Department of Health for trauma care and services and used to
1241	match federal funds under a cooperative agreement between the
1242	division and the State Department of Health. The division, in
1243	conjunction with the State Department of Health, may use grants,
1244	waivers, demonstrations, enhanced reimbursements, Upper Payment
1245	Limits Programs, supplemental payments, or other projects as
1246	necessary in the development and implementation of this
1247	reimbursement program.

- 1248 (53) Targeted case management services for high-cost 1249 beneficiaries may be developed by the division for all services 1250 under this section.
- 1251 (54) [Deleted]
- 1252 The plan of care for therapy Therapy services. 1253 services may be developed to cover a period of treatment for up to 1254 six (6) months, but in no event shall the plan of care exceed a 1255 six-month period of treatment. The projected period of treatment 1256 must be indicated on the initial plan of care and must be updated 1257 with each subsequent revised plan of care. Based on medical 1258 necessity, the division shall approve certification periods for less than or up to six (6) months, but in no event shall the 1259 1260 certification period exceed the period of treatment indicated on the plan of care. The appeal process for any reduction in therapy 1261 1262 services shall be consistent with the appeal process in federal 1263 regulations.

L264	(56) Prescribed pediatric extended care centers
L265	services for medically dependent or technologically dependent
L266	children with complex medical conditions that require continual
L267	care as prescribed by the child's attending physician, as
L268	determined by the division.

- 1269 (57)No Medicaid benefit shall restrict coverage for 1270 medically appropriate treatment prescribed by a physician and 1271 agreed to by a fully informed individual, or if the individual 1272 lacks legal capacity to consent by a person who has legal authority to consent on his or her behalf, based on an 1273 1274 individual's diagnosis with a terminal condition. As used in this paragraph (57), "terminal condition" means any aggressive 1275 1276 malignancy, chronic end-stage cardiovascular or cerebral vascular 1277 disease, or any other disease, illness or condition which a 1278 physician diagnoses as terminal.
- 1279 (58) Treatment services for persons with opioid
  1280 dependency or other highly addictive substance use disorders. The
  1281 division is authorized to reimburse eligible providers for
  1282 treatment of opioid dependency and other highly addictive
  1283 substance use disorders, as determined by the division. Treatment
  1284 related to these conditions shall not count against any physician
  1285 visit limit imposed under this section.
- 1286 (59) The division shall allow beneficiaries between the 1287 ages of ten (10) and eighteen (18) years to receive vaccines 1288 through a pharmacy venue. The division and the State Department

1289	of Health shall coordinate and notify OB-GYN providers that the
1290	Vaccines for Children program is available to providers free of
1291	charge.

- 1292 (60) Border city university-affiliated pediatric 1293 teaching hospital.
- 1294 (a) Payments may only be made to a border city 1295 university-affiliated pediatric teaching hospital if the Centers 1296 for Medicare and Medicaid Services (CMS) approve an increase in 1297 the annual request for the provider payment initiative authorized under 42 CFR Section 438.6(c) in an amount equal to or greater 1298 1299 than the estimated annual payment to be made to the border city university-affiliated pediatric teaching hospital. The estimate 1300 1301 shall be based on the hospital's prior year Mississippi managed 1302 care utilization.
- 1303 As used in this paragraph (60), the term 1304 "border city university-affiliated pediatric teaching hospital" 1305 means an out-of-state hospital located within a city bordering the 1306 eastern bank of the Mississippi River and the State of Mississippi 1307 that submits to the division a copy of a current and effective 1308 affiliation agreement with an accredited university and other 1309 documentation establishing that the hospital is 1310 university-affiliated, is licensed and designated as a pediatric hospital or pediatric primary hospital within its home state, 1311 maintains at least five (5) different pediatric specialty training 1312 programs, and maintains at least one hundred (100) operated beds 1313

1314	dedicated	exclusively	for the	treatment	of	patients	under	the	age
1315	of twenty-	one (21) yea	ars.						

- 1316 (c) The cost of providing services to Mississippi
  1317 Medicaid beneficiaries under the age of twenty-one (21) years who
  1318 are treated by a border city university-affiliated pediatric
  1319 teaching hospital shall not exceed the cost of providing the same
  1320 services to individuals in hospitals in the state.
- (d) It is the intent of the Legislature that
  payments shall not result in any in-state hospital receiving
  payments lower than they would otherwise receive if not for the
  payments made to any border city university-affiliated pediatric
  teaching hospital.
- 1326 (e) This paragraph (60) shall stand repealed on 1327 July 1, \* \* \* 2029.
- 1328 (61) Autism spectrum disorder services. The division 1329 shall develop and implement a method for reimbursement of autism 1330 spectrum disorder services based on a continuum of care for best 1331 practices in medically necessary early intervention treatment. 1332 The division shall work in consultation with the Department of 1333 Mental Health, healthcare providers, the Autism Advisory 1334 Committee, and other stakeholders relevant to the autism industry 1335 to develop these reimbursement rates. The requirements of this 1336 subsection shall apply to any autism spectrum disorder services

rendered under the authority of the Medicaid State Plan and any

Home and Community Based Services Waiver authorized under this

1337

section through which autism spectrum disorder services are	
<pre>provided.</pre>	
(62) Preparticipation physical evaluations. The	
division shall reimburse for preparticipation physical evaluation	ons
of beneficiaries in a manner as determined by the division.	
(63) Glucagon-like peptide-1 (GLP-1) agonist	
medications that have been approved for chronic weight manageme	nt
by the United States Food and Drug Administration (FDA). The	
division shall, in a manner as determined by the division,	
reimburse for FDA-approved GLP-1 agonist medications prescribed	<u> </u>  -
for chronic weight management and/or for management of addition	<u>al</u>
conditions in the discretion of the medical provider.	
(64) Coverage and reimbursement for postpartum	
depression screening. The division and any managed care entity	
described in subsection (H) of this section shall provide cover	age
for postpartum depression screening required pursuant to Section	n
41-140-5. Such coverage shall provide for additional	
reimbursement for the administration of postpartum depression	
screening adequate to compensate the health care provider for t	<u>he</u>
provision of such screening and consistent with ensuring broad	
access to postpartum depression screening in line with	
evidence-based guidelines.	
(65) Nonstatin medications. The division shall prov	ide
coverage and reimbursement, in a manner as determined by the	
division, for any nonstatin medication that has a unique	

1364	indication	on to	reduce	the	risk	of	а	major	car	diovascu	ılar	event	in
1 2 6 5	20 20 2 20 20 20 20 20 20 20 20 20 20 20		++05 0	n d a	d -		20.1		0.50	no+			
1303	primary p	prevei	ition a	na s	econa	r.A	$^{1}$	reventi	-011	patients	·		

- 1366 (B) Planning and development districts participating in the
  1367 home- and community-based services program for the elderly and
  1368 disabled as case management providers shall be reimbursed for case
  1369 management services at the maximum rate approved by the Centers
  1370 for Medicare and Medicaid Services (CMS).
- 1371 The division may pay to those providers who participate 1372 in and accept patient referrals from the division's emergency room 1373 redirection program a percentage, as determined by the division, 1374 of savings achieved according to the performance measures and 1375 reduction of costs required of that program. Federally qualified 1376 health centers may participate in the emergency room redirection program, and the division may pay those centers a percentage of 1377 1378 any savings to the Medicaid program achieved by the centers' 1379 accepting patient referrals through the program, as provided in 1380 this subsection (C).
- 1381 (D) (1) As used in this subsection (D), the following terms
  1382 shall be defined as provided in this paragraph, except as
  1383 otherwise provided in this subsection:
- 1384 (a) "Committees" means the Medicaid Committees of
  1385 the House of Representatives and the Senate, and "committee" means
  1386 either one of those committees.
- 1387 (b) "Rate change" means an increase, decrease or 1388 other change in the payments or rates of reimbursement, or a

change in any payment methodology that results in an increase,
decrease or other change in the payments or rates of
reimbursement, to any Medicaid provider that renders any services
authorized to be provided to Medicaid recipients under this
article.

- change, the division shall give notice to the chairmen of the committees at least \* \* \* fifteen (15) calendar days before the proposed rate change is scheduled to take effect. The division shall furnish the chairmen with a concise summary of each proposed rate change along with the notice, and shall furnish the chairmen with a copy of any proposed rate change upon request. The division also shall provide a summary and copy of any proposed rate change to any other member of the Legislature upon request.
- If the chairman of either committee or both 1403 1404 chairmen jointly object to the proposed rate change or any part 1405 thereof, the chairman or chairmen shall notify the division and 1406 provide the reasons for their objection in writing not later than 1407 seven (7) calendar days after receipt of the notice from the 1408 division. The chairman or chairmen may make written 1409 recommendations to the division for changes to be made to a 1410 proposed rate change.
- 1411 (4) (a) The chairman of either committee or both

  1412 chairmen jointly may hold a committee meeting to review a proposed

  1413 rate change. If either chairman or both chairmen decide to hold a

1394

1395

1396

1397

1398

1399

1400

1401

1414	meeting, they shall notify the division of their intention in
1415	writing within seven (7) calendar days after receipt of the notice
1416	from the division, and shall set the date and time for the meeting
1417	in their notice to the division, which shall not be later than
1418	fourteen (14) calendar days after receipt of the notice from the
1419	division.

- After the committee meeting, the committee or 1420 (b) 1421 committees may object to the proposed rate change or any part 1422 The committee or committees shall notify the division thereof. 1423 and the reasons for their objection in writing not later than 1424 seven (7) calendar days after the meeting. The committee or 1425 committees may make written recommendations to the division for 1426 changes to be made to a proposed rate change.
- If both chairmen notify the division in writing 1428 within seven (7) calendar days after receipt of the notice from 1429 the division that they do not object to the proposed rate change 1430 and will not be holding a meeting to review the proposed rate change, the proposed rate change will take effect on the original 1431 1432 date as scheduled by the division or on such other date as 1433 specified by the division.
- 1434 (a) If there are any objections to a proposed rate 1435 change or any part thereof from either or both of the chairmen or 1436 the committees, the division may withdraw the proposed rate change, make any of the recommended changes to the proposed rate 1437 1438 change, or not make any changes to the proposed rate change.

1439	(b) If the division does not make any changes to
1440	the proposed rate change, it shall notify the chairmen of that
1441	fact in writing, and the proposed rate change shall take effect on
1442	the original date as scheduled by the division or on such other
1443	date as specified by the division.

- 1444 (c) If the division makes any changes to the
  1445 proposed rate change, the division shall notify the chairmen of
  1446 its actions in writing, and the revised proposed rate change shall
  1447 take effect on the date as specified by the division.
- 1448 (7) Nothing in this subsection (D) shall be construed
  1449 as giving the chairmen or the committees any authority to veto,
  1450 nullify or revise any rate change proposed by the division. The
  1451 authority of the chairmen or the committees under this subsection
  1452 shall be limited to reviewing, making objections to and making
  1453 recommendations for changes to rate changes proposed by the
  1454 division.
- 1455 (8) If the division needs to expedite the fifteen-day

  1456 legislative notice set forth in paragraph (2) of this subsection

  1457 (D), the division shall notify both chairmen.
- 1458 (E) Notwithstanding any provision of this article, no new
  1459 groups or categories of recipients and new types of care and
  1460 services may be added without enabling legislation from the
  1461 Mississippi Legislature, except that the division may authorize
  1462 those changes without enabling legislation when the addition of
  1463 recipients or services is ordered by a court of proper authority.

L464	(F) The executive director shall keep the Governor advised
L465	on a timely basis of the funds available for expenditure and the
L466	projected expenditures. Notwithstanding any other provisions of
L467	this article, if current or projected expenditures of the division
L468	are reasonably anticipated to exceed the amount of funds
L469	appropriated to the division for any fiscal year, the Governor,
L470	after consultation with the executive director, shall take all
L471	appropriate measures to reduce costs, which may include, but are
L472	not limited to:

- 1473 (1) Reducing or discontinuing any or all services that 1474 are deemed to be optional under Title XIX of the Social Security 1475 Act;
- 1476 (2) Reducing reimbursement rates for any or all service 1477 types;
- 1478 (3) Imposing additional assessments on health care 1479 providers; or
- 1480 (4) Any additional cost-containment measures deemed 1481 appropriate by the Governor.
- To the extent allowed under federal law, any reduction to services or reimbursement rates under this subsection (F) shall be accompanied by a reduction, to the fullest allowable amount, to the profit margin and administrative fee portions of capitated payments to organizations described in paragraph (1) of subsection (H).

1488 Beginning in fiscal year 2010 and in fiscal years thereafter, 1489 when Medicaid expenditures are projected to exceed funds available for the fiscal year, the division shall submit the expected 1490 1491 shortfall information to the PEER Committee not later than 1492 December 1 of the year in which the shortfall is projected to 1493 occur. PEER shall review the computations of the division and 1494 report its findings to the Legislative Budget Office not later 1495 than January 7 in any year.

- 1496 Notwithstanding any other provision of this article, it shall be the duty of each provider participating in the Medicaid 1497 1498 program to keep and maintain books, documents and other records as 1499 prescribed by the Division of Medicaid in accordance with federal 1500 laws and regulations.
- Notwithstanding any other provision of this 1501 (H) 1502 article, the division is authorized to implement (a) a managed 1503 care program, (b) a coordinated care program, (c) a coordinated 1504 care organization program, (d) a health maintenance organization program, (e) a patient-centered medical home program, (f) an 1505 1506 accountable care organization program, (g) provider-sponsored 1507 health plan, or (h) any combination of the above programs. 1508 condition for the approval of any program under this subsection 1509 (H)(1), the division shall require that no managed care program, coordinated care program, coordinated care organization program, 1510 1511 health maintenance organization program, or provider-sponsored 1512 health plan may:

PAGE 58

1513		(a)	Pay provi	iders at a	rate t	that :	is l	ess	than	the
1514	Medicaid All	Patient	Refined	Diagnosis	Relate	ed Gr	oups	(AF	R-DRG	3)
1515	reimbursement	rate;								

- 1516 Override the medical decisions of hospital (b) 1517 physicians or staff regarding patients admitted to a hospital for 1518 an emergency medical condition as defined by 42 US Code Section This restriction (b) does not prohibit the retrospective 1519 1520 review of the appropriateness of the determination that an 1521 emergency medical condition exists by chart review or coding 1522 algorithm, nor does it prohibit prior authorization for 1523 nonemergency hospital admissions;
  - (c) Pay providers at a rate that is less than the normal Medicaid reimbursement rate. It is the intent of the Legislature that all managed care entities described in this subsection (H), in collaboration with the division, develop and implement innovative payment models that incentivize improvements in health care quality, outcomes, or value, as determined by the division. Participation in the provider network of any managed care, coordinated care, provider-sponsored health plan, or similar contractor shall not be conditioned on the provider's agreement to accept such alternative payment models;
- (d) Implement a prior authorization and utilization review program for medical services, transportation services and prescription drugs that is more stringent than the prior authorization processes used by the division in its

1524

1525

1526

1527

1528

1529

1530

1531

1532

1538	administration of the Medicaid program. Not later than December
1539	2, 2021, the contractors that are receiving capitated payments
1540	under a managed care delivery system established under this
1541	subsection (H) shall submit a report to the Chairmen of the House
1542	and Senate Medicaid Committees on the status of the prior
1543	authorization and utilization review program for medical services,
1544	transportation services and prescription drugs that is required to
1545	be implemented under this subparagraph (d);
1546	(e) [Deleted]

1547

1548

1549

1550

1551

1552

1553

1554

1555

1556

1557

1558

1559

1560

1561

1562

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

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

Each health maintenance organization, coordinated care organization, provider-sponsored health plan, or other organization paid for services on a capitated basis by the division under any managed care program or coordinated care program implemented by the division under this section shall use a clear set of level of care quidelines in the determination of medical necessity and in all utilization management practices, including the prior authorization process, concurrent reviews, retrospective reviews and payments, that are consistent with

widely accepted professional standards of care. Organizations
participating in a managed care program or coordinated care
program implemented by the division may not use any additional
criteria that would result in denial of care that would be
determined appropriate and, therefore, medically necessary under
those levels of care guidelines.

- 1569 Notwithstanding any provision of this section, the 1570 recipients eligible for enrollment into a Medicaid Managed Care 1571 Program authorized under this subsection (H) may include only 1572 those categories of recipients eligible for participation in the 1573 Medicaid Managed Care Program as of January 1, 2021, the 1574 Children's Health Insurance Program (CHIP), and the CMS-approved 1575 Section 1115 demonstration waivers in operation as of January 1, 1576 No expansion of Medicaid Managed Care Program contracts may 1577 be implemented by the division without enabling legislation from 1578 the Mississippi Legislature.
- 1579 Any contractors receiving capitated payments (3) (a) under a managed care delivery system established in this section 1580 1581 shall provide to the Legislature and the division statistical data 1582 to be shared with provider groups in order to improve patient 1583 access, appropriate utilization, cost savings and health outcomes 1584 not later than October 1 of each year. Additionally, each contractor shall disclose to the Chairmen of the Senate and House 1585 1586 Medicaid Committees the administrative expenses costs for the 1587 prior calendar year, and the number of full-equivalent employees

1588	located in the State of Mississippi dedicated to the Medicaid and
1589	CHIP lines of business as of June 30 of the current year.
1590	(b) The division and the contractors participating
1591	in the managed care program, a coordinated care program or a
1592	provider-sponsored health plan shall be subject to annual program
1593	reviews or audits performed by the Office of the State Auditor,
1594	the PEER Committee, the Department of Insurance and/or independent
1595	third parties.
1596	(c) Those reviews shall include, but not be
1597	limited to, at least two (2) of the following items:
1598	(i) The financial benefit to the State of
1599	Mississippi of the managed care program,
1600	(ii) The difference between the premiums paid
1601	to the managed care contractors and the payments made by those
1602	contractors to health care providers,
1603	(iii) Compliance with performance measures
1604	required under the contracts,
1605	(iv) Administrative expense allocation
1606	methodologies,
1607	(v) Whether nonprovider payments assigned as
1608	medical expenses are appropriate,
1609	(vi) Capitated arrangements with related
1610	party subcontractors,

1611

1612

allocations,

(vii) Reasonableness of corporate

1614	which they are used,
1615	(ix) The effectiveness of subcontractor
1616	oversight, including subcontractor review,
1617	(x) Whether health care outcomes have been
1618	improved, and
1619	(xi) The most common claim denial codes to
1620	determine the reasons for the denials.
1621	The audit reports shall be considered public documents and
1622	shall be posted in their entirety on the division's website.
1623	(4) All health maintenance organizations, coordinated
1624	care organizations, provider-sponsored health plans, or other
1625	organizations paid for services on a capitated basis by the
1626	division under any managed care program or coordinated care
1627	program implemented by the division under this section shall
1628	reimburse all providers in those organizations at rates no lower
1629	than those provided under this section for beneficiaries who are
1630	not participating in those programs.
1631	(5) No health maintenance organization, coordinated
1632	care organization, provider-sponsored health plan, or other
1633	organization paid for services on a capitated basis by the
1634	division under any managed care program or coordinated care
1635	program implemented by the division under this section shall
1636	require its providers or beneficiaries to use any pharmacy that

PAGE 63

1613

(viii) Value-added benefits and the extent to

1637 ships, mails or delivers prescription drugs or legend drugs or 1638 devices.

1639 Not later than December 1, 2021, the (6) 1640 contractors who are receiving capitated payments under a managed 1641 care delivery system established under this subsection (H) shall 1642 develop and implement a uniform credentialing process for providers. Under that uniform credentialing process, a provider 1643 1644 who meets the criteria for credentialing will be credentialed with 1645 all of those contractors and no such provider will have to be 1646 separately credentialed by any individual contractor in order to 1647 receive reimbursement from the contractor. Not later than December 2, 2021, those contractors shall submit a report to the 1648 1649 Chairmen of the House and Senate Medicaid Committees on the status 1650 of the uniform credentialing process for providers that is 1651 required under this subparagraph (a).

1652 (b) If those contractors have not implemented a uniform credentialing process as described in subparagraph (a) by 1653 1654 December 1, 2021, the division shall develop and implement, not 1655 later than July 1, 2022, a single, consolidated credentialing 1656 process by which all providers will be credentialed. Under the 1657 division's single, consolidated credentialing process, no such 1658 contractor shall require its providers to be separately credentialed by the contractor in order to receive reimbursement 1659 from the contractor, but those contractors shall recognize the 1660

1661 credentialing of the providers by the division's credentialing 1662 process.

1663 The division shall require a uniform provider 1664 credentialing application that shall be used in the credentialing 1665 process that is established under subparagraph (a) or (b). If the 1666 contractor or division, as applicable, has not approved or denied 1667 the provider credentialing application within sixty (60) days of 1668 receipt of the completed application that includes all required 1669 information necessary for credentialing, then the contractor or 1670 division, upon receipt of a written request from the applicant and 1671 within five (5) business days of its receipt, shall issue a 1672 temporary provider credential/enrollment to the applicant if the 1673 applicant has a valid Mississippi professional or occupational license to provide the health care services to which the 1674 1675 credential/enrollment would apply. The contractor or the division 1676 shall not issue a temporary credential/enrollment if the applicant 1677 has reported on the application a history of medical or other professional or occupational malpractice claims, a history of 1678 1679 substance abuse or mental health issues, a criminal record, or a 1680 history of medical or other licensing board, state or federal 1681 disciplinary action, including any suspension from participation 1682 in a federal or state program. The temporary 1683 credential/enrollment shall be effective upon issuance and shall 1684 remain in effect until the provider's credentialing/enrollment 1685 application is approved or denied by the contractor or division.

L686	The contractor or division shall render a final decision regarding
L687	credentialing/enrollment of the provider within sixty (60) days
L688	from the date that the temporary provider credential/enrollment is
1689	issued to the applicant.

- (d) If the contractor or division does not render a final decision regarding credentialing/enrollment of the provider within the time required in subparagraph (c), the provider shall be deemed to be credentialed by and enrolled with all of the contractors and eligible to receive reimbursement from the contractors.
- 1696 (7) (a) Each contractor that is receiving capitated 1697 payments under a managed care delivery system established under 1698 this subsection (H) shall provide to each provider for whom the contractor has denied the coverage of a procedure that was ordered 1699 1700 or requested by the provider for or on behalf of a patient, a 1701 letter that provides a detailed explanation of the reasons for the 1702 denial of coverage of the procedure and the name and the 1703 credentials of the person who denied the coverage. The letter 1704 shall be sent to the provider in electronic format.
- 1705 (b) After a contractor that is receiving capitated
  1706 payments under a managed care delivery system established under
  1707 this subsection (H) has denied coverage for a claim submitted by a
  1708 provider, the contractor shall issue to the provider within sixty
  1709 (60) days a final ruling of denial of the claim that allows the
  1710 provider to have \* \* \* an appeal with the division. If a

1711 contractor does not issue a final ruling of denial within sixty

1712 (60) days as required by this subparagraph (b), the provider's

1713 claim shall be deemed to be automatically approved and the

1714 contractor shall pay the amount of the claim to the provider.

1715 (c) After a contractor has issued a final ruling

1716 of denial of a claim submitted by a provider, the division

1717 shall \* \* \* provide an opportunity for an appeal on the matter of

1718 the disputed claim between the contractor and the provider within

1719 sixty (60) days, and shall render a decision on the matter within

1720 thirty (30) days after the date of the  $\star \star \star$  appeal.

1721 (8) It is the intention of the Legislature that the

division evaluate the feasibility of using a single vendor to

1723 administer pharmacy benefits provided under a managed care

1724 delivery system established under this subsection (H). Providers

1725 of pharmacy benefits shall cooperate with the division in any

1726 transition to a carve-out of pharmacy benefits under managed care.

1727 (9) The division shall evaluate the feasibility of

1728 using a single vendor to administer dental benefits provided under

a managed care delivery system established in this subsection (H).

Providers of dental benefits shall cooperate with the division in

1731 any transition to a carve-out of dental benefits under managed

1732 care.

1722

1729

1730

1733 (10) It is the intent of the Legislature that any

1734 contractor receiving capitated payments under a managed care

1735 delivery system established in this section shall implement

innovative programs to improve the health and well-being of members diagnosed with prediabetes and diabetes.

1738 It is the intent of the Legislature that any 1739 contractors receiving capitated payments under a managed care 1740 delivery system established under this subsection (H) shall work 1741 with providers of Medicaid services to improve the utilization of 1742 long-acting reversible contraceptives (LARCs). Not later than 1743 December 1, 2021, any contractors receiving capitated payments 1744 under a managed care delivery system established under this subsection (H) shall provide to the Chairmen of the House and 1745 Senate Medicaid Committees and House and Senate Public Health 1746 Committees a report of LARC utilization for State Fiscal Years 1747 1748 2018 through 2020 as well as any programs, initiatives, or efforts made by the contractors and providers to increase LARC 1749 1750 utilization. This report shall be updated annually to include 1751 information for subsequent state fiscal years.

1752 The division is authorized to make not more than (12)1753 one (1) emergency extension of the contracts that are in effect on 1754 July 1, 2021, with contractors who are receiving capitated 1755 payments under a managed care delivery system established under 1756 this subsection (H), as provided in this paragraph (12). 1757 maximum period of any such extension shall be one (1) year, and under any such extensions, the contractors shall be subject to all 1758 1759 of the provisions of this subsection (H). The extended contracts

shall be revised to incorporate any provisions of this subsection (H).

- 1762 (I) [Deleted]
- 1763 (J) There shall be no cuts in inpatient and outpatient
  1764 hospital payments, or allowable days or volumes, as long as the
  1765 hospital assessment provided in Section 43-13-145 is in effect.
  1766 This subsection (J) shall not apply to decreases in payments that
  1767 are a result of: reduced hospital admissions, audits or payments
  1768 under the APR-DRG or APC models, or a managed care program or
  1769 similar model described in subsection (H) of this section.
- 1770 (K) In the negotiation and execution of such contracts
  1771 involving services performed by actuarial firms, the Executive
  1772 Director of the Division of Medicaid may negotiate a limitation on
  1773 liability to the state of prospective contractors.
- The Division of Medicaid shall reimburse for services 1774 1775 provided to eligible Medicaid beneficiaries by a licensed birthing 1776 center in a method and manner to be determined by the division in 1777 accordance with federal laws and federal regulations. 1778 division shall seek any necessary waivers, make any required 1779 amendments to its State Plan or revise any contracts authorized 1780 under subsection (H) of this section as necessary to provide the 1781 services authorized under this subsection. As used in this subsection, the term "birthing centers" shall have the meaning as 1782 1783 defined in Section 41-77-1(a), which is a publicly or privately 1784 owned facility, place or institution constructed, renovated,

planned to occur away from the mother's usual residence follows a documented period of prenatal care for a normal uncomplicated pregnancy which has been determined to be low risk through a	L785	leased or otherwise established where nonemergency births are
	L786	planned to occur away from the mother's usual residence following
1788 pregnancy which has been determined to be low risk through a	L787	a documented period of prenatal care for a normal uncomplicated
	L788	pregnancy which has been determined to be low risk through a

1789 formal risk-scoring examination.

(M)

1790

1791 service providers that provide an assessment, triage or treatment

The Division of Medicaid shall reimburse ambulance

- 1792 for eligible Medicaid beneficiaries. The reimbursement rate for
- 1793 an ambulance service provider whose operators provide an
- 1794 <u>assessment</u>, triage or treatment shall be reimbursed at a rate or
- 1795 methodology as determined by the division. The division shall
- 1796 consult with the Mississippi Ambulance Alliance in determining the
- 1797 <u>initial rate or methodology</u>, and the division shall give due
- 1798 <u>consideration of the inclusion in the Transforming Reimbursement</u>
- 1799 for Emergency Ambulance Transportation program.
- 1800 ( \* \* \* $\underline{\mathbf{N}}$ ) This section shall stand repealed on July 1, \* \* \* 1801 2029.
- SECTION 3. Section 43-13-121, Mississippi Code of 1972, is amended as follows:
- 1804 43-13-121. (1) The division shall administer the Medicaid 1805 program under the provisions of this article, and may do the 1806 following:
- 1807 (a) Adopt and promulgate reasonable rules, regulations
  1808 and standards, with approval of the Governor, and in accordance

1809	with the Administrative Procedures Law, Section 25-43-1.101 et
1810	seq.:
1811	(i) Establishing methods and procedures as may be
1812	necessary for the proper and efficient administration of this
1813	article;
1814	(ii) Providing Medicaid to all qualified
1815	recipients under the provisions of this article as the division
1816	may determine and within the limits of appropriated funds;
1817	(iii) Establishing reasonable fees, charges and
1818	rates for medical services and drugs; in doing so, the division
1819	shall fix all of those fees, charges and rates at the minimum
1820	levels absolutely necessary to provide the medical assistance
1821	authorized by this article, and shall not change any of those
1822	fees, charges or rates except as may be authorized in Section
1823	43-13-117;
1824	(iv) Providing for fair and impartial hearings;
1825	(v) Providing safeguards for preserving the
1826	confidentiality of records; and
1827	(vi) For detecting and processing fraudulent
1828	practices and abuses of the program;
1829	(b) Receive and expend state, federal and other funds
1830	in accordance with court judgments or settlements and agreements
1831	between the State of Mississippi and the federal government, the
1832	rules and regulations promulgated by the division, with the
1833	approval of the Governor, and within the limitations and

1834	restrictions	of	this	article	and	within	the	limits	of	funds
1835	available for	r th	nat pu	urpose;						

1836 Subject to the limits imposed by this article and (C) subject to the provisions of subsection (8) of this section, to 1837 1838 submit a Medicaid plan to the United States Department of Health 1839 and Human Services for approval under the provisions of the federal Social Security Act, to act for the state in making 1840 1841 negotiations relative to the submission and approval of that plan, 1842 to make such arrangements, not inconsistent with the law, as may be required by or under federal law to obtain and retain that 1843 1844 approval and to secure for the state the benefits of the 1845 provisions of that law.

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

1855 (d) In accordance with the purposes and intent of this 1856 article and in compliance with its provisions, provide for aged 1857 persons otherwise eligible for the benefits provided under Title

1846

1847

1848

1849

1850

1851

1852

1853

L858	XVIII	of	the	federal	Social	Security	Act	bу	expenditure	of	funds
L859	availa	able	e for	those	purposes	5 <b>;</b>					

- 1860 (e) To make reports to the United States Department of
  1861 Health and Human Services as from time to time may be required by
  1862 that federal department and to the Mississippi Legislature as
  1863 provided in this section;
- 1864 (f) Define and determine the scope, duration and amount
  1865 of Medicaid that may be provided in accordance with this article
  1866 and establish priorities therefor in conformity with this article;
- 1867 (g) Cooperate and contract with other state agencies
  1868 for the purpose of coordinating Medicaid provided under this
  1869 article and eliminating duplication and inefficiency in the
  1870 Medicaid program;
- 1871 (h) Adopt and use an official seal of the division;
- 1872 (i) Sue in its own name on behalf of the State of
  1873 Mississippi and employ legal counsel on a contingency basis with
  1874 the approval of the Attorney General;
- (j) To recover any and all payments incorrectly made by
  the division to a recipient or provider from the recipient or
  provider receiving the payments. The division shall be authorized
  to collect any overpayments to providers sixty (60) days after the
  conclusion of any administrative appeal \*\*\*. To recover those
  payments, the division may use the following methods, in addition
  to any other methods available to the division:

1882	(i) The division shall report to the Department of
1883	Revenue the name of any current or former Medicaid recipient who
1884	has received medical services rendered during a period of
1885	established Medicaid ineligibility and who has not reimbursed the
1886	division for the related medical service payment(s). The
1887	Department of Revenue shall withhold from the state tax refund of
1888	the individual, and pay to the division, the amount of the
1889	payment(s) for medical services rendered to the ineligible
1890	individual that have not been reimbursed to the division for the
1891	related medical service payment(s).

- 1892 (ii) The division shall report to the Department of Revenue the name of any Medicaid provider to whom payments were 1893 1894 incorrectly made that the division has not been able to recover by 1895 other methods available to the division. The Department of Revenue shall withhold from the state tax refund of the provider, 1896 1897 and pay to the division, the amount of the payments that were 1898 incorrectly made to the provider that have not been recovered by 1899 other available methods;
- (k) To recover any and all payments by the division

  fraudulently obtained by a recipient or provider. Additionally,

  if recovery of any payments fraudulently obtained by a recipient

  or provider is made in any court, then, upon motion of the

  Governor, the judge of the court may award twice the payments

  recovered as damages;

to conduct such investigations as it may deem necessary and requisite of alleged or suspected violations or abuses of the provisions of this article or of the regulations adopted under
provisions of this article or of the regulations adopted under
reconstructions of one alleged of the regulations adopted ander
this article, including, but not limited to, fraudulent or
unlawful act or deed by applicants for Medicaid or other benefits,
or payments made to any person, firm or corporation under the
terms, conditions and authority of this article, to suspend or
disqualify any provider of services, applicant or recipient for
gross abuse, fraudulent or unlawful acts for such periods,
including permanently, and under such conditions as the division
deems proper and just, including the imposition of a legal rate of
interest on the amount improperly or incorrectly paid. Recipients
who are found to have misused or abused Medicaid benefits may be
locked into one (1) physician and/or one (1) pharmacy of the
recipient's choice for a reasonable amount of time in order to
educate and promote appropriate use of medical services, in
accordance with federal regulations. $\underline{*}$ * * The convictions of a
recipient or a provider in a state or federal court for abuse,
fraudulent or unlawful acts under this chapter shall constitute an
automatic disqualification of the recipient or automatic
disqualification of the provider from participation under the
Medicaid program.

a judgment entered on a plea of nolo contendere or a

A conviction, for the purposes of this chapter, shall include

1929

L931	nonadjudicated guilty plea and shall have the same force as a
L932	judgment entered pursuant to a guilty plea or a conviction
L933	following trial. A certified copy of the judgment of the court of
L934	competent jurisdiction of the conviction shall constitute prima
L935	facie evidence of the conviction for disqualification purposes;
L936	(m) Establish and provide such methods of
L937	administration as may be necessary for the proper and efficient
L938	operation of the Medicaid program, fully utilizing computer
L939	equipment as may be necessary to oversee and control all current
L940	expenditures for purposes of this article, and to closely monitor
L941	and supervise all recipient payments and vendors rendering
L942	services under this article. Notwithstanding any other provision
L943	of state law, the division is authorized to enter into a ten-year
L944	contract(s) with a vendor(s) to provide services described in this
L945	paragraph (m). Notwithstanding any provision of law to the
L946	contrary, the division is authorized to extend its Medicaid * * $\star$
L947	<pre>Enterprise System * * * and fiscal agent services, including all</pre>
L948	related components and services, contracts in effect on June
L949	30, * * * <u>2025</u> , for * * * <u>additional five-year periods if the</u>
L950	system continues to meet the needs of the state, the annual cost
L951	continues to be a fair market value, and the rate of increase is
L952	no more than five percent (5%) or the current Consumer Price
L953	Index, whichever is less. Notwithstanding any other provision of
L954	state law, the division is authorized to enter into a two-vear

PAGE 76

1955	contract	ending	no	later	than	June	30,	2027,	with	a	vendor	to
1956	provide	support	of	the d	ivisi	on's	elia:	ibilit	/ svst	ter	n;	

- 1957 (n) To cooperate and contract with the federal 1958 government for the purpose of providing Medicaid to Vietnamese and 1959 Cambodian refugees, under the provisions of Public Law 94-23 and 1960 Public Law 94-24, including any amendments to those laws, only to 1961 the extent that the Medicaid assistance and the administrative 1962 cost related thereto are one hundred percent (100%) reimbursable 1963 by the federal government. For the purposes of Section 43-13-117, persons receiving Medicaid under Public Law 94-23 and Public Law 1964 1965 94-24, including any amendments to those laws, shall not be 1966 considered a new group or category of recipient; and
  - (o) The division shall impose penalties upon Medicaid only, Title XIX participating long-term care facilities found to be in noncompliance with division and certification standards in accordance with federal and state regulations, including interest at the same rate calculated by the United States Department of Health and Human Services and/or the Centers for Medicare and Medicaid Services (CMS) under federal regulations.
- 1974 (2) The division also shall exercise such additional powers
  1975 and perform such other duties as may be conferred upon the
  1976 division by act of the Legislature.
- 1977 (3) The division, and the State Department of Health as the 1978 agency for licensure of health care facilities and certification 1979 and inspection for the Medicaid and/or Medicare programs, shall

1967

1968

1969

1970

1971

1972

1980 contract for or otherwise provide for the consolidation of on-site 1981 inspections of health care facilities that are necessitated by the 1982 respective programs and functions of the division and the 1983 department.

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

2005 prescriptions and other records relating to medical care and 2006 services furnished by the provider to a recipient or designated 2007 recipients of Medicaid services under investigation. 2008 absence of the voluntary submission of the books, papers, 2009 documents, medical charts, prescriptions and other records, the 2010 Governor, the executive director, or other designated person may issue and serve subpoenas instantly upon the provider, his or her 2011 2012 agent, servant or employee for the production of the books, 2013 papers, documents, medical charts, prescriptions or other records 2014 during an audit or investigation of the provider. If any provider 2015 or his or her agent, servant or employee refuses to produce the records after being duly subpoenaed, the executive director may 2016 2017 certify those facts and institute contempt proceedings in the 2018 manner, time and place as authorized by law for administrative 2019 proceedings. As an additional remedy, the division may recover 2020 all amounts paid to the provider covering the period of the audit 2021 or investigation, inclusive of a legal rate of interest and a 2022 reasonable attorney's fee and costs of court if suit becomes 2023 necessary. Division staff shall have immediate access to the 2024 provider's physical location, facilities, records, documents, 2025 books, and any other records relating to medical care and services 2026 rendered to recipients during regular business hours.

2027 (5) If any person in proceedings before the division
2028 disobeys or resists any lawful order or process, or misbehaves
2029 during a hearing or so near the place thereof as to obstruct the

2030 hearing, or neglects to produce, after having been ordered to do 2031 so, any pertinent book, paper or document, or refuses to appear after having been subpoenaed, or upon appearing refuses to take 2032 2033 the oath as a witness, or after having taken the oath refuses to 2034 be examined according to law, the executive director shall certify 2035 the facts to any court having jurisdiction in the place in which 2036 it is sitting, and the court shall thereupon, in a summary manner, 2037 hear the evidence as to the acts complained of, and if the 2038 evidence so warrants, punish that person in the same manner and to the same extent as for a contempt committed before the court, or 2039 2040 commit that person upon the same condition as if the doing of the 2041 forbidden act had occurred with reference to the process of, or in 2042 the presence of, the court.

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

2043

2044

2045

2046

2047

2048

2049

2050

2051

2052

2053

2055 supplies provided before the suspension or termination. When this 2056 provision is violated by a provider of services that is a clinic, 2057 group, corporation or other association, the division may suspend 2058 or terminate that organization from participation. Suspension may be applied by the division to all known affiliates of a provider, 2059 2060 provided that each decision to include an affiliate is made on a 2061 case-by-case basis after giving due regard to all relevant facts 2062 and circumstances. The violation, failure or inadequacy of 2063 performance may be imputed to a person with whom the provider is affiliated where that conduct was accomplished within the course 2064 2065 of his or her official duty or was effectuated by him or her with 2066 the knowledge or approval of that person.

- (7) The division may deny or revoke enrollment in the Medicaid program to a provider if any of the following are found to be applicable to the provider, his or her agent, a managing employee or any person having an ownership interest equal to five percent (5%) or greater in the provider:
- 2072 (a) Failure to truthfully or fully disclose any and all
  2073 information required, or the concealment of any and all
  2074 information required, on a claim, a provider application or a
  2075 provider agreement, or the making of a false or misleading
  2076 statement to the division relative to the Medicaid program.
- 2077 (b) Previous or current exclusion, suspension,
  2078 termination from or the involuntary withdrawing from participation
  2079 in the Medicaid program, any other state's Medicaid program,

2067

2068

2069

2070

Medicare or any other public or private health or health insurance program. If the division ascertains that a provider has been convicted of a felony under federal or state law for an offense that the division determines is detrimental to the best interest of the program or of Medicaid beneficiaries, the division may refuse to enter into an agreement with that provider, or may terminate or refuse to renew an existing agreement.

- 2087 (c) Conviction under federal or state law of a criminal
  2088 offense relating to the delivery of any goods, services or
  2089 supplies, including the performance of management or
  2090 administrative services relating to the delivery of the goods,
  2091 services or supplies, under the Medicaid program, any other
  2092 state's Medicaid program, Medicare or any other public or private
  2093 health or health insurance program.
- 2094 (d) Conviction under federal or state law of a criminal 2095 offense relating to the neglect or abuse of a patient in 2096 connection with the delivery of any goods, services or supplies.
- 2097 (e) Conviction under federal or state law of a criminal 2098 offense relating to the unlawful manufacture, distribution, 2099 prescription or dispensing of a controlled substance.
- 2100 (f) Conviction under federal or state law of a criminal 2101 offense relating to fraud, theft, embezzlement, breach of 2102 fiduciary responsibility or other financial misconduct.

2103	(	(g) (	Convict	cion	under	federa	al or	state	law	of a	criminal
2104	offense pur	nishak	ole by	impr	risonme	ent of	a yea	ar or 1	more	that	involves
2105	moral turni	tude.	or ac	ats a	against	the e	-lder	lv.ch	ildre	n or	infirm.

- 2106 (h) Conviction under federal or state law of a criminal 2107 offense in connection with the interference or obstruction of any 2108 investigation into any criminal offense listed in paragraphs (c) 2109 through (i) of this subsection.
- 2110 (i) Sanction for a violation of federal or state laws
  2111 or rules relative to the Medicaid program, any other state's
  2112 Medicaid program, Medicare or any other public health care or
  2113 health insurance program.
- 2114 (j) Revocation of license or certification.
- 2115 (k) Failure to pay recovery properly assessed or
  2116 pursuant to an approved repayment schedule under the Medicaid
  2117 program.
- 2118 (1) Failure to meet any condition of enrollment.
- 2119 (8) (a) As used in this subsection (8), the following terms
  2120 shall be defined as provided in this paragraph, except as
  2121 otherwise provided in this subsection:
- (i) "Committees" means the Medicaid Committees of
  the House of Representatives and the Senate, and "committee" means
  either one of those committees.
- 2125 (ii) "State Plan" means the agreement between the 2126 State of Mississippi and the federal government regarding the 2127 nature and scope of Mississippi's Medicaid Program.

2128		(iii)	"State	Plan	Amendme	nt" mea	ns a	change	to	the
2129	State Plan, v	which must	be app	proved	by the	Center	s for	r Medica	re	and
2130	Medicaid Serv	zices (CMS	) befor	re its	implem	entatio	n.			

- 2131 (b) Whenever the Division of Medicaid proposes a State 2132 Plan Amendment, the division shall give notice to the chairmen of 2133 the committees at least \* \* \* fifteen (15) calendar days before the proposed State Plan Amendment is filed with CMS. The division 2134 2135 shall furnish the chairmen with a concise summary of each proposed 2136 State Plan Amendment along with the notice, and shall furnish the 2137 chairmen with a copy of any proposed State Plan Amendment upon 2138 request. The division also shall provide a summary and copy of 2139 any proposed State Plan Amendment to any other member of the 2140 Legislature upon request.
- If the chairman of either committee or both 2141 2142 chairmen jointly object to the proposed State Plan Amendment or 2143 any part thereof, the chairman or chairmen shall notify the division and provide the reasons for their objection in writing 2144 2145 not later than seven (7) calendar days after receipt of the notice 2146 from the division. The chairman or chairmen may make written 2147 recommendations to the division for changes to be made to a 2148 proposed State Plan Amendment.
- (d) (i) The chairman of either committee or both
  chairmen jointly may hold a committee meeting to review a proposed
  State Plan Amendment. If either chairman or both chairmen decide
  to hold a meeting, they shall notify the division of their

- intention in writing within seven (7) calendar days after receipt of the notice from the division, and shall set the date and time for the meeting in their notice to the division, which shall not be later than fourteen (14) calendar days after receipt of the notice from the division.
- committees may object to the proposed State Plan Amendment or any part thereof. The committee or committees shall notify the division and the reasons for their objection in writing not later than seven (7) calendar days after the meeting. The committee or committees may make written recommendations to the division for changes to be made to a proposed State Plan Amendment.
- (e) If both chairmen notify the division in writing
  within seven (7) calendar days after receipt of the notice from
  the division that they do not object to the proposed State Plan
  Amendment and will not be holding a meeting to review the proposed
  State Plan Amendment, the division may proceed to file the
  proposed State Plan Amendment with CMS.
- (f) (i) If there are any objections to a proposed rate change or any part thereof from either or both of the chairmen or the committees, the division may withdraw the proposed State Plan Amendment, make any of the recommended changes to the proposed State Plan Amendment, or not make any changes to the proposed State Plan Amendment.

2177	(ii) If the division does not make any changes to
2178	the proposed State Plan Amendment, it shall notify the chairmen of
2179	that fact in writing, and may proceed to file the State Plan
2180	Amendment with CMS

- 2181 (iii) If the division makes any changes to the
  2182 proposed State Plan Amendment, the division shall notify the
  2183 chairmen of its actions in writing, and may proceed to file the
  2184 State Plan Amendment with CMS.
- 2185 (g) Nothing in this subsection (8) shall be construed
  2186 as giving the chairmen or the committees any authority to veto,
  2187 nullify or revise any State Plan Amendment proposed by the
  2188 division. The authority of the chairmen or the committees under
  2189 this subsection shall be limited to reviewing, making objections
  2190 to and making recommendations for changes to State Plan Amendments
  2191 proposed by the division.
- 2192 (i) If the division does not make any changes to
  2193 the proposed State Plan Amendment, it shall notify the chairmen of
  2194 that fact in writing, and may proceed to file the proposed State
  2195 Plan Amendment with CMS.
- 2196 (ii) If the division makes any changes to the 2197 proposed State Plan Amendment, the division shall notify the 2198 chairmen of the changes in writing, and may proceed to file the 2199 proposed State Plan Amendment with CMS.

2201	fifteen-day legislative notice set forth in paragraph (b) of this
2202	subsection (8), the division will notify both chairmen.
2203	(h) Nothing in this subsection (8) shall be construed
2204	as giving the chairmen of the committees any authority to veto,
2205	nullify or revise any State Plan Amendment proposed by the
2206	division. The authority of the chairmen of the committees under
2207	this subsection shall be limited to reviewing, making objections
2208	to and making recommendations for suggested changes to State Plan
2209	Amendments proposed by the division.
2210	SECTION 4. Section 43-13-305, Mississippi Code of 1972, is
2211	amended as follows:
2212	43-13-305. (1) By accepting Medicaid from the Division of
2213	Medicaid in the Office of the Governor, the recipient shall, to
2214	the extent of the payment of medical expenses by the Division of
2215	Medicaid, be deemed to have made an assignment to the Division of
2216	Medicaid of any and all rights and interests in any third-party
2217	benefits, hospitalization or indemnity contract or any cause of

(iii) If the division needs to expedite the

2225	the Division of Medicaid as his or her true and lawful
2226	attorney-in-fact in his or her name, place and stead in collecting
2227	any and all amounts due and owing for medical expenses paid by the
2228	Division of Medicaid against such person, firm or corporation.

(2) Whenever a provider of medical services or the Division of Medicaid submits claims to an insurer on behalf of a Medicaid recipient for whom an assignment of rights has been received, or whose rights have been assigned by the operation of law, the insurer must respond within sixty (60) days of receipt of a claim by forwarding payment or issuing a notice of denial directly to the submitter of the claim. The failure of the insuring entity to comply with the provisions of this section shall subject the insuring entity to recourse by the Division of Medicaid in accordance with the provision of Section 43-13-315. In the case of a responsible insurer, other than the insurers exempted under federal law, that requires prior authorization for an item or service furnished to a recipient, the insurer shall accept authorization provided by the Division of Medicaid that the item or service is covered under the state plan (or waiver of such plan) for such recipient, as if such authorization were the prior authorization made by the third party for such item or service. The Division of Medicaid shall be authorized to endorse any and all, including, but not limited to, multi-payee checks, drafts, money orders or other negotiable instruments representing Medicaid payment recoveries that are received by the Division of Medicaid.

2229

2230

2231

2232

2233

2234

2235

2236

2237

2238

2239

2240

2241

2242

2243

2244

2245

2246

2247

2248

2250	(3) Court orders or agreements for medical support shall
2251	direct such payments to the Division of Medicaid, which shall be
2252	authorized to endorse any and all checks, drafts, money orders or
2253	other negotiable instruments representing medical support payments
2254	which are received. Any designated medical support funds received
2255	by the State Department of Human Services or through its local
2256	county departments shall be paid over to the Division of Medicaid.
2257	When medical support for a Medicaid recipient is available through
2258	an absent parent or custodial parent, the insuring entity shall
2259	direct the medical support payment(s) to the provider of medical
2260	services or to the Division of Medicaid.

- SECTION 5. Section 43-11-1, Mississippi Code of 1972, is amended as follows:
- 2263 43-11-1. When used in this chapter, the following words 2264 shall have the following meaning:
- 2265 "Institutions for the aged or infirm" means a place 2266 either governmental or private that provides group living 2267 arrangements for four (4) or more persons who are unrelated to the 2268 operator and who are being provided food, shelter and personal 2269 care, whether any such place is organized or operated for profit 2270 The term "institution for the aged or infirm" includes 2271 nursing homes, pediatric skilled nursing facilities, psychiatric 2272 residential treatment facilities, convalescent homes, homes for 2273 the aged, adult foster care facilities and special care facilities 2274 for paroled inmates, provided that these institutions fall within

275	the scope of the definitions set forth above. The term
276	"institution for the aged or infirm" does not include hospitals,
277	clinics or mental institutions devoted primarily to providing
278	medical service, and does not include any private residence in
279	which the owner of the residence is providing personal care
2280	services to disabled or homeless veterans under an agreement with
2281	and in compliance with the standards prescribed by, the United
2282	States Department of Veterans Affairs, if the owner of the
2283	residence also provided personal care services to disabled or
2284	homeless veterans at any time during calendar year 2008.

- 2285 (b) "Person" means any individual, firm, partnership, 2286 corporation, company, association or joint-stock association, or 2287 any licensee herein or the legal successor thereof.
- (c) "Personal care" means assistance rendered by
  personnel of the home to aged or infirm residents in performing
  one or more of the activities of daily living, which includes, but
  is not limited to, the bathing, walking, excretory functions,
  feeding, personal grooming and dressing of such residents.
- 2293 (d) "Psychiatric residential treatment facility" means
  2294 any nonhospital establishment with permanent facilities which
  2295 provides a twenty-four-hour program of care by qualified
  2296 therapists, including, but not limited to, duly licensed mental
  2297 health professionals, psychiatrists, psychologists,
  2298 psychotherapists and licensed certified social workers, for
  2299 emotionally disturbed children and adolescents referred to such

2300	facility by a c	court, local	school	district or	bу	the Depa	artment of
2301	Human Services.	who are no	t in an	acute phase	of	illness	requiring

- 2302 the services of a psychiatric hospital, and are in need of such
- 2303 restorative treatment services. For purposes of this paragraph,
- 2304 the term "emotionally disturbed" means a condition exhibiting one
- 2305 or more of the following characteristics over a long period of
- 2306 time and to a marked degree, which adversely affects educational
- 2307 performance:
- 2308 1. An inability to learn which cannot be explained
- 2309 by intellectual, sensory or health factors;
- 2310 2. An inability to build or maintain satisfactory
- 2311 relationships with peers and teachers;
- 3. Inappropriate types of behavior or feelings
- 2313 under normal circumstances;
- 4. A general pervasive mood of unhappiness or
- 2315 depression; or
- 2316 5. A tendency to develop physical symptoms or
- 2317 fears associated with personal or school problems. An
- 2318 establishment furnishing primarily domiciliary care is not within
- 2319 this definition.
- 2320 (e) "Pediatric skilled nursing facility" means an
- 2321 institution or a distinct part of an institution that is primarily
- 2322 engaged in providing to inpatients skilled nursing care and
- 2323 related services for persons under twenty-one (21) years of age

- who require medical or nursing care or rehabilitation services for the rehabilitation of injured, disabled or sick persons.
- 2326 (f) "Licensing agency" means the State Department of 2327 Health.
- (g) "Medical records" mean, without restriction, those
  medical histories, records, reports, summaries, diagnoses and
  prognoses, records of treatment and medication ordered and given,
  notes, entries, x-rays and other written or graphic data prepared,
  kept, made or maintained in institutions for the aged or infirm
  that pertain to residency in, or services rendered to residents
  of, an institution for the aged or infirm.
- 2335 "Adult foster care facility" means a home setting (h) 2336 for vulnerable adults in the community who are unable to live independently due to physical, emotional, developmental or mental 2337 2338 impairments, or in need of emergency and continuing protective 2339 social services for purposes of preventing further abuse or 2340 neglect and for safeguarding and enhancing the welfare of the abused or neglected vulnerable adult. Adult foster care programs 2341 2342 shall be designed to meet the needs of vulnerable adults with 2343 impairments through individual plans of care, which provide a 2344 variety of health, social and related support services in a 2345 protective setting, enabling participants to live in the community. Adult foster care programs may be (i) traditional, 2346 2347 where the foster care provider lives in the residence and is the 2348 primary caregiver to clients in the home; (ii) corporate, where

2349 the foster care home is operated by a corporation with shift staff 2350 delivering services to clients; or (iii) shelter, where the foster 2351 care home accepts clients on an emergency short-term basis for up 2352 to thirty (30) days.

2353 (i) "Special care facilities for paroled inmates" means 2354 long-term care and skilled nursing facilities licensed as special 2355 care facilities for medically frail paroled inmates, formed to 2356 ease the burden of prison overcrowding and provide compassionate 2357 release and medical parole initiatives while impacting economic 2358 outcomes for the Mississippi prison system. The facilities shall 2359 meet all Mississippi Department of Health and federal Center for 2360 Medicaid Services (CMS) requirements and shall be regulated by 2361 both agencies; provided, however, such regulations shall not be as 2362 restrictive as those required for personal care homes and other 2363 institutions devoted primarily to providing medical services. 2364 facilities will offer physical, occupational and speech therapy, 2365 nursing services, wound care, a dedicated COVID services unit, individualized patient centered plans of care, social services, 2366 2367 spiritual services, physical activities, transportation, 2368 medication, durable medical equipment, personalized meal plans by 2369 a licensed dietician and security services. There may be up to 2370 three (3) facilities located in each Supreme Court district, to be 2371 designated by the Chairman of the State Parole Board or his 2372 designee.

2373	(j) "Adult day care facility" means a public agency or
2374	private organization, or a subdivision of such an agency or
2375	organization, that:
2376	(i) Provides the following items and services:
2377	1. Nursing services;
2378	2. Transportation of the individual to and
2379	from such adult day care facility in connection with any such item
2380	or service;
2381	3. Meals;
2382	4. A program of supervised activities that
2383	meets such criteria as the licensing agency determines and is
2384	appropriately designed to promote physical and mental health that
2385	is furnished to the individual by such a facility in a group
2386	setting for a period not greater than twelve (12) hours per day;
2387	5. The administration of medication by a
2388	licensed nurse, and a medication management program to minimize
2389	unnecessary or inappropriate use of prescription drugs and adverse
2390	events due to unintended prescription drug-to-drug interactions;
2391	and
2392	(ii) Meets such standards established by the
2393	licensing agency to assure quality of care and such other
2394	requirements as the licensing agency finds necessary in the
2395	interest of the health and safety of individuals who are furnished
2396	services in the facility.

2397 **SECTION 6.** Section 43-11-8, Mississippi Code of 1972, is 2398 amended as follows:

43-11-8. (1) An application for a license for an adult 2399 foster care facility or for an adult day care facility shall be 2400 2401 made to the licensing agency upon forms provided by it and shall 2402 contain such information as the licensing agency reasonably 2403 requires, which may include affirmative evidence of ability to 2404 comply with such reasonable standards, rules and regulations as 2405 are lawfully prescribed hereunder. Each application for a license 2406 for an adult foster care facility or for an adult day care 2407 facility shall be accompanied by a license fee of Ten Dollars 2408 (\$10.00) for each person or bed of licensed capacity, with a 2409 minimum fee per home or institution of Fifty Dollars (\$50.00), 2410 which shall be paid to the licensing agency. Any increase in the fee charged by the licensing agency under this subsection shall be 2411 2412 in accordance with the provisions of Section 41-3-65.

(2) A license, unless suspended or revoked, shall be renewable annually upon payment by the licensee of an adult foster care facility or of an adult day care facility, except for personal care homes, of a renewal fee of Ten Dollars (\$10.00) for each person or bed of licensed capacity in the institution, with a minimum renewal fee per institution of Fifty Dollars (\$50.00), which shall be paid to the licensing agency, and upon filing by the licensee and approval by the licensing agency of an annual report upon such uniform dates and containing such information in

2413

2414

2415

2416

2417

2418

2419

2420

2422 such form as the licensing agency prescribes by regulation. 2423 increase in the fee charged by the licensing agency under this 2424 subsection shall be in accordance with the provisions of Section 2425 41-3-65. Each license shall be issued only for the premises and 2426 person or persons or other legal entity or entities named in the 2427 application and shall not be transferable or assignable except 2428 with the written approval of the licensing agency. Licenses shall 2429 be posted in a conspicuous place on the licensed premises. 2430 SECTION 7. Section 43-11-13, Mississippi Code of 1972, is 2431 amended as follows: 2432 43-11-13. (1)The licensing agency shall adopt, amend, promulgate and enforce such rules, regulations and standards, 2433 2434 including classifications, with respect to all institutions for 2435 the aged or infirm to be licensed under this chapter as may be 2436 designed to further the accomplishment of the purpose of this chapter in promoting adequate care of individuals in those 2437 2438 institutions in the interest of public health, safety and welfare. 2439 Those rules, regulations and standards shall be adopted and 2440 promulgated by the licensing agency and shall be recorded and

main office in the State of Mississippi, entitled "Rules, 2443 Regulations and Minimum Standards for Institutions for the Aged or

indexed in a book to be maintained by the licensing agency in its

2444 Infirm" and the book shall be open and available to all

2445 institutions for the aged or infirm and the public generally at

all reasonable times. Upon the adoption of those rules, 2446

2441

2447 regulations and standards, the licensing agency shall mail copies 2448 thereof to all those institutions in the state that have filed with the agency their names and addresses for this purpose, but 2449 2450 the failure to mail the same or the failure of the institutions to 2451 receive the same shall in no way affect the validity thereof. 2452 rules, regulations and standards may be amended by the licensing 2453 agency, from time to time, as necessary to promote the health, 2454 safety and welfare of persons living in those institutions.

- (2) The licensee shall keep posted in a conspicuous place on the licensed premises all current rules, regulations and minimum standards applicable to fire protection measures as adopted by the licensing agency. The licensee shall furnish to the licensing agency at least once each six (6) months a certificate of approval and inspection by state or local fire authorities. Failure to comply with state laws and/or municipal ordinances and current rules, regulations and minimum standards as adopted by the licensing agency, relative to fire prevention measures, shall be prima facie evidence for revocation of license.
- 2465 (3) The State Board of Health shall promulgate rules and
  2466 regulations restricting the storage, quantity and classes of drugs
  2467 allowed in personal care homes and adult foster care facilities.
  2468 Residents requiring administration of Schedule II Narcotics as
  2469 defined in the Uniform Controlled Substances Law may be admitted
  2470 to a personal care home. Schedule drugs may only be allowed in a
  2471 personal care home if they are administered or stored utilizing

2455

2456

2457

2458

2459

2460

2461

2462

2463

2472 proper procedures under the direct supervision of a licensed 2473 physician or nurse.

- 2474 Notwithstanding any determination by the licensing (4)agency that skilled nursing services would be appropriate for a 2475 2476 resident of a personal care home, that resident, the resident's 2477 quardian or the legally recognized responsible party for the 2478 resident may consent in writing for the resident to continue to 2479 reside in the personal care home, if approved in writing by a 2480 licensed physician. However, no personal care home shall allow 2481 more than two (2) residents, or ten percent (10%) of the total 2482 number of residents in the facility, whichever is greater, to 2483 remain in the personal care home under the provisions of this 2484 subsection (4). This consent shall be deemed to be appropriately 2485 informed consent as described in the regulations promulgated by 2486 the licensing agency. After that written consent has been 2487 obtained, the resident shall have the right to continue to reside 2488 in the personal care home for as long as the resident meets the 2489 other conditions for residing in the personal care home. A copy 2490 of the written consent and the physician's approval shall be 2491 forwarded by the personal care home to the licensing agency.
- 2492 (b) The State Board of Health shall promulgate rules
  2493 and regulations restricting the handling of a resident's personal
  2494 deposits by the director of a personal care home. Any funds given
  2495 or provided for the purpose of supplying extra comforts,
  2496 conveniences or services to any resident in any personal care

2497 home, and any funds otherwise received and held from, for or on 2498 behalf of any such resident, shall be deposited by the director or other proper officer of the personal care home to the credit of 2499 2500 that resident in an account that shall be known as the Resident's 2501 Personal Deposit Fund. No more than one (1) month's charge for 2502 the care, support, maintenance and medical attention of the 2503 resident shall be applied from the account at any one time. 2504 the death, discharge or transfer of any resident for whose benefit 2505 any such fund has been provided, any unexpended balance remaining in his personal deposit fund shall be applied for the payment of 2506 2507 care, cost of support, maintenance and medical attention that is 2508 accrued. If any unexpended balance remains in that resident's 2509 personal deposit fund after complete reimbursement has been made 2510 for payment of care, support, maintenance and medical attention, 2511 and the director or other proper officer of the personal care home 2512 has been or shall be unable to locate the person or persons 2513 entitled to the unexpended balance, the director or other proper officer may, after the lapse of one (1) year from the date of that 2514 2515 death, discharge or transfer, deposit the unexpended balance to 2516 the credit of the personal care home's operating fund.

(c) The State Board of Health shall promulgate rules and regulations requiring personal care homes to maintain records relating to health condition, medicine dispensed and administered, and any reaction to that medicine. The director of the personal care home shall be responsible for explaining the availability of

2517

2518

2519

2520

2522	those	records	to	the	family	of	the	resident	at	any	time	upon
2523	reasor	nable red	gues	st.								

- 2524 (5) The State Board of Health and the Mississippi Department 2525 of Corrections shall jointly issue rules and regulations for the 2526 operation of the special care facilities for paroled inmates.
- 2527 (6) (a) For the purposes of this subsection (6):
- 2528 (i) "Licensed entity" means a hospital, nursing
- 2529 home, personal care home, home health agency, hospice or adult
- 2530 foster care facility;
- 2531 (ii) "Covered entity" means a licensed entity or a
- 2532 health care professional staffing agency;
- 2533 (iii) "Employee" means any individual employed by
- 2534 a covered entity, and also includes any individual who by contract
- 2535 provides to the patients, residents or clients being served by the
- 2536 covered entity direct, hands-on, medical patient care in a
- 2537 patient's, resident's or client's room or in treatment or recovery
- 2538 rooms. The term "employee" does not include health care
- 2539 professional/vocational technical students performing clinical
- 2540 training in a licensed entity under contracts between their
- 2541 schools and the licensed entity, and does not include students at
- 2542 high schools located in Mississippi who observe the treatment and
- 2543 care of patients in a licensed entity as part of the requirements
- 2544 of an allied-health course taught in the high school, if:
- 2545 1. The student is under the supervision of a
- 2546 licensed health care provider; and

2547	2. The student has signed an affidavit that
2548	is on file at the student's school stating that he or she has not
2549	been convicted of or pleaded guilty or nolo contendere to a felony
2550	listed in paragraph (d) of this subsection (6), or that any such
2551	conviction or plea was reversed on appeal or a pardon was granted
2552	for the conviction or plea. Before any student may sign such an
2553	affidavit, the student's school shall provide information to the
2554	student explaining what a felony is and the nature of the felonies
2555	listed in paragraph (d) of this subsection (6).

2556 However, the health care professional/vocational technical 2557 academic program in which the student is enrolled may require the 2558 student to obtain criminal history record checks. 2559 incidences, paragraph (a) (iii) 1 and 2 of this subsection (6) does 2560 not preclude the licensing entity from processing submitted 2561 fingerprints of students from healthcare-related 2562 professional/vocational technical programs who, as part of their 2563 program of study, conduct observations and provide clinical care 2564 and services in a covered entity.

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

2565

2566

2567

2568

2569

2570

2572	addition, the licensing agency shall require the covered entity to
2573	perform a disciplinary check with the professional licensing
2574	agency of each employee, if any, to determine if any disciplinary
2575	action has been taken against the employee by that agency.
2576	Except as otherwise provided in paragraph (c) of this
2577	subsection (6), no such employee hired on or after July 1, 2003,
2578	shall be permitted to provide direct patient care until the
2579	results of the criminal history record check have revealed no
2580	disqualifying record or the employee has been granted a waiver.
2581	In order to determine the employee applicant's suitability for
2582	employment, the applicant shall be fingerprinted. Fingerprints
2583	shall be submitted to the licensing agency from scanning, with the
2584	results processed through the Department of Public Safety's
2585	Criminal Information Center. The fingerprints shall then be
2586	forwarded by the Department of Public Safety to the Federal Bureau
2587	of Investigation for a national criminal history record check.
2588	The licensing agency shall notify the covered entity of the
2589	results of an employee applicant's criminal history record check.
2590	If the criminal history record check discloses a felony
2591	conviction, guilty plea or plea of nolo contendere to a felony of
2592	possession or sale of drugs, murder, manslaughter, armed robbery,
2593	rape, sexual battery, sex offense listed in Section 45-33-23(h),
2594	child abuse, arson, grand larceny, burglary, gratification of lust
2595	or aggravated assault, or felonious abuse and/or battery of a
2596	vulnerable adult that has not been reversed on appeal or for which

a pardon has not been granted, the employee applicant shall not be eligible to be employed by the covered entity.

- 2599 (c) Any such new employee applicant may, however, be
  2600 employed on a temporary basis pending the results of the criminal
  2601 history record check, but any employment contract with the new
  2602 employee shall be voidable if the new employee receives a
  2603 disqualifying criminal history record check and no waiver is
  2604 granted as provided in this subsection (6).
- 2605 Under regulations promulgated by the State Board of (d) Health, the licensing agency shall require every employee of a 2606 covered entity employed before July 1, 2003, to sign an affidavit 2607 2608 stating that he or she has not been convicted of or pleaded guilty 2609 or nolo contendere to a felony of possession or sale of drugs, 2610 murder, manslaughter, armed robbery, rape, sexual battery, any sex 2611 offense listed in Section 45-33-23(h), child abuse, arson, grand 2612 larceny, burglary, gratification of lust, aggravated assault, or 2613 felonious abuse and/or battery of a vulnerable adult, or that any such conviction or plea was reversed on appeal or a pardon was 2614 2615 granted for the conviction or plea. No such employee of a covered 2616 entity hired before July 1, 2003, shall be permitted to provide 2617 direct patient care until the employee has signed the affidavit 2618 required by this paragraph (d). All such existing employees of covered entities must sign the affidavit required by this 2619 2620 paragraph (d) within six (6) months of the final adoption of the regulations promulgated by the State Board of Health. If a person 2621

2622 signs the affidavit required by this paragraph (d), and it is 2623 later determined that the person actually had been convicted of or pleaded quilty or nolo contendere to any of the offenses listed in 2624 2625 this paragraph (d) and the conviction or plea has not been 2626 reversed on appeal or a pardon has not been granted for the 2627 conviction or plea, the person is quilty of perjury. If the 2628 offense that the person was convicted of or pleaded guilty or nolo 2629 contendere to was a violent offense, the person, upon a conviction 2630 of perjury under this paragraph, shall be punished as provided in Section 97-9-61. If the offense that the person was convicted of 2631 2632 or pleaded quilty or nolo contendere to was a nonviolent offense, 2633 the person, upon a conviction of perjury under this paragraph, 2634 shall be punished by a fine of not more than Five Hundred Dollars 2635 (\$500.00), or by imprisonment in the county jail for not more than 2636 six (6) months, or by both such fine and imprisonment.

(e) The covered entity may, in its discretion, allow any employee who is unable to sign the affidavit required by paragraph (d) of this subsection (6) or any employee applicant aggrieved by an employment decision under this subsection (6) to appear before the covered entity's hiring officer, or his or her designee, to show mitigating circumstances that may exist and allow the employee or employee applicant to be employed by the covered entity. The covered entity, upon report and recommendation of the hiring officer, may grant waivers for those mitigating circumstances, which shall include, but not be limited

2637

2638

2639

2640

2641

2642

2643

2644

2645

2647 (i) age at which the crime was committed; (ii) circumstances 2648 surrounding the crime; (iii) length of time since the conviction and criminal history since the conviction; (iv) work history; (v) 2649 2650 current employment and character references; and (vi) other 2651 evidence demonstrating the ability of the individual to perform 2652 the employment responsibilities competently and that the 2653 individual does not pose a threat to the health or safety of the 2654 patients of the covered entity.

- 2655 The licensing agency may charge the covered entity (f) submitting the fingerprints a fee not to exceed Fifty Dollars 2656 2657 (\$50.00), which covered entity may, in its discretion, charge the 2658 same fee, or a portion thereof, to the employee applicant. Any 2659 increase in the fee charged by the licensing agency under this 2660 paragraph shall be in accordance with the provisions of Section 2661 41-3-65. Any costs incurred by a covered entity implementing this subsection (6) shall be reimbursed as an allowable cost under 2662 Section 43-13-116. 2663
- 2664 If the results of an employee applicant's criminal 2665 history record check reveals no disqualifying event, then the 2666 covered entity shall, within two (2) weeks of the notification of 2667 no disqualifying event, provide the employee applicant with a 2668 notarized letter signed by the chief executive officer of the covered entity, or his or her authorized designee, confirming the 2669 2670 employee applicant's suitability for employment based on his or her criminal history record check. An employee applicant may use 2671

2672	that letter for a period of two (2) years from the date of the
2673	letter to seek employment with any covered entity without the
2674	necessity of an additional criminal history record check. Any
2675	covered entity presented with the letter may rely on the letter
2676	with respect to an employee applicant's criminal background and is
2677	not required for a period of two (2) years from the date of the
2678	letter to conduct or have conducted a criminal history record
2679	check as required in this subsection (6).

- 2680 The licensing agency, the covered entity, and their (h) 2681 agents, officers, employees, attorneys and representatives, shall 2682 be presumed to be acting in good faith for any employment decision 2683 or action taken under this subsection (6). The presumption of 2684 good faith may be overcome by a preponderance of the evidence in 2685 any civil action. No licensing agency, covered entity, nor their 2686 agents, officers, employees, attorneys and representatives shall 2687 be held liable in any employment decision or action based in whole 2688 or in part on compliance with or attempts to comply with the 2689 requirements of this subsection (6).
- 2690 (i) The licensing agency shall promulgate regulations 2691 to implement this subsection (6).
- 2692 (j) The provisions of this subsection (6) shall not 2693 apply to:
- 2694 (i) Applicants and employees of the University of 2695 Mississippi Medical Center for whom criminal history record checks

2696	and fingerprinting are obtained in accordance with Section
2697	37-115-41; or
2698	(ii) Health care professional/vocational technical
2699	students for whom criminal history record checks and
2700	fingerprinting are obtained in accordance with Section 37-29-232.
2701	(7) The State Board of Health shall promulgate rules,
2702	regulations and standards regarding the operation of adult foster
2703	care facilities and adult day care facilities.
2704	(8) Beginning July 1, 2026, to operate an adult day care
2705	facility in Mississippi, the facility provider shall be licensed
2706	with the licensing division of the State Department of Health.
2707	Mississippi Medicaid waiver providers are required to have a state
2708	license and have a Medicaid provider contract with the Division of
2709	Medicaid.
2710	Facilities shall be licensed to serve clients based on the
2711	size and capacity of the facility. The facilities shall be
2712	required to provide nursing services, nutritional services,
2713	socialization and therapeutic activities. The facilities shall
2714	maintain, at a minimum, a staff-to-client ratio in accordance with
2715	the State Department of Health's standards. Standards governing
2716	the quality of care and services rendered shall be developed with
2717	input from all stakeholders, including the Division of Medicaid.
2718	In addition to providing adult day care services, the licensed
2719	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. It is the intent of the Legislature to expand access to Medicaid-funded home- and community-based services for

2725 eligible nursing facility residents who choose those services.
2726 The Executive Director of the Division of Medicaid is authorized

2727 to transfer funds allocated for nursing facility services for

2728 eligible residents to cover the cost of services available through

2729 the Independent Living Waiver, the Traumatic Brain Injury/Spinal

2730 Cord Injury Waiver, the Elderly and Disabled Waiver, and the

2731 Assisted Living Waiver programs when eligible residents choose

2732 those community services. The amount of funding transferred by

2733 the division shall be sufficient to cover the cost of home- and

2734 community-based waiver services for each eligible nursing

2735 facility \* \* \*  $\frac{\text{resident}}{\text{mesident}}$  who \* \* \*  $\frac{\text{chooses}}{\text{chooses}}$  those services. The

2736 number of nursing facility residents who return to the community

2737 and home- and community-based waiver services shall not count

2738 against the total number of waiver slots for which the Legislature

2739 appropriates funding each year. Any funds remaining in the

2740 program when a former nursing facility resident ceases to

2741 participate in a home- and community-based waiver program under

2742 this provision shall be returned to nursing facility funding.

2743 **SECTION 9.** Section 43-13-117.7, Mississippi Code of 1972, is

2744 amended as follows:

- 2745 43-13-117.7. Notwithstanding any other provisions of Section
- 2746 43-13-117, the division shall not reimburse or provide coverage
- 2747 for gender transition procedures for \* \* \* any person \* \* \*.
- 2748 **SECTION 10.** Section 37-33-167, Mississippi Code of 1972, is
- 2749 amended as follows:
- 2750 37-33-167. The State Department of Rehabilitation Services,
- 2751 through the Office of Disability Determination Services, may enter
- 2752 into agreements with the federal Social Security Administration or
- 2753 its successor and other state agencies for the purpose of
- 2754 performing eligibility determinations for Medicaid assistance
- 2755 payments for those persons who qualify therefor under Section
- 2756 43-13-115 \* \* \* , and may adopt such methods of administration as
- 2757 may be necessary to secure the full benefits of federal
- 2758 appropriations for medical assistance for such persons.
- 2759 **SECTION 11.** Section 43-13-145, Mississippi Code of 1972, is
- 2760 amended as follows:
- 43-13-145. (1) (a) Upon each nursing facility licensed by
- 2762 the State of Mississippi, there is levied an assessment in an
- 2763 amount set by the division, equal to the maximum rate allowed by
- 2764 federal law or regulation, for each licensed and occupied bed of
- 2765 the facility.
- 2766 (b) A nursing facility is exempt from the assessment
- 2767 levied under this subsection if the facility is operated under the
- 2768 direction and control of:

2769	(i) The United States Veterans Administration or
2770	other agency or department of the United States government; or
2771	(ii) The State Veterans Affairs Board.
2772	(2) (a) Upon each intermediate care facility for
2773	individuals with intellectual disabilities licensed by the State
2774	of Mississippi, there is levied an assessment in an amount set by
2775	the division, equal to the maximum rate allowed by federal law or
2776	regulation, for each licensed and occupied bed of the facility.
2777	(b) An intermediate care facility for individuals with
2778	intellectual disabilities is exempt from the assessment levied
2779	under this subsection if the facility is operated under the
2780	direction and control of:
2781	(i) The United States Veterans Administration or
2782	other agency or department of the United States government;
2783	(ii) The State Veterans Affairs Board; or
2784	(iii) The University of Mississippi Medical
2785	Center.
2786	(3) (a) Upon each psychiatric residential treatment
2787	facility licensed by the State of Mississippi, there is levied ar
2788	assessment in an amount set by the division, equal to the maximum
2789	rate allowed by federal law or regulation, for each licensed and
2790	occupied bed of the facility.
2791	(b) A psychiatric residential treatment facility is
2792	exempt from the assessment levied under this subsection if the

facility is operated under the direction and control of:

2794			(	(i) The	Uni	ted	Sta	ites	Vet	erans	Administration	or
2795	other a	agency	or	departm	ent	of	the	Unit	ted	States	government;	

2796 (ii) The University of Mississippi Medical Center;

2797 or

2801

2802

2803

2804

2805

2806

2807

2808

2809

2810

2811

2812

2813

2814

2815

2816

2817

2818

2798 (iii) A state agency or a state facility that
2799 either provides its own state match through intergovernmental
2800 transfer or certification of funds to the division.

(4) Hospital assessment.

Subject to and upon fulfillment of the (a) (i) requirements and conditions of paragraph (f) below, and notwithstanding any other provisions of this section, an annual assessment on each hospital licensed in the state is imposed on each non-Medicare hospital inpatient day as defined below at a rate that is determined by dividing the sum prescribed in this subparagraph (i), plus the nonfederal share necessary to maximize the Disproportionate Share Hospital (DSH) and Medicare Upper Payment Limits (UPL) Program payments and hospital access payments and such other supplemental payments as may be developed pursuant to Section 43-13-117(A)(18), by the total number of non-Medicare hospital inpatient days as defined below for all licensed Mississippi hospitals, except as provided in paragraph (d) below. If the state-matching funds percentage for the Mississippi Medicaid program is sixteen percent (16%) or less, the sum used in the formula under this subparagraph (i) shall be Seventy-four Million Dollars (\$74,000,000.00). If the state-matching funds

2819	percentage for the Mississippi Medicaid program is twenty-four
2820	percent (24%) or higher, the sum used in the formula under this
2821	subparagraph (i) shall be One Hundred Four Million Dollars
2822	(\$104,000,000.00). If the state-matching funds percentage for the
2823	Mississippi Medicaid program is between sixteen percent (16%) and
2824	twenty-four percent (24%), the sum used in the formula under this
2825	subparagraph (i) shall be a pro rata amount determined as follows:
2826	the current state-matching funds percentage rate minus sixteen
2827	percent (16%) divided by eight percent (8%) multiplied by Thirty
2828	Million Dollars (\$30,000,000.00) and add that amount to
2829	Seventy-four Million Dollars (\$74,000,000.00). However, no
2830	assessment in a quarter under this subparagraph (i) may exceed the
2831	assessment in the previous quarter by more than Three Million
2832	Seven Hundred Fifty Thousand Dollars (\$3,750,000.00) (which would
2833	be Fifteen Million Dollars (\$15,000,000.00) on an annualized
2834	basis), unless such increase is to maximize federal funds that are
2835	available to reimburse hospitals for services provided under new
2836	programs for hospitals, for increased supplemental payment
2837	programs for hospitals or to assist with state matching funds as
2838	authorized by the Legislature. The division shall publish the
2839	state-matching funds percentage rate applicable to the Mississippi
2840	Medicaid program on the tenth day of the first month of each
2841	quarter and the assessment determined under the formula prescribed
2842	above shall be applicable in the quarter following any adjustment
2843	in that state-matching funds percentage rate. The division shall

notify each hospital licensed in the state as to any projected increases or decreases in the assessment determined under this subparagraph (i). However, if the Centers for Medicare and Medicaid Services (CMS) does not approve the provision in Section 43-13-117(39) requiring the division to reimburse crossover claims for inpatient hospital services and crossover claims covered under Medicare Part B for dually eligible beneficiaries in the same manner that was in effect on January 1, 2008, the sum that otherwise would have been used in the formula under this subparagraph (i) shall be reduced by Seven Million Dollars (\$7,000,000.00). 

subparagraph (i), an additional annual assessment provided under subparagraph (i), an additional annual assessment on each hospital licensed in the state is imposed on each non-Medicare hospital inpatient day as defined below at a rate that is determined by dividing twenty-five percent (25%) of any provider reductions in the Medicaid program as authorized in Section 43-13-117(F) for that fiscal year up to the following maximum amount, plus the nonfederal share necessary to maximize the Disproportionate Share Hospital (DSH) and inpatient Medicare Upper Payment Limits (UPL) Program payments and inpatient hospital access payments, by the total number of non-Medicare hospital inpatient days as defined below for all licensed Mississippi hospitals: in fiscal year 2010, the maximum amount shall be Twenty-four Million Dollars (\$24,000,000.00); in fiscal year 2011, the maximum amount shall be

2869 Thirty-two Million Dollars (\$32,000,000.00); and in fiscal year 2870 2012 and thereafter, the maximum amount shall be Forty Million 2871 Dollars (\$40,000,000.00). Any such deficit in the Medicaid 2872 program shall be reviewed by the PEER Committee as provided in Section 43-13-117(F). 2873 2874 (iii) In addition to the assessments provided in subparagraphs (i) and (ii), an additional annual assessment on 2875 2876 each hospital licensed in the state is imposed pursuant to the 2877 provisions of Section 43-13-117(F) if the cost-containment 2878 measures described therein have been implemented and there are 2879 insufficient funds in the Health Care Trust Fund to reconcile any 2880 remaining deficit in any fiscal year. If the Governor institutes 2881 any other additional cost-containment measures on any program or 2882 programs authorized under the Medicaid program pursuant to Section 2883 43-13-117(F), hospitals shall be responsible for twenty-five 2884 percent (25%) of any such additional imposed provider cuts, which 2885 shall be in the form of an additional assessment not to exceed the 2886 twenty-five percent (25%) of provider expenditure reductions. 2887 Such additional assessment shall be imposed on each non-Medicare 2888 hospital inpatient day in the same manner as assessments are 2889 imposed under subparagraphs (i) and (ii). 2890 Definitions. (b) 2891 (i) [Deleted]

2892

PAGE 114

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

2894	means total hospital inpatient days including subcomponent days
2895	less Medicare inpatient days including subcomponent days from the
2896	hospital's most recent Medicare cost report for the second
2897	calendar year preceding the beginning of the state fiscal year, on
2898	file with CMS per the CMS HCRIS database, or cost report submitted
2899	to the Division if the HCRIS database is not available to the
2900	division, as of June 1 of each year.
2901	a. Total hospital inpatient days shall
2902	be the sum of Worksheet S-3, Part 1, column 8 row 14, column 8 row
2903	16, and column 8 row 17, excluding column 8 rows 5 and 6.
2904	b. Hospital Medicare inpatient days
2905	shall be the sum of Worksheet S-3, Part 1, column 6 row 14, column
2906	6 row 16.00, and column 6 row 17, excluding column 6 rows 5 and 6.
2907	c. Inpatient days shall not include
2908	residential treatment or long-term care days.
2909	2. "Subcomponent inpatient day" means the
2910	number of days of care charged to a beneficiary for inpatient
2911	hospital rehabilitation and psychiatric care services in units of
2912	full days. A day begins at midnight and ends twenty-four (24)

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

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

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

a patient begins a leave of absence is not counted as a day unless

discharge or death occur on the day of admission. If admission

"Non-Medicare hospital inpatient day"

2893

2913

2914

2915

2916

2918	and discharge or death occur on the same day, the day is
2919	considered a day of admission and counts as one (1) subcomponent
2920	inpatient day.

- The assessment provided in this subsection is 2921 (C) 2922 intended to satisfy and not be in addition to the assessment and 2923 intergovernmental transfers provided in Section 43-13-117(A)(18). 2924 Nothing in this section shall be construed to authorize any state 2925 agency, division or department, or county, municipality or other 2926 local governmental unit to license for revenue, levy or impose any 2927 other tax, fee or assessment upon hospitals in this state not 2928 authorized by a specific statute.
- 2929 (d) Hospitals operated by the United States Department
  2930 of Veterans Affairs and state-operated facilities that provide
  2931 only inpatient and outpatient psychiatric services shall not be
  2932 subject to the hospital assessment provided in this subsection.
- 2933 (e) Multihospital systems, closure, merger, change of 2934 ownership and new hospitals.
- 2935 (i) If a hospital conducts, operates or maintains
  2936 more than one (1) hospital licensed by the State Department of
  2937 Health, the provider shall pay the hospital assessment for each
  2938 hospital separately.
- 2939 (ii) Notwithstanding any other provision in this 2940 section, if a hospital subject to this assessment operates or 2941 conducts business only for a portion of a fiscal year, the 2942 assessment for the state fiscal year shall be adjusted by

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

- 2949 (iii) The division shall determine the tax for new
  2950 hospitals and hospitals that undergo a change of ownership in
  2951 accordance with this section, using the best available
  2952 information, as determined by the division.
- 2953 (f) Applicability.

2956

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

The assessment is determined to be an

- impermissible tax under Title XIX of the Social Security Act; or

  (ii) CMS revokes its approval of the division's

  2959 2009 Medicaid State Plan Amendment for the methodology for DSH

  payments to hospitals under Section 43-13-117(A)(18).
- 2961 (5) Each health care facility that is subject to the 2962 provisions of this section shall keep and preserve such suitable 2963 books and records as may be necessary to determine the amount of 2964 assessment for which it is liable under this section. The books 2965 and records shall be kept and preserved for a period of not less 2966 than five (5) years, during which time those books and records shall be open for examination during business hours by the 2967

2968 division, the Department of Revenue, the Office of the Attorney 2969 General and the State Department of Health.

2970 (6) [Deleted]

2977

2978

2979

2980

2981

2982

2983

2984

2985

2986

2987

2988

2989

2990

2991

- 2971 (7) All assessments collected under this section shall be 2972 deposited in the Medical Care Fund created by Section 43-13-143.
- 2973 (8) The assessment levied under this section shall be in 2974 addition to any other assessments, taxes or fees levied by law, 2975 and the assessment shall constitute a debt due the State of 2976 Mississippi from the time the assessment is due until it is paid.
  - (9) (a) If a health care facility that is liable for payment of an assessment levied by the division does not pay the assessment when it is due, the division shall give written notice to the health care facility demanding payment of the assessment within ten (10) days from the date of delivery of the notice. the health care facility fails or refuses to pay the assessment after receiving the notice and demand from the division, the division shall withhold from any Medicaid reimbursement payments that are due to the health care facility the amount of the unpaid assessment and a penalty of ten percent (10%) of the amount of the assessment, plus the legal rate of interest until the assessment is paid in full. If the health care facility does not participate in the Medicaid program, the division shall turn over to the Office of the Attorney General the collection of the unpaid assessment by civil action. In any such civil action, the Office of the Attorney General shall collect the amount of the unpaid

assessment and a penalty of ten percent (10%) of the amount of the assessment, plus the legal rate of interest until the assessment is paid in full.

2996 As an additional or alternative method for 2997 collecting unpaid assessments levied by the division, if a health 2998 care facility fails or refuses to pay the assessment after 2999 receiving notice and demand from the division, the division may 3000 file a notice of a tax lien with the chancery clerk of the county 3001 in which the health care facility is located, for the amount of 3002 the unpaid assessment and a penalty of ten percent (10%) of the 3003 amount of the assessment, plus the legal rate of interest until the assessment is paid in full. Immediately upon receipt of 3004 3005 notice of the tax lien for the assessment, the chancery clerk 3006 shall forward the notice to the circuit clerk who shall enter the notice of the tax lien as a judgment upon the judgment roll and 3007 3008 show in the appropriate columns the name of the health care 3009 facility as judgment debtor, the name of the division as judgment creditor, the amount of the unpaid assessment, and the date and 3010 3011 time of enrollment. The judgment shall be valid as against 3012 mortgagees, pledgees, entrusters, purchasers, judgment creditors 3013 and other persons from the time of filing with the clerk. 3014 amount of the judgment shall be a debt due the State of 3015 Mississippi and remain a lien upon the tangible property of the 3016 health care facility until the judgment is satisfied. 3017 judgment shall be the equivalent of any enrolled judgment of a

3018 court of record and shall serve as authority for the issuance of 3019 writs of execution, writs of attachment or other remedial writs.

3020 (a) To further the provisions of Section 3021 43-13-117(A)(18), the Division of Medicaid shall submit to the 3022 Centers for Medicare and Medicaid Services (CMS) any documents 3023 regarding the hospital assessment established under subsection (4) 3024 of this section. In addition to defining the assessment 3025 established in subsection (4) of this section if necessary, the 3026 documents shall describe any supplement payment programs and/or payment methodologies as authorized in Section 43-13-117(A)(18) if 3027 3028 necessary.

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

3029

3030

3031

3032

3033

3034

3035

3036

3037

3038

3039

3041	(11) The division shall implement DSH and supplemental
3042	payment calculation methodologies that result in the maximization
3043	of available federal funds

- 3044 (12) The DSH payments shall be paid on or before December 3045 31, March 31, and June 30 of each fiscal year, in increments of one-third (1/3) of the total calculated DSH amounts. Supplemental payments developed pursuant to Section 43-13-117(A)(18) shall be 3048 paid monthly.
- 3049 (13) Payment.
- (a) The hospital assessment as described in subsection (4) for the nonfederal share necessary to maximize the Medicare Upper Payments Limits (UPL) Program payments and hospital access payments and such other supplemental payments as may be developed pursuant to Section 43-3-117(A)(18) shall be assessed and collected monthly no later than the fifteenth calendar day of each month.
- 3057 (b) The hospital assessment as described in subsection 3058 (4) for the nonfederal share necessary to maximize the 3059 Disproportionate Share Hospital (DSH) payments shall be assessed 3060 and collected on December 15, March 15 and June 15.
- 3061 (c) The annual hospital assessment and any additional 3062 hospital assessment as described in subsection (4) shall be 3063 assessed and collected on September 15 and on the 15th of each 3064 month from December through June.

3065	(14) If for any reason any part of the plan for annual DSH
3066	and supplemental payment programs to hospitals provided under
3067	subsection (10) of this section and/or developed pursuant to
3068	Section 43-13-117(A)(18) is not approved by CMS, the remainder of
3069	the plan shall remain in full force and effect.

- 3070 (15) Nothing in this section shall prevent the Division of
  3071 Medicaid from facilitating participation in Medicaid supplemental
  3072 hospital payment programs by a hospital located in a county
  3073 contiguous to the State of Mississippi that is also authorized by
  3074 federal law to submit intergovernmental transfers (IGTs) to the
  3075 State of Mississippi to fund the state share of the hospital's
  3076 supplemental and/or MHAP payments.
- 3077 (16) This section shall stand repealed on July 1, 2028.
- 3078 **SECTION 12.** Section 43-13-115.1, Mississippi Code of 1972, 3079 is amended as follows:
- 3080 43-13-115.1. (1) Ambulatory prenatal care shall be
  3081 available to a pregnant woman under this article during a
  3082 presumptive eligibility period in accordance with the provisions
  3083 of this section.
- 3084 (2) For purposes of this section, the following terms shall 3085 be defined as provided in this subsection:
- 3086 (a) "Presumptive eligibility" means a reasonable
  3087 determination of Medicaid eligibility of a pregnant woman made by
  3088 a qualified provider based only on the countable family income of
  3089 the woman, which allows the woman to receive ambulatory prenatal

3090	care under this article during a presumptive eligibility period
3091	while the Division of Medicaid makes a determination with respect
3092	to the eligibility of the woman for Medicaid.

- 3093 (b) "Presumptive eligibility period" means, with 3094 respect to a pregnant woman, the period that:
- 3095 (i) Begins with the date on which a qualified
  3096 provider determines, on the basis of preliminary information, that
  3097 the total countable net family income of the woman does not exceed
  3098 the income limits for eligibility of pregnant women in the
  3099 Medicaid state plan; and
- 3100 (ii) Ends with, and includes, the earlier of:
- 3101 1. The day on which a determination is made 3102 with respect to the eligibility of the woman for Medicaid;
- 2. In the case of a woman who does not file 3104 an application by the last day of the month following the month 3105 during which the provider makes the determination referred to in
- 3106 subparagraph (i) of this paragraph, such last day; or
- 3. Sixty (60) days after the day that the growider makes the determination referred to in subparagraph (i) of this paragraph.
- 3110 (c) "Qualified provider" means any provider that meets
  3111 the definition of "qualified provider" under 42 USC Section
  3112 1396r-1. The term includes, but is not limited to, county health
  3113 departments, federally qualified health centers (FQHCs), and other

3114	entities	approved a	nd	designated	by	the	Divisio	n of	Medicaio	d to
3115	conduct	presumptive	e]	ligibility	dete	ermir	nations	for	pregnant	women.

- (3) A pregnant woman shall be deemed to be presumptively 3116 3117 eligible for ambulatory prenatal care under this article if a 3118 qualified provider determines, on the basis of preliminary 3119 information, that the total countable net family income of the 3120 woman does not exceed the income limits for eligibility of 3121 pregnant women in the Medicaid state plan. \* \* \* A pregnant woman 3122 who is determined to be presumptively eligible may receive no more 3123 than one (1) presumptive eligibility period per pregnancy.
- 3124 (4) A qualified provider that determines that a pregnant 3125 woman is presumptively eligible for Medicaid shall:
- 3126 (a) Notify the Division of Medicaid of the
  3127 determination within five (5) working days after the date on which
  3128 determination is made; and
- 3129 (b) Inform the woman at the time the determination is 3130 made that she is required to make application for Medicaid by not 3131 later than the last day of the month following the month during 3132 which the determination is made.
- 3133 (5) A pregnant woman who is determined by a qualified 3134 provider to be presumptively eligible for Medicaid shall make 3135 application for Medicaid by not later than the last day of the 3136 month following the month during which the determination is made.
- 3137 (6) The Division of Medicaid shall provide qualified 3138 providers with such forms as are necessary for a pregnant woman to

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

3143 **SECTION 13.** Section 41-7-191, Mississippi Code of 1972, is 3144 amended as follows:

3145 41-7-191. (1) No person shall engage in any of the 3146 following activities without obtaining the required certificate of need:

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

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

3159 (c) Any change in the existing bed complement of any
3160 health care facility through the addition or conversion of any
3161 beds or the alteration, modernizing or refurbishing of any unit or
3162 department in which the beds may be located; however, if a health
3163 care facility has voluntarily delicensed some of its existing bed

3148

3149

3150

3151

3152

3153

3154

3155

3156

3157

3164	complement, it may later relicense some or all of its delicensed
3165	beds without the necessity of having to acquire a certificate of
3166	need. The State Department of Health shall maintain a record of
3167	the delicensing health care facility and its voluntarily
3168	delicensed beds and continue counting those beds as part of the
3169	state's total bed count for health care planning purposes. If a
3170	health care facility that has voluntarily delicensed some of its
3171	beds later desires to relicense some or all of its voluntarily
3172	delicensed beds, it shall notify the State Department of Health of
3173	its intent to increase the number of its licensed beds. The State
3174	Department of Health shall survey the health care facility within
3175	thirty (30) days of that notice and, if appropriate, issue the
3176	health care facility a new license reflecting the new contingent
3177	of beds. However, in no event may a health care facility that has
3178	voluntarily delicensed some of its beds be reissued a license to
3179	operate beds in excess of its bed count before the voluntary
3180	delicensure of some of its beds without seeking certificate of
3181	need approval;

- 3182 (d) Offering of the following health services if those 3183 services have not been provided on a regular basis by the proposed 3184 provider of such services within the period of twelve (12) months 3185 prior to the time such services would be offered:
- 3186 (i) Open-heart surgery services;
- 3187 (ii) Cardiac catheterization services;

PAGE 126

3188	(iii) Comprehensive inpatient rehabilitation
3189	services;
3190	(iv) Licensed psychiatric services;
3191	(v) Licensed chemical dependency services;
3192	(vi) Radiation therapy services;
3193	(vii) Diagnostic imaging services of an invasive
3194	nature, i.e. invasive digital angiography;
3195	(viii) Nursing home care as defined in
3196	subparagraphs (iv), (vi) and (viii) of Section 41-7-173(h);
3197	(ix) Home health services;
3198	(x) Swing-bed services;
3199	(xi) Ambulatory surgical services;
3200	(xii) Magnetic resonance imaging services;
3201	(xiii) [Deleted]
3202	(xiv) Long-term care hospital services;
3203	(xv) Positron emission tomography (PET) services;
3204	(e) The relocation of one or more health services from
3205	one physical facility or site to another physical facility or
3206	site, unless such relocation, which does not involve a capital
3207	expenditure by or on behalf of a health care facility, (i) is to a
3208	physical facility or site within five thousand two hundred eighty
3209	(5,280) feet from the main entrance of the health care facility
3210	where the health care service is located, or (ii) is the result of
3211	an order of a court of appropriate jurisdiction or a result of
3212	pending litigation in such court, or by order of the State

3213	Department of Health, or by order of any other agency or legal
3214	entity of the state, the federal government, or any political
3215	subdivision of either, whose order is also approved by the State
3216	Department of Health.

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

  (i) the acquisition of any major medical equipment used only for

  research purposes, and (ii) the acquisition of major medical

  equipment to replace medical equipment for which a facility is

  already providing medical services and for which the State

  Department of Health has been notified before the date of such

  acquisition shall be exempt from this paragraph; an acquisition

  for less than fair market value must be reviewed, if the

  acquisition at fair market value would be subject to review;
- 3227 Changes of ownership of existing health care 3228 facilities in which a notice of intent is not filed with the State 3229 Department of Health at least thirty (30) days prior to the date such change of ownership occurs, or a change in services or bed 3230 3231 capacity as prescribed in paragraph (c) or (d) of this subsection 3232 as a result of the change of ownership; an acquisition for less 3233 than fair market value must be reviewed, if the acquisition at 3234 fair market value would be subject to review;
- 3235 (h) The change of ownership of any health care facility 3236 defined in subparagraphs (iv), (vi) and (viii) of Section 3237 41-7-173(h), in which a notice of intent as described in paragraph

3217

3218

3219

3220

3221

3222

3223

3224

3225

3238	(a)	has	not	been	filed	and	if	the	Executive	Director	. Division	of

- 3239 Medicaid, Office of the Governor, has not certified in writing
- 3240 that there will be no increase in allowable costs to Medicaid from
- 3241 revaluation of the assets or from increased interest and
- 3242 depreciation as a result of the proposed change of ownership;
- 3243 (i) Any activity described in paragraphs (a) through
- 3244 (h) if undertaken by any person if that same activity would
- 3245 require certificate of need approval if undertaken by a health
- 3246 care facility;
- 3247 (j) Any capital expenditure or deferred capital
- 3248 expenditure by or on behalf of a health care facility not covered
- 3249 by paragraphs (a) through (h);
- 3250 (k) The contracting of a health care facility as
- 3251 defined in subparagraphs (i) through (viii) of Section 41-7-173(h)
- 3252 to establish a home office, subunit, or branch office in the space
- 3253 operated as a health care facility through a formal arrangement
- 3254 with an existing health care facility as defined in subparagraph
- 3255 (ix) of Section 41-7-173 (h);
- 3256 (1) The replacement or relocation of a health care
- 3257 facility designated as a critical access hospital shall be exempt
- 3258 from subsection (1) of this section so long as the critical access
- 3259 hospital complies with all applicable federal law and regulations
- 3260 regarding such replacement or relocation;
- 3261 (m) Reopening a health care facility that has ceased to
- 3262 operate for a period of sixty (60) months or more, which reopening

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

- (2) The State Department of Health shall not grant approval for or issue a certificate of need to any person proposing the new construction of, addition to, or expansion of any health care facility defined in subparagraphs (iv) (skilled nursing facility) and (vi) (intermediate care facility) of Section 41-7-173(h) or the conversion of vacant hospital beds to provide skilled or intermediate nursing home care, except as hereinafter authorized:
- (a) The department may issue a certificate of need to any person proposing the new construction of any health care facility defined in subparagraphs (iv) and (vi) of Section 41-7-173(h) as part of a life care retirement facility, in any county bordering on the Gulf of Mexico in which is located a National Aeronautics and Space Administration facility, not to exceed forty (40) beds. From and after July 1, 1999, there shall be no prohibition or restrictions on participation in the Medicaid program (Section 43-13-101 et seq.) for the beds in the health care facility that were authorized under this paragraph (a).
- 3282 (b) The department may issue certificates of need in
  3283 Harrison County to provide skilled nursing home care for
  3284 Alzheimer's disease patients and other patients, not to exceed one
  3285 hundred fifty (150) beds. From and after July 1, 1999, there
  3286 shall be no prohibition or restrictions on participation in the

3287	Medicaio	d program	(Sectio	n 43-	-13-101	et	seq.)	for	the	beds	in	the
3288	nursing	facilities	s that	were	author	ized	under	thi	s pa	aragra	aph	(b).

3289 The department may issue a certificate of need for the addition to or expansion of any skilled nursing facility that 3290 3291 is part of an existing continuing care retirement community 3292 located in Madison County, provided that the recipient of the 3293 certificate of need agrees in writing that the skilled nursing 3294 facility will not at any time participate in the Medicaid program 3295 (Section 43-13-101 et seq.) or admit or keep any patients in the 3296 skilled nursing facility who are participating in the Medicaid 3297 This written agreement by the recipient of the 3298 certificate of need shall be fully binding on any subsequent owner of the skilled nursing facility, if the ownership of the facility 3299 is transferred at any time after the issuance of the certificate 3300 3301 of need. Agreement that the skilled nursing facility will not 3302 participate in the Medicaid program shall be a condition of the 3303 issuance of a certificate of need to any person under this paragraph (c), and if such skilled nursing facility at any time 3304 3305 after the issuance of the certificate of need, regardless of the 3306 ownership of the facility, participates in the Medicaid program or 3307 admits or keeps any patients in the facility who are participating 3308 in the Medicaid program, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and 3309 3310 shall deny or revoke the license of the skilled nursing facility, at the time that the department determines, after a hearing 3311

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

3318 The State Department of Health may issue a (d) 3319 certificate of need to any hospital located in DeSoto County for 3320 the new construction of a skilled nursing facility, not to exceed one hundred twenty (120) beds, in DeSoto County. From and after 3321 3322 July 1, 1999, there shall be no prohibition or restrictions on participation in the Medicaid program (Section 43-13-101 et seq.) 3323 3324 for the beds in the nursing facility that were authorized under 3325 this paragraph (d).

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

3335 (f) The State Department of Health may issue a 3336 certificate of need for conversion of a county hospital facility

3326

3327

3328

3329

3330

3331

3332

3333

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

certificate of need for the construction or expansion of nursing facility beds or the conversion of other beds to nursing facility beds in either Hinds, Madison or Rankin County, not to exceed sixty (60) beds. From and after July 1, 1999, there shall be no prohibition or restrictions on participation in the Medicaid program (Section 43-13-101 et seq.) for the beds in the nursing facility that were authorized under this paragraph (g).

- (h) The State Department of Health may issue a certificate of need for the construction or expansion of nursing facility beds or the conversion of other beds to nursing facility beds in either Hancock, Harrison or Jackson County, not to exceed sixty (60) beds. From and after July 1, 1999, there shall be no prohibition or restrictions on participation in the Medicaid program (Section 43-13-101 et seq.) for the beds in the facility that were authorized under this paragraph (h).
- 3359 (i) The department may issue a certificate of need for the new construction of a skilled nursing facility in Leake
  3361 County, provided that the recipient of the certificate of need

3362	agrees in writing that the skilled nursing facility will not at
3363	any time participate in the Medicaid program (Section 43-13-101 et
3364	seq.) or admit or keep any patients in the skilled nursing
3365	facility who are participating in the Medicaid program. This
3366	written agreement by the recipient of the certificate of need
3367	shall be fully binding on any subsequent owner of the skilled
3368	nursing facility, if the ownership of the facility is transferred
3369	at any time after the issuance of the certificate of need.
3370	Agreement that the skilled nursing facility will not participate
3371	in the Medicaid program shall be a condition of the issuance of a
3372	certificate of need to any person under this paragraph (i), and if
3373	such skilled nursing facility at any time after the issuance of
3374	the certificate of need, regardless of the ownership of the
3375	facility, participates in the Medicaid program or admits or keeps
3376	any patients in the facility who are participating in the Medicaid
3377	program, the State Department of Health shall revoke the
3378	certificate of need, if it is still outstanding, and shall deny or
3379	revoke the license of the skilled nursing facility, at the time
3380	that the department determines, after a hearing complying with due
3381	process, that the facility has failed to comply with any of the
3382	conditions upon which the certificate of need was issued, as
3383	provided in this paragraph and in the written agreement by the
3384	recipient of the certificate of need. The provision of Section
3385	41-7-193(1) regarding substantial compliance of the projection of
3386	need as reported in the current State Health Plan is waived for

3387 the purposes of this paragraph. The total number of nursing 3388 facility beds that may be authorized by any certificate of need issued under this paragraph (i) shall not exceed sixty (60) beds. 3389 3390 If the skilled nursing facility authorized by the certificate of 3391 need issued under this paragraph is not constructed and fully 3392 operational within eighteen (18) months after July 1, 1994, the 3393 State Department of Health, after a hearing complying with due process, shall revoke the certificate of need, if it is still 3394 3395 outstanding, and shall not issue a license for the skilled nursing 3396 facility at any time after the expiration of the eighteen-month 3397 period.

3398 The department may issue certificates of need to ( i ) 3399 allow any existing freestanding long-term care facility in 3400 Tishomingo County and Hancock County that on July 1, 1995, is 3401 licensed with fewer than sixty (60) beds. For the purposes of 3402 this paragraph (j), the provisions of Section 41-7-193(1) 3403 requiring substantial compliance with the projection of need as 3404 reported in the current State Health Plan are waived. From and 3405 after July 1, 1999, there shall be no prohibition or restrictions 3406 on participation in the Medicaid program (Section 43-13-101 et 3407 seq.) for the beds in the long-term care facilities that were 3408 authorized under this paragraph (j).

3409 (k) The department may issue a certificate of need for 3410 the construction of a nursing facility at a continuing care 3411 retirement community in Lowndes County. The total number of beds

3412	that may be authorized under the authority of this paragraph (k)
3413	shall not exceed sixty (60) beds. From and after July 1, 2001,
3414	the prohibition on the facility participating in the Medicaid
3415	program (Section 43-13-101 et seq.) that was a condition of
3416	issuance of the certificate of need under this paragraph (k) shall
3417	be revised as follows: The nursing facility may participate in
3418	the Medicaid program from and after July 1, 2001, if the owner of
3419	the facility on July 1, 2001, agrees in writing that no more than
3420	thirty (30) of the beds at the facility will be certified for
3421	participation in the Medicaid program, and that no claim will be
3422	submitted for Medicaid reimbursement for more than thirty (30)
3423	patients in the facility in any month or for any patient in the
3424	facility who is in a bed that is not Medicaid-certified. This
3425	written agreement by the owner of the facility shall be a
3426	condition of licensure of the facility, and the agreement shall be
3427	fully binding on any subsequent owner of the facility if the
3428	ownership of the facility is transferred at any time after July 1,
3429	2001. After this written agreement is executed, the Division of
3430	Medicaid and the State Department of Health shall not certify more
3431	than thirty (30) of the beds in the facility for participation in
3432	the Medicaid program. If the facility violates the terms of the
3433	written agreement by admitting or keeping in the facility on a
3434	regular or continuing basis more than thirty (30) patients who are
3435	participating in the Medicaid program, the State Department of
3436	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.

- (1) 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.
- 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

3462	the nursing facility if the ownership of the nursing facility is
3463	transferred at any time after the issuance of the certificate of
3464	need. After this written agreement is executed, the Division of
3465	Medicaid and the State Department of Health shall not certify any
3466	of the beds in the nursing facility for participation in the
3467	Medicaid program. If the nursing facility violates the terms of
3468	the written agreement by admitting or keeping in the nursing
3469	facility on a regular or continuing basis any patients who are
3470	participating in the Medicaid program, the State Department of
3471	Health shall revoke the license of the nursing facility, at the
3472	time that the department determines, after a hearing complying
3473	with due process, that the nursing facility has violated the
3474	condition upon which the certificate of need was issued, as
3475	provided in this paragraph and in the written agreement. If the
3476	certificate of need authorized under this paragraph is not issued
3477	within twelve (12) months after July 1, 2001, the department shall
3478	deny the application for the certificate of need and shall not
3479	issue the certificate of need at any time after the twelve-month
3480	period, unless the issuance is contested. If the certificate of
3481	need is issued and substantial construction of the nursing
3482	facility beds has not commenced within eighteen (18) months after
3483	July 1, 2001, the State Department of Health, after a hearing
3484	complying with due process, shall revoke the certificate of need
3485	if it is still outstanding, and the department shall not issue a
3486	license for the nursing facility at any time after the

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

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

3492

3493

3494

3495

3496

3497

3498

3499

3500

3501

3502

3503

3504

3505

3506

3507

3508

3509

3510

3512	shall deny or revoke the license of the skilled nursing facility,
3513	at the time that the department determines, after a hearing
3514	complying with due process, that the facility has failed to comply
3515	with any of the conditions upon which the certificate of need was
3516	issued, as provided in this paragraph and in the written agreement
3517	by the recipient of the certificate of need. The total number of
3518	nursing facility beds that may be authorized by any certificate of
3519	need issued under this paragraph (n) shall not exceed sixty (60)
3520	beds. If the certificate of need authorized under this paragraph
3521	is not issued within twelve (12) months after July 1, 1998, the
3522	department shall deny the application for the certificate of need
3523	and shall not issue the certificate of need at any time after the
3524	twelve-month period, unless the issuance is contested. If the
3525	certificate of need is issued and substantial construction of the
3526	nursing facility beds has not commenced within eighteen (18)
3527	months after July 1, 1998, the State Department of Health, after a
3528	hearing complying with due process, shall revoke the certificate
3529	of need if it is still outstanding, and the department shall not
3530	issue a license for the nursing facility at any time after the
3531	eighteen-month period. However, if the issuance of the
3532	certificate of need is contested, the department shall require
3533	substantial construction of the nursing facility beds within six
3534	(6) months after final adjudication on the issuance of the
3535	certificate of need.

3536	(o) The department may issue a certificate of need for
3537	the new construction, addition or conversion of skilled nursing
3538	facility beds in Leake County, provided that the recipient of the
3539	certificate of need agrees in writing that the skilled nursing
3540	facility will not at any time participate in the Medicaid program
3541	(Section 43-13-101 et seq.) or admit or keep any patients in the
3542	skilled nursing facility who are participating in the Medicaid
3543	program. This written agreement by the recipient of the
3544	certificate of need shall be fully binding on any subsequent owner
3545	of the skilled nursing facility, if the ownership of the facility
3546	is transferred at any time after the issuance of the certificate
3547	of need. Agreement that the skilled nursing facility will not
3548	participate in the Medicaid program shall be a condition of the
3549	issuance of a certificate of need to any person under this
3550	paragraph (o), and if such skilled nursing facility at any time
3551	after the issuance of the certificate of need, regardless of the
3552	ownership of the facility, participates in the Medicaid program or
3553	admits or keeps any patients in the facility who are participating
3554	in the Medicaid program, the State Department of Health shall
3555	revoke the certificate of need, if it is still outstanding, and
3556	shall deny or revoke the license of the skilled nursing facility,
3557	at the time that the department determines, after a hearing
3558	complying with due process, that the facility has failed to comply
3559	with any of the conditions upon which the certificate of need was
3560	issued, as provided in this paragraph and in the written agreement

3561 by the recipient of the certificate of need. The total number of 3562 nursing facility beds that may be authorized by any certificate of need issued under this paragraph (o) shall not exceed sixty (60) 3563 3564 If the certificate of need authorized under this paragraph 3565 is not issued within twelve (12) months after July 1, 2001, the 3566 department shall deny the application for the certificate of need 3567 and shall not issue the certificate of need at any time after the 3568 twelve-month period, unless the issuance is contested. 3569 certificate of need is issued and substantial construction of the 3570 nursing facility beds has not commenced within eighteen (18) 3571 months after July 1, 2001, the State Department of Health, after a 3572 hearing complying with due process, shall revoke the certificate 3573 of need if it is still outstanding, and the department shall not issue a license for the nursing facility at any time after the 3574 3575 eighteen-month period. However, if the issuance of the 3576 certificate of need is contested, the department shall require 3577 substantial construction of the nursing facility beds within six (6) months after final adjudication on the issuance of the 3578 3579 certificate of need.

3580 (p) The department may issue a certificate of need for
3581 the construction of a municipally owned nursing facility within
3582 the Town of Belmont in Tishomingo County, not to exceed sixty (60)
3583 beds, provided that the recipient of the certificate of need
3584 agrees in writing that the skilled nursing facility will not at
3585 any time participate in the Medicaid program (Section 43-13-101 et

3586	seq.) or admit or keep any patients in the skilled nursing
3587	facility who are participating in the Medicaid program. This
3588	written agreement by the recipient of the certificate of need
3589	shall be fully binding on any subsequent owner of the skilled
3590	nursing facility, if the ownership of the facility is transferred
3591	at any time after the issuance of the certificate of need.
3592	Agreement that the skilled nursing facility will not participate
3593	in the Medicaid program shall be a condition of the issuance of a
3594	certificate of need to any person under this paragraph (p), and if
3595	such skilled nursing facility at any time after the issuance of
3596	the certificate of need, regardless of the ownership of the
3597	facility, participates in the Medicaid program or admits or keeps
3598	any patients in the facility who are participating in the Medicaid
3599	program, the State Department of Health shall revoke the
3600	certificate of need, if it is still outstanding, and shall deny or
3601	revoke the license of the skilled nursing facility, at the time
3602	that the department determines, after a hearing complying with due
3603	process, that the facility has failed to comply with any of the
3604	conditions upon which the certificate of need was issued, as
3605	provided in this paragraph and in the written agreement by the
3606	recipient of the certificate of need. The provision of Section
3607	41-7-193(1) regarding substantial compliance of the projection of
3608	need as reported in the current State Health Plan is waived for
3609	the purposes of this paragraph. If the certificate of need
3610	authorized under this paragraph is not issued within twelve (12)

3611	months after July 1, 1998, the department shall deny the
3612	application for the certificate of need and shall not issue the
3613	certificate of need at any time after the twelve-month period,
3614	unless the issuance is contested. If the certificate of need is
3615	issued and substantial construction of the nursing facility beds
3616	has not commenced within eighteen (18) months after July 1, 1998,
3617	the State Department of Health, after a hearing complying with due
3618	process, shall revoke the certificate of need if it is still
3619	outstanding, and the department shall not issue a license for the
3620	nursing facility at any time after the eighteen-month period.
3621	However, if the issuance of the certificate of need is contested,
3622	the department shall require substantial construction of the
3623	nursing facility beds within six (6) months after final
3624	adjudication on the issuance of the certificate of need.
3625	(q) (i) Beginning on July 1, 1999, the State
3626	Department of Health shall issue certificates of need during each
3627	of the next four (4) fiscal years for the construction or
3628	expansion of nursing facility beds or the conversion of other beds
3629	to nursing facility beds in each county in the state having a need
3630	for fifty (50) or more additional nursing facility beds, as shown
3631	in the fiscal year 1999 State Health Plan, in the manner provided
3632	in this paragraph (q). The total number of nursing facility beds
3633	that may be authorized by any certificate of need authorized under
3634	this paragraph (q) shall not exceed sixty (60) beds.

8635	(ii) Subject to the provisions of subparagraph
8636	(v), during each of the next four (4) fiscal years, the department
8637	shall issue six (6) certificates of need for new nursing facility
8638	beds, as follows: During fiscal years 2000, 2001 and 2002, one
8639	(1) certificate of need shall be issued for new nursing facility
8640	beds in the county in each of the four (4) Long-Term Care Planning
8641	Districts designated in the fiscal year 1999 State Health Plan
8642	that has the highest need in the district for those beds; and two
8643	(2) certificates of need shall be issued for new nursing facility
8644	beds in the two (2) counties from the state at large that have the
8645	highest need in the state for those beds, when considering the
8646	need on a statewide basis and without regard to the Long-Term Care
8647	Planning Districts in which the counties are located. During
8648	fiscal year 2003, one (1) certificate of need shall be issued for
8649	new nursing facility beds in any county having a need for fifty
8650	(50) or more additional nursing facility beds, as shown in the
8651	fiscal year 1999 State Health Plan, that has not received a
8652	certificate of need under this paragraph (q) during the three (3)
8653	previous fiscal years. During fiscal year 2000, in addition to
8654	the six (6) certificates of need authorized in this subparagraph,
8655	the department also shall issue a certificate of need for new
8656	nursing facility beds in Amite County and a certificate of need
8657	for new nursing facility beds in Carroll County.
8658	(iii) Subject to the provisions of subparagraph
8659	(v) the certificate of need issued under subnaragraph (ii) for

3660	nursing facility beds in each Long-Term Care Planning District
3661	during each fiscal year shall first be available for nursing
3662	facility beds in the county in the district having the highest
3663	need for those beds, as shown in the fiscal year 1999 State Health
3664	Plan. If there are no applications for a certificate of need for
3665	nursing facility beds in the county having the highest need for
3666	those beds by the date specified by the department, then the
3667	certificate of need shall be available for nursing facility beds
3668	in other counties in the district in descending order of the need
3669	for those beds, from the county with the second highest need to
3670	the county with the lowest need, until an application is received
3671	for nursing facility beds in an eligible county in the district.
3672	(iv) Subject to the provisions of subparagraph
3673	(v), the certificate of need issued under subparagraph (ii) for
3674	nursing facility beds in the two (2) counties from the state at
3675	large during each fiscal year shall first be available for nursing
3676	facility beds in the two (2) counties that have the highest need
3677	in the state for those beds, as shown in the fiscal year 1999
3678	State Health Plan, when considering the need on a statewide basis
3679	and without regard to the Long-Term Care Planning Districts in
3680	which the counties are located. If there are no applications for
3681	a certificate of need for nursing facility beds in either of the
3682	two (2) counties having the highest need for those beds on a
3683	statewide basis by the date specified by the department, then the
3684	certificate of need shall be available for nursing facility beds

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

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

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

3690

3691

3692

3693

3694

3695

3696

3697

3698

3699

3700

3701

3702

3703

3704

3705

3710	County,	and	one	(1)	of	the	applicants	is	а	count	y-owned	hosp	ital	
------	---------	-----	-----	-----	----	-----	------------	----	---	-------	---------	------	------	--

- 3711 located in the county where the nursing facility beds are
- 3712 available, the department shall give priority to the county-owned
- 3713 hospital in granting the certificate of need if the following
- 3714 conditions are met:
- 3715 1. The county-owned hospital fully meets all
- 3716 applicable criteria and standards required to obtain a certificate
- 3717 of need for the nursing facility beds; and
- 3718 2. The county-owned hospital's qualifications
- 3719 for the certificate of need, as shown in its application and as
- 3720 determined by the department, are at least equal to the
- 3721 qualifications of the other applicants for the certificate of
- 3722 need.
- 3723 (r) (i) Beginning on July 1, 1999, the State
- 3724 Department of Health shall issue certificates of need during each
- 3725 of the next two (2) fiscal years for the construction or expansion
- 3726 of nursing facility beds or the conversion of other beds to
- 3727 nursing facility beds in each of the four (4) Long-Term Care
- 3728 Planning Districts designated in the fiscal year 1999 State Health
- 3729 Plan, to provide care exclusively to patients with Alzheimer's
- 3730 disease.
- 3731 (ii) Not more than twenty (20) beds may be
- 3732 authorized by any certificate of need issued under this paragraph
- 3733 (r), and not more than a total of sixty (60) beds may be
- 3734 authorized in any Long-Term Care Planning District by all

3736 the total number of beds that may be authorized by all certificates of need issued under this paragraph (r) during any 3737 3738 fiscal year shall not exceed one hundred twenty (120) beds, and 3739 the total number of beds that may be authorized in any Long-Term 3740 Care Planning District during any fiscal year shall not exceed forty (40) beds. Of the certificates of need that are issued for 3741 3742 each Long-Term Care Planning District during the next two (2) 3743 fiscal years, at least one (1) shall be issued for beds in the 3744 northern part of the district, at least one (1) shall be issued 3745 for beds in the central part of the district, and at least one (1) 3746 shall be issued for beds in the southern part of the district. 3747 (iii) The State Department of Health, in consultation with the Department of Mental Health and the Division 3748 3749 of Medicaid, shall develop and prescribe the staffing levels, 3750 space requirements and other standards and requirements that must 3751 be met with regard to the nursing facility beds authorized under 3752 this paragraph (r) to provide care exclusively to patients with 3753 Alzheimer's disease.

certificates of need issued under this paragraph (r). However,

3754 (s) The State Department of Health may issue a
3755 certificate of need to a nonprofit skilled nursing facility using
3756 the Green House model of skilled nursing care and located in Yazoo
3757 City, Yazoo County, Mississippi, for the construction, expansion
3758 or conversion of not more than nineteen (19) nursing facility
3759 beds. For purposes of this paragraph (s), the provisions of

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

3767 The State Department of Health shall issue 3768 certificates of need to the owner of a nursing facility in operation at the time of Hurricane Katrina in Hancock County that 3769 was not operational on December 31, 2005, because of damage 3770 3771 sustained from Hurricane Katrina to authorize the following: 3772 the construction of a new nursing facility in Harrison County; 3773 (ii) the relocation of forty-nine (49) nursing facility beds from 3774 the Hancock County facility to the new Harrison County facility; 3775 (iii) the establishment of not more than twenty (20) non-Medicaid 3776 nursing facility beds at the Hancock County facility; and (iv) the 3777 establishment of not more than twenty (20) non-Medicaid beds at 3778 the new Harrison County facility. The certificates of need that 3779 authorize the non-Medicaid nursing facility beds under 3780 subparagraphs (iii) and (iv) of this paragraph (t) shall be 3781 subject to the following conditions: The owner of the Hancock 3782 County facility and the new Harrison County facility must agree in 3783 writing that no more than fifty (50) of the beds at the Hancock County facility and no more than forty-nine (49) of the beds at 3784

3785	the Harrison County facility will be certified for participation
3786	in the Medicaid program, and that no claim will be submitted for
3787	Medicaid reimbursement for more than fifty (50) patients in the
3788	Hancock County facility in any month, or for more than forty-nine
3789	(49) patients in the Harrison County facility in any month, or for
3790	any patient in either facility who is in a bed that is not
3791	Medicaid-certified. This written agreement by the owner of the
3792	nursing facilities shall be a condition of the issuance of the
3793	certificates of need under this paragraph (t), and the agreement
3794	shall be fully binding on any later owner or owners of either
3795	facility if the ownership of either facility is transferred at any
3796	time after the certificates of need are issued. After this
3797	written agreement is executed, the Division of Medicaid and the
3798	State Department of Health shall not certify more than fifty (50)
3799	of the beds at the Hancock County facility or more than forty-nine
3800	(49) of the beds at the Harrison County facility for participation
3801	in the Medicaid program. If the Hancock County facility violates
3802	the terms of the written agreement by admitting or keeping in the
3803	facility on a regular or continuing basis more than fifty (50)
3804	patients who are participating in the Medicaid program, or if the
3805	Harrison County facility violates the terms of the written
3806	agreement by admitting or keeping in the facility on a regular or
3807	continuing basis more than forty-nine (49) patients who are
3808	participating in the Medicaid program, the State Department of
3809	Health shall revoke the license of the facility that is in

3810 violation of the agreement, at the time that the department 3811 determines, after a hearing complying with due process, that the facility has violated the agreement. 3812

(u) The State Department of Health shall issue a certificate of need to a nonprofit venture for the establishment, construction and operation of a skilled nursing facility of not more than sixty (60) beds to provide skilled nursing care for ventilator dependent or otherwise medically dependent pediatric patients who require medical and nursing care or rehabilitation services to be located in a county in which an academic medical center and a children's hospital are located, and for any construction and for the acquisition of equipment related to those The facility shall be authorized to keep such ventilator dependent or otherwise medically dependent pediatric patients beyond age twenty-one (21) in accordance with regulations of the State Board of Health. For purposes of this paragraph (u), 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, and the provisions of Section 41-7-197 requiring a formal certificate of need hearing process are waived. The beds authorized by this paragraph shall be counted as pediatric skilled nursing facility beds for health planning purposes under Section 41-7-171 et seq. There shall be no prohibition of or restrictions on participation in the Medicaid

3813

3814

3815

3816

3817

3818

3819

3820

3821

3822

3823

3824

3825

3826

3827

3828

3829

3830

3831

3832

3834 program for the person receiving the certificate of need 3835 authorized by this paragraph.

- 3836 The State Department of Health may grant approval for 3837 and issue certificates of need to any person proposing the new 3838 construction of, addition to, conversion of beds of or expansion 3839 of any health care facility defined in subparagraph (x) 3840 (psychiatric residential treatment facility) of Section 41-7-173(h). The total number of beds which may be authorized by 3841 3842 such certificates of need shall not exceed three hundred thirty-four (334) beds for the entire state. 3843
- Of the total number of beds authorized under this 3844 (a) 3845 subsection, the department shall issue a certificate of need to a 3846 privately owned psychiatric residential treatment facility in 3847 Simpson County for the conversion of sixteen (16) intermediate care facility for individuals with intellectual disabilities 3848 3849 (ICF-IID) beds to psychiatric residential treatment facility beds, 3850 provided that facility agrees in writing that the facility shall 3851 give priority for the use of those sixteen (16) beds to 3852 Mississippi residents who are presently being treated in out-of-state facilities. 3853
- 3854 (b) Of the total number of beds authorized under this
  3855 subsection, the department may issue a certificate or certificates
  3856 of need for the construction or expansion of psychiatric
  3857 residential treatment facility beds or the conversion of other
  3858 beds to psychiatric residential treatment facility beds in Warren

3859	County, not to exceed sixty (60) psychiatric residential treatment
3860	facility beds, provided that the facility agrees in writing that
3861	no more than thirty (30) of the beds at the psychiatric
3862	residential treatment facility will be certified for participation
3863	in the Medicaid program (Section 43-13-101 et seq.) for the use of
3864	any patients other than those who are participating only in the
3865	Medicaid program of another state, and that no claim will be
3866	submitted to the Division of Medicaid for Medicaid reimbursement
3867	for more than thirty (30) patients in the psychiatric residential
3868	treatment facility in any day or for any patient in the
3869	psychiatric residential treatment facility who is in a bed that is
3870	not Medicaid-certified. This written agreement by the recipient
3871	of the certificate of need shall be a condition of the issuance of
3872	the certificate of need under this paragraph, and the agreement
3873	shall be fully binding on any subsequent owner of the psychiatric
3874	residential treatment facility if the ownership of the facility is
3875	transferred at any time after the issuance of the certificate of
3876	need. After this written agreement is executed, the Division of
3877	Medicaid and the State Department of Health shall not certify more
3878	than thirty (30) of the beds in the psychiatric residential
3879	treatment facility for participation in the Medicaid program for
3880	the use of any patients other than those who are participating
3881	only in the Medicaid program of another state. If the psychiatric
3882	residential treatment facility violates the terms of the written
3883	agreement by admitting or keeping in the facility on a regular or

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

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

- (c) Of the total number of beds authorized under this subsection, the department shall issue a certificate of need to a hospital currently operating Medicaid-certified acute psychiatric beds for adolescents in DeSoto County, for the establishment of a forty-bed psychiatric residential treatment facility in DeSoto County \* \* . There shall be no prohibition or restrictions on participation in the Medicaid program (Section 43-13-101 et seq.) for the person(s) receiving the certificate of need authorized under this paragraph (c) or for the beds converted pursuant to the authority of that certificate of need that would not apply to any other psychiatric residential treatment facility.
- 3906 (d) Of the total number of beds authorized under this 3907 subsection, the department may issue a certificate or certificates 3908 of need for the construction or expansion of psychiatric

3891

3892

3893

3894

3895

3896

3897

3898

3899

3900

3901

3902

3903

3904

3910 beds to psychiatric treatment facility beds, not to exceed thirty (30) psychiatric residential treatment facility beds, in either 3911 Alcorn, Tishomingo, Prentiss, Lee, Itawamba, Monroe, Chickasaw, 3912 3913 Pontotoc, Calhoun, Lafayette, Union, Benton or Tippah County. 3914 Of the total number of beds authorized under this 3915 subsection (3) the department shall issue a certificate of need to 3916 a privately owned, nonprofit psychiatric residential treatment 3917 facility in Hinds County for an eight-bed expansion of the 3918 facility, provided that the facility agrees in writing that the 3919 facility shall give priority for the use of those eight (8) beds 3920 to Mississippi residents who are presently being treated in 3921 out-of-state facilities. 3922 The department shall issue a certificate of need to 3923 a one-hundred-thirty-four-bed specialty hospital located on 3924 twenty-nine and forty-four one-hundredths (29.44) commercial acres 3925 at 5900 Highway 39 North in Meridian (Lauderdale County), 3926 Mississippi, for the addition, construction or expansion of 3927 child/adolescent psychiatric residential treatment facility beds 3928 in Lauderdale County. As a condition of issuance of the 3929 certificate of need under this paragraph, the facility shall give 3930 priority in admissions to the child/adolescent psychiatric 3931 residential treatment facility beds authorized under this

residential treatment facility beds or the conversion of other

paragraph to patients who otherwise would require out-of-state

placement. The Division of Medicaid, in conjunction with the

3932

3933

3934 Department of Human Services, shall furnish the facility a list of 3935 all out-of-state patients on a quarterly basis. Furthermore, notice shall also be provided to the parent, custodial parent or 3936 quardian of each out-of-state patient notifying them of the 3937 3938 priority status granted by this paragraph. For purposes of this 3939 paragraph, the provisions of Section 41-7-193(1) requiring 3940 substantial compliance with the projection of need as reported in 3941 the current State Health Plan are waived. The total number of 3942 child/adolescent psychiatric residential treatment facility beds 3943 that may be authorized under the authority of this paragraph shall 3944 be sixty (60) beds. There shall be no prohibition or restrictions on participation in the Medicaid program (Section 43-13-101 et 3945 3946 seq.) for the person receiving the certificate of need authorized under this paragraph or for the beds converted pursuant to the 3947 authority of that certificate of need. 3948

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

3949

3950

3951

3952

3953

3954

3955

3956

3957

3959 for the person(s) receiving the certificate(s) of need authorized 3960 under this paragraph (a) or for the beds converted pursuant to the authority of that certificate of need. In issuing any new 3961 certificate of need for any child/adolescent psychiatric or 3962 3963 child/adolescent chemical dependency beds, either by new 3964 construction or conversion of beds of another category, the department shall give preference to beds which will be located in 3965 3966 an area of the state which does not have such beds located in it, 3967 and to a location more than sixty-five (65) miles from existing 3968 beds. Upon receiving 2020 census data, the department may amend 3969 the State Health Plan regarding child/adolescent psychiatric and 3970 child/adolescent chemical dependency beds to reflect the need 3971 based on new census data.

3972 (i) [Deleted]

3973

3974

3975

3976

3977

3978

3979

3980

3981

3982

3983

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

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

3986 (iii) The department may issue a certificate or 3987 certificates of need for the construction or expansion of 3988 child/adolescent psychiatric beds or the conversion of other beds 3989 to child/adolescent psychiatric beds in Warren County. 3990 purposes of this subparagraph (iii), the provisions of Section 41-7-193(1) requiring substantial compliance with the projection 3991 3992 of need as reported in the current State Health Plan are waived. 3993 The total number of beds that may be authorized under the 3994 authority of this subparagraph shall not exceed twenty (20) beds. 3995 There shall be no prohibition or restrictions on participation in 3996 the Medicaid program (Section 43-13-101 et seq.) for the person 3997 receiving the certificate of need authorized under this 3998 subparagraph or for the beds converted pursuant to the authority 3999 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

4000

4001

4002

4003

4004

4005

4006

4007

authorize the construction, expansion or conversion of the beds 4010 authorized under this subparagraph.

The department shall issue a certificate of 4011 4012 need to the Region 7 Mental Health/Retardation Commission for the 4013 construction or expansion of child/adolescent psychiatric beds or 4014 the conversion of other beds to child/adolescent psychiatric beds in any of the counties served by the commission. For purposes of 4015 4016 this subparagraph (iv), the provisions of Section 41-7-193(1) 4017 requiring substantial compliance with the projection of need as 4018 reported in the current State Health Plan are waived. The total 4019 number of beds that may be authorized under the authority of this 4020 subparagraph shall not exceed twenty (20) beds. There shall be no 4021 prohibition or restrictions on participation in the Medicaid 4022 program (Section 43-13-101 et seq.) for the person receiving the 4023 certificate of need authorized under this subparagraph or for the 4024 beds converted pursuant to the authority of that certificate of 4025 need.

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

4026

4027

4028

4029

4030

4031

4032

4034	participating in the Medicaid program in any of such adult
4035	psychiatric beds. This written agreement by the recipient of the
4036	certificate of need shall be fully binding on any subsequent owner
4037	of the hospital if the ownership of the hospital is transferred at
4038	any time after the issuance of the certificate of need. Agreement
4039	that the adult psychiatric beds will not be certified for
4040	participation in the Medicaid program shall be a condition of the
4041	issuance of a certificate of need to any person under this
4042	subparagraph (v), and if such hospital at any time after the
4043	issuance of the certificate of need, regardless of the ownership
4044	of the hospital, has any of such adult psychiatric beds certified
4045	for participation in the Medicaid program or admits or keeps any
4046	Medicaid patients in such adult psychiatric beds, the State
4047	Department of Health shall revoke the certificate of need, if it
4048	is still outstanding, and shall deny or revoke the license of the
4049	hospital at the time that the department determines, after a
4050	hearing complying with due process, that the hospital has failed
4051	to comply with any of the conditions upon which the certificate of
4052	need was issued, as provided in this subparagraph and in the
4053	written agreement by the recipient of the certificate of need.
4054	(vi) The department may issue a certificate or
4055	certificates of need for the expansion of child psychiatric beds
4056	or the conversion of other beds to child psychiatric beds at the
4057	University of Mississippi Medical Center. For purposes of this

subparagraph (vi), the provisions of Section 41-7-193(1) requiring

4059 substantial compliance with the projection of need as reported in 4060 the current State Health Plan are waived. The total number of 4061 beds that may be authorized under the authority of this 4062 subparagraph shall not exceed fifteen (15) beds. There shall be 4063 no prohibition or restrictions on participation in the Medicaid 4064 program (Section 43-13-101 et seq.) for the hospital receiving the 4065 certificate of need authorized under this subparagraph or for the 4066 beds converted pursuant to the authority of that certificate of 4067 need.

- 4068 From and after July 1, 1990, no hospital, (b) 4069 psychiatric hospital or chemical dependency hospital shall be 4070 authorized to add any child/adolescent psychiatric or 4071 child/adolescent chemical dependency beds or convert any beds of 4072 another category to child/adolescent psychiatric or 4073 child/adolescent chemical dependency beds without a certificate of 4074 need under the authority of subsection (1)(c) and subsection 4075 (4) (a) of this section.
- 4076 (5) The department may issue a certificate of need to a
  4077 county hospital in Winston County for the conversion of fifteen
  4078 (15) acute care beds to geriatric psychiatric care beds.
- 4079 (6) The State Department of Health shall issue a certificate
  4080 of need to a Mississippi corporation qualified to manage a
  4081 long-term care hospital as defined in Section 41-7-173(h)(xii) in
  4082 Harrison County, not to exceed eighty (80) beds, including any
  4083 necessary renovation or construction required for licensure and

4084 certification, provided that the recipient of the certificate of 4085 need agrees in writing that the long-term care hospital will not 4086 at any time participate in the Medicaid program (Section 43-13-101 4087 et seq.) \* \* \* except as a crossover enrolled provider. 4088 written agreement by the recipient of the certificate of need 4089 shall be fully binding on any subsequent owner of the long-term 4090 care hospital, if the ownership of the facility is transferred at 4091 any time after the issuance of the certificate of need. Agreement 4092 that the long-term care hospital will not participate in the 4093 Medicaid program except as a crossover enrolled provider shall be a condition of the issuance of a certificate of need to any person 4094 4095 under this subsection (6), and if such long-term care hospital at 4096 any time after the issuance of the certificate of need, regardless 4097 of the ownership of the facility, participates in the Medicaid 4098 program \* \* \* except as a crossover enrolled provider, the State 4099 Department of Health shall revoke the certificate of need, if it 4100 is still outstanding, and shall deny or revoke the license of the long-term care hospital, at the time that the department 4101 4102 determines, after a hearing complying with due process, that the 4103 facility has failed to comply with any of the conditions upon 4104 which the certificate of need was issued, as provided in this 4105 subsection and in the written agreement by the recipient of the 4106 certificate of need. For purposes of this subsection, the provisions of Section 41-7-193(1) requiring substantial compliance 4107 4108 with the projection of need as reported in the current State

4109	Health Plan are waived.	This subsection	(6)	shall	be	retroactive
4110	to July 1, 2023.					

4111	(7) The State Department of Health may issue a certificate
4112	of need to any hospital in the state to utilize a portion of its
4113	beds for the "swing-bed" concept. Any such hospital must be in
4114	conformance with the federal regulations regarding such swing-bed
4115	concept at the time it submits its application for a certificate
4116	of need to the State Department of Health, except that such
4117	hospital may have more licensed beds or a higher average daily
4118	census (ADC) than the maximum number specified in federal
4119	regulations for participation in the swing-bed program. Any
4120	hospital meeting all federal requirements for participation in the
4121	swing-bed program which receives such certificate of need shall
4122	render services provided under the swing-bed concept to any
4123	patient eligible for Medicare (Title XVIII of the Social Security
4124	Act) who is certified by a physician to be in need of such
4125	services, and no such hospital shall permit any patient who is
4126	eligible for both Medicaid and Medicare or eligible only for
4127	Medicaid to stay in the swing beds of the hospital for more than
4128	thirty (30) days per admission unless the hospital receives prior
4129	approval for such patient from the Division of Medicaid, Office of
4130	the Governor. Any hospital having more licensed beds or a higher
4131	average daily census (ADC) than the maximum number specified in
4132	federal regulations for participation in the swing-bed program
4133	which receives such certificate of need shall develop a procedure

4134 to ensure that before a patient is allowed to stay in the swing 4135 beds of the hospital, there are no vacant nursing home beds available for that patient located within a fifty-mile radius of 4136 the hospital. When any such hospital has a patient staying in the 4137 4138 swing beds of the hospital and the hospital receives notice from a 4139 nursing home located within such radius that there is a vacant bed available for that patient, the hospital shall transfer the 4140 4141 patient to the nursing home within a reasonable time after receipt 4142 of the notice. Any hospital which is subject to the requirements 4143 of the two (2) preceding sentences of this subsection may be 4144 suspended from participation in the swing-bed program for a reasonable period of time by the State Department of Health if the 4145 4146 department, after a hearing complying with due process, determines that the hospital has failed to comply with any of those 4147 4148 requirements.

4149 The Department of Health shall not grant approval for or 4150 issue a certificate of need to any person proposing the new construction of, addition to or expansion of a health care 4151 4152 facility as defined in subparagraph (viii) of Section 41-7-173(h), 4153 except as hereinafter provided: Effective July 1, 2025, the 4154 department \* \* \* shall issue a certificate of need to a nonprofit 4155 corporation located in Madison County, Mississippi, for the construction, expansion or conversion of not more than \* \* \* forty 4156 (40) beds in a community living program for developmentally 4157 disabled adults in a facility as defined in subparagraph (viii) of 4158

- 4159 Section 41-7-173(h). For purposes of this subsection (8), the provisions of Section 41-7-193(1) requiring substantial compliance 4160 4161 with the projection of need as reported in the current State Health Plan and the provisions of Section 41-7-197 requiring a 4162 4163 formal certificate of need hearing process are waived. 4164 shall be no prohibition or restrictions on participation in the 4165 Medicaid program for the person receiving the certificate of need 4166 authorized under this subsection (8).
- 4167 The Department of Health shall not grant approval for or 4168 issue a certificate of need to any person proposing the 4169 establishment of, or expansion of the currently approved territory 4170 of, or the contracting to establish a home office, subunit or 4171 branch office within the space operated as a health care facility 4172 as defined in Section 41-7-173(h)(i) through (viii) by a health 4173 care facility as defined in subparagraph (ix) of Section 4174 41-7-173(h).
- 4175 (10) Health care facilities owned and/or operated by the 4176 state or its agencies are exempt from the restraints in this 4177 section against issuance of a certificate of need if such addition or expansion consists of repairing or renovation necessary to 4178 4179 comply with the state licensure law. This exception shall not 4180 apply to the new construction of any building by such state 4181 facility. This exception shall not apply to any health care facilities owned and/or operated by counties, municipalities, 4182

4183 districts, unincorporated areas, other defined persons, or any 4184 combination thereof.

4185 The new construction, renovation or expansion of or 4186 addition to any health care facility defined in subparagraph (ii) 4187 (psychiatric hospital), subparagraph (iv) (skilled nursing 4188 facility), subparagraph (vi) (intermediate care facility), subparagraph (viii) (intermediate care facility for individuals 4189 4190 with intellectual disabilities) and subparagraph (x) (psychiatric 4191 residential treatment facility) of Section 41-7-173(h) which is 4192 owned by the State of Mississippi and under the direction and 4193 control of the State Department of Mental Health, and the addition 4194 of new beds or the conversion of beds from one category to another 4195 in any such defined health care facility which is owned by the 4196 State of Mississippi and under the direction and control of the 4197 State Department of Mental Health, shall not require the issuance 4198 of a certificate of need under Section 41-7-171 et seq., 4199 notwithstanding any provision in Section 41-7-171 et seq. to the 4200 contrary.

4201 (12) The new construction, renovation or expansion of or
4202 addition to any veterans homes or domiciliaries for eligible
4203 veterans of the State of Mississippi as authorized under Section
4204 35-1-19 shall not require the issuance of a certificate of need,
4205 notwithstanding any provision in Section 41-7-171 et seq. to the
4206 contrary.

4207	(13) The repair or the rebuilding of an existing, operating
4208	health care facility that sustained significant damage from a
4209	natural disaster that occurred after April 15, 2014, in an area
4210	that is proclaimed a disaster area or subject to a state of
4211	emergency by the Governor or by the President of the United States
4212	shall be exempt from all of the requirements of the Mississippi
4213	Certificate of Need Law (Section 41-7-171 et seq.) and any and all
4214	rules and regulations promulgated under that law, subject to the
4215	following conditions:

- (a) The repair or the rebuilding of any such damaged health care facility must be within one (1) mile of the pre-disaster location of the campus of the damaged health care facility, except that any temporary post-disaster health care facility operating location may be within five (5) miles of the pre-disaster location of the damaged health care facility;
- (b) The repair or the rebuilding of the damaged health care facility (i) does not increase or change the complement of its bed capacity that it had before the Governor's or the President's proclamation, (ii) does not increase or change its levels and types of health care services that it provided before the Governor's or the President's proclamation, and (iii) does not rebuild in a different county; however, this paragraph does not restrict or prevent a health care facility from decreasing its bed capacity that it had before the Governor's or the President's proclamation, or from decreasing the levels of or decreasing or

4232	eliminating the types of health care services that it provided
4233	before the Governor's or the President's proclamation, when the
4234	damaged health care facility is repaired or rebuilt;

- (c) The exemption from Certificate of Need Law provided under this subsection (13) is valid for only five (5) years from the date of the Governor's or the President's proclamation. If actual construction has not begun within that five-year period, the exemption provided under this subsection is inapplicable; and
- (d) The Division of Health Facilities Licensure and
  Certification of the State Department of Health shall provide the
  same oversight for the repair or the rebuilding of the damaged
  health care facility that it provides to all health care facility
  construction projects in the state.
- For the purposes of this subsection (13), "significant damage" to a health care facility means damage to the health care facility requiring an expenditure of at least One Million Dollars (\$1,000,000.00).
- 4249 The State Department of Health shall issue a 4250 certificate of need to any hospital which is currently licensed 4251 for two hundred fifty (250) or more acute care beds and is located 4252 in any general hospital service area not having a comprehensive 4253 cancer center, for the establishment and equipping of such a 4254 center which provides facilities and services for outpatient 4255 radiation oncology therapy, outpatient medical oncology therapy, 4256 and appropriate support services including the provision of

4235

4236

4237

4238

radiation therapy services. The provisions of Section 41-7-193(1)
regarding substantial compliance with the projection of need as
reported in the current State Health Plan are waived for the
purpose of this subsection.

4261 (15) The State Department of Health may authorize the
4262 transfer of hospital beds, not to exceed sixty (60) beds, from the
4263 North Panola Community Hospital to the South Panola Community
4264 Hospital. The authorization for the transfer of those beds shall
4265 be exempt from the certificate of need review process.

4266 (16)The State Department of Health shall issue any 4267 certificates of need necessary for Mississippi State University 4268 and a public or private health care provider to jointly acquire 4269 and operate a linear accelerator and a magnetic resonance imaging 4270 Those certificates of need shall cover all capital 4271 expenditures related to the project between Mississippi State 4272 University and the health care provider, including, but not 4273 limited to, the acquisition of the linear accelerator, the 4274 magnetic resonance imaging unit and other radiological modalities; 4275 the offering of linear accelerator and magnetic resonance imaging 4276 services; and the cost of construction of facilities in which to 4277 locate these services. The linear accelerator and the magnetic 4278 resonance imaging unit shall be (a) located in the City of Starkville, Oktibbeha County, Mississippi; (b) operated jointly by 4279 4280 Mississippi State University and the public or private health care provider selected by Mississippi State University through a 4281

4282 request for proposals (RFP) process in which Mississippi State 4283 University selects, and the Board of Trustees of State Institutions of Higher Learning approves, the health care provider 4284 4285 that makes the best overall proposal; (c) available to Mississippi 4286 State University for research purposes two-thirds (2/3) of the 4287 time that the linear accelerator and magnetic resonance imaging 4288 unit are operational; and (d) available to the public or private 4289 health care provider selected by Mississippi State University and 4290 approved by the Board of Trustees of State Institutions of Higher Learning one-third (1/3) of the time for clinical, diagnostic and 4291 4292 treatment purposes. For purposes of this subsection, the 4293 provisions of Section 41-7-193(1) requiring substantial compliance 4294 with the projection of need as reported in the current State 4295 Health Plan are waived.

The State Department of Health shall issue a 4296 4297 certificate of need for the construction of an acute care hospital 4298 in Kemper County, not to exceed twenty-five (25) beds, which shall be named the "John C. Stennis Memorial Hospital." In issuing the 4299 certificate of need under this subsection, the department shall 4300 4301 give priority to a hospital located in Lauderdale County that has 4302 two hundred fifteen (215) beds. For purposes of this subsection, 4303 the provisions of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in the current 4304 4305 State Health Plan and the provisions of Section 41-7-197 requiring a formal certificate of need hearing process are waived. 4306

shall be no prohibition or restrictions on participation in the

Medicaid program (Section 43-13-101 et seq.) for the person or

entity receiving the certificate of need authorized under this

subsection or for the beds constructed under the authority of that

certificate of need.

- 4312 (18)The planning, design, construction, renovation, addition, furnishing and equipping of a clinical research unit at 4313 4314 any health care facility defined in Section 41-7-173(h) that is 4315 under the direction and control of the University of Mississippi Medical Center and located in Jackson, Mississippi, and the 4316 addition of new beds or the conversion of beds from one (1) 4317 category to another in any such clinical research unit, shall not 4318 4319 require the issuance of a certificate of need under Section 4320 41-7-171 et seq., notwithstanding any provision in Section 4321 41-7-171 et seq. to the contrary.
- 4323 (20) Nothing in this section or in any other provision of

[Repealed]

- Section 41-7-171 et seq. shall prevent any nursing facility from designating an appropriate number of existing beds in the facility as beds for providing care exclusively to patients with Alzheimer's disease.
- 4328 (21) Nothing in this section or any other provision of
  4329 Section 41-7-171 et seq. shall prevent any health care facility
  4330 from the new construction, renovation, conversion or expansion of
  4331 new beds in the facility designated as intensive care units,

(19)

- 4332 negative pressure rooms, or isolation rooms pursuant to the
- 4333 provisions of Sections 41-14-1 through 41-14-11, or Section
- 4334 41-14-31. For purposes of this subsection, the provisions of
- 4335 Section 41-7-193(1) requiring substantial compliance with the
- 4336 projection of need as reported in the current State Health Plan
- 4337 and the provisions of Section 41-7-197 requiring a formal
- 4338 certificate of need hearing process are waived.
- 4339 **SECTION 14.** The following shall be codified as Section
- 4340 83-9-47, Mississippi Code of 1972:
- 4341 83-9-47. (1) An insurer providing coverage for prescription
- 4342 drugs shall not require or impose any step therapy protocol with
- 4343 respect to a drug that is approved by the United States Food and
- 4344 Drug Administration for the treatment of postpartum depression.
- 4345 (2) As used in this section, "insurer" means any hospital,
- 4346 health or medical expense insurance policy, hospital or medical
- 4347 service contract, employee welfare benefit plan, contract or
- 4348 agreement with a health maintenance organization or a preferred
- 4349 provider organization, health and accident insurance policy, or
- 4350 any other insurance contract of this type, including a group
- 4351 insurance plan. However, the term "insurer" does not include a
- 4352 preferred provider organization that is only a network of
- 4353 providers and does not define health care benefits for the purpose
- 4354 of coverage under a health care benefits plan.
- 4355 **SECTION 15.** The following shall be codified as Section
- 4356 41-140-1, Mississippi Code of 1972:

4357	41-140-1. Definitions.	(1) "Maternal health care facility"
4358	means any facility that provi	des prenatal or perinatal care,
4359	including, but not limited to	, hospitals, clinics and other
4360	physician facilities.	

- 4361 (2) "Maternal health care provider" means any physician,
  4362 nurse or other authorized practitioner that attends to pregnant
  4363 women and mothers of infants.
- 4364 **SECTION 16.** The following shall be codified as Section 4365 41-140-3, Mississippi Code of 1972:
- 4366 <u>41-140-3.</u> Education and awareness. (1) The State
  4367 Department of Health shall develop written educational materials
  4368 and information for health care professionals and patients about
  4369 maternal mental health conditions, including postpartum
  4370 depression.
- 4371 (a) The materials shall include information on the 4372 symptoms and methods of coping with postpartum depression, as well 4373 treatment options and resources;
- 4374 (b) The State Department of Health shall periodically
  4375 review the materials and information to determine their
  4376 effectiveness and ensure they reflect the most up-to-date and
  4377 accurate information;
- 4378 (c) The State Department of Health shall post on its 4379 website the materials and information; and

4380	(d)	The State	Departm	nent of	Health	shall make	available	3
4381	or distribute	the materi	als and	informa	tion in	physical	form upon	
4382	request.							

- 4383 (2) Hospitals that provide birth services shall provide
  4384 departing new parents and other family members, as appropriate,
  4385 with written materials and information developed under subsection
  4386 (1) of this section, upon discharge from such institution.
- 4387 (3) Any facility, physician, health care provider or nurse
  4388 midwife who renders prenatal care, postnatal care, or pediatric
  4389 infant care, shall provide the materials and information developed
  4390 under subsection (1)(a) of this section, to any woman who presents
  4391 with signs of a maternal mental health disorder.
- 4392 **SECTION 17.** The following shall be codified as Section 4393 41-140-5, Mississippi Code of 1972:
- 4394 41-140-5. Screening and linkage to care. (1) 4395 physician, health care provider, or nurse midwife who renders 4396 postnatal care or who provides pediatric infant care shall ensure 4397 that the postnatal care patient or birthing mother of the 4398 pediatric infant care patient, as applicable, is offered screening 4399 for postpartum depression, and, if such patient or birthing mother 4400 does not object to such screening, shall ensure that such patient 4401 or birthing mother is appropriately screened for postpartum 4402 depression in line with evidence-based guidelines, such as the 4403 Bright Futures Toolkit developed by the American Academy of Pediatrics. 4404

4405	(2) If a health care provider administering screening in
4406	accordance with this section determines, based on the screening
4407	methodology administered, that the postnatal care patient or
4408	birthing mother of the pediatric infant care patient is likely to
4409	be suffering from postpartum depression, such health care provider
4410	shall provide appropriate referrals, including discussion of
4411	available treatments for postpartum depression, including
4412	pharmacological treatments.

- SECTION 18. The following shall be codified as Section 83-9-48, Mississippi Code of 1972:
- 4415 83-9-48. Coverage of screening for postpartum depression.
- 4416 (1) An insurer shall provide coverage for postpartum depression
  4417 screening required pursuant to Section 41-140-3. Such coverage
  4418 shall provide for additional reimbursement for the administration
  4419 of postpartum depression screening adequate to compensate the
  4420 health care provider for the provision of such screening and
  4421 consistent with ensuring broad access to postpartum depression
  4422 screening in line with evidence-based guidelines.
  - (2) As used in this section, "insurer" means any hospital, health or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, contract or agreement with a health maintenance organization or a preferred provider organization, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan. However, the term "insurer" does not include a

4423

4424

4425

4426

4427

4428

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.

4433 <u>SECTION 19.</u> Section 43-13-107, Mississippi Code of 1972, is 4434 amended as follows:

435 43-13-107. (1) The Division of Medicaid is created in the
436 Office of the Governor and established to administer this article
437 and perform such other duties as are prescribed by law.

4438 The Governor shall appoint a full-time executive (2) (a) 4439 director, with the advice and consent of the Senate, who shall be 4440 either (i) a physician with administrative experience in a medical 4441 care or health program, or (ii) a person holding a graduate degree 4442 in medical care administration, public health, hospital administration, or the equivalent, or (iii) a person holding a 4443 4444 bachelor's degree with at least three (3) years' experience in 4445 management-level administration of, or policy development for, 4446 Medicaid programs. Provided, however, no one who has been a member of the Mississippi Legislature during the previous three 4447 4448 (3) years may be executive director. The executive director shall 4449 be the official secretary and legal custodian of the records of 4450 the division; shall be the agent of the division for the purpose 4451 of receiving all service of process, summons and notices directed to the division; shall perform such other duties as the Governor 4452 may prescribe from time to time; and shall perform all other 4453 4454 duties that are now or may be imposed upon him or her by law.

4455		(b	) T	he	executive	director	shall	serve	at	the	will	and
4456	pleasure	of	the (	Gov	vernor.							

- 4457 The executive director shall, before entering upon the discharge of the duties of the office, take and subscribe to 4458 4459 the oath of office prescribed by the Mississippi Constitution and 4460 shall file the same in the Office of the Secretary of State, and 4461 shall execute a bond in some surety company authorized to do 4462 business in the state in the penal sum of One Hundred Thousand 4463 Dollars (\$100,000.00), conditioned for the faithful and impartial 4464 discharge of the duties of the office. The premium on the bond 4465 shall be paid as provided by law out of funds appropriated to the 4466 Division of Medicaid for contractual services.
- 4467 The executive director, with the approval of the Governor and subject to the rules and regulations of the State 4468 4469 Personnel Board, shall employ such professional, administrative, 4470 stenographic, secretarial, clerical and technical assistance as 4471 may be necessary to perform the duties required in administering 4472 this article and fix the compensation for those persons, all in 4473 accordance with a state merit system meeting federal requirements. 4474 When the salary of the executive director is not set by law, that 4475 salary shall be set by the State Personnel Board. No employees of 4476 the Division of Medicaid shall be considered to be staff members of the immediate Office of the Governor; however, Section 4477 25-9-107(c)(xv) shall apply to the executive director and other 4478 administrative heads of the division. 4479

4480	(3) (a) There is established a Medical Care Advisory
4481	Committee, which shall be the committee that is required by
4482	federal regulation to advise the Division of Medicaid about health
4483	and medical care services.

- 4484 (b) The advisory committee shall consist of not less 4485 than eleven (11) members, as follows:
- 4486 (i) The Governor shall appoint five (5) members,
  4487 one (1) from each congressional district and one (1) from the
  4488 state at large;
- 4489 (ii) The Lieutenant Governor shall appoint three 4490 (3) members, one (1) from each Supreme Court district;
- 4491 (iii) The Speaker of the House of Representatives 4492 shall appoint three (3) members, one (1) from each Supreme Court 4493 district.
- All members appointed under this paragraph shall either be health care providers or consumers of health care services. One (1) member appointed by each of the appointing authorities shall be a board-certified physician.
- (c) The respective Chairmen of the House Medicaid

  Committee, the House Public Health and Human Services Committee,

  the House Appropriations Committee, the Senate Medicaid Committee,

  the Senate Public Health and Welfare Committee and the Senate

  Appropriations Committee, or their designees, one (1) member of

  the State Senate appointed by the Lieutenant Governor and one (1)

  member of the House of Representatives appointed by the Speaker of

4505 the House, shall serve as ex officio nonvoting members of the 4506 advisory committee.

- 4507 (d) In addition to the committee members required by
  4508 paragraph (b), the advisory committee shall consist of such other
  4509 members as are necessary to meet the requirements of the federal
  4510 regulation applicable to the advisory committee, who shall be
  4511 appointed as provided in the federal regulation.
- 4512 (e) The chairmanship of the advisory committee shall be 4513 elected by the voting members of the committee annually and shall 4514 not serve more than two (2) consecutive years as chairman.
- 4515 (f) The members of the advisory committee specified in paragraph (b) shall serve for terms that are concurrent with the 4516 4517 terms of members of the Legislature, and any member appointed 4518 under paragraph (b) may be reappointed to the advisory committee. 4519 The members of the advisory committee specified in paragraph (b) 4520 shall serve without compensation, but shall receive reimbursement 4521 to defray actual expenses incurred in the performance of committee 4522 business as authorized by law. Legislators shall receive per diem 4523 and expenses, which may be paid from the contingent expense funds 4524 of their respective houses in the same amounts as provided for 4525 committee meetings when the Legislature is not in session.
- 4526 (g) The advisory committee shall meet not less than
  4527 quarterly, and advisory committee members shall be furnished
  4528 written notice of the meetings at least ten (10) days before the
  4529 date of the meeting.

1530	(h) The executive director shall submit to the advisory
1531	committee all amendments, modifications and changes to the state
1532	plan for the operation of the Medicaid program, for review by the
1533	advisory committee before the amendments, modifications or changes
1534	may be implemented by the division.
1535	(i) The advisory committee, among its duties and
1536	responsibilities, shall:
1537	(i) Advise the division with respect to
1538	amendments, modifications and changes to the state plan for the
1539	operation of the Medicaid program;
1540	(ii) Advise the division with respect to issues
1541	concerning receipt and disbursement of funds and eligibility for
1542	Medicaid;
1543	(iii) Advise the division with respect to
1544	determining the quantity, quality and extent of medical care
1545	provided under this article;
1546	(iv) Communicate the views of the medical care
1547	professions to the division and communicate the views of the
1548	division to the medical care professions;
1549	(v) Gather information on reasons that medical
1550	care providers do not participate in the Medicaid program and
1551	changes that could be made in the program to encourage more
1552	providers to participate in the Medicaid program, and advise the
1553	division with respect to encouraging physicians and other medical

care providers to participate in the Medicaid program;

4555	(vi) Provide a written report on or before
4556	November 30 of each year to the Governor, Lieutenant Governor and
4557	Speaker of the House of Representatives.
4558	(j) Effective July 9, 2025, there is established a
4559	Medicaid Advisory Committee and Beneficiary Advisory Committee as
4560	required pursuant to federal regulations. The Medicaid Advisory
4561	Committee shall consist of no more than twenty (20) members. All
4562	members of the Medical Care Advisory Committee serving on January

4564 Committee and such members shall serve until July 1, 2028. Such 4565 members shall not be reappointed for immediately successive and

1, 2025, shall be selected to serve on the Medicaid Advisory

- 4566 consecutive terms. If any such member resigns, then the division
- 4567 shall replace the member for the remainder of the term. Other
- 4568 members of the Medicaid Advisory Committee and Beneficiary
- 4569 Advisory Committee shall be selected by the division consistent
- with federal regulations. Committee member terms shall not be 4570
- followed immediately by a consecutive term for the same member, on 4571
- 4572 a rotating and continuous basis.
- 4573 (4)There is established a Drug Use Review Board, which (a)
- 4574 shall be the board that is required by federal law to:
- 4575 (i) Review and initiate retrospective drug use,
- 4576 review including ongoing periodic examination of claims data and
- 4577 other records in order to identify patterns of fraud, abuse, gross
- overuse, or inappropriate or medically unnecessary care, among 4578

4579	physicians	, pharmacists	and	individual	Ls rece	eiving D	Medica	aid
4580	benefits o	r associated	with	specific d	drugs d	or grou	ps of	drugs.

- 4581 (ii) Review and initiate ongoing interventions for 4582 physicians and pharmacists, targeted toward therapy problems or 4583 individuals identified in the course of retrospective drug use 4584 reviews.
- 4585 (iii) On an ongoing basis, assess data on drug use
  4586 against explicit predetermined standards using the compendia and
  4587 literature set forth in federal law and regulations.
- 4588 (b) The board shall consist of not less than twelve 4589 (12) members appointed by the Governor, or his designee.
- 4590 (c) The board shall meet at least quarterly, and board 4591 members shall be furnished written notice of the meetings at least 4592 ten (10) days before the date of the meeting.
- 4593 The board meetings shall be open to the public, 4594 members of the press, legislators and consumers. Additionally, 4595 all documents provided to board members shall be available to 4596 members of the Legislature in the same manner, and shall be made 4597 available to others for a reasonable fee for copying. 4598 patient confidentiality and provider confidentiality shall be 4599 protected by blinding patient names and provider names with 4600 numerical or other anonymous identifiers. The board meetings shall be subject to the Open Meetings Act (Sections 25-41-1 4601 4602 through 25-41-17). Board meetings conducted in violation of this section shall be deemed unlawful. 4603

4604	(5)	(a)	There	is	established	a	Pharmacy	and	Thera	apeutic	S
4605	Committee,	whic	h shal	.l be	e appointed	bу	the Gove	ernor	, or	his	
4606	designee.										

- The committee shall meet as often as needed to 4607 (b) 4608 fulfill its responsibilities and obligations as set forth in this 4609 section, and committee members shall be furnished written notice 4610 of the meetings at least ten (10) days before the date of the 4611 meeting.
- 4612 The committee meetings shall be open to the public, 4613 members of the press, legislators and consumers. Additionally, 4614 all documents provided to committee members shall be available to 4615 members of the Legislature in the same manner, and shall be made 4616 available to others for a reasonable fee for copying. However, patient confidentiality and provider confidentiality shall be 4617 4618 protected by blinding patient names and provider names with 4619 numerical or other anonymous identifiers. The committee meetings 4620 shall be subject to the Open Meetings Act (Sections 25-41-1 4621 through 25-41-17). Committee meetings conducted in violation of 4622 this section shall be deemed unlawful.
- 4623 After a thirty-day public notice, the executive 4624 director, or his or her designee, shall present the division's 4625 recommendation regarding prior approval for a therapeutic class of drugs to the committee. However, in circumstances where the 4626 division deems it necessary for the health and safety of Medicaid 4627 4628 beneficiaries, the division may present to the committee its

4629	recommendations regarding a particular drug without a thirty-day
4630	public notice. In making that presentation, the division shall
4631	state to the committee the circumstances that precipitate the need
4632	for the committee to review the status of a particular drug
4633	without a thirty-day public notice. The committee may determine
4634	whether or not to review the particular drug under the
4635	circumstances stated by the division without a thirty-day public
4636	notice. If the committee determines to review the status of the
4637	particular drug, it shall make its recommendations to the
4638	division, after which the division shall file those
4639	recommendations for a thirty-day public comment under Section
4640	25-43-7(1).

- 4641 Upon reviewing the information and recommendations, 4642 the committee shall forward a written recommendation approved by a 4643 majority of the committee to the executive director, or his or her 4644 designee. The decisions of the committee regarding any 4645 limitations to be imposed on any drug or its use for a specified 4646 indication shall be based on sound clinical evidence found in 4647 labeling, drug compendia, and peer-reviewed clinical literature 4648 pertaining to use of the drug in the relevant population.
- 4649 (f) Upon reviewing and considering all recommendations
  4650 including recommendations of the committee, comments, and data,
  4651 the executive director shall make a final determination whether to
  4652 require prior approval of a therapeutic class of drugs, or modify

4653	existing prior	approval	requirements	for	a	therapeutic	class	of
4654	drugs.							

- 4655 At least thirty (30) days before the executive director implements new or amended prior authorization decisions, 4656 4657 written notice of the executive director's decision shall be 4658 provided to all prescribing Medicaid providers, all Medicaid 4659 enrolled pharmacies, and any other party who has requested the 4660 notification. However, notice given under Section 25-43-7(1) will 4661 substitute for and meet the requirement for notice under this 4662 subsection.
- (h) Members of the committee shall dispose of matters

  4664 before the committee in an unbiased and professional manner. If a

  4665 matter being considered by the committee presents a real or

  4666 apparent conflict of interest for any member of the committee,

  4667 that member shall disclose the conflict in writing to the

  4668 committee chair and recuse himself or herself from any discussions

  4669 and/or actions on the matter.
- 4670 **SECTION**  $\underline{20}$ . This act shall take effect and be in force from 4671 and after its passage.